Manager and Location Building:
John P. Duvendeck– Lewis Cass Building, 320 S. Walnut
Contract Number#_____

Amendment No. 1 to the Agreement Between
Michigan Department of Health and Human Services
And

PIHP_____
For
The Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs

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

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

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

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

5. **The Specific Changes are Identified Below:**
   a. Part I, Section 18.1.13 Home and Community Based Services
   b. Part II, Section 7.9.3 Standard Consent Form
   c. Part II, Section 7.10.6 Trauma Policy and new attachment P7.10.6.1 Trauma Policy
   d. Part II, Section 8.4 MDHHS Funding to include Habilitative Supports Waiver, Child Waiver Program and Serious Emotional Disturbance Waiver
   e. Part II, Section 8.4.2 Contract Withhold
   f. Contract attachment P7.7.1.1 PIHP Reporting to include new MUNC reporting dates, DD Proxy and Performance Indicator System changes, removal of Recovery Policy & Practice report due dates, adding Veteran Services Navigator data collection and PBI narrative reporting dates
   g. Contract attachment P8.0.1 MDHHS Funding – FY20 Milliman Medicaid Rate Certification

6. Original Agreement Conditions

It is understood and agreed that all other conditions of the original agreement remain the same.

7. Special Certification:

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

Signature Section:

For the Michigan Department of Health and Human Services

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

For the CONTRACTOR:

Name (print)	Title (print)
Signature	Date

18.1.13 HCBS Transition Implementation

The PIHPs and their provider network will work with MDHHS to assure full compliance with the Home and Community Based Setting requirements for CMS approved Medicaid Authorities and the state's approved transition plan no later than March 2022 as required by the rule, and outlined in the Medicaid Provider Manual HCBS chapter. Activities required of the PIHP to are to complete survey process with new and existing providers, review data collected from survey, notify providers of corrective action, collect corrective action, approve corrective action and monitor to assure both initial and ongoing compliance.

Effective October 1, 2017, the PIHP will not enter into new contracts with new providers of services covered by the Federal HCBS Rule (42 CFR Parts 430,431, 435, 436, 440, 441 and 447) unless the provider has obtained provisional approval status through completion of the HCBS New Provider Survey, demonstrating that the provider does not require heightened scrutiny. Provisional approval allows a new provider or an existing provider with a new setting or service to provide services to HCBS participants pending the full survey process. Providers and participants will receive the comprehensive HCBS survey within 90 days of the individuals IPOS. Providers will complete the HCBS survey and cooperate with the PIHP to demonstrate 100% compliance with the Federal HCBS rule and State requirements as promulgated by the Michigan Department of Health and Human Services and documented in the Michigan Statewide Transition Plan. Failure to complete the provisional approval process and the ongoing compliance assessments will result in the exclusion from participating in Medicaid or Healthy Michigan Plan funded HCBS services.

7.9.3 MDHHS Standard Consent Form

It is the intent of the parties to promote the use and acceptance of the standard release form that was created by MDHHS under Public Act 129 of 2014. Accordingly, the PIHPs have the opportunity to participate in the Department's annual review of the DCH-3927 and to submit comments to the Department regarding challenges and successes with using DCH-3927.

There are remaining issues to be addressed before the standard consent form can be used to support electronic Health Information Exchange. However, for all non-electronic Health Information Exchange environments, the PIHP shall implement a written policy that requires the PIHP and its provider network to use, accept, and honor the standard release form that was created by MDHHS under Public Act 129 of 2014. This policy will recognize that under Public Act 559 of 2016, written consent is not needed in all situations.

7.10.6 PIHP Trauma Policy

The PIHPs, through their direct service operations and their network providers, shall develop a trauma-informed system for all ages and across the services spectrum in accordance with the MDHHS/BHDDA Trauma Policy (Attachment 7.10.6.1).

Michigan Department of Health & Human Services
Behavioral Health and Developmental Disabilities Administration

TRAUMA POLICY

The purpose of the policy is to address the trauma in the lives of the people served by the public behavioral health system. The policy is promulgated to promote the understanding of trauma and its impact, ensure the development of a trauma informed system and the availability of trauma specific services for all populations served. Trauma is defined as:

> *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.*[1]

Policy

It is the policy of Michigan Department of Health and Human Services – Behavioral Health and Developmental Disabilities Administration (MDHHS - BHDDA) that Prepaid Inpatient Health Plans (PIHPs), through their direct service operations and their network providers, shall develop a trauma-informed system for all ages and across the services spectrum and shall ensure that the following essential elements are provided:

I. Adoption of trauma informed culture: values, principles and development of a trauma informed system of care ensuring safety and preventing re-traumatization.
II. Engagement in organizational self-assessment of trauma informed care
III. Adoption of approaches that prevent and address secondary trauma of staff (See Exhibit A)
IV. Screening for trauma exposure and related symptoms for each population
V. Trauma-specific assessment for each population
VI. Trauma-specific services for each population using evidence based practice(s) (EBPs); or evidence informed practice(s) are provided in addition to EBPs
VII. PIHPs through their direct service operations and their network providers shall join with other community organizations to support the development of a trauma informed community that promotes behavioral health and reduces the likelihood of mental illness and substance use disorders. [2, 3]

Standards

To ensure a trauma informed behavioral health system, the following standards are required to meet the stated policy.

[1] Substance Abuse Mental Health Services Administration (SAMHSA), http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx
[2] Substance Abuse and Mental Health Services Administration, Leading Change: SAMHSA's Role and Actions 2011-2012.

[3] SAMHSA's Initiatives, Preventing Substance Abuse and Mental Illness, 2010.

Policy		Standards - Requirements
I.	**Adoption of trauma informed Culture: values, principles and development of a trauma informed system of care ensuring safety and preventing retraumatization**	(a.) The PIHP shall, through its direct service operations and its network providers, develop and support a Quality Improvement committee with representatives from children, adult, SUD, I/DD services and consumers. The committee's primary focus is to ensure the building and maintaining of trauma informed care within the PIHP's direct service operations and its network providers. (b.) The PIHP, through its direct services operations and its network providers, shall ensure that all staff, including direct care staff, are trained/has ongoing training in trauma informed care. Online module is available for use in training but other curriculums can be utilized as long as they address the points delineated in the next paragraph. (online module: *Creating Cultures of Trauma Informed Care* with Roger Fallot, Ph.D. of Community Connections, Washington, DC is available at http://improvingmipractice.org). Training needs to be updated on a regular basis due to changes in the research and/or evidence based approaches. Staff trained in trauma informed care should (1.) understand what trauma is and the principles of trauma informed care; (2.) know the impact of trauma on a child's and/or adult's life; (3.) know strategies to mitigate the impact of the trauma(s); (4) understand retraumatization and its impact and (5) understand traumatic loss which may include the loss of a therapeutic, direct care or service relationship. (c.) Policies and procedures shall ensure a trauma informed system of care is supported and that the policies address trauma issues, re-traumatization and secondary trauma of staff.
II.	**Engagement in organizational self-assessment of trauma informed care**	(a.) The PIHP Quality Improvement committee conducts an organizational self-assessment to evaluate the extent to which current agency's policies are trauma-informed, identify organizational strengths and barriers, including an environmental scan to ensure that the environment/building(s) do(es) not re-traumatize. An online module is available to assist the committee in their self-assessment. No specific self-assessment tool is

Policy		Standards - Requirements	
			recommended but it is recommended that the tool being used is comprehensive and ensures that all aspects of the organization is assessed (administration, clinical services, staff capacity, environment, etc.) Online module is available for use--*Creating Cultures of Trauma-Informed Care: Assessing your Agency* with Roger Fallot, Ph.D. & Lori L. Beyer, LICSW, Community Connections, Washington, DC is available at http://improvingmipractice.org). The self-assessment is updated every three (3) years.
III.	**Adoption of approaches that prevent and address Secondary Trauma of staff**	(a.)	The PIHP, through direct services operations and its network providers, adopt approaches that prevent and address secondary traumatic stress of all staff, including, but not limited to: • Opportunity for supervision • Trauma-specific incident debriefing • Training • Self-care • Other organizational support (e.g., employee assistance program).
IV.	**Screening for trauma exposure and related symptoms for each population**	(a.)	PIHP, through direct service operations and provider network, shall use a culturally competent, standardized and validated screening tool appropriate for each population during the intake process and other points as clinically appropriate.[1], [2]
V.	**Trauma –specific assessment for each population**	(a.)	PIHP shall, through direct service operations and provider network, use a culturally competent, standardized and validated assessment instrument appropriate for each population. Trauma assessment is administered based on the outcome of the trauma screening. [3]

[1] ACE tool is a population screen and does not screen for related symptoms
[2] Examples of standardized, validated screening tools are provided in the trauma section of the website, www.improvingMIpractices.org.
[3] Examples of standardized, validated assessment tools are provided in the trauma section of the website, www.improvingMIpractices.org.

Policy		Standards - Requirements
VI.	**Trauma-specific services for each population using EBP(s) or evidence informed practices are provided in addition to EBPs**	(a.) The PIHP, through its direct service operations and network providers, shall use evidence-based trauma specific services for each population in sufficient capacity to meet the need. The services are delivered within a trauma informed environment.[4]
VII.	**PIHP through its direct service operations and its network providers, shall join with other community organizations to support the development of a trauma informed community that promotes behavioral health and reduces the likelihood of mental illness and substance use disorders.**	(a.) PIHP and its network providers shall join with community organizations, agencies, community collaboratives (i.e., MPCBs) and community coalitions (i.e., Substance Abuse Coalitions, Child Abuse and Neglect Councils, Great Start Collaboratives, neighborhood coalitions, etc.) to support the development of a trauma informed community that promotes healthy environments for children, adults and their families. (b.) Education on recovery and the reduction of stigma are approaches supported in a trauma informed community. (c.) Substance abuse prevention programming is provided using a SAMHSA approved, evidence based and trauma informed approach.

[4] Examples of trauma-specific services are provided in the trauma section of the website, www.improvingMIpractices.org

Exhibit A. Source is the National Child Traumatic Stress Network, Secondary Traumatic Stress Committee. (2011). Secondary traumatic stress: A fact sheet for child-serving professionals. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

Secondary Traumatic Stress and Related Conditions: Sorting One from Another

Secondary Traumatic Stress refers to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic material. Several other terms captures elements of this definition but are not all interchangeable with it.

Compassion fatigue, a less stigmatizing way to describe secondary traumatic stress, has been used interchangeably with the term.

Vicarious trauma refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client. It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person's traumatic material.

Compassion satisfaction refers to the positive feelings derived from competent performance as a trauma professional. It is characterized by positive relationships with colleagues, and the conviction that one's work makes a meaningful contribution to clients and society.

Burnout is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress; the term is not used to describe the effects of indirect trauma exposure specifically.

8.4 MDHHS Funding

MDHHS funding includes both Medicaid funds related to the 1115 Waiver, 1915(i) Waiver, the 1915(c) Children Waivers [i.e., HSW/CWP/SEDW] , and the 1115 Healthy Michigan Plan. The financing in this contract is always contingent on the annual Appropriation Act. CMHSPs within a PIHP may, but are not required to, use GF formula funds to provide services not covered under the 1115, 1915(i) and 1915(c) waivers for Medicaid beneficiaries who are individuals with serious mental illness, serious emotional disturbances or developmental disabilities, or underwrite a portion of the cost of covered services to these beneficiaries. MDHHS reserves the right to disallow such use of General Funds if it believes that the CMHSP was not appropriately assigning costs to Medicaid and to General Funds in order to maximize the savings allowed within the risk corridors.

Specific financial detail regarding the MDHHS funding is provided as Attachment P 8.0.1.

8.4.1. Medicaid

The MDHHS shall provide to the PIHP both the state and federal share of Medicaid funds as a capitated payment based upon a per eligible per month (PEPM) methodology. The MDHHS will provide access to an electronic copy of the names of the Medicaid eligible people for whom a capitation payment is made. A PEPM is determined for each of the populations covered by this contract, which includes services for people with a developmental disability, a mental illness or emotional disturbance, and people with a substance use disorder as reflected in this contract. PEPM is made to PIHP for all eligibles in its region, not just those with the above-named diagnoses.

The Medicaid PEPM rates, annual estimates of eligible by PIHP and rate cells, are attached to this contract. The actual number of Medicaid eligibles shall be determined monthly and the PIHP shall be notified of the eligibles in their service area via the pre-payment process.

Beginning with the first month of this contract, the PIHP shall receive a pre-payment equal to one month. The MDHHS shall not reduce the PEPM to the PIHP to offset a statewide increase in the number of beneficiaries. All PEPM rates must be certified as falling within the actuarially sound rate range.

The Medicaid PEPM rates effective October 1, 2019 will be supplied as part of Attachment P 8.0.1. The actual number of Medicaid eligibles shall be determined monthly and the PIHP shall be notified of the eligibles in their service area via the pre-payment process.

The MDHHS shall provide to the PIHP both the state and federal share of Medicaid funds as a capitated payment based upon a per 1915 (c) enrollee per month methodology. The MDHHS will provide access to an electronic copy of the names of the Medicaid eligible and the enrolled people for whom a 1915 (c) waiver capitation payment is made.

8.4.1.1 Medicaid Rate Calculation

The Medicaid financing strategy used by the MDHHS, as stated in the 1115 Waiver, is to contain the growth of Medicaid expenditures, not to create savings.

The Medicaid Rate Calculation is based on the actuarial documentation letter from Milliman USA. Five sets of rate calculations are required: 1) one set of factors for the 1115 state plan and 1915(i) [formerly (b)(3)] services; 2) one set of factors for 1915 (c) Habilitation Supports Waiver services; 3) one set of factors for 1915 (c) Children's Waiver Program services; 4) one set of factors for 1915 (c) Waiver for Children with Serious Emotional Disturbances; 5) one set of factors for the 1115 Healthy Michigan Plan. The Milliman USA letter documents the calculation rate methodology and provides the required certification regarding actuarial soundness as required by the Balanced Budget Act Rules effective

August 13, 2002. The chart of rates and factors contained in the actuarial documentation is included in Attachment P.8.0.1.

The MDHHS shall not reduce the 1115, 1915(i) PEPM, 1115 Health Michigan Plan PEPM or the C-waiver rates to the PIHP to offset a statewide increase in the number of Medicaid eligibles. All PEPM rates must be certified as falling within the actuarially sound rate range.

8.4.1.2 Medicaid Payments

MDHHS will provide the PIHP eight managed care payments each month for the Medicaid covered specialty services under the listed Benefit Plan (BP). When applicable, additional payments may be scheduled (e.g. retro-rate implementation and up to 6 months retro eligibility). HIPAA compliant 834 and 820 transactions will provide eligibility and remittance information.

- Base Rates for Benefit Plan (BHMA, BHMA-MHP, BHMA-HMP, BHMA-HMP-MHP, HSW-MC, SED-MC, CWP-MC)
- Recovery of payments previously made for beneficiaries prior to MDHHS notification of death
- Recovery of payments previously made for beneficiaries, who upon retrospective review, did not meet all the Benefit Plan enrollment requirements
- Modifications to any of the Benefit Plan's rate development factors
- For HSW enrollees of a PIHP that includes the county of financial responsibility (COFR), referred to as the "responsible PIHP", but whose county of residence is in another PIHP, referred to as the "residential PIHP", the HSW capitation payment will be paid to the COFR within the "responsible PIHP" based on the multiplicative factor for the "residential PIHP".

The PIHP must be able to receive and transmit HIPAA compliant files, such as:

- 834 – Enrollment/Eligibility
- 820 – Payment / Remittance Advice
- 837 – Encounter

8.4.1.3 Medicaid State Plan and (i) Payments

The capitation payment for the state plan and (i) Mental Health, Developmental Disability and Substance Abuse services is based on all Medicaid eligibles within the PIHP region, ,persons residing in an ICF/IID or individuals enrolled in a Program for All Inclusive Care (PACE) organization, individuals incarcerated, and individuals with a Medicaid deductible.

8.4.1.4.a 1915(c) Habilitation Supports Waiver Payments

The 1915(c) Habilitation Supports Waiver (HSW) capitation payment will be made to the PIHPs based on HSW beneficiaries who have enrolled through the MDHHS enrollment process and have met the following requirements:

- Has a developmental disability (as defined by Michigan law)
- Is Medicaid-eligible (as defined in the CMS approved waiver)
- Is residing in a community setting
- If not for HSW services would require ICF/IID level of care services
- Chooses to participate in the HSW in lieu of ICF/IID services

Beneficiaries enrolled in the HSW Benefit Plan may not be enrolled simultaneously in any other 1915(c) waivers, such as the Children's Waiver Program (CWP) and Waiver for Children with Serious Emotional Disturbances (SEDW). The PIHP will not receive payments for HSW beneficiaries enrolled who reside

in an ICF/IID, Nursing Home, CCI, or are incarcerated for an entire month. The PIHP will not receive payments for HSW beneficiaries enrolled with a Program All Inclusive Care (PACE) organization.

Enrollment Management: The 1915(c) HSW and 1915(i) uses an "attrition management" model that allows PIHPs to "fill in behind" attrition with new beneficiaries up to the limits established in the CMS-approved waiver. MDHHS has allocated certificates to each of the PIHPs. The process for filling a certificate involves the following steps: 1) the PIHPs submit applications for Medicaid beneficiaries for enrollment based on vacant certificates within the PIHP and includes required documentation that supports the eligibility for HSW; 2) MDHHS personnel reviews the PIHP enrollment applications; and 3) MDHHS personnel approves (within the constraint of the total yearly number of available waiver certificates and priority populations described in the CMS-approved waiver) those beneficiaries who meet the requirements described above.

The MDHHS may reallocate an existing HSW certificate from one PIHP to another if:

- the PIHP has presented no suitable candidate for enrollment in the HSW within 60 days of the certificate being vacated; and
- there is a high priority candidate (person exiting the ICF/IID or at highest risk of needing ICF/ IID placement, or young adult aging off CWP) in another PIHP where no certificate is available. MDHHS personnel review all disenrollments from the HSW prior to the effective date of the action by the PIHP excluding deaths and out-of-state moves which are reviewed after the effective date.

HSW Capitation Payments: Per attachment P.8.0.1, the HSW capitation payment will be based upon:

The HSW capitation payment will be scheduled and/or adjusted to occur monthly in accordance to the requirement factors listed in 8.4.1.4a and the payment factors in 8.4.1.2. Additional payments may be scheduled as required

Encounters for provision of services authorized in the CMS approved waiver must contain HK modifier to be recognized as valid HSW encounters. Encounters must be processed and submitted on time, as defined in section 7.8.2 Claims Management System and the Reporting Requirements Attachment P7.7.1.1, in order to assure timely HSW service verification. Per waiver application, HSW enrollees must receive at least one HSW service each month in order to remain on the HSW.

8.4.1.4.b 1915(c) Children's Waiver Program.

A. The PIHP shall identify children who meet the eligibility criteria for the Children's Waiver Program Benefit Plan and submit to MDHHS prescreens for those children.

B. The PIHP shall carry out administrative and operational functions delegated by MDHHS to the PIHPs as specified in the CMS approved (c) waiver application. These delegated functions include: level of care determination; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; quality assurance and quality improvement activities.

C. The PIHP shall determine the appropriate Category of Care/Intensity of Care and the amount of publicly funded hourly care for each Children's Waiver Program recipient per the Medicaid Provider Manual.

D. The PIHP shall assure that services are provided in amount, scope, and duration as specified in the approved plan.

E. The PIHP shall comply with policy covering credentialing, temporary/provisional credentialing and re-credentialing processes for those individuals and organizational providers directly or contractually employed by the PIHPs, as it pertains to the rendering of services within the Children's Waiver Program. PIHPs are responsible for ensuring that each provider, directly or contractually employed, credentialed or non-credentialed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual qualifications and requirements. Please reference the applicable licensing statutes and standards, as well as the Medicaid Provider manual should you have questions concerning scope of practice or whether Medicaid funds can be used to pay for a specific service. Through the Critical Incident Reporting System, the PIHP will report the following incidents for children on the CWP: Suicide; Non-suicide death; Arrest of Consumer; Emergency Medical Treatment due to injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions; Hospitalization due to Injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions.

The Children's Waiver Program (CWP) capitation payment will be made to the PIHPs based on CWP beneficiaries who have enrolled through the MDHHS enrollment process and have met the following requirements:

- Has a developmental disability (as defined by Michigan law)
- Is Medicaid-eligible (as defined in the CMS approved waiver)
- Is residing in a community setting
- If not for CWP services would require ICF/IID level of care services
- Chooses to participate in the CWP in lieu of ICF/IID services
- Receives at least one CWP approved service to each month enrolled

Beneficiaries enrolled in the CWP may not be enrolled simultaneously in any other 1915(c) waivers. In addition, beneficiaries enrolled in the CWP may not be enrolled simultaneously in the Habilitation Supports Waiver (HSW), Waiver for Children with Serious Emotional Disturbances (SEDW). The beneficiaries enrolled in the CWP may not be enrolled simultaneously with a Program All Inclusive Care (PACE) organization. The PIHP needs to assure that CWP services will not be provided for CWP enrolled beneficiaries who reside in an ICF/IID, Nursing Home, CCI, or are incarcerated for an entire month.

CWP Capitation Payments:

The CWP capitation payment will be scheduled and/or adjusted to occur monthly in accordance to the requirement factors listed in 8.4.1.4b and the payment factors in 8.4.1.2. Additional payments may be scheduled as required.

8.4.1.4.c 1915(c) Waiver for Children with Serious Emotional Disturbances

The intent of this program is to provide Home and Community Based Waiver Services, as approved by Centers for Medicare and Medicaid Services (CMS) for children with Serious Emotional Disturbances Benefit Plan, along with state plan services in accordance with the Medicaid Provider Manual.

A. PIHP shall assess eligibility for the SEDW and submit applications to the MDHHS for those children the PIHP determines are eligible. For children determined ineligible for the SEDW, the

PIHP, on behalf of MDHHS, informs the family of its right to request a fair hearing by providing written adequate notice of denial of the SEDW to the family.

B. The PIHP shall carry out administrative and operational functions delegated by MDHHS to the PIHPs as specified in the CMS approved (c) waiver application. These delegated functions include: level of care determination; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; quality assurance and quality improvement activities.

C. The PIHP shall assure that services are provided in amount, scope and duration as specified in the approved plan of service. Wraparound is a required service for all participants in the SEDW and PIHPs must assure sufficient service capacity to meet the needs of SEDW recipients.

D. The PIHP shall comply with credentialing, temporary/provisional credentialing and re-credentialing processes for those individuals and organizational providers directly or contractually employed by the PIHPs, as it pertains to the rendering of services within the SEDW. PIHPs are responsible for ensuring that each provider, directly or contractually employed, credentialed or non-credentialed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual qualifications and requirements.

E. Through the Critical Incident Reporting System (CIRS), the PIHP will report the following incidents for children on the SEDW**:** Suicide; Non suicide Death; Arrest of Consumer; Emergency Medical Treatment Due to Injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions; Hospitalization due to Injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions.

The Waiver for Children with Serious Emotional Disturbance (SEDW) capitation payment will be made to the PIHPs based on SEDW beneficiaries who have enrolled through the MDHHS enrollment process. Beneficiaries enrolled in the SEDW may not be enrolled simultaneously in any other 1915(c) waivers. In addition, beneficiaries enrolled in the SEDW may not be enrolled simultaneously in the Children's Waiver Program (CWP) and the Habilitation Supports Waiver (HSW) under the 1115 demonstration waiver. The beneficiaries enrolled in the SEDW may not be enrolled simultaneously with a Program All Inclusive Care (PACE) organization. The PIHP must assure that SEDW services will not be provided for SEDW enrolled beneficiaries who reside in an institutional setting, including a Psychiatric Hospital, CCI, or are incarcerated for an entire month.

SEDW Capitation Payments: The SEDW capitation payment will be scheduled and/or adjusted to occur monthly in accordance to the requirement factors listed in 8.4.1.2 and the payment factors in 8.4.1.4c Additional payments may be scheduled as required.

MDHHS SEDW Child Welfare Project Procedural Requirements

- Develop local agreements with County local MDHHS offices outlining roles and responsibilities regarding the MDHHS SEDW Child Welfare Project.
- Local MDHHS workers, PIHP SEDW Coordinator, CMHSP SEDW Leads and Wraparound Supervisors identify a specific referral process for children identified as potentially eligible for the SEDW.
- Participate in required SEDW Child Welfare Project State/Local technical assistance meetings and trainings.

