PIHP REPORTING REQUIREMENTS FOR MEDICAID SPECIALTY SUPPORTS AND SERVICES BENEFICIARIES

Effective 10/1/08

Table of Contents

	Section	Page
1.	**Introduction**	**2**
2.	**Table of Reporting Due Dates (Updated for FY'09)**	**4**
3.	**Quality Improvement Data**	**5**
4.	**Encounter Data Per Consumer**	**20**
5.	**Medicaid Utilization and Net Cost Report**	
	a. **Instructions**	**24**
	b. **Format for reporting: see www.michigan.gov/mdch click on Mental Health & Substance Abuse, then "Reporting Requirements"**	
6.	**Section 460 Report on Cost Allocation**	**30**
	a. **Instructions**	
	b. **Format for reporting: see www.michigan.gov/mdch click on Mental Health & Substance Abuse, then "Reporting Requirements"**	
7.	**PIHP Performance Indicator System (Changes for FY'09)**	**39**
	a. **Due Dates**	**42**
8.	**Quality Management Data**	**43**
	a. **Consumer functioning**	
	b. **Consumer satisfaction**	

FY 2009 MDCH/PIHP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT MENTAL HEALTH REPORTING REQUIREMENTS

Introduction

The Michigan Department of Community Health reporting requirements for the FY2009 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 Abuse Coordinating Agencies (CAs).

Companions to the requirements in this attachment are

- "Supplemental Instructions for Encounter and Quality Improvement Data Submissions" which contains clarifications, value ranges, and edit parameters for the encounter and quality improvement (demographic) data, as well as examples that will assist PIHP staff in preparing data for submission to MDCH.
- Mental Health Codelist that contains the Medicaid covered services as well as services that may be paid by general fund and the CPT and HCPCs codes that MDCH and EDIT have assigned to them.
- Cost per code instructions that contain 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, Version 6.0" is a codebook with instructions on what data to collect for, and how to calculate and report, performance indicators

These documents are posted on the MDCH 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 MDCH 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 MDCH including:

- Legislative boilerplate annual reporting and semi-annual updates
- Managed Care Contract Management

- System Performance Improvement
- Statewide Planning
- Centers for Medicare and Medicaid (CMS) reporting
- Actuarial activities

Where accuracy standards for collecting and reporting QI data are noted in the contract, it is expected that PIHPs will meet those standards.

Individual consumer level data received at MDCH is kept confidential and published reports will display only aggregate data. Only a limited number of MDCH 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.

PIHP REPORTING REQUIREMENTS
FY 2009 DATA REPORT DUE DATES

	Nov08	Dec	Jan09	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec09	Jan10
1. Consumer level** a. Quality Improvement (monthly)[1] b. Encounter (monthly)[1]	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
2.PIHP level															
a. Medicaid Utilization and Net Cost Report (Effective 10/1/07: annually)[2]			√					√							√
b .Section 460 Cost Allocation Report (annually)															√
c. Section 460 Cost Allocation Plan (annually)											√				
b. Performance indicators (quarterly)[2]					√			√			√			√	
c. Sentinel events (semi-annually)[2]					√			√			√			√	
d. Consumer Satisfaction (annually) [2]										√					

NOTES:

1. Send data to MDCH MIS via DEG
2. Send data to MDCH, Mental Health and Substance Abuse Administration, Division of Quality Management and Planning

**Consumer level data must be submitted immediately 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.

PIHP level reports are due at 5 p.m. on the last day of the month checked

PIHP REPORTING REQUIREMENTS
QUALITY IMPROVEMENT DATA

Demographic or "quality improvement" (QI) data is required to be reported for each consumer and for whom an encounter data record or fee-for service claim (for Children's Waiver) is being submitted. Encounter data is reported within 30 days after the claim for the service is adjudicated, or in cases where claims payment is not part of the PIHP's business practice, within 30 days following the end of the month in which services were delivered. QI data is reported year-to-date. The first report for the fiscal year will contain records for all consumers whose claims were adjudicated the first month, the next month's report will contain records of all consumers whose claims were adjudicated in month one and month two, etc. Corrective QI file updates are allowed from the PIHP to replace a rejected file, or a file that contained rejected records.

Method for submission: The QI data is to be submitted in a delimited format, with the columns identified by the delimiter, rather then by column "from" and "to" indicators.

Due dates: The first QI data should be submitted during the same month the first encounter data is submitted. Encounter and QI data are due 30 days after a claim is adjudicated or services were rendered (see above note). Reporting adjudicated claims will enable the PIHP to accurately report on the amount paid for the service and on third party reimbursements.

Who to report: Report on each consumer who received a service from the PIHP, and from each CMHSP in the case of an affiliation, regardless of funding stream. The exception is when a PIHP or CMHSP contracts with another PIHP or CMHSP, or a Medicaid Health Plan contracts with a PIHP or CMHSP to provide mental health services. In that case, the PIHP or CMHSP that delivers the service does not report the encounter.

Who submits consumer-level data: The PIHP must report the encounter and QI data for all mental health and developmental disabilities (MH/DD) Medicaid beneficiaries in its entire service area/affiliation. The PIHP must report the encounter data for all substance abuse Medicaid beneficiaries in its service area. QI data for Medicaid beneficiaries receiving services from the Substance Abuse Coordinating Agencies (CAs) are not required to be reported by the PIHP. Some PIHPs may choose, however, to collect QI data from the CAs and forward it to MDCH. Encounter and QI data for non-Medicaid MH/DD beneficiaries may be reported by the CMHSP affiliate, as applicable. However, in order to ensure that people who move to and from Medicaid eligibility throughout the year, it is preferred that the PIHP report all encounter and QI data for all mental health beneficiaries in its service area/affiliation.

Notes:

1. Demographic Information must be updated at least annually, such as at the time of annual planning. **A consumer demographic record must be submitted for each month the consumer receives services, and for which an encounter record or fee-for-service claim (Children's Waiver) is being submitted. Failure to meet this standard may result in rejection of a file and contract action**.
2. Numbers missing from the sequence of options represent items deleted from previous

reporting requirements.

3. Items with an * require that 95% of records contain a value in that field and that the values be within acceptable ranges (see each item for the ranges). Items with ** require that 100% of the records contain a value in the field, and the values are in the proper format and within acceptable ranges. Failure to meet the 100% standard will result in rejection of the file or record.
4. A "Supplemental Instructions for Encounter and Quality Improvement Data Submissions" issued by MDCH should be used for file layouts.
5. Some demographic items are reported on both the HIPAA/4010A1 Health Care Claim transaction and the QI data report for ease of calculating population numbers during the year.

The following is a description of the individual consumer demographic elements for which data is required of Community Mental Health Services Programs.

****1. *Reporting Period* (REPORTPD)**
The last day of the month during which consumers received services covered by this report. Report year, month, day: ccyymmdd.

****2.a. *PIHP Payer Identification Number* (PIHPID)**
The MDCH-assigned 9-digit payer identification number must be used to identify the PIHP with all data transmissions.

2.b. *CMHSP Payer Identification Number* (CMHID)
The MDCH-assigned 9-digit payer identification number must be used to identify the CMHSP with all data transmissions.

****3. *Consumer Unique ID* (CONID)**
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 or CMHSP 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 837/4010A1 encounter for each consumer. **If the consumer identification number does not have 11 characters, it may cause rejection of a file.**

---

4. *Social Security Number* (SSNO)
The nine-digit integer must be recorded, if available.
Blank = Unreported [Leave nine blanks]

***5. *Medicaid ID Number* (MCIDNO)**
Enter the eight-digit integer for consumers with a Medicaid number.
Blank = Unreported [Leave eight blanks]
Consumers with Program Eligibility (#26) indicating Medicaid (~~26.01~~, 26.04, and/or 26.06) must have a Medicaid ID number (Standard = 95%)

PIHP REPORTING REQUIREMENTS

6. Leave blank beginning with FY'06 service reporting

7. ***Corrections Related Status*** **(CORSTAT)**

For persons under the jurisdiction of a corrections or law enforcement program during treatment, indicate the location/jurisdiction involved at the time of annual update

1 = In prison
2 = In jail
3 = Paroled from prison
4 = Probation from jail
5 = Juvenile detention center
6 = Court supervision
7 = Not under the jurisdiction of a corrections or law enforcement program
8 = Awaiting trial
9 = Awaiting sentencing
10= Consumer refused to provide information
11= Minor (under age 18) who was referred by the court
12= Arrested and booked
13= Diverted from arrest or booking
Blank = Unknown

****8.*** ***Residential Living Arrangement*** **(RESID) Effective 10/1/07, 95% completeness required**

Indicate the consumer's residential situation or arrangement at the time of intake if it occurred during the reporting period, or at the time of annual update of consumer information during the period. Reporting categories are as follows:

1 = Homeless on the street or in a shelter for the homeless
2 = Living in a private residence with natural or adoptive family member(s). "Family member" means parent, stepparent, sibling, child, or grandparent of the primary consumer; or an individual upon whom the primary consumer is dependent for at least 50% of his or her financial support.
3 = Living in a private residence not owned by the PIHP, CMHSP or the contracted provider, alone or with spouse or non-relative(s).
5 = Foster family home (Include all foster family arrangements regardless of number of beds)
6 Specialized residential home - Includes any adult foster care facility certified to provide a specialized program per DMH Administrative Rules, 3/9/96, R 330.1801 (Include all specialized residential, regardless of number of beds)
8 = General residential home (Include all general residential regardless of number of beds)
"General residential home" means a licensed foster care facility not certified to provide specialized program (per the DMH Administrative Rules)
10 = Prison/jail/juvenile detention center
11 = Deleted (AIS/MR)
12= Nursing Care Facility

PIHP REPORTING REQUIREMENTS

13= Institutional setting (congregate care facility, boarding schools, Child Caring Institutions, state facilities)
16 = Supported Independence Program (lease is held by CMHSP or provider)
Blank = Unreported

---

9. Total Annual Income **(TOTINC)**

Indicate the total amount of gross income of the individual consumer if he/she is single; or that of the consumer and his/her spouse if married; or that of the parent(s) of a minor consumer at the time of service initiation or most recent plan review. “Income” is defined as income that is identified as taxable personal income in section 30 of Act No. 281 of the Public Acts of 1967, as amended, being 206.30 of the Michigan Compiled Laws, and non-taxable income, which can be expected to be available to the individual and spouse not more than 2 years subsequent to the determination of liability.

Round to the nearest dollar; do not include commas, dollar signs or decimal points.
-Household income = $_ _ _ _ _ _.00 [Example: $10,358.34 = _10358]
-Blank = Unreported
-Acceptable range is $0 to $999,999

---

10. Number of Dependents **(NUMDEP)**

Enter the number of dependents claimed in determining ability-to-pay. “Dependents” means those individuals who are allowed as exemptions pursuant to section 30 of Act No. 281 of the Public Acts of 1967, as amended, being 206.30 of the Michigan Compiled Laws. Single individuals living in an AFC or independently are considered one exemption, therefore enter “1” for number of dependents.

# of dependents =_ _ Blank = Unreported

****11. Employment Status*** **(EMPLOY)**

Indicate current employment status as it relates to principal employment for consumers age 18 and over. Use #8 for consumers under 18 years old. Reporting categories are as follows:

1 = Employed full time (30 hours or more per week) competitively or self-employed.
2 = Employed part time (less than 30 hours per week) in competitively or self-employed.
3 = Unemployed - looking for work, and/or on layoff from job
4= Not in the competitive labor force - includes homemaker, student age 18 and over, day program participant, resident or inmate of an institution (including nursing home)
6 = Retired from work
7 = Sheltered workshop or work services participant in non-integrated setting
8 = Not applicable to the person (e.g., child under 18)
9 = In supported employment only (See definition page 64)
10= In supported employment and competitive employment

PIHP REPORTING REQUIREMENTS

11= In unpaid work
Blank = Unreported
Note: "Competitive employment" means that the individual is working in a job that was open for anyone to apply, not just persons with disabilities.

---

12. Education **(EDUC)**

Indicate the level attained at the time of the most recent admission or annual update. For children attending pre-school that is not special education, use "blank=unreported." Reporting categories are as follows:

1 = Completed less than high school
2 = Completed special education, high school, or GED
3 = In school - Kindergarten through 12th grade
4 = In training program
6 = In Special Education
7 = Attended or is attending undergraduate college
8 = College graduate
Blank = Unreported

---

13. Wraparound Service **(WRAP)**

1 = Receives Wraparound Services
2 = Does not receive wraparound

---

14. Functional Assessment **(FUNCTOOL)**

Functional assessments are administered with individuals who newly request non-emergent services, with individuals who will be receiving ongoing non-emergent services following emergency services, and annually thereafter with persons receiving non-emergent ongoing services. Indicate which of the following tools was used for the most recent functional assessment:

The **Child and Adolescent Functional Assessment Scale (CAFAS)** must be administered with all children, aged 7 through 17 years, newly requesting non-emergent services, and annually thereafter.

- ♦ No tool is used with **adults with mental illness or individuals with developmental disabilities**; therefore, this category should be left blank.

1 = ***CAFAS** (used with children 7 through 17)

Blank = None

---

15. Scale Scores **(SC#1-10)**

Indicate for 15.1 through 15.10 the 8 child functioning subscales and the two caregiver subscales to two decimals for the CAFAS Leave blank for **adults with mental illness and** persons with developmental disabilities.

15.1= Scale Score #1

PIHP REPORTING REQUIREMENTS

CAFAS Role Performance - School: Value = 00.00 - 30.00

15.2= Scale Score #2

CAFAS Role Performance - Home: Value = 00.00 - 30.00

15.3= Scale Score #3

CAFAS Role Performance - Community: Value = 00.00 - 30.00

15.4= Scale Score #4

CAFAS Behavior Toward Others: Value = 00.00 - 30.00

15.5= Scale Score #5

CAFAS Moods/Emotions: Value = 00.00 - 30.00

15.6= Scale Score #6

CAFAS Self-Harmful Behavior: Value = 00.00 - 30.00

15.7= Scale Score #7

CAFAS Substance Abuse: Value = 00.00 - 30.00

15.8= Scale Score #8

CAFAS Thinking: Value = 00.00 - 30.00

15.9= Scale Score #9

CAFAS Primary Caregiver - Material Needs: Value = 00.00 - 30.00

15.10= Scale Score #10

CAFAS Primary Caregiver - Family/Social Support: Value = 00.00 - 30.00

---

16. Interval and Date of Most Recent Functional Assessment

Indicate the interval of the most recent assessment (per #15) and the date of the assessment. For persons with developmental disabilities indicate whether this is a new consumer ("1") or whether this is a continuing consumer for whom recent annual planning took place and needs for assistance were discussed.

16.01 Interval of most recent functional assessment (RECASS)

1 = New consumer
2 = Annual functional assessment for continuing consumer or annual planning for continuing consumer with developmental disabilities
3 = Assessment at termination, if appropriate
4 = Not appropriate for this person
5 = Not assessed during this time period
6= An interval that is neither initial, annual, or termination
Blank = none or unrecorded

16.02 Date of most recent functional assessment (DATASS) Enter the date of the assessment noted above: ccyymmdd

---

****17. Disability Designation***

Enter yes for all that apply, enter no for all that do not apply. To meet standard at least one field must have a "1."

17.01: Developmental disability (Individual meets the 1996 Mental Health Code Definition of Developmental Disability regardless of whether or not they receive services from

the DD or MI services arrays) **(DD)**
1 = Yes
2 = No
3 = Not evaluated

17.02: Mental Illness or Serious Emotional Disturbance (Has DSM-IV diagnosis, exclusive of mental retardation, developmental disability, or substance abuse disorder) **(MI)**
1 = Yes
2 = No
3 = Not evaluated

17.03: Substance Abuse Disorder/SUD (as defined in Section 6107 of the public health code. Act 368 of the Public Health Acts of 1978, being section 333.6107 of the MCL)**.** Indicate the appropriate substance use disorder related status at the time of intake, and subsequently at annual update. **(SA)**.

2= No, individual does not have an SUD
3= Not evaluated for SUD (e.g., person is an infant, in crisis situation, etc.)
4 = Individual has one or more DSM-IV substance use disorder(s), diagnosis codes 291xx, 292xx, 303xx, 304xx, 305xx, with at least one disorder either active or in partial remission (use within past year).
5 = Individual has one or more DSM-IV substance use disorder(s), diagnosis codes 291xx, 292xx, 303xx, 304xx, 305xx, and all coded substance use disorders are in full remission (no use for one year). This includes cases where the disorder is in full remission and the consumer is on agonist therapy or is in a controlled environment.
6 = Results from a screening or assessment suggest substance use disorder. This includes indications, provisional diagnoses, or "rule-out diagnoses.

---

18. **Reporting element deleted in FY'03-04**
Leave blank beginning with FY'04 service reporting

PROXY MEASURES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Note: The following 6 elements are proxy measures for level of functioning for people with developmental disabilities. The information is obtained or observed when an individual begins receiving public mental health services for the first time, and/or at the time of annual planning. For purposes of these data elements, "Assistance" means the hands-on help from a paid ***or*** *un-paid person or technological support needed to enable the individual to achieve the desired future agreed upon during planning.*

****19. Predominant Communication Style (People with developmental disabilities only)*** **(COMSTYLE) 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.

PIHP REPORTING REQUIREMENTS

3= Interpreter used - this includes a foreign language or sign language interpreter, or someone who knows the consumer well enough to interpret speech or behavior.
4= Alternative language used - this includes a foreign language, or sign language.
Blank= Unreported

****20. Assistance for Independence Needed (People with developmental disabilities only)***
95% completeness and accuracy required

Indicate below all areas of daily living activities in which the individual needs regular, ongoing assistance. It does not include those situations in which the individual is temporarily unable to perform due to a short illness.

20.1 Mobility Assistance includes technology and equipment such as wheelchairs, and/or personal assistance such as help with transferring and transporting. **(MA)**
1 = Yes, assistance is needed
2 = No, assistance is not needed
Blank =Unreported

20.2 Medication Administration includes administering, observing or reminding **(RX)**
1 = Yes, assistance is needed
2 = No, assistance is not needed
Blank = Unreported

20.3 Personal Assistance includes help with bathing, toileting, dressing, grooming, and/or eating **(PA)**
1 = Yes, assistance is needed
2 = No, assistance is not needed
Blank = Unreported

20.4 Household Assistance includes help with such tasks as cooking, shopping, budgeting, and light housekeeping **(HD)**
1 = Yes, assistance is needed
2 = No, assistance is not needed
Blank = Unreported

20.5 Community Assistance includes help with transportation, purchasing, and money handling. **CA)**
1 = Yes, assistance is needed
2 = No, assistance is not needed
Blank = Unreported

****21. Nature of Support System (People with developmental disabilities only)*** **(NATSUPP) 95% completeness and accuracy required**

Indicate how family and friends are involved with the consumer. "Involved" means consumer gets together with family/friends on a regular basis, for example, monthly or more often.

1= Family and/or friends are not involved
2 = Family and/or friends are involved, but do not provide assistance

3 = Family and/or friends provide limited assistance, such as intermittent or up to once a month
4 = Family and/or friends provide moderate assistance, such as several times a month up to several times a week
5 = Family and/or friends provide extensive assistance, such as daily assistance to full-time care giving
Blank= Information unavailable

****22. Status of Existing Support System (People with Developmental Disabilities only)*** **(STATSUPP) 95% completeness and accuracy required**

Indicate whether family/friend caregiver status is at risk; including instances of caregiver disability/illness, aging, and/or re-location. "At risk" means is caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether.
1 = Yes, care giver status is at risk
2 = No, care giver status is not at risk
3 = No care giver is involved
Blank = Unreported or information unavailable

****23. Health Status (People with developmental disabilities only)*** **95% completeness and accuracy required**

Indicate below all areas in which assistance (personal or technology) is required:

23.1 Vision (requiring accommodations beyond glasses) **(VOS)**
1 = No vision problems, or no assistance needed
2 = Limited assistance is needed such as intermittent help up to once a month
3 = Moderate assistance is needed such as monthly to several times a week
4 = Extensive assistance is needed such as daily to full-time help
Blank = Unreported

23.2 Hearing (requiring accommodations beyond a hearing aid) **(HEAR)**
1 = No hearing problems, or no assistance needed
2 = Limited assistance is needed such as intermittent help up to once a month
3 = Moderate assistance is needed such as monthly to several times a week
4 = Extensive assistance is needed such as daily to full-time help
Blank = Unreported

23.3 Other physical/medical characteristics requiring personal intervention **(OTH)**
1 = No physical/medical characteristics, or no assistance needed
2 = Limited assistance is needed such as intermittent help up to once a month
3 = Moderate assistance is needed such as monthly to several times a week
4 = Extensive assistance is needed such as daily to full-time help
Blank = Unreported

****24. Assistance for Accommodating Challenging Behaviors (People with developmental***

PIHP REPORTING REQUIREMENTS

disabilities only) **(BEHAVIOR) 95% completeness and accuracy required**

Indicate the level of assistance the consumer needs, if any to accommodate challenging behaviors. "Challenging behaviors" include those that endanger self and/or others to those that prohibit functioning independently in the home or participating in the community.

1 = No challenging behaviors, or no assistance needed
2 = Limited assistance needed, such as intermittent help up to once a month
3 = Moderate assistance needed, such as monthly to several times a week
4 = Extensive assistance needed, such as daily assistance to full-time help
Blank = Unreported

---

25. Gender (GENDER)

Identify consumer as male or female.
M = Male
F = Female

****26. Program Eligibility* (PE)**

Indicate ALL programs or plans in which the individual is enrolled and/or from which funding is received directly by the individual/family or on his/her/family's behalf.
Every item MUST have a response of "1" or "2" to meet standard.

26.1 Reporting element deleted in FY'03-04

26.2 Adoption Subsidy **(PE_ASUB)**
1 = Yes
2 = No

26.3 Medicare **(PE_MCARE)**
1 = Yes
2 = No

26.4 Medicaid (except Children's Waiver) **(PE_MCAID)**
1 = Yes
2 = No

26.5 MIChild Program **(PE_MIC)**
1 = Yes
2 = No

26.6 Medicaid Children's Waiver **(PE_CHW)**
1 = Yes
2 = No

PIHP REPORTING REQUIREMENTS

26.7 SDA, SSI, SSDI **(PE_SSI)**
1= Yes
2= No

26.8 Commercial Health Insurance or Service Contract (EAP, HMO) **(PE_COM)**
1 = Yes
2 = No

26.9 Program or plan is not listed above **(PE_OTH)**
1= Yes
2= No

26.10 Individual is not enrolled in or eligible for a program or plan **(PE_INELG)**
1= Yes
2= No

26.11 Individual is enrolled in the Adult Benefit Waiver **(PE_ABW)**
1= Yes
2= No

---

27. Parental Status **(PARSTAT)**

Indicate if the consumer (no matter what age) is the natural or adoptive parent of a minor child (under 18 years old)
1= Yes
2= No
Blank = Unreported

---

28. Children Served by Family Independence Agency

Indicate whether minor child is enrolled in an FIA program. If the consumer is an adult or if the consumer is a child not enrolled in any of the FIA programs, enter 2=No.

28.01 Child served by FIA for abuse and neglect (FIA_AN)
1= Yes
2= No
Blank = Unreported

28.02 Child served by another FIA program (FIA_OT)
1= Yes
2= No
Blank = Unreported

---

29. Children Enrolled in Early On **(CHILDEOP)**

Indicate whether minor child is enrolled in the Early On program. If the consumer is an adult

PIHP REPORTING REQUIREMENTS

or if the consumer is a child not enrolled in the Early On program, enter 2=No.

1= Yes
2= No
Blank = Unreported

***30. Date of birth* (DOB)**

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. Use blank = Unknown

---

***31. Primary Language Spoken* (PLS)**

Enter the three-letter ISO/NISO 639-2(B) code of the language that is the primary language the individual speaks. The web site for the code list is http://lcweb/loc.gov/standards/iso639-2/langhome.html. If the individual does not speak at all, enter the code of the language that he/she understands. Use blank = Unknown

---

***32. Hispanic* (HIS)**

Indicate whether the person is Hispanic or Latino or not, or their ethnicity is unknown. Must use one these codes:

1. Hispanic or Latino
2. Not Hispanic or Latino
3. Unknown

***33. Race 1, Race 2, Race3* (RACE1, RACE2, RACE3)**

There are three separate fields for race, each one character long. RACE1 is required for individuals with service dates after 9/30/2005. RACE2 and RACE3 are for individuals who report more than one race. Report one race in each field. RACE2 and RACE3 are optional, but please use a blank to hold the place if there is no value for either.

Use these codes:

a. White - A person having origins in any of the original peoples of Europe
b. Black or African American - A person having origins in any of the Black racial groups of Africa.
c. American Indian or Alaskan Native - American Indian, Eskimo, and Aleut, having origins in any of the native peoples of North America
d. Asian - A person having origins in any of the original peoples of the far East, Southeast Asia, or the Indian subcontinent.
e. Native Hawaiian or other Pacific Islander
f. Some other race
g. Unknown Race
h. Consumer refused to provide

PIHP REPORTING REQUIREMENTS

***34. Minimum Wage* (MINW)**

Indicate if the consumer is currently earning minimum wage or more.
1 = Yes
2 = No
3 = Not Applicable (e.g., person is not working)
Blank = Unreported

***35. Beds* (BEDS)**

Number of beds must be entered when the consumer resides in one of the following living arrangement reported in #8 RESID:

Foster family home (#5)
Specialized residential home (#6)
General residential home (#8)
Institutional setting (#13)

Enter the one character that best represents the number of licensed beds in one of the arrangements listed above. The field will be edited for 1,2,3,4 or blank.
1 = 1- 3 beds
2 = 4 - 6 beds
3 = 7 - 15 beds
4 = 16+ beds
Blank = Unknown or Not Applicable

ENCOUNTERS PER MENTAL HEALTH, DEVELPMENTAL DISABILITY, AND SUBSTANCE ABUSE 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.

Encounters per Beneficiary

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. Every MH/DD encounter record reported must have a corresponding quality improvement (QI) or demographic record reported at the same time. Failure to report both an encounter record and a QI record for a consumer receiving services will result in contract action. SA encounter records do not require a corresponding quality improvement (QI) or demographic record to be reported by the PIHP. * PIHP's and CMHSPs that contract with another PIHP or CMHSP or a Medicaid Health Plan contracts with a PIHP or CMHSP to provide mental health services should include that consumer in the encounter and QI data sets. In those cases the PIHP or CMHSP that provides the service via a contract should not report the consumer in this data set.

~~[*While both parties recognize the value in integrating Medicaid substance abuse data into the PIHP encounter data set, both parties recognize that a number of factors, outside of the control of the PIHP, may hinder the timely submission of accurate and complete encounter data for all substance abuse Medicaid beneficiaries in its service area. These factors include, among others: the opportunity for the mismatch of QI data, submitted by the CAs, and the encounter data, submitted by the PIHP; historic difficulties in integrating Medicaid substance abuse data into the MDCH data warehouse; and the inherent differences between the encounter data structure of the CA system and that of the PIHP system.]~~ ***Deleted FY07.***

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

(ASCX12N 837 version 4010A1, hereafter referred to as the 837/4010A1), as appropriate.

- The 837/4010A1 requires a small set of specific demographic data: gender, diagnosis, Medicaid number, 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 837/4010A includes a "header" and "trailer" that allows it to be uploaded via the DEG (data exchange gateway) to MDCH's Management Information System (MIS).
- The remaining demographic data, in HIPAA parlance called "Quality Improvement" data, shall be submitted in a separate file to MIS. This file is uploaded via the DEG therefore must be accompanied by headers and trailers.

The information on HIPAA contained in this contract relates only to the data that MDCH 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/mdch.

Data that is uploaded via the DEG must follow the HIPAA-prescribed formats for the 837/4010A1 (institutional, professional and dental) and MDCH-prescribed formats for QI data. The 837/4010A1 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), and the Michigan Uniform Billing Manual. The procedure codes in these coding systems require standard units that must be used in reporting on the 837/4010A1.

MDCH has produced a codelist 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 codelist is available on the MDCH web site.

The following elements reported on the 837/4010A1 encounter format will be used by MDCH 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 MDCH's web site) for

additional elements required of all 837/4010A1 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)**
The MDCH-assigned 9-digit payer identification number must be used to identify the PIHP with all data transactions.

1.b. ***CMHSP Plan Identification Number*** **(CMHID)**
The MDCH-assigned 9-digit payer identification number must be used to identify the CMHSP with all mental health and/or developmental disabilities transactions.

1.c. ***CA Plan Identification Number (CAID)***
The MDCH-assigned 9-digit payer identification number must be used to identify the Substance Abuse Coordinating Agency with all Substance Abuse data transactions

2. ***Identification Code/Subscriber Primary Identifier (please see the details in the submitter's manual)*
Eight-digit Medicaid number must be entered for a **Medicaid** 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 codelist for service/support provided. The codelist is located on the MDCH web site. Do not use procedure codes that are not on the codelist.

10. Procedure Modifier Code*

Enter modifier as required for Habilitation Supports Waiver services provided to enrollees; 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*:**
Enter a value of at least $1.00.

*****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. Facility Code
Enter the specified code for where the service was provided, such as an office, inpatient hospital, etc.

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 837/4010 Professional, or the 837/4010 Institutional format is used).

FY'09 PIHP MEDICAID UTILIZATION AND AGGREGATE NET COST REPORT

This report provides the aggregate Medicaid service data necessary for MDCH management of PIHP contracts and rate-setting by the actuary. In the case of an affiliation, the PIHP must report this data as an aggregation of all Medicaid services provided in the service area by its affiliates. Medicaid Substance Abuse services provided by Substance Abuse Coordinating Agencies are now included in this report, effective 10/1/06. 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 (affiliation, if applicable) must be reported on this utilization and cost report.

RULES FOR REPORTING ON MEDICAID UTILIZATION AND AGGREGATE NET COST REPORT

Background:

Per the CMHSP and PIHP contracts with the Department of Community Health, beginning FY07 the community mental health system is required to submit three cost reports:

> The 18 PIHP Medicaid Utilization and Aggregate Net Cost report replaces the PIHP Medicaid Sub-element cost report. It will be used by the state's actuary in the analysis of the encounter data and costs. As such, the Medicaid report is an internal report. The actuary will use this report to review Medicaid managed care administration costs and determine the administrative load for the future rates. The report will also be used to compare the volume of units reported with the encounter data.
>
> The 46 CMHSP Sub-Element Cost reports will continue to be used by MDCH to comply with the MDCH Appropriations Act Section 404 boilerplate requirements.
>
> Section 460 of P.A. 354, 2005, required that MDCH develop methodology and instructions for reporting direct service costs and administrative costs. In order to respond to the mandate, new instructions and reporting format are contained in this attachment. See FY'07 Section 460 PIHP Cost Allocation Report later in this document.

The report contained herein resulted from the system's experiences of reporting allowed amounts, the PIHP sub-element reports, and the Medicaid "bucket" reports for FY'04. This report consolidates those three reports into one report per the recommendations of the Encounter Data Integrity Team (EDIT), III. EDIT determined, and MDCH agreed, that "allowed amounts" as defined in the current contract is no longer a valid concept. Instead it was agreed that PIHPs

should report the total Medicaid expenditure per procedure code, then a unit rate would be derived from dividing the expenditures by the total number of units. EDIT therefore proposed to MDCH that the requirements for reporting a financial amount with each encounter be waived except for those procedures that require an actual amount (e.g., housing assistance, environmental modifications, etc.). Instead, the PIHPs would report at six months and 12 months the total cases, total units and total Medicaid expenditures per procedure code. This report is the result of MDCH's agreement with EDIT's proposal.

This change in reporting is expected to result in information that is consistent with the Financial Status Report, and with the units and cases reported via the encounter data system to the MDCH data warehouse. The reporting template will reside on the MDCH web site.

I. Medicaid units, cases, and costs per procedure code

- **a.** Enter the number of Medicaid **units** per procedure code that were provided during the period of this report. The number of units should be consistent with the number of Medicaid units for that procedure code that were reported to the MDCH warehouse for Medicaid beneficiaries. Follow the same rules for reporting units in this report that are followed for reporting encounters. Refer to the Mental Health HCPCS and Revenue Code Chart on the MDCH web site, the Mental Health and Substance Abuse Chapter of the Medicaid Provider Manual (also on the MDCH web site) and the Costing Per Code document issued by MDCH.
- **b.** Report state plan services, 1915(b)(3) or additional services, and Habilitation Supports Waiver (HSW) services in separate columns on the spreadsheet. Note that some procedures are reportable under more than one column. An example is supports coordination which is a (b)(3) service as well as a HSW service. Enter the appropriate number of units and expenditures in the HSW column for HSW enrollees only (distinguished in the encounter data by a HK modifier that accompanies the procedure code).
- **c.** Peer-delivered: changes have been made to reflect the addition of Peer Specialist H0038, it has a row for units, costs, and cases that were reported in the encounter data. There is also a row for Peer-Delivered/drop ins that were reported in the encounter data as H0023; and finally there remains a row for peer-delivered expenditures (typically drop-in center activities) that were **not** captured by encounter data. **Do not** aggregate the units, cases and costs and report in the row for cost-only peer-delivered. **Do not** combine the costs from any of these rows.
- **d.** Several codes have rows without modifiers as well as rows with modifiers: 90849 (HS modifier used to distinguish when a beneficiary is not present), H2106 and T1020 (TF and TG modifiers used to distinguish nursing home mental health monitoring from targeted case management). It is important that the appropriate number of units, cases and costs are entered into the correct rows for these procedures. **Do not** aggregate the units, cases and costs for the modified procedures into one row.

e. Rows for procedure codes that were deleted by CMS effective January 1, 2006, or deleted as a service (HSW Dental) by MDCH, have been retained for any reporting of those codes that may have occurred the first three months of the fiscal year.

f. Enter the **unique number of Medicaid cases** per procedure code. This number should reflect the unduplicated number of Medicaid beneficiaries who were provided the service during the reporting period.

g. Enter the total Medicaid expenditures per procedure code (see exclusions below) by State Plan Services in column I, for 1915(b)(3) Services in column K, for HSW Services in column M, and finally in column O the sum of the Medicaid expenditures by procedure.

h. In the final column (P), calculate the aggregate net cost per unit by dividing the total units in column N by the total expenditures in column O.

II. Total Medicaid MH/DD/SA Cases and Costs

a. In row II, column G, enter the total unduplicated cases served during the period. This total should not be the sum of the rows above, but rather a count of all Medicaid beneficiaries who received services reported above.

b. In row II, sums of the costs in columns I, K, M and O will automatically calculate.

III. Total Medicaid MH/DD Cases and Costs

a. In row III, column G, enter the total unduplicated MH/DD cases served during the period. This total should not be the sum of the rows above, but rather a count of all Medicaid beneficiaries who received services reported above.

b. In row III, enter the sum of the costs for MH/DD services in columns I, K, M and O.

IV. **Medicaid Substance Abuse Cases and Costs**

a. In row IV, column G, enter the total unduplicated Medicaid SA cases served during the period. This total should not be the sum of the rows above, but rather a count of all Medicaid SA beneficiaries who received services reported above. Enter the sum of the costs for Medicaid SA services in columns I, K and O.

V. Medicaid Program Administration MH/DD/SA

a. In row V, column N, enter any Medicaid Program Administrative cost that are included in the Total Medicaid costs in row II, column O above.

VI. Medicaid Direct Service Costs MH/DD/SA

a. Row VI will automatically deduct Medicaid Program Administration from row V. column N. above to yield Direct Service Costs. This amount must equal the Direct Service Costs reported on the Section 460 Cost Allocation Report.

VII. **Medicaid Managed Care Administration MH/DD/SA**

a. Cost of Medicaid managed care administration performed by the PIHP (including

administrative functions delegated to CMHSP affiliates, CAs, and/or prime subcontractors-for the MH/DD/SA benefit).

b. Refer to the document entitled "Establishing Managed Care Administrative Costs" (revised June 2005) for determining the Medicaid administrative costs to be entered in row VII, column N of this report.

~~VIII.~~ **Total Medicaid Administrative Costs:** The costs of Medicaid administration will automatically calculate by adding rows V and VII. This amount should equal the cost of Medicaid administration reported on the Section 460 PIHP Cost Allocation Report

IX. **Total Medicaid MH/DD/SA Service and Administration Costs:** Sum of the service and administration costs will automatically calculate

X. Spend-down

a. Enter in column O the amount of general fund expended for spend-down that needs to be deducted from the amount above; OR
b. Enter in column N the amount of general fund expended for spend-down that has already been deducted from the amount above.

XI. Medicaid MH/DD/SA Net Expenses: Spend-down in column O will automatically be deducted from total expenses to yield the net expenses.

XII. Reconciling items to Financial Status Report (FSR)

a. Current Period ISF Contributions (deposits) to ISF from Current Year Reserve Accounts & Internal Service Fund report ,section 3 row b.2
b. Enter Medicaid costs charged to GF for Medicaid services that are not included in PIHP reported Medicaid costs. Such as affiliate (spoke CMHSP) redirection of GF.
c. QAAP tax from FSR row K 4.
d. Prior year adjustments included in costs on the PIHP FSR not included in the MUNC encounter rates
e. SSI and other reimbursements from FSR row K2
f. Other. Adjustments needed to reconcile costs on the MUNC report to the Medicaid costs on the FSR. For each amount reported also provide a short description of the type of cost/adjustment. Such as dental services not on the MUNC and IBNR included in the FSR. If more than three lines are needed please attach a detail listing for amount included on row f.
g. Total reconciling items to Financial Status Report Sum of XI. a. b. c. d. e. and f.

XIII. Adjusted MUNC report Medicaid costs.

This is the sum or rows X and XI g.

XIV. Financial Status Report (FSR)

a. Prior year savings expended for MH/DD Medicaid services from FSR row G.2,
b. Medicaid ISF abatement from FSR row G.3
c. Medicaid expenses from FSR row K
d. FSR total Medicaid Expenses. Sum of rows XIII. a., b, and c.
e. Difference be row XI g and row XIII d

EXCLUSIONS

The following expenditures must be excluded from the Medicaid Utilization and Cost Report:

1. Local contribution to Medicaid
2. Payments made into internal service funds (ISFs) or risk pools. (Note: these payments must **not** be incorporated into allowable amounts either; the actuary will use the ISF reports submitted with the final FSR to identify use of fiscal year Medicaid revenues for funding of ISF)
3. Provider of administrative service organization (ASO) services to other entities, including PIHP/hub ASO activities provided to CMHSP affiliates/spokes for non-Medicaid services
4. Write-offs for prior years
5. Substance Abuse services provided by the CMHSP under provider contract with CAs (these show up in the report from the CA)
6. Workshop production costs (these costs should be offset by income for the products).
7. Medicare payments for inpatient days

ADDITIONAL DO'S AND DON'TS

1. Do e**xclude room and board** costs
2. Do include costs and services that were funded by FY03 savings or carry-forward or by funds pulled **out** of the ISFs.
3. Do include costs and services for persons with co-occurring conditions where Medicaid revenues were used by the PIHP or its affiliate CMHSPs to purchase or provide such services using Medicaid funds that were **not** paid to the CA.
4. Do submit an encounter that matches the accrual assumptions for fee-for-service activities where an end-of-year financial accrual is made for services incurred but where a claim has not been processed.
5. Do assume that the CAs are providing a Medicaid and a Total service use/cost report
6. Do **not** include the 1915(c) Developmental Disabilities Children's Waiver, Adult Benefits Waiver, MI Child, or Fee for Service Medicaid Injectable medications in this Medicaid report
7. If services are provided by a CMHSP to another CMHSP/PIHP though an earned contract, the COFR CMHSP should report these costs, NOT the providing CMHSP
8. Do report on <u>separate rows</u> in this report:
   - Community Psychiatric Inpatient
   - Inpatient in a community institution for mental disease (IMD)

SECTION 460 PIHP COST ALLOCATION REPORT
Effective 10/1/06

Background

Section 460 of Public Acts 154 of 2005 and 330 of 2006 required that the Michigan Department of Community Health develop methods and instructions for allocating administrative costs and reporting requirements for the Pre-Paid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs), and their sub-contractors. This document contains MDCH's response to the legislation and is reflective of the values of a public mental health system. The first phase of the activity, to commence October 1, 2006, involves PIHPs, CMHSPs, and their "prime subcontractors" defined as those entities from which administrative functions and/or direct services are purchased and which further sub-contract with other entities for administrative and/or direct services in fulfillment of their obligations to the contract. Prime subcontractors include the affiliate CMHSPs of the PIHPs, substance abuse coordinating agencies (CAs) that manage Medicaid services, Managed Comprehensive Provider Networks (MCPNs) and all other entities that meet the definition of prime subcontractor.

Effective October 1, 2007, PIHPs and CMHSPs shall collect and report direct service and administrative cost data from other subcontract providers. Instructions and templates for reporting are located on the MDCH web site: www.michigan.gov/mdch , click on Mental Health and Substance Abuse, then Reporting Requirements. During this second phase of the Section 460 activity, six PIHPs/CMHSPs and two prime subcontractors will also voluntarily calculate and report their FY'07 administrative service costs as defined by the IRS 990 (reporting form for non-profit organizations) by March 31, 2008. Following receipt of this data, MDCH will analyze their administrative service costs reported on the Section 460 report compared with their administrative service costs reported on the IRS 990 to determine if there are material differences that would necessitate changes in reporting methodology in Phase III which will commence FY'09.

In recognition that Phase II of this effort (carried out in FY 2008) is still in the developmental stage, with many questions related to the validity of data, accuracy in measurement, and interpretation of the data and in recognition of the fact that Section 460 of the Appropriations Act requires that only the progress (and not the data) of the effort be reported to the legislature, none of the data generated by Phase II of this report will be reported to the legislature or the public, until after the full Phase II review and analysis, including the analysis of the difference in administrative rates as captured using the 460 definitions from those captured using IRS 990 definitions. This includes the Phase II data collected for PIHPs, CMHSP affiliates, prime subcontractors, non-profit contractors, or for-profit contractors.

When the Phase II data is reported the Section 460 Report for Medicaid Managed Mental Health Supports and Services contains the PIHP Medicaid direct and administrative costs with an explanation that the Balanced Budget Act defines administrative functions that a managed care organization must perform, whether a PIHP or HMO. The explanation will also indicate that the Mental Health Code requires certain administrative functions with examples like recipient rights, community needs assessment and school-to-community transition services, that are unique to

Michigan's public mental health system and therefore not comparable to other health care organizations. The Section 460 Report submitted to the Legislature, after the Phase II analysis outlined above, contains each PIHP's Medicaid direct service costs and administrative costs for each their prime sub-contractors, and the direct service and administrative costs of other subcontract providers.

While many of the administrative functions are derived from the Balanced Budget Act or Mental Health Code requirements, and are delegated by the PIHP to their prime sub-contractors, certain core functions, such as human resources, information systems, and executive director exist in PIHPs and the prime subcontractors regardless of funding stream. The costs of these core functions must be allocated to the PIHP as Medicaid administrative expenditures according to an allocation methodology that is consistent with Office of Management and Budget Circular A-87.

The Cost Allocation model in response to Section 460 uses A-87 as its foundation. The first step of the process requires that each PIHP develop a cost allocation plan and submit it to MDCH prior to the beginning of a fiscal year (no later than September 30th) except for the FY'07 when it will be due February 28, 2007. It is expected that the cost plans indicate what has been delegated to another entity and what has not, and the methods being used to allocate costs. MDCH will review the plans, and may comment if a plan contains a questionable allocation methodology, but will not approve plans. The PIHPs' annual independent audit will review actual cost allocations and compare to the prospective methodologies in the cost plans.

Instructions and electronic templates for reporting will be issued by MDCH six weeks prior to the due date and are also located on the MDCH web site: www.michigan.gov/mdch , click on Mental Health and Substance Abuse, then Reporting Requirements. Included in the instructions are: 1) steps for determining "allowable" expenditures per applicable state and federal regulations; 2) a diagram depicting where the line is drawn between direct service costs and administrative costs; 3) steps for allocating costs to either direct service and administration; 4) glossary of terms; 5) a flow chart for allocation steps; and 6) reporting for subcontract providers.

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM
VERSION 6.0
FOR PIHPS

The Michigan Mission Based Performance Indicator System (version 1.0) was first implemented in FY'97. That original set of indicators reflected nine months of work by more than 90 consumers, advocates, CMHSP staff, MDCH staff and others. The original purposes for the development of the system remain. Those purposes include:

- 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 databased mechanism to assist MDCH 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. 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, Version 6.0, August 2005" codebook. Electronic templates for reporting will be issued by MDCH six weeks prior to the due date.

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM, VERSION 6.0 FOR PIHPS

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 SA). **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 SA) **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 SA (sub-acute detox discharges)

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

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 minimum wage or more from employment activities (competitive, supported or self employment, or sheltered workshop).

10. The percent of MI and DD children and adults 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 quarterly number of sentinel events per thousand Medicaid beneficiaries served (MI adults, MI children, persons with DD, HSW enrollees, and SA).

Note: Indicators #2, 3, 4, 5 and 12 include Medicaid beneficiaries who receive substance abuse services managed by the Substance Abuse Coordinating Agencies.

PIHP PERFORMANCE INDICATOR REPORTING DUE DATES

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screen	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
2. 1st request	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
3. 1st service	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
4. Follow-up	10/01 to 12/31	3/31	1/01 to 3/31	~~6/01~~ 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	MDCH
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	MDCH
7. Admin. Costs*	10/01 to 9/30	1/31							MDCH
8. Competitive employment*	10/01 to 9/30								MDCH
9. Minimum wage*	10/01 to 9/30								MDCH
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. Sentinel Events	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

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

STATE LEVEL DATA COLLECTION

Functional/Symptom Status

1. Changes in Child and Adolescent Functional Assessment Scale (CAFAS) scores for children with emotional disturbance between **initial or annual and termination** assessments. Indicators:

    Percent of children/adolescents who experience increased level of functioning
    Percent of children/adolescents who experience decreased level of psychological distress
    Percent of children/adolescents who experience increased activities with family, friends, neighbors, or social groups
    Average level of impairment in children/adolescents with substance abuse problems
    Percent of children/adolescents who were in juvenile detention the past year.

Change effective 10/1/06

-An annual survey using MHSIP 28 items for adults with MI and substance use disorder, and MHSIP Youth and Family survey for families of children with SED will be conducted. Surveys are available on the MHSIP web site and have been translated into several languages. See www.mhsip.org/surveylink.htm
-Beginning FY'07, the PIHPs will conduct the survey in the month of May for all people (regardless of medical assistance eligibility) currently receiving services in specific programs.
-Programs to be selected annually by QIC based on volume of units, expenditures, complaints and site review information.
-The raw data is due August 31st to MDCH each year on an Excel template to be provided by MDCH.