MILLIMAN CLIENT REPORT

Behavioral Health Encounter Data Quality Methodology and Instructions – SFY 2025 Period 1

State of Michigan, Department of Health and Human Services

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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 a reporting template for the Encounter Quality Initiative (EQI), which includes 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 one exception is non-Medicaid SUD services provided outside of the CCBHC demonstration, which are not required to be reported in the EQI for SFY 2025 Period 1 (SFY 2025 P1). If the PIHP or CMHSP chooses to report SUD non-managed care services in the EQI for SFY 2025 P1, it should be added to the *Notes* tab that they are doing so.

The following provides 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.

For the purposes of this analysis, each CMHSP and PIHP will submit the information as requested above to MDHHS. Figure 1 includes the timing for each of the steps in the SFY 2025 P1 Behavioral Health EQI process. Encounters will be pulled for purposes of the EQI comparison using the April 3rd data extract, with future extracts being used for purposes of capitation rate setting.

FIGURE 1: SFY 2025 P1 BH EQI SCHEDULE

BH EQI PROCESS STEP	DEADLINE
Template provided to PIHPs and CMHSPs	First business day in April
Milliman detailed encounter provided by DHHS to PIHPs	April 3rd extract by April 15th or next business day
Detailed encounter corrections due	Last business day in April
Optum data to Milliman	May 3rd
PIHPs submit reports to DHHS	Last business day in May
Milliman delivers utilization comparison to PIHPs via DRIVE	First business day in July
Response to observations due to DHHS, explaining variances/questions/or corrective action plans as appropriate	Last business day in July

To aid in the validation of encounter data, we are 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 hosted by Milliman where MDHHS and the PIHPs can access 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.

The EQI Data Collection Tool provides a pre-populated template for each CMHSP and PIHP to summarize and submit their understanding of the Medicaid utilization and expenditures 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 other-funded (e.g., via grants) services. The CMHSP template includes the Medicaid behavioral health, non-managed care General Fund, and other-funded populations and services. The dual CMHSP/PIHP template includes all populations included in either the PIHP or CMHSP templates.

For purposes of SFY 2025 P1, non-managed care SUD services provided at a CCBHC demonstration site will be required within EQI reporting. All other non-managed care SUD (i.e., Substance Abuse Prevention and Treatment Block Grant, SUD General Fund, and other non-managed care SUD funds administered in EGrAMS that are reported to the state for the section 904 legislative report) units and costs reporting are consistent with prior periods and are not required within the EQI but can be included. If the PIHP or CMHSP chooses to report SUD non-managed care services in the EQI for SFY 2025 P1, it should be added to the *Notes* tab that they are doing so. We will be working with the EQI Workgroup to determine if and how non-Medicaid SUD units and costs should be included within subsequent EQI reporting.

PIHPs are expected to report encounters for services for which providers were paid (paid claims), third party reimbursed, and/or any services provided directly by the Contractor. Encounter data is collected and reported for every individual for which a claim was adjudicated, or service rendered during the month by the Contractor (directly or via contract) regardless of payment source or funding stream. (MDHHS/PIHP contract 3.1 Project Management Reporting section, Encounter Data Reporting; MDHHS/CMHSP Contract Attachment C6.5.1.1). MDHHS provides additional guidance for CMHSP direct-run services that the scope of encounter reporting includes both encounters for which third party covers 100% of the cost and as well as encounters for which non-MDHHS dollars pay for the service. Currently this guidance does not apply to providers external to the PIHP or CMHSP as MDHHS recognizes that collecting information from external providers when the CMHSP or PIHP has $0 liability to pay may be unduly burdensome.

The EQI Data Collection Tool includes the following tabs to collect cumulative information for the October 2024 to January 2025 time period (SFY 2025 P1) using claims submitted to MDHHS as of March 31, 2025. ***Due to the attestation provided at the entity level, each CMHSP and PIHP will be responsible for submitting their respective report to MDHHS at qmpmeasures@michigan.gov.***

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

- Attestation (Required)
- Service Code Set
- Eligibility and Revenue (Required - Regional PIHP tools only)
- Provider Contract Description (Optional)
- Service UNC (Required)
- Service Cat UNC – CMHSP (Auto-populated in CMHSP and Dual tools, requires input in PIHP tools)
- Service Cat UNC – PIHP (Auto-populated in Regional PIHP tools only)
- Elig Source Summary
- Final DR Clinical CC Summ (Required - CMHSP and Dual CMHSP/PIHP Only)
- COB Summary (Optional)
- Non-Benefit Expenses (Required)
- Other Expenses (Required)
- Spend-Down Summary (Required)
- Financial Reconciliation (Required)
- Notes

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) Waiver for Children with Serious Emotional Disturbance (SEDW), and the 1915(c) Children's Waiver Program(CWP).

Lastly, the templates include a stratification for non-managed care beneficiaries receiving services covered via state *General Fund* as well as all *Other* fund sources and non-managed care services for Medicaid enrollees.

This report contains the instructions to assist the CMHSPs and PIHPs in completing the template with eligibility, revenue, expense, and utilization information for the SFY 2025 P1 behavioral health EQI process. This report also includes the methodology that we will utilize to map 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 monthly.

The *Service Code Set* tab in the EQI Data Collection Tool provides a listing of each service included in Michigan's behavioral 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 *SFY 2025 Behavioral Health Code Charts and Provider Qualifications.xlsx (Updated 12/16/24)* file 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 EQI reporting, the Community Mental Health Association of Michigan is sponsoring a Standard Cost Allocation (SCA) Workgroup, which includes participation from MDHHS and Milliman, to provide further guidance to the field regarding the EQI reporting requirement. One of the goals of this Standard Cost Allocation Workgroup that relates to the 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 provider administration, or managed care administrative expenses.

In SFY 2025, we anticipate that some CMHSPs and PIHPs will complete the EQI template using existing methodologies to allocate administrative costs while others have transitioned to using the SCA methodology. An input has been added to the *Attestation* tab to document whether the SCA methodology was followed to complete SFY 2025 EQI reporting.

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 Cat UNC – CMHSP* tab includes a reporting split to capture expenses from all the CMHSPs in their region. Services contracted through the PIHP and not the CMHSP should be entered in the *Service UNC* tab and the *Service Cat UNC – PIHP* tab.
    - Following validation of encounter data, Regional PIHPs are instructed to input the *Service Cat UNC – CMHSP* tab from each CMHSP template into the PIHPs *Service Cat UNC – CMHSP* tab.
    - The *Service UNC* tab of Regional PIHPs is limited to Services Contracted through the PIHP.
- CMHSP templates collect expense information for the Medicaid, General Fund, and Other funded beneficiaries.
- Dual CMHSP/PIHP templates are consistent with all other CMHSP templates.

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

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 individual's 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 without a capitation payment 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 2 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 2: 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 3 provides the applicable qualifying eligibility program codes to identify the DAB population separately from the TANF population for purposes of EQI reporting splits required in SFY 2025.

FIGURE 3: ELIGIBILITY PROGRAM CODE MAPPING

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

Although the MI Health Link program enrollees are not separately identified in the EQI, 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 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 capitation and Medicaid eligibility files based on the fields provided in Figure 4 below. This shows eligibility based on county of residence as well as the PIHP that received a capitation payment for the beneficiary. The PIHP for the HSW population is assigned using CONTRACTOR ID. 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 1915(c) waiver and 1915(c) non-waiver individuals.

- The COFR PIHP is anticipated to continue submitting encounters in SFY 2025 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 future EQI data validation.

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 4 outlines the data field used by Milliman for identifying PIHP for each of the applicable data feeds.

FIGURE 4: 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). 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. Using the 270/271 data is considered a "last resort" option, as Milliman does not have access to the files, and therefore the 270/271 files will not be utilized in EQI reporting and reconciliation.

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 11, 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" from the 834.
    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 7 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 this template 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 should be considered and reflected on the *Service UNC* tab**:
    a. 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 SEDW).
    b. 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.

12. Based on discussions with the EQI workgroup, the following overrides may be necessary for encounters reflecting Medicaid services provided to Medicaid beneficiaries but covered by other funding sources (i.e., they were identified as Medicaid using the logic described above and reported as such on the *Service UNC* tab, but they were not funded by Medicaid). These units and expenditures should be reported based on the logic above in the Service UNC, and then the funding source can be adjusted on the *Financial Reconciliation* tab using the following overrides. These override reconciling items will net zero expenditures between all fund sources as this reconciliation illustrates a shift of funds.
    a. Fund source overrides due to services provided in jail
    b. Fund source overrides due to other reasons
        i. Example 1. To follow Medicaid billing rules and other federal regulations should be input as *General Fund expenditures for services not billable due to an exception*
            1. 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 will require an override.
        ii. Example 2. Grant identification
            1. Services that are only partially paid for by grants should retain the program and population assigned from the eligibility file, with expenditures shifting from Medicaid or General Fund to the Grant (i.e., Other) fund source using the *Expenditures for services covered by Grant Funding* reconciling item on the *Financial Reconciliation* tab.

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 Cat UNC tabs

PIHPs can paste in each of the CMHSP values from each respective *Service Cat UNC – CMHSP* tab after validating the Medicaid information. General Fund and Grant utilization 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.

Other Expenses

For the Medicaid and HMP expense category rows, the PIHP should summarize the applicable information reported from each CMHSP and then add in any additional Other Expenses incurred by the PIHP outside of the CMHSP contracts. Any additional Other Expenses incurred by the PIHP outside of the CMHSP contracts should be included in the Other fund source column of the *Other Expense* tab.

IV. Methodology and Instructions

The following sections provide the methodology and instructions for completing each of the tabs included in the template and information on the detailed encounters data extract.

Attestation (Required)

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.

Service Code Set (No User Inputs)

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 HCPCS 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, SUD, or CCBHC – this column represents which benefit the service will be allocated to for purposes of capitation rate development. Note, if a claim line has a CCBHC service code, has a T1040 on the claim, and was provided by a CCBHC (based on billing NPI) then it is marked as a CCBHC claim.
- 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.

Eligibility and Revenue (Required for PIHP and Dual CMHSP/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 10 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
- CCBHC Supplemental Revenue
- 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’).

Provider Contract Description (Optional)

The purpose of this tab is to provide extra detail on the contracted non-fee-for-service providers. This tab stratifies total Medicaid/HMP dollars by provider. CMHSPs and PIHPs are meant to split out these expenditures by the provider they are attributable to and provide detail on the contract type, which can be selected from a series of options in a drop down. The total amount entered in the "Total Medicaid/HMP Dollars Captured by Contract" column should match exactly the amount entered in the "Contracted Provider Net Expenditures (Non-FFS)" column on the [Service UNC] tab.

Non-fee-for-service payments should be defined as any form of payment that is not strictly a service expenditure paid at a fee schedule rate to a provider. This includes alternative payment methods such as:

- Case Rates
- Value-Based Purchasing
- Sub-Capitation
- Bonus Payments
- Staffing Grants
- Bundled Payments
- Prospective Payments
- Other

In the case of incentives, bonuses, and withholds being paid at a service level, but in addition to the base fee-for-service payment, please enter those expenditures on the [Other Expenses] tab in the "Incentives, Bonuses, Withholds, and Other Settlements Paid to Providers" row.

Service UNC (Required)

The purpose of this tab is to capture the utilization and net expenditures for each service code, program, and population combination. 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 an elig/service 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). We also have provided lines for reporting of costs for services related to mental health or substance use disorder versus the Section 223 Certified Community Behavioral Health Clinic (CCBHC) Demonstration. MH and SUD services will be identified using member ID type 88/89 and the CCBHC services are identified by having a T1040 claim line.

Please note the MH and SUD rows in the Service UNC tab have been consolidated into MH/SUD rows. This reduces the total number of rows within the Service UNC tab and reduces the level of granularity at which PIHPs and CMHSPs report non-CCBHC services. The PIHP/CMHSP should report any costs incurred under either MH or SUD funding under the MH/SUD row for that particular service.

Please note it is optional to split contracted expenditures and units on the Service UNC tab by non-FFS arrangements and FFS arrangements. This split is in an effort to understand potential layered on expenditures and units that occur with non-FFS contracted arrangements. The expenditures entered in the "Contracted Provider Net Expenditures (Non-FFS)" column should match in total the "Total Medicaid/HMP Dollars Captured by Contract" of the [Provider Contract Description] tab.

The CMHSP/PIHP should report the utilization 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. For CCBHC rows, Designated Collaborating Organization (DCO) units and corresponding expenses should be reported under the Network Provider column. We will be identifying a CMHSP Direct-Run service if the Billing Provider NPI is the CMHSP for non-CCBHC encounters. Reference C provides a list of NPIs that are classified as Direct-Run for each CMHSP.
3. Summarize units from the encounter claim file by the Service Code Index, Program, Population, MH/SUD/CCBHC, and whether the service is CMHSP Direct-Run or a Contracted through a Network Provider.

The *Service UNC* tab holds several rows with an Elig/Fund Source of "Non-Medicaid" and a Program of "Medicaid". In these instances, the Elig/Fund Source indicates that the service is not covered by Medicaid because it is not a Medicaid service. For example, 92627 is listed in the *Service Code Set* tab as not having State Plan coverage or 1915(i) coverage, meaning it is not a Medicaid service (except for 1915(c) CWP enrollees). However, the Program of eligibility for the individual receiving this service can still be "Medicaid" under the DAB or TANF populations.

Utilization and net expenditures should be reported for services provided by a CMHSP separately from other services contracted through a mental health and substance abuse network provider. For CCBHC services, the contracted network provider columns should be leveraged for DCO service utilization and cost.

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

- Other population rows of the *Service UNC* tab (if covering the full cost of the service)
- Other population rows of the *Non-Benefit Expenses* tab
- Other fund source column of the *Other Expense* tab
- Other fund source column of the *Financial Reconciliation* tab for the row entitled *Expenditures for services covered by Grant Funding*

The CMHSP and dual CMHSP/PIHP template includes all the managed care populations as well as rows for general fund and other fund sources. The regional PIHP only includes rows for services contracted through the PIHP (other than the CMHSP) for all Medicaid managed care and Other fund sources.

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 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.

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 *SFY 2025 Behavioral Health Code Charts and Provider Qualifications.xlsx*[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 units and expenditures, net of COB, should be reported in the applicable CMHSP Direct-Run or Contracted 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 "Elig/Service 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/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

[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**.

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 several 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). Since HRA is available only at the Medicaid level, payments should be split between DAB and TANF based on the proportional expenditures reported in the *Service UNC* tab. 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 (H0038SUD rows), 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 into one row.

I. Several codes have rows without modifiers as well as rows with modifiers: for example, 90849 (UN modifier used to distinguish when 2 patients are served), H0031 (WY 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 for the modified procedures into one row.

J. Enter the total net 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.

K. The net cost per unit will be automatically calculated by dividing the net expenditures 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 net 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 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/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

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, units, 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, units, and costs for Intermediate Care Facilities for Intellectual and Development Disability (ICF/MR) was retired in SFY16.

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 *Notes* tab. These are typically additional activities provided to individual consumers for which CMHSPs use general funds.

Service Cat UNC – CMHSP (Required)

This tab summarizes the data submitted into the *Service UNC* tab at the service category level. The CMHSP and dual CMHSP/PIHP template includes all the managed care populations as well as rows for Other and general fund services. The CMHSP and dual CMHSP/PIHP template does not require any input in the *Service Cat UNC – CMHSP* tab because it is automatically calculated. This information is intended to be incorporated by the regional PIHPs into their respective EQI template (i.e., the regional PIHP copies values from the *Service Cat UNC – CMHSP* tab of each CMHSP template and pastes them into the *Service Cat UNC – CMHSP* tab of the PIHP template under the corresponding rows of that CMHSP.

Service Cat UNC – PIHP (No User Input)

The regional PIHP template includes a second version of the *Service Cat UNC* tab that summarizes data submitted for services contracted through the PIHP. This *Service Cat UNC – PIHP* tab is automatically calculated and does not require any input.

Elig Source Summary – CMHSP (No User Input)

This tab is only on the CMHSP and Dual CMHSP/PIHP templates. This tab summarizes the data submitted into the *Service UNC* tab by Eligibility/Service Source, Program, Population and CCBHC vs. Non-CCBHC. The first table summarizes all non-health home (S0280) services, while the bottom table shows the summary of health home services only. The summary columns correspond exactly with what is on the *Service UNC* tabs. No input is required for this tab, as all information is automatically calculated for reconciliation purposes.

Elig Source Summary – PIHP (No User Input)

This tab is only on the PIHP templates. This tab summarizes the data submitted into the *Service UNC* tab and the *Service Cat UNC – CMHSP* tab by Eligibility/Service Source, Program, Population and CCBHC vs. Non-CCBHC. The first table summarizes all non-health home (S0280) services, while the bottom table shows the summary of health home services only. The summary columns correspond exactly with what is on the *Service UNC* tabs. No input is required for this tab, as all information is automatically calculated for reconciliation purposes.

Final Direct-Run Clinical Cost Center Summary (CMHSP and Dual CMHSP/PIHP Only) (Required)

This tab is meant to be copied and pasted directly from the *Standard Cost Allocation Tool* tab of the same name. If the CMHSP is not utilizing the SCA tool, this tab should be filled out using the tool or methodology that the CMHSP is using to comply with MDHHS' SCA requirements.

COB Summary (Optional)

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, HMP, General Fund, and Other). We have included common payers and have also allowed users to attribute COB revenue to additional payers for both direct-run and contracted expenditures. The COB entries are meant to reflect net costs, so the COB payments should be reduced by any write-offs to reflect the total net costs. A row has also been included to capture any incurred but not reported (IBNR) COB revenue that is expected to be collected. We also have split this tab by CCBHC and Non-CCBHC expenditures.

Reporting of PA 423 Transferred Funds

Due to ongoing discussions for COB reporting, service level expenditures are to be reported on a net cost basis. With expenditures being reported on a net cost basis, reporting of PA 423 transferred funds has been moved to a reconciling item within the *Financial Reconciliation* tab and is no longer included on the *COB Summary* tab.

Non-Benefit Expenses (Required)

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.
- **Hospital Reimbursement Adjustment (HRA)** - MDHHS maintains a hospital rate adjustment (HRA) program, which increases funding to hospitals for inpatient psychiatric treatment. The goal of the HRA is to sustain community psychiatric inpatient capacity and remove Medicaid access barriers. The HRA expenditures by 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). Since HRA is available only at the Medicaid level, payments should be split between DAB and TANF based on the proportional expenditures reported in the *Service UNC* tab.

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 other subcontractors 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 plus any other subcontractor non-benefit expenses. Both retained and delegated expenses can be transferred to the CCBHC columns of the *Financial Reconciliation* tab by using the Reconciling Items rows included.

Other Expenses (Required)

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* tab**. 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 on the *Notes* tab. 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. Provider stability expenses not associated with service utilization.
H. 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). Administrative health home expenses should correspond to the 20% of health home revenues retained by the PIHP.
I. Michigan Rehabilitation Services (MRS), MRS Cash Match.
J. PASARR (not reported as encounter or claim).
K. Other Grant expenses associated with MH grants.
L. Room & Board (not reported in S9976) funded by grants or general funds.
M. Laboratory Procedures.
N. Local Match for State Psychiatric Inpatient.
O. DHS Worker for eligibility determination.
P. Transportation (not reported as encounter or claim).
Q. Prior year adjustments.
R. Jail Treatment Services - Not Embedded in General Fund Service Cost.
S. Mental Health Code Functions, separately for Medicaid and General Fund.
    a. Jail Diversion
    b. Recipient Rights Process
    c. Other MH Code Functions (specify in notes)
T. Injectable Medications (not reported as encounter or claim).
U. General Fund expenditures on Supportive Innovation Grant.
V. Other General Fund or Grant expenses for costs associated with services in which an encounter was not submitted.
    a. The *Other Expenses* tab for both PIHP and CMHSP entities includes lines for both General Fund and Grant costs associated with encounterable services where an encounter was not submitted.
W. CCBHC Section 223 Demo Expenses not included on *Service UNC* tab.
    a. Note, the *Financial Reconciliation* tab transfers these expenditures to the applicable “CCBHC” columns, despite being reported as Medicaid/HMP on this tab.

Spend-Down Summary (Required)

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*.

Financial Reconciliation (Required)

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). The pre-determined reconciling items are as follows:

- PA 423 Transfer.
- Payments (or Receipts) Related to ISF.
- Expenditures for services covered by Grant Funding.
- Expenditures for services covered by General Fund.
- Jail Service Overrides.
- Other Service Overrides.
- CCBHC PPS vs Expense Adjustment.
- Transportation reported and billed separately.

Also note the regional PIHP templates separately identify CMHSP General Fund expenditures reported on the *Service UNC* tab and exclude these expenditures from the *Grand Total PIHP Expenses*.

This tab has columns split out for CCBHC expenditures and revenue. For certain items, such as non-benefit expenses, the reconciling items section can be used to transfer expenses from Non-CCBHC columns to CCBHC columns. Additionally, this tab transfers the CCBHC Section 223 row from *Other Expenses – PIHP* tab from the Medicaid/HMP columns to the applicable CCBHC columns.

Additionally, health home is included on this tab, but is identified separately from all other items in each section. The purpose behind this decision is due to health home being excluded from the FSR comparison.

V. Detailed Encounter Extract

MDHHS provides a detailed encounter data extract at the beginning of each EQI cycle to support CMHSPs and PIHPs with submitting complete and accurate EQI reports and encounter data. These extracts will be made available for each PIHP based on encounter data submitted by each PIHP into MDHHS' data warehouse consistent with the schedule outlined in Figure 1. Reference D contains a full list of fields in the detailed encounters extract. The following sections provide additional information on fields created by Milliman for this extract.

Paid

The following outlines how the paid field is created.

1. The paid field is determined either at a header or claim line detail level, indicated by the DollarFlag field (also included in data extract):
    a. For each claim line if Invoice_Type is not equal to "I" and HEADER_FROM_SVC_DATE and HEADER_TO_SVC_DATE are not the same month then DollarFlag is assigned "Line".
    b. If the header amount (described below) is not equal to 0 and the line amount (described below) equals 0 then DollarFlag is assigned "Header".
    c. For all other claim lines, DollarFlag is assigned "Line".
2. If DollarFlag equals "Header" then paid equals sum of HEADER_OTH_PAYER_COB_PAID_AMT and HEADER_OTH_PAYER_ADJ_AMT_X when HEADER_OTH_PAYER_ADJ_REASON_X equals "24" or "104".
    a. The Header amount is allocated to each claim line based on the proportion of the total billed amount.
3. If DollarFlag equals "Line" then paid equals the sum of LINE_OTH_PAYER_PAID_AMT and LINE_OTH_PAYER_ADJ_AMT_X when LINE_OTH_PAYER_ADJ_REASON_X equals "24" or "104".

EQI Population

This field corresponds to "Population" in *Service UNC* tab of the EQI template and is calculated consistent with the population methodology described in the Mater Eligibility File Logic section.

Please note that Milliman does distinguish between "General Fund" and "Other" populations in the detailed encounters. These populations would make up the "Non-Medicaid" portion of the EQI Population field.

Program

This field corresponds to "Program" in *Service UNC* tab of the EQI template. The following outlines how the field is created.

1. If EQ Population is not "Non-Medicaid" or "HMP" then Program equals "Medicaid".
2. If EQI Population is "Non-Medicaid" then Program equals "Non-Managed Care".
3. If EQI Population is "HMP" then Program equals "HMP".

Elig_Service_Source

Elig_service_Source corresponds to "Elig/Service Source" column in *Service UNC* tab of the EQI template. The following outlines how the field is created.

1. If the Member is "Non-Medicaid", then it is equal to "Non-Medicaid".
2. If the service code and Member is CWP/SED/HSW eligible then Elig_Service_Source is "1915(c)".
3. Otherwise, if the encounter has a service code that is listed as not state plan or 1915(i) in the *Service Code Set* tab or the member is not Medicaid eligible then it is equal to "Non-Medicaid".
4. All other encounters are listed as "Medicaid".

Full_service_Code_EQI

This field corresponds to the Service Code Index on the *Service UNC* tab in the EQI template. It is calculated by matching the HCPCS, modifiers, revenue code, and/or hospital type on the encounter to a service code in the *Service Code Set* tab in the EQI template. Reference B contains a crosswalk of possible modifier combinations and how they will be mapped to the correct modifier order for reporting purposes.

Jail Flag

This field identifies services that were provided in a jail setting. Encounters with a "QJ" modifier or a FACILITY_TYPE_CODE of "09" are considered services provided in a jail setting. Please note that in the detailed encounters, jail services are not automatically considered non-Medicaid to align with the Service UNC expectations.

Override Reason

This field provides brief reason as to why an encounter is "Non-Managed Care" or "Non-Medicaid". For example, if the beneficiary of the claim does not have a matching eligibility or capitation record the claim is considered "Non-Managed Care" and the override reason is set to "No Eligibility record". Other reasons include the claim does not have a beneficiary with an eligible benefit plan or capitation payment. Please note that if the beneficiary has an eligible benefit plan or capitation payment they will be list as "BH Managed Care" and will have an override reason of "N/A".

LOCUS Related Fields

Level of Care Utilization System (LOCUS) scores and other related fields will be included in the detailed data extract. These fields are derived from Behavioral Health Treatment Episode Data Set (BH-TEDS) admission and discharge data submitted into MDHHS' data warehouse. The following is a brief description of each field.

- LOCUS Score – The composite LOCUS score that was current for the associated encounter at the time the encounter was rendered.
- LOCUS From Date – The starting date for when the LOCUS score was current. Based on the estimated LOCUS assessment date.
- LOCUS To Date – The ending date for when the LOCUS score was current. This would be the day before another assessment was completed.
- LOCUS Source – Whether the score was pulled from discharge or admission BH-TEDS data.
- LOCUS Payer ID – The MDHHS-assigned 7-digit ID associated with the PIHP paying for the LOCUS assessment that was current for the associated encounter.

VI. Limitations and Qualifications

The EQI Data Collection Tool and accompanying instructions have been prepared for the internal use of MDHHS along with the intended PIHP recipients. No portion may be provided to or relied upon by any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third-party recipient of its work. Likewise, third parties are instructed that they are to place no reliance upon this tool prepared for MDHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has developed this tool to collect information that will assist MDHHS in calculation and assessment of the Medicaid Encounter Data. We have reviewed the tool, including its inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The tool relies on data and information to be input by the PIHPs. To the extent that the data and information provided in the tool is not accurate or is not complete, the resulting values may likewise be inaccurate or incomplete.

We perform a limited review of the data used directly in our analysis for reasonableness and consistency to identify material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Qualifications:
Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors/creators of the EQI Data Collection Tool and accompanying instructions are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses associated with this communication.