- Collect and report to MDHHS all data as requested by MDHHS.

8.4.1.5 Expenditures for Medicaid 1115 State Plan, 1915(i), 1915(c), 1115 Healthy Michigan Services

On an ongoing basis, the PIHP can flexibly and interchangeably expend capitation payments received through all sources or "buckets." Once capitation payments are received, the PIHP may spend any funds received on 1115 state plan, 1915(i), 1115 Healthy Michigan Plan, or 1915(c) waiver services. All funds must be spent on Medicaid beneficiaries for Medicaid services. Surplus funding generated in either Medicaid or Healthy Michigan may be utilized to cover a funding deficit in the other fund only after that fund sources risk reserve has been fully utilized.

While there is flexibility in month-to-month expenditures and service utilization related to all "buckets," the PIHP must submit encounter data on service utilization - with transaction code modifiers that identify the service as 1115 state plan, (1915(i) services, or 1915(c) services – and this encounter data (including cost information) will serve as the basis for future 1115 state plan, (i) services, and 1915(c) waiver capitation payment rate development.

The PIHP has certain coverage obligations to and to Medicaid beneficiaries under the 1115 waiver (both state plan and (i) services), and to enrollees under the 1915(c) waiver. It must use capitation payments to address these obligations.

8.4.2 Contract Withholds

The Department shall withhold .2% of the approved capitation payment to each PIHP. The withheld funds shall be issued by the Department to the PIHP in the following amounts within 60 days of when the required report is received by the Department:

1. .04% for timely submission of the Projection Financial Status Report – Medicaid
2. .04% for timely submission of the Interim Financial Status Report – Medicaid
3. .04% for timely submission of the Final Medicaid Contract Reconciliation and Cash Settlement
4. .04% for timely submission of the Medicaid Utilization and Cost Report
5. .04% for timely submission of encounters (defined in Attachment P 7.7.1.1.)

8.4.2.1 Performance Bonus Incentive Pool

A. Withhold and Metrics

Pursuant to Sec. 105d(18) of PA 107 of 2013, the Department shall withhold 0.75% of payments to specialty prepaid health plans for the purpose of establishing a performance bonus incentive pool (hereafter referred to as "PBIP"). Distribution of funds from the PBIP is contingent on the PIHP's results on the joint metrics detailed in section 8.4.2.1.1, the narrative report detailed in section 8.4.2.1.2, and the PIHP-only metrics detailed in section 8.4.2.1.3.

B. Assessment and Distribution

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

The 0.75% PBIP withhold shall be distributed as follows:

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

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

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

Category	Description	Criteria/Deliverables
J.1. Implementation of Joint Care Management Processes (35 points)	Collaboration between entities for the ongoing coordination and integration of services	Each MHP and PIHP will continue to document joint care plans in CC360 for members with appropriate severity/risk who have been identified as receiving services from both entities. The risk stratification criteria is determined in writing by the PIHP-MHP Collaboration Workgroup in consultation with MDHHS. MDHHS will quarterly select beneficiaries randomly and review their care plans within CC360. Measurement period October 1, 2019 through September 30, 2020.
J.2. Follow-up After Hospitalization for Mental Illness within 30 Days (FUH) using HEDIS descriptions or mutually agreed modifications thereto. (65points)	The percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.	Plans will meet set standards for follow-up within 30 Days for each rate (ages 6-20 and ages 21 and older). Plans will be measured against an adult minimum standard of 58% and a child minimum standard of 70%. See MDHHS BHDDA reporting requirement website for measure specifications, at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html Measurement period will be January 1-December 31, 2019. The points will be awarded based on MHP/PIHP combination performance measure rates. The total potential points will be the same regardless of the number of MHP/PIHP combinations for a given entity.
J.3. Plan All-cause Readmission (PCR) using HEDIS descriptions or mutually agreed modifications thereto.	For members 18 years of age or older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	This measure will be **informational only.** Measurement period will be January 1-December 31, 2019. Plans will be expected to review and validate data with the goal of setting benchmarks for FY21.

J.4. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) using HEDIS descriptions or mutually agreed modifications thereto.)	Members 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days.	This measure will be **informational only.** Measurement period will be January 1-December 31, 2019. Plans will be expected to review and validate data with the goal of setting benchmarks for FY21.

8.4.2.1.2 Performance Bonus Narrative Reports (40% of withhold)
PIHPs will submit a qualitative narrative report to MDHHS in accordance with Contract Attachment P.7.7.1.1 PIHP Reporting Requirements by November 15th following the end of the Fiscal Year. The narrative shall contain a summary of efforts, activities, and achievements of the PIHP (and component CMHSPs if applicable) The specific information to be addressed in the narrative is below

a. Metric: Increased participation in patient-centered medical homes characteristics:
    1. Comprehensive Care
    2. Patient-Centered
    3. Coordinated Care
    4. Accessible Services
    5. Quality & Safety

Points for Narrative Reports required under this section, and section 8.4.2.1.3, shall be awarded on a pass/fail basis, with full credit awarded for submitted narrative reports, without regard to the substantive information provided. MDHHS shall provide consultation draft review response to PIHPs by January 15th of the following Fiscal Year. PIHPs shall have until January 31st to reply to MDHHS with information.

8.4.2.1.3 PIHP-only Pay for Performance Measure(s) (10% of withhold)
PIHPs will be incentivized on at least one nationally recognized quality measure.

Measure	Description	Deliverables
P.1. PA 107 of 2013 Sec. 105d (18): Identification of enrollees who may be eligible for services through the Veteran's Administration (100 points)	Timely submission of the Veteran Services Navigator (VSN). Data Collection form through DCH File transfer. Improve and maintain data quality on BH-TEDS military and veteran fields.	1. The measurement period for the VSN Data Collection form will be the current fiscal year. The VSN Data Collection form will be submitted to BHDDA by the last day of the month following the end of each quarter. 2. The measurement period for the BH-Teds data quality monitoring will be 10/01/2019 through 03/31/2020. Plans will be expected to monitor BH-TEDS records showing "not collected" on military and veteran fields. By 06/01/2020, Plans will submit a 1-2 page narrative report on findings and any actions taken to improve data quality.
P.2. PA 107 of 2013 Sec. 105d (18): Increased data sharing with other providers	Send ADT messages for purposes of care coordination through health information exchange.	This measure will be informational only. PIHPs will assess IT system, PIHP and trading partner capabilities in HIE ADT exchange. PIHP shall submit to BHDDA a Report no longer than four (4) pages by 7/31/20 addressing IT system; PIHP and trading partner capabilities; barriers to HIE ADT exchange; remediation efforts and plans; and direct incremental costs.
P.3. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) using HEDIS descriptions or mutually agreed modifications thereto.	The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: -Initiation of AOD Treatment: The percentage of enrollees who initiate treatment within 14 calendar days of the diagnosis. -Engagement of AOD Treatment: The percentage of enrollees who initiated treatment and who had two or more additional AOD services or MAT within 34 calendar days of the initiation visit.	This measure will be informational only. Measurement period will be January 1-December 31, 2019. PIHPs will be expected to review and validate data with the goal of setting benchmarks for FY21

PIHP REPORTING REQUIREMENTS
Effective 10-1-19
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PIHP REPORTING REQUIREMENTS

FY 2020 MDHHS/PIHP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT

REPORTING REQUIREMENTS

Introduction

The Michigan Department of Health and Human Services reporting requirements for the FY2020 Master contract with pre-paid inpatient health plans (PIHPs) are contained in this attachment. The requirements include the data definitions and dates for submission of reports on Medicaid beneficiaries for whom the PIHP is responsible: persons with mental illness and persons with developmental disabilities served by mental health programs; and persons with substance use disorders served by the mental health programs or substance use disorder programs. These requirements do not cover Medicaid beneficiaries who receive their mental health benefit through the Medicaid Health Plans, and with whom the CMHSPs and PIHPs may contract (or subcontract with an entity that contracts with the Medicaid Health Plans) to provide the mental health benefit.

Companions to the requirements in this attachment are

- "Supplemental Instructions for Encounter Data Submissions" which contains clarifications, value ranges, and edit parameters for the encounter data, as well as examples that will assist PIHP staff in preparing data for submission to MDHHS.
- PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes. Code list that contains the Medicaid covered services as well as services that may be paid by general fund and the CPT and HCPCs codes that MDHHS and EDIT have assigned to them The code list also includes instructions on use of modifiers; the acceptable activities that may be reflected in the cost of each procedure; and whether an activity needs to be face-to-face in order to count.
- "Establishing Managed Care Administrative Costs" that provides instructions on what managed care functions should be included in the allocation of expenditures to managed care administration.
- "Michigan's Mission-Based Performance Indicator System" is a codebook with instructions on what data to collect for, and how to calculate and report, performance indicators.
- SUD Guidelines and instructions as found in the Agreement

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

Collection of each element contained in the master contract attachment is required. Data reporting must be received by 5 p.m. on the due dates (where applicable) in the acceptable format(s) and by the MDHHS staff identified in the instructions. Failure to meet this standard will result in contract action.

The reporting of the data by PIHPs described within these requirements meets several purposes at

PIHP REPORTING REQUIREMENTS

MDHHS including:

- Legislative boilerplate annual reporting and semi-annual updates
- Managed Care Contract Management
- System Performance Improvement
- Statewide Planning
- Centers for Medicare and Medicaid (CMS) reporting
- External Quality Review
- Actuarial activities

Individual consumer level data received at MDHHS is kept confidential and published reports will display only aggregate data. Only a limited number of MDHHS staff have access to the database that contains social security numbers, income level, and diagnosis, for example. Individual level data will be provided back to the agency that submitted the data for encounter data validation and improvement. This sharing of individual level data is permitted under the HIPAA Privacy Rules, Health Care Operations.

FINANCIAL PLANNING, REPORTING AND SETTLEMENT

The PIHP shall provide the financial reports to MDHHS as listed below. Forms, instructions and other reporting resources are posted to the MDHHS website address at: http://www.michigan.gov/mdhhs/0,1607,7-132-2941_38765---,00.html

Submit completed reports electronically (Excel or Word) to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov except for reports noted in table below.

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

PIHP REPORTING REQUIREMENTS

7/31/2020	SUD – Expenditure Report	Quarterly	April 1 to June 30
8/15/2020	Program Integrity Activities	Quarterly	April 1 to June 30 using OIG's case tracking system
8/15/2020	SUD – Charitable Choice Report	Annually	October 1 to September 30
8/15/2020	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Shared Risk Calculation & Risk Financing	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Internal Service Fund	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Settlement Worksheet	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Reconciliation & Cash Settlement	Projection (Use tab in FSR Bundle)	October 1 to September 30
9/30/2020	Medicaid Unit Net Cost Report (MUNC)	Eight Month October to May	See Attachment P 7.7.1.1. Submit report to: QMPMeasures@michigan.gov
10/1/2020	Medicaid YEC Accrual	Final	October 1 to September 30
10/1/2020	SUD YEC Accrual	Final	October 1 to September 30
10/1/2020	SUD Budget Report	Projection	October 1 to September 30
		~~Four month report June to Sept~~	
11/10/2020	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Shared Risk Calculation & Risk Financing	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Internal Service Fund	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Settlement Worksheet	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Reconciliation & Cash Settlement	Interim (Use tab in FSR Bundle)	October 1 to September 30
11/15/2020	Program Integrity Activities	Quarterly	July 1 to September 30 using OIG's case tracking system
11/30/2020	SUD – Expenditure Report	Quarterly/Final	July 1 to September 30
12/31/2020	Medicaid Services Verification Report	Annually	October 1 to September 30
2/15/2021	Program Integrity Activities	Quarterly	October 1 to December 31 using OIG's case tracking system
2/28/2021	SUD – Primary Prevention Expenditures by Strategy Report	Annually	October 1to September 30
2/28/2021	SUD Budget Report	Final	October 1 to September 30

PIHP REPORTING REQUIREMENTS

2/28/2021	SUD – Legislative Report/Section 408	Annually	October 1 to September 30
2/28/2021	SUD – Special Project Report: (Applies only to PIHP's with earmarked allocations for Flint Odyssey House Sacred Heart Rehab Center Saginaw Odyssey House)	Annually	October 1 to September 30
2/28/2021	PIHP Medicaid FSR Bundle – MA. HMP, Autism & SUD	Final (Use tab in FSR Bundle)	October 1 to September 30
	Shared Risk Calculation & Risk Financing	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Internal Service Fund	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Settlement Worksheet	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Reconciliation & Cash Settlement	Final (Use tab in FSR Bundle)	October 1 to September 30
2/28/2021	Medicaid Unit Net Cost Report (MUNC)	October to September	See Attachment P 7.7.1.1. Submit report to: QMPMeasures@michigan.gov
2/28/2021	PIHP Executive Administrative Expenditures Survey for Sec. 904(2)(k)	Annually	October 1 to September 30
2/28/2021	Medical Loss Ratio	Annually	October 1 to September 30
2/28/2021	Attestation to accuracy, completeness, and truthfulness of claims and payment data	Annually	For the fiscal year ending 9/30/2020 Submit report to: QMPMeasures@michigan.gov
3/31/2021	SUD - Maintenance of Effort (MOE) Report	Annually	October 1 to September 30
4/01/2021	Direct Care Wage Attestation Form	Annually	For fiscal year ending 9/30/2020
6/30/2021	SUD – Audit Report	Annually	October 1 to September 30 (Due 9 months after close of fiscal year)
30 Days after submission	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter.	Annually	October 1 to September 30 Submit reports to: MDHHSAuditReports@michigan.gov
30 Days after submission	Compliance exam and plan of correction	Annually	October 1 to September 30 Submit reports to: MDHHSAuditReports@michigan.gov

PIHP NON-FINANCIAL REPORTING REQUIREMENTS SCHEDULE INCLUDING SUD REPORTS

The PIHP shall provide the following reports to MDHHS as listed below.

PIHP REPORTING REQUIREMENTS

Due Date	**Report Title**	**Report Period**
10/30/2019	Strategic Enhancement Report	October 1 to September 30
1/15/2020	Michigan Gambling Disorder Prevention Project (MGDPP) 1Q Narrative Report*	October 1 to December 31. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
1/31/2020	Children Referral Report	October 1 to December 31
1/31/2020	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 to December 31
1/31/2020	Veteran Services Navigator (VSN) Data Collection form	October 1 to December 31 Submit through: DCH-File Transfer
2/19/2020	SUD Master Retail List	October 1 to September 30
03/31/2020	Performance Indicators	October 1 to December 31, 2019 Submit to: QMPMeasures@michigan.gov
4/15/2020	Michigan Gambling Disorder Prevention Project (MGDPP) 2Q Narrative Report*	January 1 to March 31 Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
4/30/2020	Children Referral Report	January 1 to March 31
4/30/2020	SUD – Injecting Drug Users 90% Capacity Treatment Report	January 1 to March 31
4/30/2020	Veteran Services Navigator (VSN) Data Collection form	January 1 to March 31 Submit through: DCH-File Transfer
4/30/2020	Sentinel Events Data Report	October 1 to March 31
06/1/2020	Narrative report on findings and any actions taken to improve data quality on BHTEDS military and veterans fields.	October 1 to March 31, 2020 Submit through: DCH-File Transfer
06/30/2020	Performance Indicators	January 1 to March 31, 2020 Submit to: QMPMeasures@michigan.gov
06/30/2020	SUD – Tobacco/ Formal Synar Inspection period	June 1-June 30 (To be reported in Youth Access to Tobacco Compliance Check Report)
7/15/2020	Compliance Check Report (CCR)	Submit to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov with cc to: ohs@michigan.gov and ColemanL7@michigan.gov
7/15/2020	Michigan Gambling Disorder Prevention Project (MGDPP) 3Q	April 1 to June 30. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.

PIHP REPORTING REQUIREMENTS

	Narrative Report*	
7/31/2020	Children Referral Report	April 1 to June 30
7/31/2020	SUD – Injecting Drug Users 90% Capacity Treatment Report	April 1 to June 30
7/31/2020	Veteran Services Navigator (VSN) Data Collection form	April 1 to June 30 Submit through: DCH-File Transfer
7/31/2020	Increased data sharing with other providers/ ADT Narrative	October 1 to June 30 Submit through: DCH-File Transfer
09/30/2020	Performance Indicators	April 1 to June 30, 2020 Submit to: QMPMeasures@michigan.gov
10/15/2020	Michigan Gambling Disorder Prevention Project (MGDPP) 4Q Narrative Report*	July 1 to September 30. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
10/31/2020	Children Referral Report	July 1 to September 30
10/31/2020	SUD – Injecting Drug Users 90% Capacity Treatment Report	July 1 to September 30
10/31/2020	SUD – Youth Access to Tobacco Activity Annual Report	October 1 to September 30
10/31/2020	Veteran Services Navigator (VSN) Data Collection form	October 1 to September 30 Submit through: DCH-File Transfer
10/31/2020	Sentinel Events Data Report	April 1 to September 30
TBD	SUD – Synar Coverage Study Canvassing Forms	Regions participating and Study Period TBD (August 2020)
11/15/2020	Performance Bonus Incentive Narrative on "Increased participation in patient-centered medical homes characteristics".	October 1 to September 30
11/30/2020	SUD – Communicable Disease (CD) Provider Information Report (Must submit only if PIHP funds CD services)	October 1 to September 30
11/30/2020	Women Specialty Services (WSS) Report	October 1 to September 30
12/31/2020	Performance Indicators	July 1 to September 30, 2020 Submit to: QMPMeasures@michigan.gov

PIHP REPORTING REQUIREMENTS

Quarterly	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 – September 30 Due last day of month, following the last month of the quarter.
Quarterly	Children Referral Report	October 1 – September 30 Due last day of month, following the last month of the quarter.
Monthly	SUD - Priority Populations Waiting List Deficiencies Report	October 1 – September 30 Due last day of month following month in which exception occurred. Must submit even if no data to report
Monthly	SUD – Behavioral Health Treatment Episode Data Set (BH-TEDS)	October 1 to September 30 Due last day of each month. Submit via DEG at : https://milogintp.michigan.gov. See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly	SUD - Michigan Prevention Data System (MPDS)	October 1 to September 30 Due last day of each month, following month in which data was uploaded. Submit to: https://mpds.sudpds.com
Monthly (minimum 12 submissions per year)	SUD - Encounter Reporting via HIPPA 837 Standard Transactions	October 1 to September 30 Submit via DEG at: https://milogintp.michigan.gov. See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly*	Consumer level* Quality Improvement Encounter	October 1 to September 30 See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly	Critical Incidents	Submit to PIHP Incident Warehouse at: https://mipihpwarehouse.org/MVC/Documentation
Monthly*	Michigan Gambling Disorder Prevention Project (MGDPP) Monthly Training Schedule*	Due on the 15th of every month which includes Gambling Disorder (GD) training dates and activities. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
Annually	SUD - Communicable Disease (CD) Provider Information Plan (Must submit only if PIHP funds CD services)	October 1 to September 30 Same due date as Annual Plan.

*Reports required for those PIHPs participating in optional programs

*Consumer level data must be submitted-within 30 days following adjudication of claims for services provided, or in cases where claims are not part of the PIHP's business practices, within 30 days following the end of the month in which services were delivered.

NOTE: To submit via DEG to MDHHS/MIS Operations
Client Admission and Discharge client records must be sent electronically to:

PIHP REPORTING REQUIREMENTS

Michigan Department of Health and Human Services
Michigan Department of Technology, Management & Budget
Data Exchange Gateway (DEG)
For admissions: put c:/4823 4823@dchbull
For discharges: put c:/4824 4824@dchbull

1. Send data to MDHHS MIS via DEG (see above)
2. Send data to MDHHS, BHDDA, Division of Quality Management and Planning
3. Web-based reporting. See instructions on MDHHS web site at www.michigan.gov/mdhhs/bhdda and click on Reporting Requirements

PIHP REPORTING REQUIREMENTS

BEHAVIORAL HEALTH TREATMENT EPISODE DATA SET (BH-TEDS) COLLECTION/RECORDING AND REPORTING REQUIREMENTS

Technical specifications-- including file formats, error descriptions, edit/error criteria, and explanatory materials on record submission are located on MDHHS's website at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

Reporting covered by these specifications includes the following:

-BH -TEDS Start Records (due monthly)

-BH-TEDS Discharge/Update/End Records (due monthly)

A. Basis of Data Reporting

The basis for data reporting policies for Michigan behavioral health includes:

1. Federal funding awarded to Michigan through the Combined SABG/MHBG Behavioral Health federal block grant.

2. SAMHSA's Behavioral Health Services Information Systems (BHSIS) award agreement administered through Synectics Management, Inc that awards MDHHS a contracted amount of funding if the data meet minimum timeliness, completeness and accuracy standards

3 Legislative boilerplate annual reporting and semi-annual updates

B. Policies and Requirements Regarding Data

BH TEDS Data reporting will encompass Behavioral Health services provided to persons supported in whole or in part with MDHHS-administered funds.

Policy:
Reporting is required for all persons whose services are paid in whole or in part with state administered funds regardless of the type of co-pay or shared funding arrangement made for the services.

For purposes of MDHHS reporting, an admission, or start, is defined as the formal acceptance of a client into behavioral health services. An admission or start has occurred if and only if the person begins receiving behavioral health services.

PIHP REPORTING REQUIREMENTS

1. Data definitions, coding and instructions issued by MDHHS apply as written. Where a conflict or difference exists between MDHHS definitions and information developed by the PIHP or locally contracted data system consultants, the MDHHS definitions are to be used.

2. All SUD data collected and recorded on BH-TEDS shall be reported using the proper Michigan Department of Licensing and Regulatory Affairs (LARA) substance abuse services site license number. LARA license numbers are the primary basis for recording and reporting data to MDHHS at the program level.

3. There must be a unique Person identifier assigned and reported. It must be 11 characters in length, and alphanumeric. This same number is to be used to report data for BH-TEDS and encounters for the individual within the PIHP. It is recommended that a method be established by the PIHP and funded programs to ensure that each individual is assigned the same identification number regardless of how many times he/she enters services in any program in the region, and that the client number be assigned to only one individual.

4. Any changes or corrections made at the PIHP on forms or records submitted by the program must be made on the corresponding forms and appropriate records maintained by the program. Each PIHP and its programs shall establish a process for making necessary edits and corrections to ensure identical records. The PIHP is responsible for making sure records at the state level are also corrected via submission of change records in data uploads.

5. PIHPs must make corrections to all records that are submitted but fail to pass the error checking routine. All records that receive an error code are placed in an error master file and are not included in the analytical database. Unless acted upon, they remain in the error file and are not removed by MDHHS.

6. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

7. The PIHP must communicate data collection, recording and reporting requirements to local providers as part of the contractual documentation. PIHPs may not add to or modify any of the above to conflict with or substantively affect State policy and expectations as contained herein.

8. Statements of MDHHS policy, clarifications, modifications, or additional requirements may be necessary and warranted. Documentation shall be forwarded accordingly.

Method for submission: BH-TEDS data are to be submitted in a fixed length format, per the file

specifications.

Due dates: BH TEDS data are due monthly. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

Who to report: The PIHP must report BH-TEDS data for all individuals with mental health, intellectual/developmental disabilities, and substance use disorders who receive services funded in whole or in part with MDHHS-administered funding. PIHPs participating in the Medicare/Medicaid integration project are not to report BH-TEDS records for beneficiaries for whom the PIHP's financial responsibility is to a non-contracted provider during the 180-day continuity of care.

PIHP REPORTING REQUIREMENTS

CHAMPS BEHAVIORAL HEALTH REGISTRY FILE

Purpose: In the past basic consumer information from the QI (MH) and TEDS (SUD) files were sent to CHAMPS to be used as a validation that the consumer being reported in the Encounters is a valid consumer for the reporting PIHP. With QI eventually being phased out during FY16 and TEDS ending on 9/30/2015, BHTEDS will be replacing them both beginning 10/1/2015. To use BHTEDS to create the CHAMPS validation file would be difficult as there would be three different types of records – mental health substance use disorder and co-occurring.

Requirement: To simplify the process of creating this validation file, BHDDA is introducing a new file called the Behavioral Health Registry file. For this file, PIHPs are required to report five fields of data with only three being required. The required fields are: PIHP Submitter ID, Consumer ID and Begin Date (date less than or equal to first Date of Service reported in Encounters.) The following two fields will only be reported if the consumer has either: Medicaid ID and MIChild ID.

The file specifications and error logic for the Registry are (will be) available on the MDHHS web site at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html.

Submissions of the BH Registry file by CHAMPS will be ready by 10/1/2015.

Data Record

Record Format: rc1041.06									
Element #	**Data Element Name**	**Picture**	**Usage**	**Format**	**From**	**To**	**Validated**	**Required**	**Definition**
1	Submitter ID	Char(4)	4		1	4	Yes	Yes	Service Bureau ID (DEG Mailbox ID)
2	Consumer ID	Char(11)	11		5	15	No	Yes	Unique Consumer ID
3	Medicaid ID	Char(10)	10		16	25	Yes	Conditional	Must present on file if available.
4	MIChild ID	Char(10)	10		26	35	Yes	Conditional	MICHILD ID [CIN] Must present on file if available.
5	Begin Date	Date	8	YYYYMMDD	36	43	Yes	Yes	

PIHP REPORTING REQUIREMENTS

ENCOUNTERS PER MENTAL HEALTH, DEVELPMENTAL DISABILITY, AND SUBSTANCE USE DISORDER BENEFICIARY
DATA REPORT

Due dates: Encounter data are due within 30 days following adjudication of the claim for the service provided, or in the case of a PIHP whose business practices do not include claims payment, within 30 days following the end of the month in which services were delivered. It is expected that encounter data reported will reflect services for which providers were paid (paid claims), third party reimbursed, and/or any services provided directly by the PIHP. Submit the encounter data for an individual on any claims adjudicated, regardless of whether there are still other claims outstanding for the individual for the month in which service was provided. In order that the department can use the encounter data for its federal and state reporting, it must have the count of units of service provided to each consumer during the fiscal year. Therefore, the encounter data for the fiscal year must be reconciled within 90 days of the end of the fiscal year. Claims for the fiscal year that are not yet adjudicated by the end of that period, should be reported as encounters with a monetary amount of "0." Once claims have been adjudicated, a replacement encounter must be submitted.

Who to Report: The PIHP must report the encounter data for all mental health and developmental disabilities (MH/DD) Medicaid beneficiaries in its entire service area for all services provided under MDHHS benefit plans. The PIHP must report the encounter data for all substance use disorder Medicaid beneficiaries in its service area. Encounter data is collected and reported for every beneficiary for which a claim was adjudicated or service rendered during the month by the PIHP (directly or via contract) regardless of payment source or funding stream. PIHP's and CMHSPs that contract with another PIHP or CMHSP to provide mental health services should include that consumer in the encounter data set. . In those cases the PIHP or CMHSP that provides the service via a contract should not report the consumer in this data set. Likewise, PIHPs or CMHSPs that contract directly with a Medicaid Health Plan, or sub-contract via another entity that contracts with a Medicaid Health Plan to provide the Medicaid mental health outpatient benefit, should not report the consumer in this data set.

The Health Insurance Portability and Accountability Act (HIPAA) mandates that all consumer level data reported after October 16, 2002 must be compliant with the transaction standards.

A summary of the relevant requirements is:

- Encounter data (service use) is to be submitted electronically on a Health Care Claim 5010.
- The encounter requires a small set of specific demographic data: gender, diagnosis, Medicaid number, race, and social security number, and name of the consumer.
- Information about the encounter such as provider name and identification number, place of service, and amount paid for the service is required.
- The 837 includes a "header" and "trailer" that allows it to be uploaded to the CHAMPS system.

PIHP REPORTING REQUIREMENTS

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- Every behavioral health encounter record must have a corresponding Behavioral Health Registry record reported prior to the submission of the Encounter. Failure to report both an encounter record and a registry record for a consumer receiving services will result in the encounter being rejected by the CHAMPS system.

The information on HIPAA contained in this contract relates only to the data that MDHHS is requiring for its own monitoring and/or reporting purposes, and does not address all aspects of the HIPAA transaction standards with which PIHPs must comply for other business partners (e.g., providers submitting claims, or third party payers). Further information is available at www.michigan.gov/mdhhs.

Data that is uploaded to CHAMPS must follow the HIPAA-prescribed formats for encounter data. The 837/5010 includes header and trailer information that identifies the sender and receiver and the type of information being submitted. If data does not follow the formats, entire files could be rejected by the electronic system.

HIPAA also requires that procedure codes, revenue codes and modifiers approved by the CMS be used for reporting encounters. Those codes are found in the Current Procedural Terminology (CPT) Manual, Fifth Edition, published by the American Medical Associations, the Health Care Financing Administration Common Procedure Coding System (HCPCS), the National Drug Codes (NDC), the Code on Dental Procedures and Nomenclature (CDPN), the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), ICD-10 and the Michigan Uniform Billing Manual. The procedure codes in these coding systems require standard units that must be used in reporting on the 837/5010.

MDHHS has produced a code list of covered Medicaid specialty and Habilitation Supports waiver supports and services names (as found in the Medicaid Provider Manual) and the CPT or HCPCS codes/service definition/units as soon as the majority of mental health services have been assigned CPT or HCPCS codes. This code list is available on the MDHHS web site.

The following elements reported on the 837/5010 encounter format will be used by MDHHS Quality Management and Planning Division for its federal and state reporting, the Contracts Management Section and the state's actuary. The items with an ** are required by HIPAA, and when they are absent will result in rejection of a file. Items with an ** must have 100% of values recorded within the acceptable range of values. Failure to meet accuracy standards on these items will result in contract action.
Refer to HIPAA 837 transaction implementation guides for exact location of the elements. Please consult the HIPAA implementation guides, and clarification documents (on MDHHS's web site) for additional elements required of all 837/5010 encounter formats. The Supplemental Instructions contain field formats and specific instructions on how to submit encounter level data.

****1.a. *PIHP Plan Identification Number* (PIHPID) or PIHP CA Function ID**

The MDHHS-assigned 7-digit payer identification number must be used to identify the

PIHP with all data transactions.

1.b. ***CMHSP Plan Identification Number*** **(CMHID)**
The MDHHS-assigned 7-digit payer identification number must be used to identify the CMHSP with all mental health and/or developmental disabilities transactions.

****2**. ***Identification Code/Subscriber Primary Identifier (please see the details in the submitter's manual)***
Ten-digit Medicaid number must be entered for a **Medicaid or MIChild** beneficiary.
If the consumer is not a beneficiary, enter the nine-digit **Social Security** number.
If consumer has neither a Medicaid number nor a Social Security number, enter the unique identification number assigned by the CMHSP or **CONID.**

****3.** ***Identification Code/Other Subscriber Primary Identifier (please see the details in the submitter's manual)***
Enter the consumer's unique identification number (**CONID**) assigned by the CMHSP **regardless** of whether it has been used above**.**

****4.** ***Date of birth***
Enter the date of birth of the beneficiary/consumer.

*****5.*** ***Diagnosis***
Enter the ICD-9 primary diagnosis of the consumer.

*****6.*** ***EPSDT***
Enter the specified code indicating the child was referred for specialty services by the EPSDT screening.

*****7.*** ***Encounter Data Identifier***
Enter specified code indicating this file is an encounter file.

*****8.*** ***Line Counter Assigned Number***
A number that uniquely identifies each of up to 50 service lines per claim.

*****9.*** ***Procedure Code***
Enter procedure code from code list for service/support provided. The code list is located on the MDHHS web site. Do not use procedure codes that are not on the code list.

****10.*** ***Procedure Modifier Code***
Enter modifier as required for Habilitation Supports Waiver services provided to enrollees; for Autism Benefit services under EPSDT; for Community Living Supports and Personal Care levels of need; for Nursing Home Monitoring; and for evidence-based practices. See

Costing per Code List.

11.** ***Monetary Amount (effective 1/1/13):
Enter the charge amount, paid amount, adjustment amount (if applicable), and adjustment code in claim information and service lines. (See Instructions for Reporting Financial Fields in Encounter Data at http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html Click on Reporting Requirements)

****12.** ***Quantity of Service***
Enter the number of units of service provided according to the unit code type. **Only whole numbers should be reported.**

13.** ***Place of Service Code
Enter the specified code for where the service was provided, such as an office, inpatient hospital, etc. (See PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes Chart at http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html Click on Reporting Requirements, then the codes chart)

14.** ***Diagnosis Code Pointer
Points to the diagnosis code at the claim level that is relevant to the service.

****15.** ***Date Time Period***
Enter date of service provided (how this is reported depends on whether the Professional, or the Institutional format is used).

****16.** ***Billing Provider Name***
Enter the name of the Billing Provider for all encounters. (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements). If the Billing Provider is a specialized licensed residential facility also report the LARA license facility number (See Instructions for Reporting Specialized Residential Facility Details at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements).

****17.** ***Rendering Provider Name***
Enter the name of the Rendering Provider when different from the Billing Provider (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

18. **Facility Location of the Specialized Residential Facility**
In instances in which the specialized licensed residential facility is not the Billing

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

****19. Provider National Provider Identifier (NPI), Employer Identification Number (EIN) or Social Security Number (SSN)*** Enter the appropriate identification number for the Billing Provider, and as applicable, the Rendering Provider. (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

ENCOUNTER TIMELINESS CALCULATION

Requirements

1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be considered in this calculation. As an example, for the timeliness metrics analyzed in December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service.
2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new methodology. See highlighted section below).

Logic

Encounter timeliness is determined by calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are only run once for each adjudication month.

The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the encounter was created for submission.

These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T. The queries include all PIHP submitted encounters, both mental health and substance abuse.

Concerns have been raised that the timeliness measure will penalize PIHPs for correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve.

The Department plans on continuing these test analyses through November 2019. The first production analyses will be run in December 2019.

PIHP MEDICAID UTILIZATION AND AGGREGATE NET COST REPORT

This report provides the aggregate Medicaid service data necessary for MDHHS management of PIHP contracts and rate-setting by the actuary. In the case of a regional entity, the PIHP must report this data as an aggregation of all Medicaid services provided in the service area by its CMHSP partners. This report includes Medicaid Substance Use Disorder services provided in the service area. The data set reflects and describes the support activity provided to or on behalf of Medicaid beneficiaries, **except** Children's Waiver beneficiaries. Refer to the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual for the complete and specific requirements for coverage for the State Plan, Additional services provided under the authority of Section 1915(b)(3) of the Social Security Act, and the Habilitation Supports Waiver. All of the aforementioned Medicaid services and supports provided in the PIHP service area must be reported on this utilization and cost report. Instructions and current templates for completing and submitting the MUNC report may be found on the MDHHS web site at http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868---,00.html. Click on Behavioral Health and Substance Abuse, then Reporting Requirements. This report is due twice a year. One for the first six months of the fiscal year which will be due August 31st of the fiscal year a full year report due on February 28th following the end of the fiscal year. Templates for these reports will be made available at least 60 days prior to the due date.

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM VERSION 6.0 FOR PIHPS

The purposes of the Michigan Mission Based Performance Indicator System (version 1.0) are:

- To clearly delineate the dimensions of quality that must be addressed by the Public Mental Health System as reflected in the Mission statements from Delivering the Promise and the needs and concerns expressed by consumers and the citizens of Michigan. Those domains are: ACCESS, EFFICIENCY, and OUTCOME.
- To develop a state-wide aggregate status report to address issues of public accountability for the public mental health system (including appropriation boilerplate requirements of the legislature, legal commitments under the Michigan Mental Health Code, etc.)
- To provide a data-based mechanism to assist MDHHS in the management of PIHP contracts that would impact the quality of the service delivery system statewide.
- To the extent possible, facilitate the development and implementation of local quality improvement systems; and

- To link with existing health care planning efforts and to establish a foundation for future quality improvement monitoring within a managed health care system for the consumers of public mental health services in the state of Michigan.

All of the indicators here are measures of PIHP performance. Therefore, performance indicators should be reported by the PIHP for all the Medicaid beneficiaries for whom it is responsible. Medicaid beneficiaries who are not receiving specialty services and supports (1915(i)(c) waivers) but are provided outpatient services through contracts with Medicaid Health Plans, or sub-contracts with entities that contract with Medicaid Health Plans are not covered by the performance indicator requirements.

Due dates for indicators vary and can be found on the table following the list of indicators. Instructions and reporting tables are located in the "Michigan's Mission-Based Performance Indicator System, Codebook. Electronic templates for reporting will be issued by MDHHS six weeks prior to the due date and also available on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html .

ACCESS

1. The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Standard = 95% in three hours**

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

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

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

4. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (All children and all adults (MI, DD) and all Medicaid SUD (sub-

acute de-tox discharges) **Standard = 95% in seven days**

5. The percent of Medicaid recipients having received PIHP managed services. (MI adults, MI children, DD adults, DD children, and SUD)

ADEQUACY/APPROPRIATENESS

6. The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.

EFFICIENCY

7. The percent of total expenditures spent on managed care administrative functions for PIHPs.

OUTCOMES

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

9. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who earn state minimum wage or more from employment activities (competitive, self-employment, or sheltered workshop).

10. The percent of children and adults with MI and DD readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days

11. The annual number of substantiated recipient rights complaints per thousand Medicaid beneficiaries with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II.

12. The percent of adults with developmental disabilities served, who live in a private residence alone, or with spouse or non-relative.

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

14. The percent of children with developmental disabilities (not including children in the Children's Waiver Program) in the quarter who receive at least one service each month other than case management and respite.

Note: Indicators #2, 3, 4, and 5 include Medicaid beneficiaries who receive substance use disorder services managed by the PIHP.

PIHP PERFORMANCE INDICATOR REPORTING DUE DATES

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screen	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
2. 1st request	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
3. 1st service	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
4. Follow-up	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
5. Medicaid penetration*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS
6. HSW services*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS
7. Admin. Costs*	10/01 to 9/30	1/31							MDHHS
8. Competitive employment*	10/01 to 9/30								MDHHS
9. Minimum wage*	10/01 to 9/30								MDHHS
10. Readmissions	10/01 to 9/30	3/31	1/01 to 3/31	6/30	4-01 to 6-30	9/30	7/01 to 9/30	12/31	PIHPs
11. RR complaints	10/01 to 9/30	12/31							PIHPs
12. & 13. Living arrangements	10/1 to 9/30	N/A							MDHHS
14. Children with DD	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS

*Indicators with * mean MDHHS collects data from encounters, quality improvement or cost reports and calculates performance indicators

STATE LEVEL DATA COLLECTION

CRITICAL INCIDENT REPORTING

PIHPs will report the following events, except Suicide, within 60 days after the end of the month in which the event occurred for individuals actively receiving services, with individual level data on consumer ID, event date, and event type:

- **Suicide** for any individual actively receiving services at the time of death, and any who have received emergency services within 30 days prior to death. Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was determined. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide. In this event the time frame described in "a" above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.
- **Non-suicide death** for individuals who were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving community living supports, supports coordination, targeted case management, ACT, Home-based, Wraparound, Habilitation Supports Waiver, SED waiver or Children's Waiver services. If reporting is delayed because the PIHP is determining whether the death was due to suicide, the submission is due within 30 days after the end of the month in which the PIHP determined the death was not due to suicide.
- **Emergency Medical treatment due to Injury or Medication Error** for people who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving either Habilitation Supports Waiver services, SED Waiver services or Children's Waiver services.
- **Hospitalization due to Injury or Medication Error** for individuals who were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.
- **Arrest of Consumer** for individuals who were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.

Methodology and instructions for reporting are posted on the MDHHS web site at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html.

EVENT NOTIFICATION

The PIHP shall immediately notify MDHHS of the following events:

1. Any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation. This report shall be submitted electronically within 48 hours of either the death, or the PIHP's receipt of notification of the death, or the PIHP's receipt of notification that a rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information:
    a. Name of beneficiary
    b. Beneficiary ID number (Medicaid, MiChild)
    c. Consumer I (CONID) if there is no beneficiary ID number
    d. Date, time and place of death (if a licensed foster care facility, include the license #)
    e. Preliminary cause of death
    f. Contact person's name and E-mail address
2. Relocation of a consumer's placement due to licensing suspension or revocation.
3. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours
4. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement.

Except for deaths, notification of the remaining events shall be made within five (5) business days to contract management staff members in MDHHS's Behavioral Health and Developmental Disabilities Administration (email: MDHHS-BHDDA-Contracts-MGMT@michigan.gov; FAX: (517) 335-5376; or phone: (517) 241-2139)

NOTIFICATION OF PROVIDER NETWORK CHANGES

The PIHP shall notify MDHHS within seven (7) days of any changes to the composition of the provider network organizations that negatively affect access to care. PIHPs shall have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that MDHHS determines to negatively affect recipient access to covered services may be grounds for sanctions.