Milliman

BEHAVIORAL HEALTH ENCOUNTER QUALITY INITIATIVE

ANSWERS TO FREQUENTLY ASKED QUESTIONS (FAQ)

As of February 9, 2021

This document provides a compilation of responses to questions and comments provided by participants of the Behavioral Health Fee Encounter Quality Initiative (EQI) presentations, training, and other discussions conducted over the past five months.

During these meetings, participants submitted questions and comments verbally, through the "chat" function provided by the conferencing service, and via e-mail. MDHHS and Milliman captured and summarized the submitted questions and comments and have provided the answers and responses below.

Note that many of the questions included in this document have been re-worded or summarized for the sake of clarity. Some have been combined with other questions because they were similar. It should also be noted that there were some comments provided that have not been included in this document as it was not related to the EQI methodology.

We have made every effort to capture the essence of each comment and question provided from the meeting.

The questions and answers have been grouped into the following categories:

- Service Code Set
- Eligibility and Revenue
- Service UNC
- COB Summary
- Non-Benefit Expenses
- Other Expenses
- Spend-down Summary
- Hazard Pay Summary
- Master Eligibility File
- Other

Note, there has been significant discussion about the reporting of SUD Grant expenditures in the EQI template. For purposes of SFY 2020, MDHHS is requesting that all entities exclude SUD grant expenditures from the EQI reporting.

Service Code Set

1. **We need to make the 90847 read 50 minutes. This was changed in the code chart recently.**

   Answer: The final EQI template will reflect all the updates made to the mental health code charts, including 90847 changing to a 50-minute service, since the draft version of the template was shared with the PIHPs.

Eligibility and Revenue

2. **Should DHIP revenue be treated the same as IPA and HRA? DHIP needs a broader discussion because it is an "incentive" and should be treated as such.**

   Answer: We have included additional rows within the *Eligibility and Revenue* tab to capture DHIP revenue. For purposes of the MLR, the DHIP incentive payments will be excluded from Premium Revenue consistent with IPA and HRA.

3. **How should the health home revenue and expenditures be reported for purposes of the EQI?**

   Answer: We have included additional rows within the *Eligibility and Revenue* tab to capture both the behavioral health and opioid health home revenue. We have also included additional rows on the *Other Expense* tab to capture behavioral health and opioid health home service and administrative expenditures.

4. **Should revenue include SUD block grant revenue?**

   Answer: No, the purpose of this tab is to report information related to the Medicaid behavioral health managed care program only.

5. **The SFY 2020 EQI Methodology and Instructions document does not reference any of the following programs:**

   a. **DHIP (Foster Care and CPS Incentive Payment)**
   b. **AUT (Autism Related Services)**
   c. **HHO (Opioid Home Health)**
   d. **HHBH (Health Home Behavioral Health)**

   Should anything be done with these programs in the EQI reporting process?

   Answer: We have added rows in the Eligibility and Revenue tab to capture revenue associated with DHIP, HHO, and HHBH. AUT is no longer active given the Autism benefit in included within the base DAB/TANF/HMP capitation payments.

Service UNC

6. **Are empty rows required to be present on Service UNC tab? Can they be excluded if there is no data to report for a given code (not utilized by PIHP/CMHSP)?**

Answer: The Service UNC tab rows were developed in a programmatic way to create every possible combination for reporting purposes. We request that the template not be edited (and empty rows to be present) to support a streamlined process of importing responses from 53 CMHSP and PIHP entities. The Service UNC tab can be copied out of the template, formulaically completed for each submission, and then pasted back into the template.

7. **Generating EQI "Service UNC" output with all empty rows included and Index / Service Code Index is not technologically friendly**

   Answer: We envision PIHPs and CMHSPs would write queries to pull down encounters at the PIHP, CMHSP, Population, Program, and Service Code level. The EQI "Service UNC" template could then be populated through a lookup Excel formula.

8. **Can you go through an example showing how T1020 General Fund costs due to Spenddown not being met for the first part of the month will be reported in "Service UNC"?**

   Answer: In the screenshot below, a month of T1020 per diem service units and expenditures has been split by Medicaid and General Fund to reflect the beneficiary meeting spend-down and becoming Medicaid eligible on the 16th of the month. If the claims are billed daily or if they have a separate line for each day, then each claim or claim line can be appropriately identified as Medicaid or General Fund based on the Medicaid eligibility file. If there is a single claim line reflecting the entire month, that claim will have to be split into two claim lines based on the Medicaid eligibility effective date to identify Medicaid eligible portion and the non-Medicaid portion. Please see *Section II. Master Eligibility File* of the EQI instructions creation for further details.

Service Code Index	Fund Source	Service Category	Reporting Units	Program	Population	CMHSP Direct-Run Units	Contracted Provider Units	Total Units	CMHSP Direct-Run Expenditures	Contracted Provider Expenditures	Total Expenditures
T1020	Medicaid	Community Living Supports	Day	BH Managed Care	DAB/TANF	15		15	1,500		1,500
T1020	Medicaid	Community Living Supports	Day	BH Managed Care	HMP			-			-
T1020	Non-Medicaid	Community Living Supports	Day	Non-Managed Care	General Fund	15		15	1,500		1,500
T1020	Non-Medicaid	Community Living Supports	Day	Non-Managed Care	Grants			-			-

9. **Are we no longer required to record the unique consumer count by service code?**

   Answer: The unique consumer count by service code is no longer required. The template will focus on validation of utilization and unit cost information.

10. **In the case of inpatient hospital, the facility bills Medicare and bills us for the balance if Medicaid still owes. Are you saying we have to gross up to the $1,000 even though it is not our cost?**

    Answer: Yes, the intent of the gross expenditure reporting is to capture the total cost of the claim, regardless of the payer. Reporting gross and net expenditures is not required for SFY 2020 reporting (you can select gross or net expenditure reporting on the Attestation tab), but it will be required beginning with SFY 2021 reporting. Regional PIHPs should work with their contracted CMHSPs to either report on a gross or net expenditure basis consistently across the geographic catchment area. MDHHS will be providing more guidance on reporting coordination of benefits on the encounter data in 2021.

11. **On the service code listing for Hospitals there is one code for hospital type 68 and revenue code 0100. On our encounter reports we have 68 and 68PP (partial payment)**

for the 0100 revenue code. Will we just add the two together? I believe it was reported separately on the old cost report

Answer: These would be reported by adding the two together with any coordination of benefits reflected in the COB column of the Service UNC tab.

12. **There are codes in here (Service UNC tab) that have a listing under the Fund Source column as "Non-Medicaid", Program of "BH Managed Care" and population of "DAB/TANF" and "HMP". Per the instruction on page 11 under the "total units and costs for all services" Non-Medicaid Information will be omitted for rate development. I do not believe it is the intention to remove these codes from rate development. For example, H2014 is one of many.**

    Answer: The Service UNC tab incorporates all possible code combinations of program population and service code index for the Medicaid population. Some of these combinations should not be populated (e.g. H2014HK for an DAB/TANF eligible member because units should be recorded under H2014). Other services (e.g. H0006 SUD Case Management) may be provided to members that are covered under the behavioral health managed care program , but the services are not covered under the Medicaid capitation rates. These services would fall under Non-Medicaid fund source and would not be included in the capitation rate development. These expenditures are, however, included within the incurred claims of the MLR calculation.

COB Summary

13. **This tab is very confusing if you are reporting Net expenditures. There is no way to reconcile this because the tab is requiring an offset from the Service UNC tab. If we are reporting net costs and there is third party revenue, there is no way to show this without the offset from the units.**

    Answer: If you are reporting net costs this tab is not required, although it would be helpful if you could populate rows 12-25 for informational purposes.

14. **How are 3rd party insurance payments being handled in relation to the cost of those services. Currently we classify those costs as GF.**

    Answer: The intent of the EQI template is to capture the gross costs for services and costs net of coordination of benefits (COB). 3rd party insurance payments should be reported under the "Direct-Run Total COB" and "Contracted Network Provider Total COB" columns on the Service UNC tab. The COB should be attributable to a given claim and assigned on the Service UNC tab to the Program and Population based on the logic outlined in *Section II. Master Eligibility File* of the EQI instructions. The COB Summary tab requires CMHSPs and PIHPs to document the source of the COB, and it also facilitates documentation of the transition of funds to PA 423 accounts.

15. **Is the COB data strictly cash basis or does it include accrual basis revenues as well?**

    Answer: The COB reported expenditures on the Service UNC tab should be on a cash basis (in other words, payments that have been received as of the reporting period encounter submissions date 1/31/2021 for the SFY 2020 EQI template). We have included

an additional row in the COB Summary tab to capture COB anticipated to be collected but not received.

16. **We directly run some residential homes. Revenue such as Food Stamp Benefits has been recorded in MA 1st and 3rd Revenues to offset MA. Is that considered COB in the EQI?**

    Answer: Room and board revenues should not be used to offset Medicaid, given that Medicaid does not pay for Room and Board expenses for residential services. In the near term, this should reduce General Fund expenditures in the EQI process. MDHHS will be providing further guidance in the future.

17. **Often times there are retrospective reviews where there is no possible chance that an accrual would have been anticipated, however, the service occurred in the prior year and therefore have costs but no units. What is the expectation for treating this type of activity?**

    Answer: This is an example of an item that should be reported as a Reconciling Item. Reconciling items that are widely used may be incorporated into the template in future reporting periods.

18. **Page 11 of the instructions, Total Units and Costs for all services, letter C – The hospitals bill for COB, not the CMH. I'm not understanding the expectation here.**

    Answer: The CMHSP is expected to capture the COB amount from the hospital. This is not a requirement for SFY 2020.

Non-Benefit Expenses

19. **Will Milliman/MDHHS be specifically indicating what is considered delegated vs. retained?**

    Answer: The following additional clarification has been added to the EQI instructions.

    Within the template, non-benefit expenses are broken out into delegated and retained expenses. Both PIHPs and CMHSPs may have retained administrative costs to the extent that they are incurring non-benefit expenses within their organization. Delegated expenses would be any non-benefit expense that is passed directly to CMHSPs by the PIHPs or to providers by the CMHSPs. PIHP delegated expenses should be equal to the sum of both retained and delegated non-benefit expenses reported by the CMHSP within their PIHP catchment area.

20. **Is this Non-Benefit Expense tab intended to replace the ACR? The ACR does not align with this tab. There might need to be further discussion on this or more clearly define what is expected of the field.**

    Answer: Yes, this tab is intended to replace the historical Administrative Cost Report (ACR), although the ACR is still required by CMHSPs in SFY 2020. MDHHS is no longer requiring the seven administrative cost categories for reporting of non-benefit expenses in future

reporting periods. Further details regarding administrative costing will be forthcoming in the standard cost allocation methodology, which will be required in reporting beginning with SFY 2022. MDHHS welcomes additional feedback related to the removal of the ACR and would be willing to have additional discussions if needed.

All CMHSP expenses attributable to the Medicaid behavioral health managed care program should be identified on either the *UNC* tabs, the *Non-Benefit Expense* tab, or the *Other Expense* tab. It is anticipated that the CMHSP expenses identified in the ACR would be captured on the *Non-Benefit Expense* tab.

Spend-down Summary

21. Is it necessary for the Regional PIHPS to report spend down for providers contracted directly with the PIHP?

Answer: For SFY 2020 we are comfortable with the Spend Down Summary reflecting on CMHSP expenditures. This has been updated in the instructions.

22. Is the spend-down tab intended to be informational only?

Answer: The Spend-down Summary will be compared to the spend-down data available in the State's data warehouse.

Hazard Pay Summary

23. If we paid hazard pay increases in encounter rates and the rate build out for the encounter includes indirect time, do we select the direct and indirect option?

Answer: If the direct care worker was paid a $2 hourly wage increase for both their direct face-to-face time with the beneficiary and their indirect non-face-to-face time, then the entity should select the *direct and indirect* option.

24. If a provider chose to pay $3 per hour for staff, would the full wage increase be reported on the Hazard Pay Summary tab or would you only include up to $2 per hour per person?

Answer: The DCW wage increases above $2 per hour would not be reported on the Hazard Pay Summary tab and would not be permissible in the DCW revenue reconciliation.

25. How should provider retainer payments made to contracted network providers be reported?

Answer: Provider retainer payments, defined as payments made to network providers that were not tied to utilization, should be reported on the Other Expenses tab. These expenses should not be reported on the Service UNC tab or the Hazard Pay Summary tab.

26. How should provider retainer payments be reported when the contract with the provider is not FFS, therefore delineation between utilization expense and stability payments are not clear?

Answer: The instructions have been updated to say the following:
CMHSPs/PIHPs should input all expenses paid to providers under the provider stability expenses row of the Other Expenses tab if the payment was made outside of your normal contract for services and it is not tied to utilization. In the case where payments were continued with less or no utilization consistent with the terms of the contract, these expenses should be reported on the Service UNC tab.

27. Is the Hazard Pay Summary tab intended to be informational only?

Answer: The Hazard Pay Summary is necessary to allow MDHHS and Milliman to either fully include or exclude the Hazard Pay expenses from the encounter data.

Other Expenses

28. Where would provider stability expenses not associated to service codes be recorded? Day Programs which were shut down don't have services to expense.

Answer: Please see the response to Question 26.

29. On the Other Expenses tab lines 28 and 29, *Local Match for Forensic and State Psychiatry*, the costs are being added to General funds on the Financial Reconciliation tab. There is no way to show costs directly charged to Local.

Answer: Expense items that are revenues offsetting General Fund expenses (in this example local match) should be input as negative expenses. These items could also be input on as reconciling items on the Financial Reconciliation tab.

Master Eligibility File

30. Are counties on the 834 taken into consideration, or just presence of an 834 record? Thinking of people living out of our catchment area for whom we pay for/report services. We would not typically get capitation payment for these people, unless they are something like HSW.

Answer: We understand there are situations in which one PIHP is the county of financial responsibility (COFR) and provides the service and another PIHP receives the capitation payment for services. The current rule is the PIHP that receives the capitation payment is to report the revenue and exposure information. For encounter reporting, the PIHP who submits the encounter to MDHHS should be reporting the utilization and expenditures. In the future, we will work with the EQI workgroup and MDHHS to view this process for possible changes.

31. In your use of the master eligibility table, will you observe PIHP "borders" or, will your processes "see" a Medicaid eligible person as having Medicaid regardless of where they are treated (such as when an out-of-region consumer is treated for crisis stabilization or has a courtesy screening in a different region)?

Answer: MDHHS and Milliman's processes see a Medicaid eligible person as having Medicaid regardless of where they are treated.

32. A clearly written rule on how to "chop up" by CMHSP the 834s and 820s sent to the PIHP by MDHHS would be appreciated. Then we would have one set of consistent rules to use across the state.

Answer: For purposes of SFY 2020 reporting, PIHPs should identify the "CMHSP" that is attributed a given Medicaid member using the logic outlined in the instructions. The bolded information was added based on feedback.

1. Within the capitation file, condense a member's payments into a single record per month
    a. Have fields designating non-waiver/waiver payments and revenue separately
    b. Non-waiver payments should include mental health state plan, mental health 1915(i), autism, and substance use disorder state plan payments.
    c. There should not be more than one 1915(c) Waiver payment, so we have only included one revenue column for those payments as well, with flags to indicate which Waiver the revenue is attributable to.
    d. Capitation file should now be unique by Member ID and month
2. **Create a unique listing of Member ID and incurred month for those who received a service (based on the month the service began). Merge this list of Member ID and incurred month against the 820 and 834 eligibility files to determine which member/month combinations where there is no eligibility. Pull the 270/271 eligibility file for this list of Member IDs and incurred months where the beneficiary was not identified in the PIHPs 820 and 834 files.**
3. Assign program and population in capitation and eligibility (834 and 270/271) files based on codes noted in the previous section. Possible population values for the BH Managed Care program include DAB/TANF, HMP, HSW, CWP, and SED. If the eligibility file does not have an applicable BH Managed Care program and population, the program should be assigned to Non-Managed Care and the population should be set to General Fund.
    a. In the eligibility file, one record per member per month will contain the non-waiver population in the population field, with Yes/No columns for each of the three 1915(c) waivers

Assign CMHSP and PIHP in the capitation and eligibility based on the county on the 820, 834, and 270/271.

33. Can the master eligibility file developed by MDHHS/Milliman be sent to us based on PIHP/CMHSP?

Answer: MDHHS/Milliman will not be providing a master eligibility file. The master eligibility file created by the PIHPs will be validated against MDHHS/Milliman's master eligibility file as part of the EQI reconciliation process.

MDHHS/Milliman will be developing a list of encounters submitted by CMHSPs/PIHPs who were not the "attributed" CMHSP/PIHP based on the county on the 820 and 834 eligibility files. This dataset can be used to validate the information identified on the 270/271 files, including most importantly the Program and Population assignment to be used for EQI purposes.

Note, all encounters submitted by CMHSPs/PIHPs (having their respective originator plan ID and/or related plan ID) to MDHHS should be reported on their respective EQI templates.

34. **Milliman's instructions for a "Master Eligibility File" do not address how they will be assigning the rows to each CMHSP. We would like some written instructions to clarify how this should be handled, to ensure everyone is on the same page.**

    Answer: All encounters submitted by CMHSPs (having their respective originator plan ID) in MDHHS' data warehouse are anticipated to be reported on their respective EQI templates..

35. **There are documented instances (discussed at the call) where a PIHP must report certain encounters for consumers that get their Medicaid out of region due to various issues (no COFR arrangements for crisis services, recent moves, etc.). Typically, these services are treated / allocated as Medicaid if consumer has Medicaid in another county. However, this would only be detectable via 270/271. Due to a new mandate of having to use "Master Eligibility File" that is fed strictly by 820/834, would CMHSP & PIHP be forced to treat these services as General Fund?**

    Answer: No, these individuals should still be identified as Medicaid eligible. Please see responses to questions 31 and 32.

36. **When creating the master eligibility file, should we ignore rows with the other programs reported on the 5093 (SPMH, SP 1915(i), Autism, SPSA)?**

    Answer: No, the revenue from each of these non-waiver payments should be summed up when condensing the capitation payment file to one record per member per month. This is discussed in Step 1 in the *Development of Master Eligibility File* section of the instructions.

37. **Would the master eligibility file have a single payment amount and then just flags that show what other (HSW, CWP, etc.) payments are included? Would there be no indication of how much of the payment is coming in for each component?**

    Answer: For purposes of filling out the EQI template, a revenue column for both waiver payments and non-waiver payments is what we have instructed to do for purposes of completing the EQI reporting. PIHPs could separate each non-waiver payment into separate columns if needed (SPMH, SP 1915(i), Autism, SPSA). There should not be more than one 1915(c) Waiver payment, so we have only included one revenue column for those payments, with flags to indicate which Waiver the revenue is attributable to.

38. **Can we just use the 270/271 to identify Spenddown persons?**

    Answer: MDHHS recommends using the 834 files. The 270/271 should only be used on an ad hoc basis if an individual is not in the 834 file or to validate or confirm beneficiaries in question. Please see the response to questions 31 and 32.

39. **What's the reasoning behind the recommendation to use the 834 over the 270/271?**

Answer: MDHHS is trying to avoid a wholesale download from the 270/271 by managed care health plans, PIHPs, and CMHSPs because they receive another data source that provides Medicaid eligibility information. Hospitals and other Medicaid providers don't receive 834 eligibility files and must check the 270/271 to determine eligibility. If health plans, PIHPs, or CMHSPs all download rosters from the 270/271, millions of records are pulled, and it slows down the system for all parties. MDHHS is recommending to only pull 270/271 records for individuals who are not identified by the PIHP/CMHSP based on their 820/834 information.

40. **If 834 doesn't match 270/271, is it the 270/271 that is considered more accurate?**

    Answer: If the daily 834 file doesn't match the 270/271, then MDHHS would appreciate being made aware of this issue right away. Please note that this is only an issue if you are looking at the daily 834 and the 270/271 on the same day. These files may not match if you are looking at different dates because Medicaid eligibility may change daily. Jackie Sproat & Kathy Haines are developing a process for this type of feedback.

41. **What source is best to use for determining HSW/SED/CWP eligibility, not necessarily payments?**

    Answer: For purposes of the EQI reporting, you should utilize the combination of capitation payments and then the eligibility files. Identification in the eligibility files is available in the 2000 loop.

42. **For people who met Spend Down (and became Medicaid eligible) after the start of COVID-19 emergency, they no longer flip between SD Not Met and SD Met. Are they still identified as SD in the COB loop of the 834?**

    Answer: Individuals who met Spend Down and became Medicaid eligible after the start of the COVID-19 emergency will not flip back to Spend Down, they will remain on Medicaid until the end of the public health emergency (PHE).

43. **Will we eventually have the opportunity to compare our master eligibility file to the version shared with Milliman?**

    Answer: Milliman will be comparing the master eligibility file to what is provided by the PIHPs at a summary level as part of the EQI reconciliation. If discrepancies are identified, more detailed discussions and comparison will be needed.

44. **Some of the eligibility Boolean fields are Y/N and some are 0/1. Can we settle on one pattern?**

    Answer: We agree it makes sense to be consistent and have updated the instructions to reflect Yes/No fields throughout.

45. **Are there code set lists for the eligibility fields:**
    - **MHL Plan Name**

- **MHP Plan Name**
- **Eligibility PIHP**
- **Non-waiver PIHP**
- **1915(c) PIHP**

We have values for these fields in our warehouse, but it might be nice to use a core data set if we share this file outside our PIHP.

Answer: This information is discussed in section II of the EQI instructions. See the following tables (pulled from the instructions) for identifying the waiver and non-waiver PIHP, including which fields are used from the corresponding files. Capitation information is expected to come from the 820 file, while benefit plan information will be found in the 834. Final values for the fields listed above should be applied in the following order

- 820 capitation file
- If not present in 820, utilize information from the 834
- If not present in the 834, utilize information from the 270/271

Note that the eligibility PIHP is the PIHP that is assigned on the 834 file while the Non-waiver PIHP would be the final PIHP assigned through the hierarchy listed in the bullets above.

FIGURE 1: MEDICAID BEHAVIORAL HEALTH MANAGED CARE ENROLLEE IDENTIFICATION

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

FIGURE 2: ELIGIBILITY PROGRAM CODE MAPPING

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

46. If one client is in both the 820-capitation file and 834-eligibility file with conflicting information, which should be used?

Answer: Consistent with the EQI Instructions document, the 820-capitation file should take priority if information is available. The 834-eligibility file serves as a secondary source where information is not available in the 820-capitation file.

Other

47. Can you freeze the header rows so the user can see the labels from any cell in the worksheet?

Answer: The freeze panes functionality is available to the user despite the template being locked down.

48. How should MI Health Link encounter and expenditures be handled under the EQI?

Answer: There are both Medicaid and Medicare covered behavioral health services for MI Health Link program enrollees who are dually eligible under the behavioral health program. