

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs FY 2019
Amendment #3

FEIN# 46-3351818
DUNS# 079148120

Manager and Location Building:
John P. Duvendeck– Lewis Cass Building, 320 S. Walnut
Contract Number# MA18000000755

**Amendment No. 3 to the Agreement Between
Michigan Department of Health and Human Services
And**

**PIHP Detroit Wayne Mental Health Authority
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, 2018 and continue through September 30, 2019.

2. Period of Amendment:

October 1, 2018 through September 30, 2019.

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, 2018 through September 30, 2019. 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:

- Contract attachment P7.0.1 PIHP Contract Financing, Medicaid Capitation Rate Amendment dated April 1, 2019
- Contract attachment P7.7.1.1 PIHP Reporting Requirements adding Direct Care Wage Attestation Form due April 1, 2020

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

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs FY 2019
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sign this agreement on behalf of the organization specified.

Signature Section:

For the Michigan Department of Health and Human Services

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

5.23.19
Date

For the CONTRACTOR:

Bernard Parker
Name (print)

Chairperson
Title (print)

[Signature]
Signature

5/1/19
Date

PIHP REPORTING REQUIREMENTS

Effective 10-1-18

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PIHP REPORTING REQUIREMENTS

**FY 2019 MDHHS/PIHP MANAGED SPECIALTY SUPPORTS AND SERVICES
CONTRACT
REPORTING REQUIREMENTS**

Introduction

The Michigan Department of Health and Human Services reporting requirements for the FY2019 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 MDHHS including:

PIHP REPORTING REQUIREMENTS

- 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.

<u>Due Date</u>	<u>Report Title</u>	<u>Report Frequency</u>	<u>Report Period and Submittal Instructions</u>
10/1/2018	SUD Budget Report	Projection/Initial	October 1 to September 30
12/3/2018	Risk Management Strategy	Annually	To cover the current fiscal year
12/31/2018	Medicaid Services Verification Report	Annually	October 1 to September 30
1/31/2019	SUD – Expenditure Report	Quarterly	October 1 to December 31
4/16/2019	SUD – Women’s Specialty Services (WSS) Mid-Year Expenditure Status Report	Mid-Year	October 1 to March 31
4/30/2019	SUD – Expenditure Report	Quarterly	January 1 to March 31
5/15/2019	Program Integrity Activities	Quarterly	January 1 to March 31 using OIG’s case tracking system
5/31/2019	Mid-Year Status Report	Mid-Year	October 1 to March 31
6/01/2019	SUD – Notice of Excess or Insufficient Funds	Projection	October 1 to September 30
7/31/2019	SUD – Expenditure Report	Quarterly	April 1 to June 30
8/15/2019	Program Integrity Activities	Quarterly	April 1 to June 30 using OIG’s case tracking system
8/15/2019	SUD – Charitable Choice Report	Annually	October 1 to September 30
8/15/2019	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Projection (Use tab in FSR Bundle)	October 1 to September 30

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	<ul style="list-style-type: none"> Medicaid – Shared Risk Calculation & Risk Financing 	Projection (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> Medicaid – Internal Service Fund 	Projection (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> Medicaid Contract Settlement Worksheet 	Projection (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> Medicaid Contract Reconciliation & Cash Settlement 	Projection (Use tab in FSR Bundle)	October 1 to September 30
8/31/2019	Medicaid Unit Net Cost Report (MUNC)	Six month report	See Attachment P 7.7.1.1. Submit report to: QMPMeasures@michigan.gov
10/1/2019	Medicaid YEC Accrual	Final	October 1 to September 30
10/1/2019	SUD YEC Accrual	Final	October 1 to September 30
10/1/2019	SUD Budget Report	Projection	October 1 to September 30
11/10/2019	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Interim (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> Medicaid – Shared Risk Calculation & Risk Financing 	Interim (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> Medicaid – Internal Service Fund 	Interim (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> Medicaid Contract Settlement Worksheet 	Interim (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> Medicaid Contract Reconciliation & Cash Settlement 	Interim (Use tab in FSR Bundle)	October 1 to September 30
11/15/2019	Program Integrity Activities	Quarterly	July 1 to September 30 using OIG's case tracking system
11/30/2019	SUD – Expenditure Report	Quarterly/Final	July 1 to September 30
12/31/2019	Medicaid Services Verification Report	Annually	October 1 to September 30
2/15/2020	Program Integrity Activities	Quarterly	October 1 to December 31 using OIG's case tracking system
2/28/2020	SUD – Primary Prevention Expenditures by Strategy Report	Annually	October 1 to September 30
2/28/2020	SUD Budget Report	Final	October 1 to September 30
2/28/2020	SUD – Legislative Report/Section 408	Annually	October 1 to September 30
2/28/2020	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
2/28/2020	PIHP Medicaid FSR Bundle – MA, HMP, Autism & SUD	Final (Use tab in FSR Bundle)	October 1 to September 30

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	Shared Risk Calculation & Risk Financing	Final (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> Medicaid – Internal Service Fund 	Final (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> Medicaid Contract Settlement Worksheet 	Final (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> Medicaid Contract Reconciliation & Cash Settlement 	Final (Use tab in FSR Bundle)	October 1 to September 30
2/28/2020	Medicaid Utilization and Cost Report (MUNC)	Final	See Attachment P 7.7.1.1. Submit report to: QMPMeasures@michigan.gov
2/28/2020	PIHP Executive Administrative Expenditures Survey for Sec. 904(2)(k)	Annually	October 1 to September 30
2/28/2020	Medical Loss Ratio	Annually	October 1 to September 30
3/31/2020	SUD - Maintenance of Effort (MOE) Report	Annually	October 1 to September 30
4/01/2020	Direct Care Wage Attestation Form	Annually	For fiscal year ending 9/30/2019
6/30/2020	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.