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 2025 Modifier Crosswalk Reference B	
EQI Reporting Modifier Combination	**Possible Encounter Reporting Modifier Combinations**
HGTS	HGTS
HGTS	TSHG
HTY4	HTY4
HTY4	Y4HT
QJ1Y	1YQJ
QJ1Y	QJ1Y
QJ2Y	2YQJ
QJ2Y	QJ2Y
QJ3Y	3YQJ
QJ3Y	QJ3Y
QJ4Y	4YQJ
QJ4Y	QJ4Y
QJ6Y	6YQJ
QJ6Y	QJ6Y
QJUJ	QJUJ
QJUJ	UJQJ
STQJ	QJST
STQJ	STQJ
TSQJ	QJTS
TSQJ	TSQJ
TSY4	TSY4
TSY4	Y4TS
UJY4	UJY4
UJY4	Y4UJ
UNQJ	QJUN
UNQJ	UNQJ
UNST	STUN
UNST	UNST
UNUJ	UJUN
UNUJ	UNUJ
UNWX	UNWX
UNWX	WXUN
UNWZ	UNWZ
UNWZ	WZUN
UNY2	UNY2
UNY2	Y2UN
UNY3	UNY3
UNY3	Y3UN
UNY4	UNY4
UNY4	Y4UN
UPQJ	QJUP
UPQJ	UPQJ

State of Michigan, Department of Health and Human Services Behavioral Health EQI Data Collection Tool SFY 2025 Modifier Crosswalk Reference B	
EQI Reporting Modifier Combination	**Possible Encounter Reporting Modifier Combinations**
UPST	STUP
UPST	UPST
UPUJ	UJUP
UPUJ	UPUJ
UPWX	UPWX
UPWX	WXUP
UPWZ	UPWZ
UPWZ	WZUP
UPY2	UPY2
UPY2	Y2UP
UPY3	UPY3
UPY3	Y3UP
UPY4	UPY4
UPY4	Y4UP
UQQJ	QJUQ
UQQJ	UQQJ
UQST	STUQ
UQST	UQST
UQUJ	UJUQ
UQUJ	UQUJ
UQWX	UQWX
UQWX	WXUQ
UQWZ	UQWZ
UQWZ	WZUQ
UQY2	UQY2
UQY2	Y2UQ
UQY3	UQY3
UQY3	Y3UQ
UQY4	UQY4
UQY4	Y4UQ
URQJ	QJUR
URQJ	URQJ
URST	STUR
URST	URST
URUJ	UJUR
URUJ	URUJ
URWX	URWX
URWX	WXUR
URWZ	URWZ
URWZ	WZUR
URY2	URY2
URY2	Y2UR

State of Michigan, Department of Health and Human Services Behavioral Health EQI Data Collection Tool SFY 2025 Modifier Crosswalk Reference B	
EQI Reporting Modifier Combination	**Possible Encounter Reporting Modifier Combinations**
URY3	URY3
URY3	Y3UR
URY4	URY4
URY4	Y4UR
USQJ	QJUS
USQJ	USQJ
USST	STUS
USST	USST
USUJ	UJUS
USUJ	USUJ
USWX	USWX
USWX	WXUS
USWZ	USWZ
USWZ	WZUS
USY2	USY2
USY2	Y2US
USY3	USY3
USY3	Y3US
USY4	USY4
USY4	Y4US
W1Y4	W1Y4
W1Y4	Y4W1
W3Y4	W3Y4
W3Y4	Y4W3
W5Y4	W5Y4
W5Y4	Y4W5
W7Y4	W7Y4
W7Y4	Y4W7
WZY4	WZY4
WZY4	Y4WZ
Y41Y	1YY4
Y41Y	Y41Y
Y42Y	2YY4
Y42Y	Y42Y
Y43Y	3YY4
Y43Y	Y43Y
Y44Y	4YY4
Y44Y	Y44Y
UNQJUJ	QJUJUN
UNQJUJ	QJUNUJ
UNQJUJ	UJQJUN
UNQJUJ	UJUNQJ

State of Michigan, Department of Health and Human Services Behavioral Health EQI Data Collection Tool SFY 2025 Modifier Crosswalk Reference B	
EQI Reporting Modifier Combination	**Possible Encounter Reporting Modifier Combinations**
UNQJUJ	UNQJUJ
UNQJUJ	UNUJQJ
UNSTQJ	QJSTUN
UNSTQJ	QJUNST
UNSTQJ	STQJUN
UNSTQJ	STUNQJ
UNSTQJ	UNQJST
UNSTQJ	UNSTQJ
UNUJY4	UJUNY4
UNUJY4	UJY4UN
UNUJY4	UNUJY4
UNUJY4	UNY4UJ
UNUJY4	Y4UJUN
UNUJY4	Y4UNUJ
UNWZY4	UNWZY4
UNWZY4	UNY4WZ
UNWZY4	WZUNY4
UNWZY4	WZY4UN
UNWZY4	Y4UNWZ
UNWZY4	Y4WZUN
UPQJUJ	QJUJUP
UPQJUJ	QJUPUJ
UPQJUJ	UJQJUP
UPQJUJ	UJUPQJ
UPQJUJ	UPQJUJ
UPQJUJ	UPUJQJ
UPSTQJ	QJSTUP
UPSTQJ	QJUPST
UPSTQJ	STQJUP
UPSTQJ	STUPQJ
UPSTQJ	UPQJST
UPSTQJ	UPSTQJ
UPUJY4	UJUPY4
UPUJY4	UJY4UP
UPUJY4	UPUJY4
UPUJY4	UPY4UJ
UPUJY4	Y4UJUP
UPUJY4	Y4UPUJ
UPWZY4	UPWZY4
UPWZY4	UPY4WZ
UPWZY4	WZUPY4
UPWZY4	WZY4UP

State of Michigan, Department of Health and Human Services Behavioral Health EQI Data Collection Tool SFY 2025 Modifier Crosswalk Reference B	
EQI Reporting Modifier Combination	**Possible Encounter Reporting Modifier Combinations**
UPWZY4	Y4UPWZ
UPWZY4	Y4WZUP
UQQJUJ	QJUJUQ
UQQJUJ	QJUQUJ
UQQJUJ	UJQJUQ
UQQJUJ	UJUQQJ
UQQJUJ	UQQJUJ
UQQJUJ	UQUJQJ
UQSTQJ	QJSTUQ
UQSTQJ	QJUQST
UQSTQJ	STQJUQ
UQSTQJ	STUQQJ
UQSTQJ	UQQJST
UQSTQJ	UQSTQJ
UQUJY4	UJUQY4
UQUJY4	UJY4UQ
UQUJY4	UQUJY4
UQUJY4	UQY4UJ
UQUJY4	Y4UJUQ
UQUJY4	Y4UQUJ
UQWZY4	UQWZY4
UQWZY4	UQY4WZ
UQWZY4	WZUQY4
UQWZY4	WZY4UQ
UQWZY4	Y4UQWZ
UQWZY4	Y4WZUQ
URQJUJ	QJUJUR
URQJUJ	QJURUJ
URQJUJ	UJQJUR
URQJUJ	UJURQJ
URQJUJ	URQJUJ
URQJUJ	URUJQJ
URSTQJ	QJSTUR
URSTQJ	QJURST
URSTQJ	STQJUR
URSTQJ	STURQJ
URSTQJ	URQJST
URSTQJ	URSTQJ
URUJY4	UJURY4
URUJY4	UJY4UR
URUJY4	URUJY4
URUJY4	URY4UJ

State of Michigan, Department of Health and Human Services Behavioral Health EQI Data Collection Tool SFY 2025 Modifier Crosswalk Reference B	
EQI Reporting Modifier Combination	**Possible Encounter Reporting Modifier Combinations**
URUJY4	Y4UJUR
URUJY4	Y4URUJ
URWZY4	URWZY4
URWZY4	URY4WZ
URWZY4	WZURY4
URWZY4	WZY4UR
URWZY4	Y4URWZ
URWZY4	Y4WZUR
USQJUJ	QJUJUS
USQJUJ	QJUSUJ
USQJUJ	UJQJUS
USQJUJ	UJUSQJ
USQJUJ	USQJUJ
USQJUJ	USUJQJ
USSTQJ	QJSTUS
USSTQJ	QJUSST
USSTQJ	STQJUS
USSTQJ	STUSQJ
USSTQJ	USQJST
USSTQJ	USSTQJ
USUJY4	UJUSY4
USUJY4	UJY4US
USUJY4	USUJY4
USUJY4	USY4UJ
USUJY4	Y4UJUS
USUJY4	Y4USUJ
USWZY4	USWZY4
USWZY4	USY4WZ
USWZY4	WZUSY4
USWZY4	WZY4US
USWZY4	Y4USWZ
USWZY4	Y4WZUS

REFERENCE C – DIRECT-RUN NPI LIST

State of Michigan, Department of Health and Human Services
Behavioral Health EQI Data Collection Tool
Direct-Run NPI List
Reference C

PIHP	CMH	NPI
NorthCare Network	Copper Country CMH Services	1205023652
NorthCare Network	Copper Country CMH Services	1225391584
NorthCare Network	Copper Country CMH Services	1306164017
NorthCare Network	Copper Country CMH Services	1760679112
NorthCare Network	Copper Country CMH Services	1780871137
NorthCare Network	Copper Country CMH Services	1881607497
NorthCare Network	Gogebic CMH Authority	1396396180
NorthCare Network	Gogebic CMH Authority	1912957143
NorthCare Network	Hiawatha Behavioral Health	1629161567
NorthCare Network	Northpointe Behavioral Healthcare Systems	1235398314
NorthCare Network	Northpointe Behavioral Healthcare Systems	1457519852
NorthCare Network	Pathways Community Mental Health	1134939929
NorthCare Network	Pathways Community Mental Health	1205953890
NorthCare Network	Pathways Community Mental Health	1326370107
NorthCare Network	Pathways Community Mental Health	1346874708
NorthCare Network	Pathways Community Mental Health	1447616073
NorthCare Network	Pathways Community Mental Health	1457680357
NorthCare Network	Pathways Community Mental Health	1477817286
NorthCare Network	Pathways Community Mental Health	1487683546
NorthCare Network	Pathways Community Mental Health	1922431691
Northern Michigan Regional Entity	AuSable Valley CMH Authority	1417011701
Northern Michigan Regional Entity	Centra Wellness Network	1063581205
Northern Michigan Regional Entity	Centra Wellness Network	1366806432
Northern Michigan Regional Entity	Centra Wellness Network	1699814905
Northern Michigan Regional Entity	North Country CMH Authority	1053474015
Northern Michigan Regional Entity	North Country CMH Authority	1366760381
Northern Michigan Regional Entity	North Country CMH Authority	1881060549
Northern Michigan Regional Entity	Northeast Michigan CMH Authority	1144378381
Northern Michigan Regional Entity	Northeast Michigan CMH Authority	1508180662
Northern Michigan Regional Entity	Northern Lakes CMH Authority	1417481136
Northern Michigan Regional Entity	Northern Lakes CMH Authority	1508967068
Northern Michigan Regional Entity	Northern Lakes CMH Authority	1518068071
Northern Michigan Regional Entity	Northern Lakes CMH Authority	1598844771
Northern Michigan Regional Entity	Northern Lakes CMH Authority	1669572657
Northern Michigan Regional Entity	Northern Lakes CMH Authority	1831599133
Lakeshore Regional Entity	Allegan County CMH Services	1215989231
Lakeshore Regional Entity	Allegan County CMH Services	1477955920
Lakeshore Regional Entity	Allegan County CMH Services	1528570322
Lakeshore Regional Entity	CMH of Ottawa County	1023159928
Lakeshore Regional Entity	CMH of Ottawa County	1033429147
Lakeshore Regional Entity	CMH of Ottawa County	1205155454
Lakeshore Regional Entity	CMH of Ottawa County	1275148843
Lakeshore Regional Entity	CMH of Ottawa County	1346232741
Lakeshore Regional Entity	CMH of Ottawa County	1376875229
Lakeshore Regional Entity	CMH of Ottawa County	1497763965
Lakeshore Regional Entity	CMH of Ottawa County	1619932381
Lakeshore Regional Entity	CMH of Ottawa County	1669514303
Lakeshore Regional Entity	CMH of Ottawa County	1679653422
Lakeshore Regional Entity	CMH of Ottawa County	1811229768
Lakeshore Regional Entity	CMH of Ottawa County	1811500812
Lakeshore Regional Entity	CMH of Ottawa County	1811901192
Lakeshore Regional Entity	CMH of Ottawa County	1871780080
Lakeshore Regional Entity	CMH of Ottawa County	1952620106
Lakeshore Regional Entity	HealthWest	1003914946
Lakeshore Regional Entity	HealthWest	1053490813
Lakeshore Regional Entity	HealthWest	1366879892
Lakeshore Regional Entity	HealthWest	1427604396
Lakeshore Regional Entity	HealthWest	1447789862

State of Michigan, Department of Health and Human Services
Behavioral Health EQI Data Collection Tool
Direct-Run NPI List
Reference C

PIHP	CMH	NPI
Lakeshore Regional Entity	HealthWest	1548589443
Lakeshore Regional Entity	HealthWest	1548753783
Lakeshore Regional Entity	HealthWest	1609332642
Lakeshore Regional Entity	HealthWest	1659440816
Lakeshore Regional Entity	HealthWest	1801176995
Lakeshore Regional Entity	Network180	1134212442
Lakeshore Regional Entity	Network180	1396404588
Lakeshore Regional Entity	Network180	1417276163
Lakeshore Regional Entity	Network180	1588935068
Lakeshore Regional Entity	West Michigan CMH System	1275646309
Lakeshore Regional Entity	West Michigan CMH System	1376017889
Lakeshore Regional Entity	West Michigan CMH System	1437537347
Lakeshore Regional Entity	West Michigan CMH System	1700103488
Lakeshore Regional Entity	West Michigan CMH System	1891833919
Southwest Michigan Behavioral Health	Barry County CMH Authority	1144787979
Southwest Michigan Behavioral Health	Barry County CMH Authority	1245981182
Southwest Michigan Behavioral Health	Barry County CMH Authority	1952357410
Southwest Michigan Behavioral Health	Barry County CMH Authority	1992263586
Southwest Michigan Behavioral Health	Berrien Mental Health Authority d/b/a Riverwood Center	1033280763
Southwest Michigan Behavioral Health	Berrien Mental Health Authority d/b/a Riverwood Center	1235390246
Southwest Michigan Behavioral Health	Berrien Mental Health Authority d/b/a Riverwood Center	1447689518
Southwest Michigan Behavioral Health	Berrien Mental Health Authority d/b/a Riverwood Center	1508801465
Southwest Michigan Behavioral Health	Berrien Mental Health Authority d/b/a Riverwood Center	1760818827
Southwest Michigan Behavioral Health	Community Mental Health & Substance Abuse Services of St. Joseph County	1366438483
Southwest Michigan Behavioral Health	Integrated Services of Kalamazoo	1477225506
Southwest Michigan Behavioral Health	Integrated Services of Kalamazoo	1508613209
Southwest Michigan Behavioral Health	Integrated Services of Kalamazoo	1710066253
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1033146915
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1053348938
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1053357327
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1063471639
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1073661484
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1093751331
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1104970995
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1124055009
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1144257023
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1215964192
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1306076500
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1306873286
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1437613221
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1467826206
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1467889386
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1518338359
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1548083629
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1548205586
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1619304458
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1700162260
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1700185840
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1801264759
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1811933153
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1841916152
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1851328736
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1851687107
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1861430381
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1871520759
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1942237821
Southwest Michigan Behavioral Health	Pines Behavioral Health Services	1962439844
Southwest Michigan Behavioral Health	Summit Pointe	1154815173
Southwest Michigan Behavioral Health	Summit Pointe	1700833555
Southwest Michigan Behavioral Health	Summit Pointe	1881823722

State of Michigan, Department of Health and Human Services
Behavioral Health EQI Data Collection Tool
Direct-Run NPI List
Reference C

PIHP	CMH	NPI
Southwest Michigan Behavioral Health	VanBuren Community Mental Health Authority	1003878554
Southwest Michigan Behavioral Health	VanBuren Community Mental Health Authority	1295097889
Southwest Michigan Behavioral Health	VanBuren Community Mental Health Authority	1780011890
Southwest Michigan Behavioral Health	VanBuren Community Mental Health Authority	1982916045
Southwest Michigan Behavioral Health	Woodlands Behavioral Healthcare Network	1659375293
Mid-State Health Network	Bay-Arenac Behavioral Health Authority	1154439438
Mid-State Health Network	Bay-Arenac Behavioral Health Authority	1912237462
Mid-State Health Network	CMH Authority of Clinton-Eaton-Ingham Counties	1265483457
Mid-State Health Network	CMH for Central Michigan	1336462001
Mid-State Health Network	CMH for Central Michigan	1336467729
Mid-State Health Network	CMH for Central Michigan	1407123482
Mid-State Health Network	CMH for Central Michigan	1609412840
Mid-State Health Network	CMH for Central Michigan	1689992299
Mid-State Health Network	CMH for Central Michigan	1881622892
Mid-State Health Network	Gratiot Integrated Health Network	1285970756
Mid-State Health Network	Gratiot Integrated Health Network	1710049242
Mid-State Health Network	Huron Behavioral Health	1659485514
Mid-State Health Network	Huron Behavioral Health	1669796694
Mid-State Health Network	LifeWays CMH	1043530603
Mid-State Health Network	LifeWays CMH	1063466274
Mid-State Health Network	LifeWays CMH	1154032498
Mid-State Health Network	LifeWays CMH	1265795694
Mid-State Health Network	LifeWays CMH	1891417085
Mid-State Health Network	Montcalm Care Network	1710074448
Mid-State Health Network	Newaygo County Mental Health Center	1184972309
Mid-State Health Network	Newaygo County Mental Health Center	1376512236
Mid-State Health Network	Newaygo County Mental Health Center	1386969996
Mid-State Health Network	Newaygo County Mental Health Center	1740629450
Mid-State Health Network	Saginaw County CMH Authority	1093031791
Mid-State Health Network	Saginaw County CMH Authority	1114110442
Mid-State Health Network	Saginaw County CMH Authority	1235497793
Mid-State Health Network	Saginaw County CMH Authority	1417300393
Mid-State Health Network	Saginaw County CMH Authority	1467778167
Mid-State Health Network	Saginaw County CMH Authority	1477879179
Mid-State Health Network	Saginaw County CMH Authority	1689778953
Mid-State Health Network	Shiawassee Health & Wellness	1174701536
Mid-State Health Network	Shiawassee Health & Wellness	1396923769
Mid-State Health Network	Shiawassee Health & Wellness	1497749279
Mid-State Health Network	Shiawassee Health & Wellness	1790008266
Mid-State Health Network	The Right Door for Hope, Recovery and Wellness	1669795522
Mid-State Health Network	The Right Door for Hope, Recovery and Wellness	1760452122
Mid-State Health Network	Tuscola Behavioral Health Systems	1275644775
Community Mental Health Partnership of Southeast MI	Lenawee CMH Authority	1912227570
Community Mental Health Partnership of Southeast MI	Lenawee CMH Authority	1962576983
Community Mental Health Partnership of Southeast MI	Livingston County CMH Authority	1033437397
Community Mental Health Partnership of Southeast MI	Livingston County CMH Authority	1235457599
Community Mental Health Partnership of Southeast MI	Livingston County CMH Authority	1346313731
Community Mental Health Partnership of Southeast MI	Livingston County CMH Authority	1760615975
Community Mental Health Partnership of Southeast MI	Monroe CMH Authority	1245303890
Community Mental Health Partnership of Southeast MI	Monroe CMH Authority	1366756157
Community Mental Health Partnership of Southeast MI	Washtenaw County CMH	1033412192
Community Mental Health Partnership of Southeast MI	Washtenaw County CMH	1609896018
Community Mental Health Partnership of Southeast MI	Washtenaw County CMH	1639132442
Detroit Wayne Mental Health Authority	Detroit Wayne Integrated Health Network	1497179170
Detroit Wayne Mental Health Authority	Detroit Wayne Integrated Health Network	1558798934
Detroit Wayne Mental Health Authority	Detroit Wayne Integrated Health Network	1609290451
Oakland Community Health Network	Oakland Community Health Network	1851478622
Macomb County C.M.H. Services	Macomb County CMH Services	1033246871
Macomb County C.M.H. Services	Macomb County CMH Services	1033539069
Macomb County C.M.H. Services	Macomb County CMH Services	1134264435

State of Michigan, Department of Health and Human Services
Behavioral Health EQI Data Collection Tool
Direct-Run NPI List
Reference C

PIHP	CMH	NPI
Macomb County C.M.H. Services	Macomb County CMH Services	1134470495
Macomb County C.M.H. Services	Macomb County CMH Services	1144578444
Macomb County C.M.H. Services	Macomb County CMH Services	1255385399
Macomb County C.M.H. Services	Macomb County CMH Services	1548397383
Macomb County C.M.H. Services	Macomb County CMH Services	1568846897
Macomb County C.M.H. Services	Macomb County CMH Services	1730563925
Macomb County C.M.H. Services	Macomb County CMH Services	1770610834
Macomb County C.M.H. Services	Macomb County CMH Services	1851433643
Macomb County C.M.H. Services	Macomb County CMH Services	1871351650
Macomb County C.M.H. Services	Macomb County CMH Services	1891951299
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1043554348
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1093124216
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1093154692
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1134569874
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1205346939
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1295070456
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1396436937
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1548617459
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1629417159
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1659710762
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1669717823
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1710326988
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1730528936
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1851630115
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1891591731
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1962140137
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1962968164
Region 10 Prepaid Inpatient Health Plan	Genesee Health System	1982018610
Region 10 Prepaid Inpatient Health Plan	Lapeer County CMH Services	1013088079
Region 10 Prepaid Inpatient Health Plan	Lapeer County CMH Services	1043095763
Region 10 Prepaid Inpatient Health Plan	Lapeer County CMH Services	1083197800
Region 10 Prepaid Inpatient Health Plan	Lapeer County CMH Services	1275585929
Region 10 Prepaid Inpatient Health Plan	Lapeer County CMH Services	1487741286
Region 10 Prepaid Inpatient Health Plan	Sanilac County CMH	1306854880
Region 10 Prepaid Inpatient Health Plan	Sanilac County CMH	1396481396
Region 10 Prepaid Inpatient Health Plan	Sanilac County CMH	1689205551
Region 10 Prepaid Inpatient Health Plan	St. Clair County CMH Services	1104670876
Region 10 Prepaid Inpatient Health Plan	St. Clair County CMH Services	1134254394
Region 10 Prepaid Inpatient Health Plan	St. Clair County CMH Services	1295083723
Region 10 Prepaid Inpatient Health Plan	St. Clair County CMH Services	1306696018
Region 10 Prepaid Inpatient Health Plan	St. Clair County CMH Services	1306981675
Region 10 Prepaid Inpatient Health Plan	St. Clair County CMH Services	1689783672
Region 10 Prepaid Inpatient Health Plan	St. Clair County CMH Services	1821133265
Region 10 Prepaid Inpatient Health Plan	St. Clair County CMH Services	1952152779

REFERENCE D – DETAILED ENCOUNTERS FIELD REFERENCE

State of Michigan, Department of Health and Human Services Behavioral Health EQI Data Collection Tool EQI Detailed Encounter Data Fields Reference D	
Field Name	**EQI/Master Eligibility Field**
ERN	
MemberID	
ClaimID	
Linenum	
ConsumerID	
EQI_Population	X
Program	X
elig_service_source	X
Gender	
LARA_ID_1	
LARA_ID_2	
aut_diag	
dd_diag	
smi_diag	
sed_diag	
sud_diag	
Revcode	
HOSPITAL_TYPE	
HCPCS	
modifier	
modifier2	
line_mod_3	
line_mod_4	
erroneous_data_value_1	
erroneous_data_value_2	
erroneous_data_value_3	
erroneous_data_value_4	
Full_Service_Code_EQI	X
HEADER_FROM_SVC_DATE	
HEADER_TO_SVC_DATE	
FromDate	
ToDate	
LINE_TO_SVC_DATE	
LINE_FROM_SVC_DATE	
LINE_TO_DATE	
LINE_FROM_DATE	
Region_Enc	X
ADJUDICATION_DATE	
CMH_Enc	X
Source	X
Service_Category	X
DirectRun_Contracted	X
Waiver_enc	

State of Michigan, Department of Health and Human Services Behavioral Health EQI Data Collection Tool EQI Detailed Encounter Data Fields Reference D	
Field Name	**EQI/Master Eligibility Field**
Jail_Flag	
Override_Reason	
DollarFlag	
Invoice_Type	
ProviderID	
prvdr_org_name	
CCBHC_Service_Code	
CCBHC_Name	
T1040_on_claim	
HEADER_RENDER_NPI	
LINE_RENDER_PROV_ID	
HEADER_OTH_PAYER_ADJ_REASON_1	
HEADER_OTH_PAYER_ADJ_REASON_2	
HEADER_OTH_PAYER_ADJ_REASON_3	
HEADER_OTH_PAYER_ADJ_REASON_4	
HEADER_OTH_PAYER_ADJ_REASON_5	
HEADER_OTH_PAYER_ADJ_REASON_6	
HEADER_OTH_PAYER_ADJ_REASON_7	
LINE_OTH_PAYER_ADJ_REASON_1	
LINE_OTH_PAYER_ADJ_REASON_2	
LINE_OTH_PAYER_ADJ_REASON_3	
LINE_OTH_PAYER_ADJ_REASON_4	
LINE_OTH_PAYER_ADJ_REASON_5	
LINE_OTH_PAYER_ADJ_REASON_6	
LINE_OTH_PAYER_ADJ_REASON_7	
HEADER_OTH_PAYER_ADJ_AMT_1	
HEADER_OTH_PAYER_ADJ_AMT_2	
HEADER_OTH_PAYER_ADJ_AMT_3	
HEADER_OTH_PAYER_ADJ_AMT_4	
HEADER_OTH_PAYER_ADJ_AMT_5	
HEADER_OTH_PAYER_ADJ_AMT_6	
HEADER_OTH_PAYER_ADJ_AMT_7	
HEADER_OTH_PAYER_COB_PAID_AMT	
LINE_OTH_PAYER_ADJ_AMT_1	
LINE_OTH_PAYER_ADJ_AMT_2	
LINE_OTH_PAYER_ADJ_AMT_3	
LINE_OTH_PAYER_ADJ_AMT_4	
LINE_OTH_PAYER_ADJ_AMT_5	
LINE_OTH_PAYER_ADJ_AMT_6	
LINE_OTH_PAYER_ADJ_AMT_7	
LINE_OTH_PAYER_PAID_AMT	
LOCUS_Score	
LOCUS_From_Date	

State of Michigan, Department of Health and Human Services Behavioral Health EQI Data Collection Tool EQI Detailed Encounter Data Fields Reference D	
Field Name	**EQI/Master Eligibility Field**
LOCUS_To_Date	
LOCUS_Source	
LOCUS_Payer_ID	
Units	X
Billed	
Paid	X

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