

	STATE OF MICHIGAN DEPARTMENT OF COMMUNITY HEALTH MEDICAID MANAGED SPECIALTY SUPPORTS AND SERVICES CONCURRENT WAIVER PROGRAMS CONTRACT	ATTACHMENT
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1.0 General Report Overview

The Financial Status Report (FSR) – Medicaid is a comprehensive report of all activity of the Community Mental Health Service Program (CMHSP), that is a Prepaid Inpatient Health Plan (PIHP), or the Regional Authority that holds the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Contract (Medicaid Contract) with the Michigan Department of Community Health (MDCH). The FSR - Medicaid summarizes the revenues and expenditures related to the Medicaid Contract. The FSR – Medicaid will identify whether there is a net surplus or deficit prior to any redirection of funding. The FSR – Medicaid will also identify any funding redirected to provide supplement to other programs for services to Medicaid consumers or redirected to address a deficit in funding.

The FSR – Medicaid will be utilized by the MDCH, in conjunction with the FSR - Healthy Michigan, as a tool to monitor the fiscal operations of the PIHP/CMHSP. In addition, this report will provide the basis for the annual contract reconciliation and cash settlement of the Medicaid Contract.

The PIHP/CMHSP shall comply with Generally Accepted Accounting Principles, along with any other federal and state regulations as defined in the Medicaid Contract. With the exception of the GF Contract - Special Fund Account – Section 226(a) of the Mental Health Code (MHC), all revenue and expenditures are required to be reported on an accrual basis of accounting. As such, the revenue and expenditure amounts reported must include all earned reimbursements and/or obligations regardless of whether they have been billed or collected. Additionally, any adjustments for uncollectible amounts or write-offs should be included. The FSR –Medicaid must reconcile to the PIHP/CMHSP's general ledger.

The PIHPs with affiliate CMHSPs and/or contracts with CAs for the provision of the Medicaid benefit will report summary level revenue and expenditure information in separate columns for each contract. The amounts reported by the PIHP on the FSR – Medicaid and the FSR – Healthy Michigan should reconcile to the FSR – All Non-Medicaid – Section I – PIHP to Affiliate Medicaid Services Contracts for each affiliate CMHSP. The MDCH may request, for select PIHPs, the reporting of prime sub-contractors in the separate columns.

The PIHP/CMHSP must certify the accuracy and completeness of the FSR –Medicaid and identify a contact person, phone number and email address that questions regarding the submission should be directed to. Please refer to the Electronic Report Submission Guidance and Report Certification Form,

2.0 Report - Due Dates

Refer to the reporting grid incorporated in Attachment P.7.8.1 of the Contract for identification of report due dates. The reporting grid can be found on the MDCH website: http://www.michigan.gov/mdch/0,4612,7-132-2941_38765---,00.htm

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3.0 Report Submission

3.1 Report Submitted via US Mail

This is no longer applicable. Electronic report submission required.

3.2 Report Submission – Electronic

The report should be submitted electronically to the department by the due date identified in 2.0 above at MDCH-MHSA-Contracts-MGMT@michigan.gov.

The report's file name must identify the reporting fiscal year, period covered (submission type), agency name, report title and date of submission. Example: For the FY 13 Year End Interim submitted from network180 for the Medicaid FSR, the file name should read **FY13 Year End Interim network180 FSR Bundle 11-10-2013**.

Note: The FSR– Medicaid is included in the FSR Bundle. It is not a stand-alone report.

Refer to the Electronic Report Submission Guidelines for report submission specifications.

4.0 Report Specific Navigation or Terminology

Within this document the terms used in these instructions shall be construed and interpreted as defined below:

Medicaid Contract: The Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Contract with selected PIHPs to manage the Concurrent 1915(b)/(c) and the Healthy Michigan Plan Programs in a designated service area and to provide a comprehensive array of specialty mental health and substance abuse services and supports.

Autism Benefit - The MDCH/PIHP Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program – 1915(i) authorizes the Autism Benefit.

