MILLIMAN CLIENT REPORT

Behavioral Health Encounter Data Quality Methodology and Instructions – SFY 2022 Period 2

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 following provide the goals of the behavioral health EQI process.

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

To aid in the validation of encounter data, we 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 that is hosted by Milliman where MDHHS and the PIHPs can access the reports like the excel reports provided for encounter data quality. It provides a dynamic view that allows users to review the PIHP and CMHSP reported information in multiple ways.

Appendix A provides a pre-populated template for each CMHSP and PIHP to summarize and submit their understanding of the Medicaid 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 grant-funded services. The CMHSP template includes the Medicaid behavioral health, non-managed care General Fund, and grant-funded populations and services. The dual CMHSP/PIHP template includes all populations included in either the PIHP or CMHSP templates.

There has been significant discussion about the reporting of non-managed care SUD expenditures in the EQI template. For the SFY22 EQI templates, do not include units or costs for services funded by 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. We will be working with the EQI Workgroup to determine if and how SUD grant utilization should be included within SFY 2023 EQI reporting.

Encounters included in the EQI analysis should be limited to those where Medicaid paid all or a portion of the expenditures and should exclude encounters entirely paid by Medicare or other third parties.

Appendix A includes the following tabs to collect cumulative information for the October 2021 to May 2022 time period using claims submitted to MDHHS as of September 30, 2022. ***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
- Service Code Set
- Service UNC
- Service Cat UNC – PIHP (Regional PIHP Only)
- Service Cat UNC – CMHSP
- Other Expenses – *Optional usage for purposes of CCBHC reconciliation*
- 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) serious emotional disturbances (SED) waiver, 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.

This report contains the instructions to assist the CMHSPs and PIHPs in completing the template with eligibility, revenue, expense, and utilization information for the October 1, 2021 to May 31, 2022 (SFY 2022 Period 2) 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 Appendix A 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 2022 Behavioral Health Code Charts and Provider Qualifications.xlsx* 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. It is our understanding that compliance with 42 CFR § 438.8 was difficult to implement for some entities during SFY 2022. 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

We anticipate that some CMHSPs and PIHPs will complete the EQI template in SFY 2022 using existing methodologies to allocate administrative costs and will transition to using the SCA methodology in SFY 2023.

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:

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

- 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, which significantly reduces the size of the Regional PIHP templates compared to SFY 2020
- CMHSP templates collect expense information for the Medicaid, General Fund, and Grant funded beneficiaries.
- Dual CMHSP/PIHP templates are consistent with all other CMHSP templates.

II. Master Eligibility File Logic

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

Program and Population Logic

Most of the tabs included in the template request information to be separated for each program and population. To assign a given individuals eligibility, service utilization, and service cost to a program and population, we would request the CMHSPs and PIHPs use the capitation file (820 data feed) as priority to assign the Medicaid population attributed to your entity. Effective October 1, 2019, MDHHS began making payments for retroactive eligible beneficiaries for up to six months. We anticipate only a small number of individuals to be retroactively Medicaid eligible for a month more than six months following the month of eligibility. We request that the CMHSPs and PIHPs identify these retroactively eligible Medicaid beneficiaries 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 1 below provides a list of the behavioral health managed care program codes used to identify the Medicaid program and corresponding populations in the capitation data as well as the qualifying benefit plans used for purposes of the eligibility file.

FIGURE 1: MEDICAID BEHAVIORAL HEALTH MANAGED CARE ENROLLEE IDENTIFICATION

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

Figure 2 provides the applicable qualifying eligibility program codes to identify the DAB population separately from the TANF population for purposes of future EQI reporting splits that will be required in SFY 2022.

FIGURE 2: ELIGIBILITY PROGRAM CODE MAPPING

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

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

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

- Enrollees are attributed to a PIHP based in the capitation and Medicaid eligibility files based on the fields provided in Figure 3 below. This shows eligibility based on county of residence as well as the PIHP that received a capitation payment for the beneficiary. For the HSW population, the PIHP is assigned based on the waiver service authorization (WSA) file, which may reflect a county different from the county of eligibility (i.e., the county of financial responsibility (COFR)). All other populations are attributed based on the county of

eligibility. Enrollees are attributed to a CMHSP for purposes of the EQI analysis based on the county of eligibility from the capitation data or Medicaid eligibility file for both waiver and non-waiver individuals.

- The county of financial responsibility (COFR) PIHP is anticipated to continue submitting encounters in SFY 2022 consistent with prior reporting periods. MDHHS is considering changes to this for future time periods to align the PIHP responsibility of submitting encounters and paying claims with the PIHP who is receiving the capitation payment.
- Encounters are assigned to the CMHSP/PIHP that submitted the encounter (identified by the originator plan ID). Encounters submitted by a PIHP for a member with a capitation payment to a different PIHP will be separately identifiable in the EQI reconciliation.

PIHP Identification

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

FIGURE 3: PIHP IDENTIFICATION

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

Development of Master Eligibility File

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

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

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

The following outlines the detailed instructions that should be used to create the master eligibility file for purposes of EQI reporting. The master eligibility file should be created by the PIHP only, and then shared with each CMHSP in their catchment area. CMHSPs should start with step 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 SED)
    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
    c. Grant identification
        i. Services that are paid for by grants should be identified and assigned as program = “Non-Managed Care” and population = “Grants”
12. Based on discussions with the EQI workgroup, the following overrides may be necessary for encounters that were assigned to Medicaid using the logic described above. These overrides are not expected to be captured on the Service UNC, but rather as a reconciling item on the *Financial Reconciliation* tab.
    a. Fund source overrides to follow Medicaid billing rules and other federal regulations should be input as *General Fund expenditures for services not billable due to an exception*
        i. CMHSPs have stated that several fund source overrides have historically been made to comply with Medicaid billing rules. One reason for overrides is that Medicaid cannot pay for services when the primary payer billing rules are not followed. An example of this is Medicare does not pay for certain services rendered by Licensed Professional Counselors (LPCs). Therefore, Medicaid and Medicare dual eligible beneficiaries receiving certain services from an LPC will require an override.
    b. Grant identification
        i. 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
    c. Such reconciling items will net zero expenditures between all fund sources as this reconciliation illustrates a shift of funds.

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 (Optional for purposes of CCBHC reconciliation)

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

For the purposes of this analysis, each CMHSP and PIHP will submit the information as requested above to MDHHS. Figure 4 includes the timing for each of the steps in the SFY 2022 Period 2 behavioral health EQI process:

FIGURE 4: SFY 2022 PERIOD 2 BH EQI SCHEDULE

BH EQI PROCESS STEP	DEADLINE
Template provided to PIHPs and CMHSPs	7/31/2022
Detailed Encounter Provided by DHHS to PIHPs	8/15/2022
Optum Data to Milliman	10/3/2022
PIHPs Submits Report to DHHS	9/30/2022
Milliman Delivers Utilization Comparison to PIHPs via DRIVE	11/1/2022
Response to observations due to DHHS, explaining variances/questions/or corrective action plans as appropriate	11/31/2022

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

Attestation

The purpose of this tab is to provide a CMHSP/PIHP representative attestation that the information submitted in the tool is current, complete, accurate, and in compliance with 42 CFR § 438.8 and 2 CFR § 200. It should be signed by a representative of the CMHSP/PIHP that is familiar with the information being reported and has the authority to make the attestation (for example, the Chief Executive Officer or Chief Financial Officer). It should also include the contact information of the individual(s) responsible for preparing the tool as submitted.

Service Code Set

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

- Index and service code index – this tab includes an index, but the primary lookup key that should be used is the service code index, as it will better facilitate comparison across multiple years in the future.
- Service codes – the possible 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 or SUD – this column represents which benefit the service will be allocated to for purposes of capitation rate development
- Qualifying coverages – these columns represent the Medicaid authority for which MDHHS has received CMS approval. If all coverages are identified as “No”, then there is no Medicaid authority, and the service is either covered via Grants or state General Fund.

Service UNC

The purpose of this tab is to capture the utilization and gross 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 a 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, substance use disorder, and 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.

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. We will be identifying a CMHSP Direct-Run service if the Billing Provider NPI is the 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.

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.

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 (beginning in SFY 2022) under the behavioral health program to MDHHS, including the Medicaid paid amount and the Medicare coordination of benefits amount, consistent with other dual eligible beneficiaries.

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 2022 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.

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.

[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

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)
   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 for FY16.

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

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

E. Any procedure codes that are not included in the template should be reported in the Notes tab. These are typically additional activities provided to individual consumers for which CMHSPs use general funds.

Service Cat UNC - CMHSP

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

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

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

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, and Population. 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

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, and Population. 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.

Other Expenses (Optional for purposes of CCBHC reconciliation)

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).
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 Forensic Center Only
O. Local Match for State Psychiatric Inpatient
P. DHS Worker for eligibility determination
Q. Transportation (not reported as encounter or claim)
R. Prior year adjustments
S. Jail Treatment Services - Embedded in General Fund Service Cost
T. Jail Treatment Services - Not Embedded in General Fund Service Cost
U. Mental Health Code Functions, separately for Medicaid and General Fund
    a. Jail Diversion
    b. Pre-admission screening (include only costs that are not reported on the Service UNC tab)

   c. 24-Hour Crisis (include only costs that are not reported on the Service UNC tab)
   d. Recipient Rights Process
   e. Other MH Code Functions (specify in notes)

V. Injectable Medications (not reported as encounter or claim)
W. General Fund expenditures on Supportive Innovation Grant
X. 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.
Y. CCBHC Section 223 Demo Expenses not included on Service UNC

Notes

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

V. Limitations and Qualifications

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

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

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

Milliman has developed certain models to support MDHHS reporting requirements included in this correspondence. The intent of the models was to fulfill requests related to Encounter Quality Initiative. We have reviewed the models, including their 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 models rely on data and information as input to the models. We have relied upon certain data and information provided by MDHHS for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this correspondence may likewise be inaccurate or incomplete. The models, including all input, calculations, and output may not be appropriate for any other purpose.

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

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

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

REFERENCE A – COUNTY CROSSWALK

REFERENCE B – MODIFIER CROSSWALK