<u>Due Date</u>	<u>Report Title</u>	<u>Report Period</u>
11/30/2018	Recovery Policy & Practice Annual Planning – Table 2	See attachment P4.13.1
1/15/2019	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 .
1/31/2019	Children Referral Report	October 1 to December 31
1/31/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 to December 31
2/19/2019	SUD Master Retail List	October 1 to September 30

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03/31/2019	Performance Indicators	October 1 to December 31, 2018 Submit to: QMPMeasures@michigan.gov
4/15/2019	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 .
4/30/2019	Children Referral Report	January 1 to March 31
4/30/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	January 1 to March 31
4/30/2019	Sentinel Events Data Report	October 1 to March 31
06/30/2019	Performance Indicators	January 1 to March 31, 2019 Submit to: QMPMeasures@michigan.gov
06/30/2019	SUD -- Tobacco/ Formal Synar Inspection period	June 1-June 30 (To be reported in Youth Access to Tobacco Compliance Check Report)
7/15/2019	Compliance Check Report (CCR)	Submit to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov with cc to: ohs@michigan.gov and ColemanL7@michigan.gov
7/15/2019	Michigan Gambling Disorder Prevention Project (MGDPP) 3Q Narrative Report*	April 1 to June 30. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov .
7/31/2019	Children Referral Report	April 1 to June 30
7/31/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	April 1 to June 30
09/30/2019	Performance Indicators	April 1 to June 30, 2019 Submit to: QMPMeasures@michigan.gov
10/15/2019	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 .
10/31/2019	Children Referral Report	July 1 to September 30
10/31/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	July 1 to September 30
10/31/2019	SUD – Youth Access to Tobacco Activity Annual Report	October 1 to September 30
10/31/2019	Sentinel Events Data Report	April 1 to September 30
TBD	SUD – Synar Coverage Study Canvassing Forms	Regions participating and Study Period TBD (August 2019)
11/30/2019	SUD – Communicable Disease (CD) Provider Information Report (Must submit only if	October 1 to September 30

PIHP REPORTING REQUIREMENTS

	PIHP funds CD services)	
11/30/2019	Women Specialty Services (WSS) Report	October 1 to September 30
12/31/2019	Performance Indicators	July 1 to September 30, 2019 Submit to: QMPMeasures@michigan.gov
2/28/2020	<u>Recovery Policy & Practice Annual Survey Information Forms – Tables 3a and 3b</u>	See attachment P4.13.1
TBD (originally 2/28/2020)	Recovery Policy & Practice Annual Reporting Matrices – Table 2	See attachment P4.13.1
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 15 th 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	October 1 to September 30 Same due date as Annual Plan.

PIHP REPORTING REQUIREMENTS

	Information Plan (Must submit only if PIHP funds CD services)	
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*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:

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.

PIHP REPORTING REQUIREMENTS

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

**PROXY MEASURES FOR PEOPLE WITH INTELLECTUAL AND
DEVELOPMENTAL DISABILITIES**

For FY19, the PIHPs are required to report a limited set of data items in the Quality Improvement (QI) file for consumers with an intellectual or developmental disability. The required items and instructions are shown below. Detailed file specifications are (will be) available on the MDHHS web site at: xxxxxxxx

Instructions: The following elements are proxy measures for people with developmental disabilities. The information is obtained from the individual's record and/or observation. Complete when an individual begins receiving public mental health services for the first time and update at least annually. Information can be gathered as part of the person-centered planning process.

For purposes of these data elements, when the term "support" is used, it means support from a paid or un-paid person or technological support needed to enable the individual to achieve his/her desired future. The kinds of support a person might need are:

- *"Limited" means the person can complete approximately 75% or more of the activity without support and the caregiver provides support for approximately 25% or less of the activity.*
- *"Moderate" means the person can complete approximately 50% of the activity and the caregiver supports the other 50%.*
- *"Extensive" means the person can complete approximately 25% of the activity and relies on the caregiver to support 75% of the activity.*
- *"Total" means the person is unable to complete the activity and the caregiver is providing 100% support.*

Fields marked with an asterisk * cannot be blank or the file will be rejected.

-
- * **Reporting Period (REPORTPD)**
The last day of the month in which the consumer data is being updated. Report year, month, day: yyymmdd.
-
- * **PIHP Payer Identification Number (PIHPID)**
The MDHHS-assigned 7-digit payer identification number must be used to identify the PIHP with all data transmissions.
- * **CMHSP Payer Identification Number (CMHID)**
The MDHHS-assigned 7-digit payer identification number must be used to identify the CMHSP with all data transmissions.
-
- * **Consumer Unique ID (CONID)**

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A numeric or alphanumeric code, of 11 characters that enables the consumer and related services to be identified and data to be reliably associated with the consumer across all of the PIHP's services. The identifier should be established at the PIHP level so agency level or sub-program level services can be aggregated across all program services for the individual. The consumer's unique ID must not be changed once established since it is used to track individuals, and to link to their encounter data over time. **A single shared unique identifier must match the identifier used in 837 encounter for each consumer.**

Social Security Number (SSNO)

The nine-digit integer must be recorded, if available.

Blank = Unreported [Leave nine blanks]

Medicaid ID Number (MCIDNO)

Enter the ten-digit integer for consumers with a Medicaid number.

Blank = Unreported [Leave ten blanks]

MICChild Number (CIN)

Blank = Unreported [Leave ten blanks]

****Disability Designation***

***Developmental disability** (Individual meets the Mental Health Code Definition of Developmental Disability regardless of whether or not they receive services from the I/DD or MI services arrays) **(DD)**

1 = Yes

2 = No

3 = Not evaluated

***Mental Illness or Serious Emotional Disturbance** individual has been evaluated and/or individual has a DSM MI diagnosis, exclusive of intellectual disability, developmental disability, or substance abuse disorder OR the individual has a Serious Emotional Disturbance.

1 = Yes

2 = No

3 = Not evaluated

Gender (GENDER)

Identify consumer as male or female.

M = Male

F = Female

Date of birth (DOB)

PIHP REPORTING REQUIREMENTS

Date of Birth - Year, month, and day of birth must be recorded in that order. Report in a string of eight characters, no punctuation: YYYYMMDD using leading zeros for days and months when the number is less than 10. For example, January 1, 1945 would be reported as 19450101.

. Predominant Communication Style (People with developmental disabilities only)
(COMTYPE) 95% completeness and accuracy required

Indicate from the list below how the individual communicates **most of the time**:

- 1= English language spoken by the individual
 - 2= Assistive technology used (includes computer, other electronic devices) or symbols such as Bliss board, or other “low tech” communication devices.
 - 3= Interpreter used - this includes a foreign language or American Sign Language (ASL) interpreter, or someone who knows the individual well enough to interpret speech or behavior.
 - 4= Alternative language used - this includes a foreign language, or sign language without an interpreter.
 - 5= Non-language forms of communication used – gestures, vocalizations or behavior.
 - 6= No ability to communicate.
- Blank= Missing

. Ability to Make Self Understood (People with developmental disabilities only) (EXPRESS)
95% completeness and accuracy required.

Ability to communicate needs, both verbal and non-verbal, to family, friends, or staff

- 1= Always Understood – Expresses self without difficulty
- 2= Usually Understood – Difficulty communicating BUT if given time and/or familiarity can be understood, little or no prompting required
- 3= Often Understood – Difficulty communicating AND prompting usually required
- 4= Sometimes Understood - Ability is limited to making concrete requests or understood only by a very limited number of people
- 5= Rarely or Never Understood – Understanding is limited to interpretation of very person-specific sounds or body language

Blank= Missing

. Support with Mobility (People with developmental disabilities only) (MOBILITY) 95%
completeness and accuracy required

- 1= Independent - Able to walk (with or without an assistive device) or propel wheelchair and move about
- 2= Guidance/Limited Support - Able to walk (with or without an assistive device) or propel wheelchair and move about with guidance, prompting, reminders, stand by support, or with limited physical support.
- 3= Moderate Support - May walk very short distances with support but uses wheelchair as primary method of mobility, needs moderate physical support to transfer, move the chair, and/or shift positions in chair or bed
- 4= Extensive Support - Uses wheelchair exclusively, needs extensive support to transfer, move the wheelchair, and/or shift positions in chair or bed
- 5= Total Support - Uses wheelchair with total support to transfer, move the

PIHP REPORTING REQUIREMENTS

wheelchair, and/or shift positions or may be unable to sit in a wheelchair; needs total support to shift positions throughout the day

Blank= Missing

. Mode of Nutritional Intake (People with developmental disabilities only) (INTAKE) 95% completeness and accuracy required

1= Normal – Swallows all types of foods

2= Modified independent – e.g., liquid is sipped, takes limited solid food, need for modification may be unknown

3= Requires diet modification to swallow solid food – e.g., mechanical diet (e.g., purée, minced) or only able to ingest specific foods

4= Requires modification to swallow liquids – e.g., thickened liquids

5= Can swallow only puréed solids AND thickened liquids

6= Combined oral and parenteral or tube feeding

7= Enteral feeding into stomach – e.g., G-tube or PEG tube

8= Enteral feeding into jejunum – e.g., J-tube or PEG-J tube

9= Parenteral feeding only—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)

Blank = Missing

Support with Personal Care (People with developmental disabilities only) (PERSONAL) 95% completeness and accuracy required.

Ability to complete personal care, including bathing, toileting, hygiene, dressing and grooming tasks, including the amount of help required by another person to assist. This measure is an overall estimation of the person's ability in the category of personal care. If the person requires guidance only for all tasks but bathing, where he or she needs extensive support, score a "2" to reflect the overall average ability. The person may or may not use assistive devices like shower or commode chairs, long-handled brushes, etc. Note: assistance with medication should NOT be included.

1= Independent - Able to complete all personal care tasks without physical support

2= Guidance/Limited Support - Able to perform personal care tasks with guidance, prompting, reminding or with limited physical support for less than 25% of the activity

3= Moderate Physical Support - Able to perform personal care tasks with moderate support of another person

4= Extensive Support - Able to perform personal care tasks with extensive support of another person

5= Total Support – Requires full support of another person to complete personal care tasks (unable to participate in tasks)

Blank = Missing

. Relationships (People with developmental disabilities only) (RELATION) 95% completeness and accuracy required

Indicate whether or not the individual has "natural supports" defined as persons outside of the mental health system involved in his/her life who provide emotional support or companionship.

1= Extensive involvement, such as daily emotional support/companionship

2= Moderate involvement, such as several times a month up to several times a week

3= Limited involvement, such as intermittent or up to once a month

PIHP REPORTING REQUIREMENTS

- 4= Involved in planning or decision-making, but does not provide emotional support/companionship
- 5= No involvement
- Blank = Missing

Status of Family/Friend Support System (People with developmental disabilities only) (SUPPSYS) 95% completeness and accuracy required

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. "At risk" means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver's help is in place.

- 1= Care giver status is not at risk
- 2= Care giver is likely to reduce current level of help provided
- 3= Care giver is likely to cease providing help altogether
- 4= Family/friends do not currently provide care
- 5= Information unavailable
- Blank = Missing

Support for Accommodating Challenging Behaviors (People with developmental disabilities only) (BEHAV) 95% completeness and accuracy required

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. "Challenging behaviors" include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision)

- 1= No challenging behaviors, or no support needed
- 2= Limited Support, such as support up to once a month
- 3= Moderate Support, such as support once a week
- 4= Extensive Support, such as support several times a week
- 5= Total Support – Intermittent, such as support once or twice a day
- 6= Total Support – Continuous, such as full-time support
- Blank = Missing

Presence of a Behavior Plan (People with developmental disabilities only) (PLAN) 95% accuracy and completeness required

Indicate the presence of a behavior plan during the past 12 months.

- 1= No Behavior Plan
- 2= Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
- 3= Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
- Blank = Missing

Use of Psychotropic Medications (People with developmental disabilities only) 95% accuracy and completeness required

Fill in the number of anti-psychotic and other psychotropic medications the individual is prescribed. See the codebook for further definition of "anti-psychotic" and "other psychotropic" and a list of the most common medications.

51.1: Number of Anti-Psychotic Medications (AP) ____

PIHP REPORTING REQUIREMENTS

Blank = Missing

51.2: Number of Other Psychotropic Medications (**OTHPSYCH**) ____

Blank = Missing

Major Mental Illness (MMI) Diagnosis (People with developmental disabilities only) 95% accuracy and completeness required

This measure identifies major mental illnesses characterized by psychotic symptoms or severe affective symptoms. Indicate whether or not the individual has one or more of the following major mental illness diagnoses: Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder (ICD code 295.xx); Delusional Disorder (ICD code 297.1); Psychotic Disorder NOS (ICD code 298.9); Psychotic Disorder due to a general medical condition (ICD codes 293.81 or 293.82); Dementia with delusions (ICD code 294.42); Bipolar I Disorder (ICD codes 296.0x, 296.4x, 296.5x, 296.6x, or 296.7); or Major Depressive Disorder (ICD codes 296.2x and 296.3x). The ICD code must match the codes provided above. Note: Any digit or no digit at all, may be substituted for each "x" in the codes.

1= One or more MMI diagnosis present

2= No MMI diagnosis present

Blank = Missing

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: rc1041.0 6	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	YYYYM MDD	36	43	Yes	Yes	

PIHP REPORTING REQUIREMENTS

**ENCOUNTERS PER MENTAL HEALTH, DEVELOPMENTAL 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.
-

Amendment #3

PIHP REPORTING REQUIREMENTS

- 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 1915 iSPA; 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.

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 19: Attachment P7.7.1.1
PIHP REPORTING REQUIREMENTS

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(b)(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. The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (MI adults, MI children, DD adults, DD children, and Medicaid SUD). **Standard = 95% in 14 days.**
3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (MI adults, MI children, DD adults, DD children, and Medicaid SUD) **Standard = 95% in 14 days**
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.

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 19: Attachment P7.7.1.1
PIHP REPORTING REQUIREMENTS

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. 1 st 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. 1 st 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.

MILLIMAN CLIENT REPORT

April 2019 Behavioral Health Medicaid Capitation Rate Amendment

State of Michigan

Department of Health and Human Services

March 14, 2019

Christopher Pettit, FSA, MAAA
Principal and Consulting Actuary

Jeremy Cunningham, FSA, MAAA
Consulting Actuary





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I. Background

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 development of actuarially sound capitation rates for the risk based managed care prepaid inpatient health plans to be effective October 1, 2018. This report provides amended state fiscal year (SFY) 2019 actuarially sound capitation rates and a summary of the methodology used in the development of the amended rates to be effective April 1, 2019. The actuarially sound capitation rates are for the Specialty Services and Supports 1915(b)(c) Waiver (SSSW), which includes the Autism benefit, and the Healthy Michigan Plan (HMP) 1115 Waiver.

This report is an amendment to the capitation rate certification report developed for SFY 2019. The previously certified capitation rates and the documentation of the development were published in the following correspondence (original certification) provided by Milliman:

- *SFY 2019 Behavioral Health Capitation Rate Certification* dated September 14, 2018

We have updated the capitation rates provided in the certification report to reflect a \$0.25 per hour increase to direct care wage (DCW) workers for the Medicaid services covered under this program. **Unless otherwise stated, the methodology and assumptions utilized is consistent with the capitation certification documentation included in the original certification.**

The capitation rates provided with this certification are "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- The capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- The capitation rates are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the contract; and,
- The capitation rates meet the requirements of 42 CFR 438.4(b).

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board, CMS, and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective for the SFY 2018 managed care program rating period.
- The *2018-2019 Medicaid Managed Care Rate Development Guide* published by CMS in May 2018.
- Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term "actuarially sound" will be defined in ASOP 49:

"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."

II. Executive Summary

Appendix 2 provides the certified capitation rates effective for April 1, 2019 to September 30, 2019, for the Disabled, Aged, and Blind (DAB), TANF, and HMP populations. Capitation rates paid to the ten regional prepaid inpatient health plans (PIHPs) are calculated by multiplying the base rate by the age-gender factor and corresponding PIHP geographic factor of the beneficiary as documented in Appendix 2. Appendix 3 provides the April 1, 2019 to September 30, 2019 capitation rates for the Habilitative Supports 1915(c) Waiver (HSW) program.

Table 1 provides a comparison of the amended rates at April 2019 relative to the rates effective for the time period October 1, 2018 to March 31, 2019 for the different populations. The rates reflected in Table 1 include amounts related to Insurance Provider Assessment (IPA) and Hospital Reimbursement Adjustment (HRA) and before application of the withhold arrangement.

Table 1 State of Michigan Department of Health and Human Services April 1, 2019 to September 30, 2019 Capitation Rates Capitation Rate PMPM Comparison (including HRA/IPA)			
Rate Category	October 1, 2018 Rates	April 1, 2019 Rates	Increase/Decrease
TANF			
Mental Health	\$ 19.44	\$ 19.46	0.1%
Substance Abuse	2.17	2.17	0.0%
Autism	4.40	4.40	0.0%
DAB			
Mental Health	278.31	282.45	1.5%
Substance Abuse	5.37	5.37	0.0%
Autism	22.14	22.14	0.0%
HMP			
Mental Health	36.94	37.03	0.2%
Substance Abuse	11.09	11.09	0.0%
Autism	0.38	0.38	0.0%
Waiver (c)			
HSW	4,938.91	5,024.31	1.7%

The estimated fiscal impact of the SFY 2019 capitation rates documented in this report represent a \$16.4 million increase to aggregate expenditures for the 6 month time period from April 1 to September 30 based on the rates noted in Table 1. These amounts are on a state and federal expenditure basis using the projected monthly enrollment for SFY 2019.

Table 2 provides the development of estimated total expenditures, as well as federal only and state only expenditures, for the average October 1, 2018 to March 31, 2019 contracted capitation rates and the proposed April 1, 2019 to September 30, 2019 capitation rates illustrated in Table 1. The federal expenditures illustrated in Table 2 are based on the federal fiscal year 2019 FMAP of 64.45% for non-HMP populations, and 93% for HMP.

Table 2			
State of Michigan			
Department of Health and Human Services			
April 1, 2019 to September 30, 2019 Capitation Rates			
Comparison of Projection of Capitation Rate Expenditures			
Values in \$ Millions (including HRA/IPA)			
Rate Category	SFY 2018 Rates	SFY 2019 Rates	Increase/Decrease
TANF			
Mental Health	\$ 137.2	\$ 137.4	\$ 0.2
Substance Abuse	15.3	15.3	0.0
Autism	31.1	31.1	(0.0)
DAB			
Mental Health	807.1	819.1	12.0
Substance Abuse	15.6	15.6	0.0
Autism	64.2	64.2	(0.0)
HMP			
Mental Health	143.5	143.9	0.3
Substance Abuse	43.1	43.1	0.0
Autism	0.1	0.1	0.0
Waiver (c)			
HSW	225.9	229.8	3.9
Total State & Federal	\$ 1,483.1	\$ 1,499.6	\$ 16.4
Total State Only	\$ 473.9	\$ 479.7	\$ 5.7
Total Federal Only	\$ 1,009.2	\$ 1,019.9	\$ 10.7

Notes:

- [1] Values have been rounded.
- [2] Values include HRA and IPA.
- [3] FMAP of 64.45% used for non-HMP populations. FMAP of 93.00% used for HMP. The FMAP reflects the SFY 2019 FMAP values. We have not reflected the enhanced FMAP for the MI Child population.
- [4] Values have been adjusted to exclude all expenditures in a given month for individuals who stayed more than 15 days in an IMD setting in that month.

A description for each of the updated appendices is included below.

- Appendix 1 contains the actuarial certification regarding the capitation rates for the April to September 2019 time period illustrated in Appendices 2 and 3.
- Appendix 2 provides the final certified capitation rates for the Disabled, Aged, and Blind (DAB), TANF, and HMP populations for the April 1, 2019 to September 30, 2019 time period.
- Appendix 3 provides the final certified capitation rates for the Habilitative Supports 1915(c) Waiver (HSW) program for the April 1, 2019 to September 30, 2019 time period.
- Appendix 4 documents the adjustments made to the underlying base experience.
- Appendix 5 illustrates the capitation rate development from the figures adjusted in Appendix 4.

III. Methodology

The methodology used in developing the amended SFY 2019 capitation rates is outlined below.

Step 1: Base Experience

We utilized the claims data underlying the SFY 2019 capitation rates, as outlined in the original certification, as base experience for the amended capitation rates. These projected claims costs are inclusive of all claims cost adjustments made to the data as outlined in the original certification.

Step 2: Adjustments for \$0.25 per hour DCW Increase

Effective October 1, 2017, MDHHS increased reimbursement for direct care wage (DCW) services by \$0.50 per hour based on the Section 1009 boilerplate language. This reimbursement change was documented and illustrated in the original SFY 2019 certification.

Effective April 1, 2019, MDHHS is increasing reimbursement for DCW services by an additional \$0.25 per hour. The following services were considered DCW services for purposes of this adjustment:

- H0043 - Community Living Supports in Independent living/own home
- H0045 - Respite Care
- H2014 - Skill-Building
- H2015 - Community Living Supports (15 Minutes)
- H2016 - Community Living Supports (Daily)
- H2023 - Supported Employment Services
- S5151 - Respite
- T1005 - Respite Care
- T1020 - Personal Care in Licensed Specialized Residential Setting
- T2015 - Out of Home Prevocational Service
- T2036 - Community Living Supports/Respite Care-Therapeutic Camping
- T2037 - Community Living Supports/Respite Care-Therapeutic Camping

Appendix 4 documents the adjustment made to underlying SFY 2017 base experience for the increased reimbursement amounts for DCW services, inclusive of the original \$0.50 per hour increase and the April 1, 2019 effective \$0.25 per hour increase. All remaining services not impacted by the DCW increase were unchanged for this amendment.

Step 3: Incorporate non-claim items and adjustments

We have not modified the administrative cost assumptions from the original certification. However, the final amended capitation rates are modified to include the impact of certain non-benefit items, such as an administrative allowance. Therefore, the per member per month non-benefit expenses included in the rates will vary from the original certification as a result of the application of administrative costs and taxes as a percentage of the total capitation rate. The impact of the previously mentioned changes illustrated on a PMPM basis in Appendix 2 include the estimated change to administrative costs within the respective amounts.

Step 4: Development and issuance of actuarial certification

An actuarial certification is included and signed by Chris Pettit, FSA, a Principal and Consulting Actuary in the Indianapolis office of Milliman. Mr. Pettit meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, in order to certify that the final rates meet the standards in 42 CFR §438.4(a).

IV. Limitations and Qualifications

The services provided for this project were performed under the signed contract between Milliman and MDHHS approved February 27, 2017.

The information contained in this letter, including the enclosures, has been prepared for the State of Michigan, Department of Health and Human Services and their consultants and advisors. It is our understanding that 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 Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

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.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

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 meet the qualification standards for performing the analyses in this report.

Appendix 1: Actuarial certification

**State of Michigan
Department of Health and Human Services
Behavioral Health Managed Care Programs
Capitation Rates Effective April 1, 2019 through September 30, 2019**

Actuarial Certification

I, Christopher T. Pettit, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of Michigan and am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

The capitation rates provided with this certification are considered "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- the capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the MCO for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

For the purposes of this certification and consistent with the requirements under 42 CFR 438.4(a), "actuarial soundness" is defined as in ASOP 49:

"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."

The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with the State of Michigan. The "actuarially sound" capitation rates that are associated with this certification are effective for the rate period April 1, 2019 through September 30, 2019.

The capitation rates are considered actuarially sound after adjustment for the amount of the withhold not expected to be earned.

The "actuarially sound" capitation rates are based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the rates.

In developing the "actuarially sound" capitation rates, I have relied upon data and information provided by the State. I have relied upon the State for audit of the data. However, I did review the data for reasonableness and consistency.

The capitation rates developed may not be appropriate for any specific PIHP. An individual PIHP will need to review the rates in relation to the benefits that it will be obligated to provide. The PIHP should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The PIHP may require rates above, equal to, or below the "actuarially sound" capitation rates that are associated with this certification.



Chris Pettit, FSA
Member, American Academy of Actuaries

March 14, 2019
Date

Appendix 2: State Plan and 1915(b)(3) Rates

State of Michigan, Department of Health and Human Services
Specialty Services and Supports Waiver
Proposed Paid Rates - April 1, 2018 to September 30, 2019

<u>Service and Population</u>	<u>State Plan</u>	<u>1915(b)(3)</u>	<u>Autism</u>	<u>IPA</u>	<u>HRA</u>
TANF Mental Health	\$ 16.91	\$ 0.77	\$ 4.40	\$ 1.20	\$ 0.58
DAB Mental Health	\$ 135.11	\$ 142.34	\$ 22.14	\$ 1.20	\$ 3.80
HMP Mental Health	\$ 32.34		\$ 0.38	\$ 1.20	\$ 3.49
TANF Substance Abuse	\$ 2.16	\$ 0.01			
DAB Substance Abuse	\$ 5.36	\$ 0.01			
HMP Substance Abuse	\$ 11.09				

April 1, 2018 to September 30, 2019 Age / Gender Factors

<u>Service and Population</u>	<u>0 - 5</u>	<u>6 - 18</u>	<u>19 - 21</u>	<u>22 - 25</u>	<u>26 - 39</u>	<u>40 - 49</u>	<u>50 - 64</u>	<u>65+</u>
Mental Health - TANF								
Male - SP	0.3800	1.3097	0.7899	0.6164	0.6969	0.6103	0.5244	0.3487
Female - SP	0.2205	1.1549	1.3457	1.9966	1.5193	1.1329	0.8100	0.1856
Male - B3	0.5946	1.3517	0.2016	0.6773	0.6042	0.4401	0.6817	0.0594
Female - B3	0.5974	0.8142	0.8048	1.4836	1.4716	1.7511	1.3496	1.9470
Male - Autism	3.7708	1.2463	0.0093					
Female - Autism	0.9508	0.2827	0.0137					
Mental Health - DAB								
Male - SP	0.6551	1.1048	1.7637	1.2199	1.5987	1.5368	1.2810	0.5435
Female - SP	0.4031	0.9500	1.3275	1.2357	1.4120	1.2349	0.9858	0.3368
Male - B3	0.0948	0.1546	0.5935	2.3761	2.8680	1.8271	1.3270	0.6540
Female - B3	0.0581	0.1118	0.5209	1.9092	2.1781	1.2052	0.8749	0.3667
Male - Autism	20.1881	4.5900	0.6204					
Female - Autism	7.4237	1.7889	0.3102					
Mental Health - HMP								
Male			0.9538	1.1993	1.2445	1.2187	1.0409	
Female			0.6807	0.7076	0.8363	1.0646	0.8044	
Male - Autism			1.3483					
Female - Autism			0.6740					
Substance Abuse - TANF								
Male	0.0397	0.2315	0.5499	2.5156	4.4666	2.6431	1.7247	0.0397
Female	0.0397	0.1159	1.0722	2.3566	4.7281	2.5511	1.5277	0.2612
Substance Abuse - DAB								
Male	0.0400	0.2088	0.3101	0.5931	1.3860	1.7401	2.4848	0.5687
Female	0.0400	0.1030	0.3185	0.6645	1.6329	1.3695	1.3362	0.1696
Substance Abuse - HMP								
Male			0.3006	0.7563	1.7441	1.4835	1.1801	
Female			0.1832	0.4402	0.9867	0.8202	0.5096	

April 1, 2018 to September 30, 2019 Geographic Factors

<u>PIHP Name</u>	<u>Mental Health</u>			<u>Substance Abuse</u>			<u>Autism</u>		
	<u>TANF</u>	<u>DAB</u>	<u>HMP</u>	<u>TANF</u>	<u>DAB</u>	<u>HMP</u>	<u>TANF</u>	<u>DAB</u>	<u>HMP</u>
Northcare Network	1.1041	1.2425	0.8292	1.2236	0.2259	0.8057	0.7599	0.7830	1.0000
Northern Michigan Regional Entity	1.3540	0.9823	0.8765	1.5305	0.7484	1.1882	1.1944	1.3322	1.0000
Lakeshore Regional Entity	0.7554	0.9754	0.6636	1.1909	0.9737	1.0608	1.0644	1.0946	1.0000
Southwest Michigan Behavioral Health	0.9847	0.9294	1.1027	1.2213	0.9498	1.3682	0.7965	0.5705	1.0000
Mid-State Health Network	1.3229	1.0804	1.1136	1.5216	0.8840	1.2353	1.3184	1.2525	1.0000
CMH Partnership of Southeast Michigan	0.7633	1.0044	0.7196	0.8860	0.7876	0.9487	1.3026	0.8332	1.0000
Detroit Wayne Mental Health Authority	1.1419	0.8450	1.1881	0.4040	1.2787	0.6651	0.7925	1.0172	1.0000
Oakland County CMH Authority	0.7463	1.3645	1.3534	1.0012	0.8051	0.8875	0.9634	0.8069	1.0000
Macomb County CMH Services	0.5262	0.9698	0.6440	0.9678	0.9211	0.9881	1.3734	1.3660	1.0000
Region 10 PIHP	0.8338	1.0726	0.7643	1.2711	1.1519	1.3692	0.6382	0.7051	1.0000

Appendix 3: Waiver (c) Rates

State of Michigan, Department of Health and Human Services
Specialty Services and Supports Waiver
Waiver Capitation Rate Development
Proposed Paid Rates - April 1, 2018 to September 30, 2019

<u>Habilitation Supports Waiver (HSW)</u>	<u>Total</u>
Rate Development Base:	\$ 1,683.25
<u>Residential Living Arrangement</u>	
Private Residence with Spouse or Non-family/Supported Independence Program	5,422.62
Specialized Residential Home	2,940.20
Private Residence with Family / Foster Home	1,961.66

Multiplicative Factor (HSW)

Northcare Network	1.0457
Northern Michigan Regional Entity	1.0492
Lakeshore Regional Entity	0.9880
Southwest Michigan Behavioral Health	1.0059
Mid-State Health Network	1.0208
CMH Partnership of Southeast Michigan	0.9830
Detroit Wayne Mental Health Authority	0.9954
Oakland County CMH Authority	0.9666
Macomb County CMH Services	0.9666
Region 10 PIHP	0.9719

Appendix 4: Claim Cost Development

State of Michigan, Department of Health and Human Services
 April 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
 Claim Cost Development
 DAB Population

Service Type	SFY 2017											Trend Adjustment	SFY 2019 Service Cost Eligibility PMPM
	Base PMPM	DCW Adjustment	MCPI Adjustment	SA Assessment Adjustment	Autism Fee Schedule Adjustment	Adjusted Base PMPM	Covered Population Adjustment	Shortage Area Adjustment	Managed Care Adjustment	IMD Adjustment	Normalized PMPM		
Mental Health													
<u>Proposed Paid Rates</u>													
State Plan Inpatient	\$ 13.08	1.0000	0.9749	1.0000	1.0000	\$ 12.75	0.9920	1.0000	1.0000	0.8988	\$ 11.37	1.0506	\$ 11.95
State Plan Outpatient	0.32	1.0000	0.9646	1.0000	1.0000	0.31	0.9920	1.0000	1.0000	0.9965	0.31	1.0506	0.32
State Plan Professional CLS	38.39	1.1259	0.9851	1.0000	1.0000	42.58	0.9920	1.0000	1.0000	1.0000	42.24	1.0506	44.38
State Plan Professional Non-CLS	62.85	1.0001	0.9797	1.0000	1.0000	61.59	0.9920	1.0000	1.0000	0.9992	61.04	1.0506	64.13
State Plan Total	\$ 114.65					\$ 117.24					\$ 114.97		\$ 120.79
B3 Professional CLS	\$ 79.17	1.0588	0.9789	1.0000	1.0000	\$ 82.05	0.9920	1.0000	1.0000	0.9998	\$ 81.38	1.0506	\$ 85.50
B3 Professional Non-CLS	39.63	1.0295	0.9824	1.0000	1.0000	40.08	0.9920	1.0000	1.0000	0.9999	39.75	1.0506	41.77
B3 Total	\$ 118.79					\$ 122.13					\$ 121.13		\$ 127.27
Total	\$ 233.44					\$ 239.36					\$ 236.10		\$ 248.06
Autism	\$ 13.16	1.0000	1.0000	1.0000	0.8304	\$ 10.93	1.8116	1.0000	1.0000	1.0000	\$ 19.80	1.0404	\$ 20.60
Substance Abuse													
<u>Proposed Paid Rates</u>													
State Plan	\$ 4.51	1.0000	0.9830	1.0115	1.0000	\$ 4.48	1.0001	1.0000	1.0000	1.0000	\$ 4.48	1.0609	\$ 4.75
B3	0.01	1.0000	1.0000	1.0000	1.0000	0.01	1.0001	1.0000	1.0000	1.0000	0.01	1.0000	0.01
Total	\$ 4.52					\$ 4.49					\$ 4.49		\$ 4.76

State of Michigan, Department of Health and Human Services
 April 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
 Claim Cost Development
 TANF Population

Service Type	SFY 2017											Trend Adjustment	SFY 2019 Service Cost Eligibility PMPM
	Base PMPM	DCW Adjustment	MCPI Adjustment	SA Assessment Adjustment	Autism Fee Schedule Adjustment	Adjusted Base PMPM	Covered Population Adjustment	Shortage Area Adjustment	Managed Care Adjustment	IMD Adjustment	Normalized PMPM		
	Mental Health												
<u>Proposed Paid Rates</u>													
State Plan Inpatient	\$ 1.99	1.0000	0.9770	1.0000	1.0000	\$ 1.94	1.0001	1.0000	1.0000	0.9907	\$ 1.92	1.0712	\$ 2.06
State Plan Outpatient	0.20	1.0000	0.9872	1.0000	1.0000	0.20	1.0001	1.0000	1.0000	0.9988	0.20	1.0712	0.21
State Plan Professional CLS	0.34	1.0526	0.9857	1.0000	1.0000	0.36	1.0001	1.0000	1.0000	0.9999	0.36	1.0712	0.38
State Plan Professional Non-CLS	11.52	1.0000	0.9774	1.0000	1.0000	11.26	1.0001	1.0000	1.0000	0.9999	11.26	1.0712	12.06
State Plan Total	\$ 14.06					\$ 13.76					\$ 13.74		\$ 14.72
B3 Professional CLS	\$0.05	1.0606	0.9773	1.0000	1.0000	\$0.05	1.0001	1.0000	1.0000	0.9991	\$0.05	1.0712	\$0.05
B3 Professional Non-CLS	0.58	1.0222	0.9749	1.0000	1.0000	0.58	1.0001	1.0000	1.0000	0.9999	0.58	1.0712	0.62
B3 Total	\$ 0.63					\$ 0.63					\$ 0.63		\$ 0.67
Total	\$ 14.68					\$ 14.39					\$ 14.37		\$ 15.39
Autism	\$2.38	1.0000	1.0000	1.0000	0.8354	\$ 1.99	1.9810	1.0000	1.0000	1.0000	\$ 3.94	1.0404	\$ 4.10
Substance Abuse													
<u>Proposed Paid Rates</u>													
State Plan	\$1.81	1.0000	0.9882	1.0184	1.0000	\$ 1.82	0.9955	1.0000	1.0000	1.0000	\$ 1.81	1.0609	\$ 1.92
B3	0.01	1.0000	1.0000	1.0000	1.0000	0.01	0.9955	1.0000	1.0000	1.0000	0.01	1.0000	0.01
Total	\$ 1.82					\$ 1.83					\$ 1.82		\$ 1.93

State of Michigan, Department of Health and Human Services
 April 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
 Claim Cost Development
 Waiver (c) Populations

Service Type	SFY 2017						Trend Adjustment	SFY 2019 Service Cost Eligibility PMPM
	Base	DCW	MCPI	Adjusted	Population	Normalized		
	PMPM	Adjustment	Adjustment	Base PMPM	Adjustment	PMPM		
<u>HSW Waiver</u>								
Community Living Supports	\$ 3,597.26	1.0575	0.9678	\$ 3,681.62	0.9926	\$ 3,654.54	1.0506	\$ 3,839.55
<u>Non-Community Living Supports</u>	<u>907.00</u>	1.0277	0.9684	<u>902.71</u>	0.9926	<u>896.07</u>	1.0506	<u>941.44</u>
Total	\$ 4,504.26			\$ 4,584.34		\$ 4,550.61		\$ 4,780.98

State of Michigan, Department of Health and Human Services
 April 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
 Claim Cost Development
 HMP Population

Service Type	SFY 2017											Trend Adjustment	SFY 2019 Service Cost Eligibility PMPM
	Base	DCW	MCPI	SA	Autism Fee	Adjusted	Covered	Shortage	Managed	IMD	Normalized		
	PMPM	Adjustment	Adjustment	Adjustment	Adjustment	Base	Population	Area	Care	Adjustment	PMPM		
Mental Health													
<u>Proposed Paid Rates</u>													
Inpatient	\$ 8.71	1.0000	0.9466	1.0000	1.0000	\$ 8.24	0.9973	1.0001	1.0000	0.9602	\$ 7.90	1.0712	\$ 8.46
Outpatient	0.20	1.0000	0.9713	1.0000	1.0000	0.19	0.9973	1.0001	1.0000	0.9947	0.19	1.0712	0.20
Professional CLS	3.07	1.0681	0.9387	1.0000	1.0000	3.08	0.9973	1.0001	1.0000	0.9988	3.07	1.0712	3.29
Professional Non-CLS	16.86	1.0017	0.9402	1.0000	1.0000	15.88	0.9973	1.0001	1.0000	0.9985	15.81	1.0712	16.94
Total	\$ 28.83					\$ 27.39					\$ 26.96		\$ 28.88
Autism	\$ 0.20	1.0000	1.0000	1.0000	0.8488	\$ 0.17	1.9810	1.0001	1.0000	1.0000	\$ 0.34	1.0404	\$ 0.35
Substance Abuse													
<u>Proposed Paid Rates</u>													
Total	\$9.67	1.0000	0.9538	1.0158	1.0000	\$9.37	0.9958	1.0001	1.0000	1.0000	\$ 9.33	1.0609	\$ 9.90

Appendix 5: Capitation Rate Development

State of Michigan, Department of Health and Human Services
 April 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
 Capitation Rate Build
 DAB Population

<u>Service Type</u>	SFY 2019 Service Cost Eligibility PMPM	Estimated Capitation to Eligibility Ratio	SFY 2019 Service Cost Capitation PMPM	Variable Admin Load	Fixed Admin Load	SFY 2019 Capitation Rate
Mental Health						
<u>Proposed Paid Rates</u>						
State Plan Inpatient	\$ 11.95	0.9590	\$ 12.46	\$ 0.52	\$ 0.39	\$ 13.37
State Plan Outpatient	0.32	0.9590	0.34	0.01	0.01	0.36
State Plan Professional CLS	44.38	0.9590	46.28	1.93	1.43	49.64
State Plan Professional Non-CLS	64.13	0.9590	66.88	2.79	2.07	71.74
State Plan Total	\$ 120.79		\$ 125.96	\$ 5.25	\$ 3.90	\$ 135.11
B3 Professional CLS	\$ 85.50	0.9590	\$ 89.16	\$ 3.72	\$ 2.76	\$ 95.64
B3 Professional Non-CLS	41.77	0.9590	43.55	1.81	1.34	46.70
B3 Total	\$ 127.27		\$ 132.71	\$ 5.53	\$ 4.10	\$ 142.34
Total	\$ 248.06		\$ 258.67	\$ 10.78	\$ 7.99	\$ 277.45
Autism	\$ 20.60	0.9590	\$ 21.48	\$ 0.66		\$ 22.14
Substance Abuse						
<u>Proposed Paid Rates</u>						
State Plan	\$ 4.75	0.9590	\$ 4.96	\$ 0.40		\$ 5.36
B3	0.01	0.9590	0.01	-		0.01
Total	\$ 4.76		\$ 4.97	\$ 0.40		\$ 5.37

State of Michigan, Department of Health and Human Services
 April 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
 Capitation Rate Build
 TANF Population

<u>Service Type</u>	SFY 2019 Service Cost Eligibility PMPM	Estimated Capitation to Eligibility Ratio	SFY 2019 Service Cost Capitation PMPM	Variable Admin Load	Fixed Admin Load	SFY 2019 Capitation Rate
Mental Health						
<u>Proposed Paid Rates</u>						
State Plan Inpatient	\$ 2.06	0.9590	\$ 2.15	\$ 0.09	\$ 0.13	\$ 2.37
State Plan Outpatient	0.21	0.9590	0.22	0.01	0.01	0.24
State Plan Professional CLS	0.38	0.9590	0.40	0.02	0.03	0.45
State Plan Professional Non-CLS	12.06	0.9590	12.58	0.52	0.75	13.85
State Plan Total	\$ 14.72		\$ 15.35	\$ 0.64	\$ 0.92	\$ 16.91
B3 Professional CLS	\$ 0.05	0.9590	\$ 0.06	\$ 0.00	\$ 0.00	\$ 0.06
B3 Professional Non-CLS	0.62	0.9590	0.64	0.03	0.04	0.71
B3 Total	\$ 0.67		\$ 0.70	\$ 0.03	\$ 0.04	\$ 0.77
Total	\$ 15.39		\$ 16.05	\$ 0.67	\$ 0.97	\$ 17.68
Autism	\$ 4.10	0.9590	\$ 4.27	\$ 0.13		\$ 4.40
Substance Abuse						
<u>Proposed Paid Rates</u>						
State Plan	\$ 1.92	0.9590	\$ 2.00	\$ 0.16		\$ 2.16
B3	0.01	0.9590	0.01	-		0.01
Total	\$ 1.93		\$ 2.01	\$ 0.16		\$ 2.17

State of Michigan, Department of Health and Human Services
 April 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
 Capitation Rate Build
 Waiver (c) Populations

<u>Service Type</u>	SFY 2019 Service Cost Eligibility PMPM	Estimated Capitation to Eligibility Ratio	SFY 2019 Service Cost Capitation PMPM	Variable Admin Load	Fixed Admin Load	SFY 2019 Capitation Rate
<u>HSW Waiver</u>						
Community Living Supports	\$ 3,839.55	0.9810	\$ 3,913.91	\$ 121.05		\$ 4,034.96
Non-Community Living Supports	941.44	0.9810	959.67	29.68		989.35
Total	\$ 4,780.98		\$ 4,873.58	\$ 150.73		\$ 5,024.31

State of Michigan, Department of Health and Human Services
 April 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
 Capitation Rate Build
 HMP Population

<u>Service Type</u>	SFY 2019 Service Cost Eligibility PMPM	Estimated Capitation to Eligibility Ratio	SFY 2019 Service Cost Capitation PMPM	Variable Admin Load	SFY 2019 Capitation Rate
Mental Health					
<u>Proposed Paid Rates</u>					
Inpatient	\$ 8.46	0.9500	\$ 8.90	\$ 0.57	\$ 9.47
Outpatient	0.20	0.9500	0.21	0.01	0.22
Professional CLS	3.29	0.9500	3.46	0.22	3.68
Professional Non-CLS	16.94	0.9500	17.83	1.14	18.97
Total	\$ 28.88		\$ 30.40	\$ 1.94	\$ 32.34
Autism	\$ 0.35	0.9500	\$ 0.37	\$ 0.01	\$ 0.38
Substance Abuse					
<u>Proposed Paid Rates</u>					
Total	\$ 9.90	0.9500	\$ 10.42	\$ 0.67	\$ 11.09