Autism Administrative Training: The activity related to the cost of clinical trainings for board certified behavior analysts, masters prepared and psychologist level providers, as well as training applied behavior analysis aides implementing applied behavior analysis (ABA) services for children receiving ABA services under the Autism benefit SHOULD be reported on the FSR – Medicaid – Row A 202 (Medicaid Services). As noted in Section 7.4.1.7 of the Contract, payment for the administrative training costs will be paid via gross adjustment to the PIHP. The administrative training payment should be recorded on the FSR – Medicaid – Row A 101c (Autism Training Payments). These costs will be taken into consideration in the Medicaid Specialty Supports and Services Contract settlement.

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GF Contract: MDCH/CMHSP Managed Mental Health Supports and Services Contract

PIHP: A CMHSP or Regional Authority that holds the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Contract with MDCH and acts as the Prepaid Inpatient Health Plan.

CMHSP: Community Mental Health Services Program that holds the GF Contract with MDCH.

Regional Authority: An entity, jointly governed by the sponsoring CMHSPs, that has meet the MDCH requirements for selection to be certified to the Center for Medicare and Medicaid Services as a PIHP.

Medicaid Consumer: A Medicaid beneficiary who requires the Medicaid services included under the 1915(b) Specialty Services Waiver; who is enrolled in the 1915(c) Habilitation Supports Waiver; or who is eligible for the Healthy Michigan Plan.

HICA: Health Insurance Claims Assessment Act. Public Act 142 of 2011 created the Health Insurance Claims Assessment Act. The legislation mandates that effective January 1, 2012, certain third party administrators, carriers and self-insured entities are required to pay an assessment on certain paid health care claims.

Healthy Michigan Plan: The Healthy Michigan Plan is a new category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan Public Act 107 of 2013 that began April 1, 2014.

The Financial Status Report - Medicaid includes cell shading to assist the end user with completion of the form.

Report headers are shaded in light green.

Cells requiring data entry are shaded in yellow.

Cells that are formula driven and should not have data entered are shaded peach or light turquoise. The cells shaded in light turquoise represent sub-totals or totals.

Select cells have conditional formatting applied so that if an erroneous entry is made the cell will turn orange.

Worksheet protection has been enabled.

Precision as displayed functionality has been enabled. As such, Excel will utilize the displayed value instead of the stored value when it recalculates formulas.

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The term “Submission Type” on the worksheet refers to the reporting period, i.e. Projection, Interim, Final.

The following numbering / sequencing have been utilized in the FSR Medicaid:

- 1 Row for entry of the name of the PIHP, CMHSP or CA for each column
- 100 Title row for revenue
- 101-189 Detail rows for reporting revenue. May include sub-totals.
- 190 Total row for revenue
- 200 Title row for expenditures
- 201-289 Detail rows for reporting expenditures. May include sub-totals.
- 290 Total row for expenditures
- 295 Sub-total row identifying net surplus (deficit) prior to any redirection
- 300 Title row for redirection of funds (TO) and FROM
- 301-389 Detail rows for reporting redirection. May include sub-totals.
- 390 Total row for redirection of funds (TO) and FROM
- 400 Total row identifying the remaining balance. The balance is calculated by taking into consideration available revenue less expenditures and adjusting for any redirections (TO) or FROM. This row will indicate whether there is a remaining balance impacts fund balance, savings or lapse. The FSR Medicaid – Column A through I

Column A is to be used by the reporting PIHP for the revenues, expenditures incurred by the PIHP. Additionally, the PIHP will use Column A to report all redirection of funds.

Column B through H – Page 1: Column B through H will be used by the PIHP to report summary level information of their contracts with affiliate CMHSPs and/ CAs for the provision of the Medicaid benefits. The amounts reported by the PIHP should reconcile to the revenues, expenditures, redirection of funds, sub-totals and totals for the affiliate CMHSPs or CAs

Column I: Column I is formula driven and represents the total of revenues, expenditures and redirections entered in Columns A through H – Page 1 and Columns J through R – Page 2.

Column J through R – Page 2: With the formation of Regional Authorities the number of affiliate CMHSPs and/or contracts with CAs has increased. To facilitate reporting, a second page has been added to the FSR - Medicaid. Columns J through R, found on the second page of the FSR – Medicaid, will be used by the PIHP to report summary level information of their contracts with affiliate CMHSPs and/ CAs for the provision of the Medicaid benefits. The amounts reported by the PIHP should reconcile to the revenues, expenditures, redirection of funds, sub-totals and totals of the affiliate CMHSPs or CAs.

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The FSR - Medicaid – Row Layout: For the most part, all rows contain an alpha reference, a numeric reference, a description, and then the amount associated to the listed elements. The alpha reference refers to the Section of the FSR (Medicaid). The number reference refers to the character of the line (revenue, expenditures, etc). The description could be a label (revenue, expenditure, etc) or a more detailed description of the item (State Plan (B), State Plan (b)(3), etc). The redirection rows include at the end of the description a reference to the partner row.

For example – A 301 (TO) CHMSP to CMHSP Earned Contracts – J 304, the “A” refers to Medicaid, the 301 indicates that this row represents a redirection to another row, the “(TO) CMHSP to CMHSP Earned Contracts” describes that Medicaid funds are being redirected to CMHSP to CMHSP Earned Contracts, the “J 304” indicates that the partner row (FROM row) is in Section J – CMHSP to CMHSP Earned Contracts, row 304 on the FSR – All Non-Medicaid.

REDIRECTS – (TO) FROM – Each PIHP/CMHSP is expected to maintain a balanced budget. However, it is acknowledged that funding and expenditures, by category may not always be equal. The “Redirected Funds (To) From” section will be the mechanism in which the PIHP/CMHSP will identify how any funding surplus or deficit was resolved. The “redirects” will identify how surplus funds are used by other programs or how deficits were covered by other funding sources. In either case, the funding source must be a legitimate source of funding for the program the funding is being redirected to cover.

The redirection of GF to Medicaid requires prior approval of the MDCH.

Every “TO” redirection will have an off-setting “FROM” transaction. The converse is also true, for every “FROM” redirection there will be a “TO” transaction. The “TO” and “From” amounts will be equal; thus all redirections will sum to zero. Following is an example:

A 333 (FROM) Risk Corridor – PIHP Share – N 301 \$100,000

This line is within the FSR – Medicaid and indicates that \$100,000 is being transferred “FROM” the FSR – All Non-Medicaid – Risk Corridor Section to fund the PIHP share of a funding deficit.

N 301 (TO) Medicaid Services – PIHP Share – A 333 (\$100,000)

This line is within the FSR – All Non-Medicaid – Risk Corridor Section and indicates that \$100,000 is being redirected “(TO)” the FSR – Medicaid to fund the PIHP share of a funding deficit.

Redirection amounts are entered in the FROM redirects and automatically linked to the TO redirects as the opposite or converse amount.

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5.0 Instructions for Completion of the Report

This report is only used by the PIHP

Enter the name of the PIHP on the line labeled “PIHP”.

Select the appropriate Fiscal Year (FY) from the drop down menu.

Select the Submission Type from the drop down menu.

Enter the date of report submission on the line labeled “Submission Date”.

Row 1 – PIHP or CMHSP or CA

Enter in column A the name of the Regional Authority / Reporting Board. Enter in columns B through H – Page 1 and columns J through R – Page 2 the names of any affiliate CMHSP or CA. As previously mentioned, the MDCH may request, for select PIHPs, the reporting of prime sub-contractors.

Row A – MEDICAID SERVICES – PIHP USE ONLY

This row is the label MEDICAID SERVICES – PIHP ONLY. The rows immediately following will represent the revenues, expenditures and redirection of funding related to the provision of the Medicaid benefit.

Row A-100 – REVENUE

This row is the label REVENUE. The rows immediately following will represent the revenues available to fund current year expenditures.

Row A-101 - STATE PLAN (B)

Enter, in Column A, the amount of funding authorization associated to the Mental Health and Substance Abuse Medicaid – Specialty Managed Care State Plan (b) capitated payments inclusive of any open accruals.

Row A-101a – DHS Incentive Payments (B)

Enter; in Column A, the amount of funding authorization associated to the Mental Health and Substance Abuse Medicaid – Specialty Managed Care State Plan (B) DHS incentive payments inclusive of any open accruals.

Row A-101b – Other Incentive Payments (B)

Enter, in Column A, the amount of funding authorization associated to the Mental Health and Substance Abuse Medicaid – Specialty Managed Care State Plan (B) incentive payments inclusive of any open accruals.

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Row A-101c – Autism Training Payments (B)

Enter, in Column A, the amount of funding authorization associated to the Autism Training payments inclusive of any open accruals.

The Autism training payments are authorized in the Medicaid Contract. Payment will be made via gross adjustments to the PIHP. The payment represents funding for the cost of clinical trainings for board certified behavior analysts, masters prepared and psychologist level providers, as well as training applied behavior analysis aides implementing applied behavior analysis (ABA) services for children receiving ABA services under the Autism benefit. The training payments will be treated as funding available to the PIHP for training and the associated costs will be included in the Medicaid cost settlement. The funding received by the PIHP should be reported here, on the FSR-Medicaid – Row A-101c. The associated costs should be reported on the FSR-Medicaid – Row A-202 – Medicaid Services.

Row A-102 - STATE PLAN (B3)

Enter, in Column A, the amount of funding authorization associated to the Mental Health and Substance Abuse Medicaid--Specialty Managed Care - State Plan (b)(3) capitated payments inclusive of any open accruals.

Row A-103 - HAB SUPPORT WAIVER (C)

Enter, in Column A, the amount of funding authorization associated to the Mental Health Medicaid-Specialty Managed Care - Habilitation Support Waiver capitated payments inclusive of any open accruals.

Row A-115 - MEDICAID MANAGED CARE - AFFILIATE CONTRACTS – COLUMN A

This cell is formula driven and will offset the revenue distributed to each of the affiliates recognized in columns B through H – Page 1 and columns J through R – Page 2. The formula is *less the amounts reported in Columns B through H – Page 1 and columns J through R – Page 2.*

Row A-115 – Medicaid Managed Care – Affiliate Contracts – Column B through H – Page 1 and Column J through R – Page 2

Enter the amount of funding distributed to each of the affiliate CMHSPs or CAs of the PIHP.

Row A-120 - SUBTOTAL - CURRENT PERIOD MEDICAID SERVICES REVENUE

These cells represent the total of Medicaid capitated payments and/or distribution of revenue to the affiliate CMHSPs or CAs. The cells are formula driven. The formula is *the sum of State Plan (B) (A 101), DHS Incentive payments (B) (A 101a), Other Incentive Payments (B) (A 101b), Autism Training Payments (A 101c), State Plan (b)(3) (A 102), Hab Support Waiver (C) (A 103), and Medicaid Managed Care – Affiliate Contracts (A 115).*

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Row A-121 - 1ST & 3RD PARTY COLLECTIONS - MEDICARE/MEDICAID CONSUMERS REPORTING BOARD

The PIHP/CMHSP is the payer of last resort and has the responsibility to identify and seek recovery from all other parties for services provided to recipients. Enter, in Column A, the funding available to the Reporting Board from 1st and 3rd party collections (consumer fee payments, insurances and Medicare) that are not included in the Special Fund Account authorized in Section 226a (PA423) of the Mental Health Code (MHC). The amount entered in this cell is for 1st and 3rd party collections associated to the cost of a person's 100% funded daily care or services.

Row A-122 - 1ST & 3RD PARTY COLLECTIONS - MEDICARE/MEDICAID CONSUMERS - AFFILIATE

The PIHP/CMHSP is the payer of last resort and has the responsibility to identify and seek recovery from all other parties for services provided to recipients. Enter, in columns B through H- Page 1 and columns J through R – Page 2, the funding available to the affiliate CMHSP or CA from 1st and 3rd party collections (consumer fee payments, insurances and Medicare) that are not included in the Special Fund Account authorized in Section 226a (PA423) of the Mental Health Code (MHC). The amount entered in this cell is for 1st and 3rd party collections associated to the cost of a person's 100% funded daily care or services.

Note: The amounts reported for affiliate 1st and 3rd party are for reporting purposes only and will not be included in the general ledger of the PIHP/CMHSP. These amounts will not be taken into consideration of the contract reconciliation and cash settlement.

Row A-123 - PRIOR YEAR MEDICAID SAVINGS (FUNDING CURRENT YEAR EXPENSES)

Enter, in Column A, the amount of earned Medicaid savings from the prior fiscal year (FY) that is being utilized to fund current year expenditures.

NOTE: In FY 14 the unspent Medicaid funding for the 15 old PIHPs will be transferred to the new Regional Authorities / PIHPs. There will not be a Medicaid Savings calculation required for the three months ended 12/31/2013 so the entire unspent Medicaid will be transferred to the new Regional Authorities / PIHPs. For FY 14, the new Regional Authorities / PIHPs will report the unspent Medicaid they received from the 15 old PIHPs on this row.

Row A-124 - ISF ABATEMENT

Enter, in Column A, the amount of Internal Service Fund (ISF) - Abatement that is being utilized to fund current year expenditures due to over funding of the ISF.

Row A-140 - SUBTOTAL - OTHER MEDICAID REVENUE

These cells represent the total Other Medicaid Revenue available to fund current year expenditures. This cell is formula driven. The formula is the *sum of 1st & 3rd Party Collections – Medicare/Medicaid Consumers – Reporting Board (A 121), 1st & 3rd Party Collections – Medicare/Medicaid Consumers – Affiliate (A 122), Prior Year Medicaid Savings (Funding Current Year Expenses) (A 123) and ISF Abatement (A 124).*

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Row A-190 - TOTAL REVENUE

These cells represent the total Medicaid services revenue available to fund current year expenditures. These cells are formula driven. The formula is the *sum of the Sub-total – Current Period Medicaid Services Revenue (A 120) and the Subtotal – Other Medicaid Revenue (A 140)*.

Row A-200 – EXPENDITURE

This row is the label EXPENDITURE. The rows immediately following will represent the expenditures for services provided and authorized in the Medicaid Contract.

Row A-201 - PIHP HICA / USE TAX

Enter the amount of accrued expenditures associated to the Medicaid HICA / Use Tax.

Row A-202 - MEDICAID SERVICES

Enter, in Column A, the amount of expenditures related to the provision of services to Medicaid consumers, as authorized in the Medicaid Contract.

Row A-203 - PAYMENT INTO MEDICAID ISF

Enter the amount of expenditures related to the contribution (deposit) into the Medicaid ISF. All deposits into the ISF must meet the criteria established in the ISF Technical Requirement of the Medicaid Contract.

Row A-204 – PSYCH HOSPITAL RATE ADJUSTER (HRA)

Enter, in Column A, the amount of expenditures related to the Psych Hospital Rate Adjuster.

Row A-290 - TOTAL EXPENDITURE

These cells represent the total Medicaid services expenditures prior to any redirects. These cells are formula driven. The formula is the *sum of PIHP HICA / USE Tax (A 201), Medicaid Services (A 202), Payments into Medicaid ISF (A 203) and Psych Hospital Rate Adjuster (A 204)*.

Row A-295 - Subtotal Net MEDICAID SERVICES SURPLUS (DEFICIT)

These cells represent the net Medicaid surplus or deficit before any redirection of funds. These cells are formula driven. The formula is *Total Revenue (A 190) less Total Expenditure (A 290)*.

Row A-300 - REDIRECTED FUNDS (TO) FROM

This row is the label Redirected Funds (TO) FROM. The rows immediately following will identify how surplus funds were used by other funding programs or how deficits were covered by other funding sources. In either case, the funding source must be a legitimate source of funding for the program the funding is being redirected to cover.

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Row A-301 - (TO) CMHSP TO CMHSP EARNED CONTRACTS - J304

This cell represents the amount of Medicaid funds that are being redirected to cover the cost of services provided to Medicaid beneficiaries above the earned CMHSP to CMHSP Earned Contract revenue. The cell is formula driven. The formula is *less FSR – All Non-Medicaid – Section J – CMHSP to CMHSP Earned Contracts – FROM Medicaid Services (J 304)*.

Row A-301a - (TO) HEALTHY MICHIGAN – AI 310

This cell represents the amount of Medicaid funds that are being redirected to cover the cost of services provided to Healthy Michigan beneficiaries above the Healthy Michigan capitation. The cell is formula driven. The formula is *less FSR – Healthy Michigan – From Medicaid (AI 301a)*.

Row A-302 - FROM CMHSP TO CMHSP EARNED CONTRACTS - J301 (explain - section AB).

Enter, in Column A, the amount of any surplus in CMHSP to CMHSP Earned Contracts related to the provision of services to Medicaid beneficiaries being redirected to Medicaid. A brief explanation should be included in Section AB identifying the rationale of this transaction.

Row A-303 - FROM NON-MDCH EARNED CONTRACTS - K301 (explain - section AB)

Enter, in Column A, the amount of any surplus Non-MDCH Earned Contract funding associated to the provision of services to Medicaid beneficiaries being redirected to Medicaid. A brief explanation should be included in section AB identifying the rationale of this transaction.

Row A-325 – Info Only – Affiliate Total Redirected Funds – I390

This data is being collected for informational purposes only and will assist in identifying the overall funding associated to the cost of providing services to Medicaid consumers for Medicaid covered benefits. Enter the amount of redirected funds, at the affiliate level, being utilized to fund all or a portion of the net Medicaid services deficit.

Row A-330 - Subtotal Redirected Funds – rows 301 – 325

This cell represents the subtotal of redirected funds to or from the FSR – All Non-Medicaid to Medicaid services prior to any redirections for an overall funding deficit. The cell is formula driven. The formula is the *sum of (TO) CMHSP to CMHSP Earned Contracts (A 301), (TO) Healthy Michigan (A 301a), FROM CMHSP to CMHSP Earned Contracts (A 302), FROM Non-MDCH Earned Contracts (A 303), and Info Only – Affiliate Total Redirected Funds (A 325)*.

Row A-331 - FROM GENERAL FUND - REDIRECTED TO UNFUNDED MEDICAID COSTS - B301

Enter, in Column A, the amount of redirected general funds (GF) being utilized to fund all or a portion of the net Medicaid services deficit. This amount must have prior approval from the MDCH as part of the PIHP's risk management plan.

Row A-332 - FROM LOCAL FUNDS - M301

Enter, in Column A, the amount of Local funds being utilized to fund all or a portion of the net Medicaid services deficit.

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Row A-333 - FROM RISK CORRIDOR - PIHP SHARE - N301

Enter, in Column A, the amount of Stop/Loss Insurance and/or ISF funds being utilized to fund all or a portion of the net Medicaid services deficit.

Row A-334 - FROM RISK CORRIDOR - MDCH SHARE - N302

Enter the amount of MDCH funds being utilized to fund the MDCH share of the net Medicaid services deficit.

Row A-390 - TOTAL REDIRECTED FUNDS

These cells represent the total of redirected funds associated to Medicaid services. These cells are formula driven. The formula is the *sum of Subtotal Redirected Funds (A 330), FROM General Fund – Redirected to Unfunded Medicaid Costs (A 331), FROM Local Funds (A 332), FROM Risk Corridor – PIHP Share (A 333) and FROM Risk Corridor – MDCH Share (A 334).*

Row A-400 - BALANCE MEDICAID SERVICES

These cells represent the net Medicaid surplus or deficit after redirection of funds. There should never be a deficit, as the PIHP identifies how the deficit was resolved utilizing the redirect section of the FSR. Any amounts greater than zero (surplus) reflected in this cell (column A) will represent unspent Medicaid funding. The Contract Reconciliation and Cash Settlement process will determine whether any unspent Medicaid funding will be earned Medicaid Savings or lapsed to MDCH. These cells are formula driven. The formula is *Subtotal Net Medicaid Services Surplus (Deficit) (A 295) plus Total Redirected Funds (A 390).*

NOTE: Column A – Reporting Board and Column I – PIHP Total are the only rows that should have amounts greater than zero. All other columns should equal zero.

ROW AB – REMARKS

This section has been provided for the PIHP to provide narrative descriptions as necessary. If this space is insufficient, please utilize the “Additional Narrative” tab within the FSR Bundle.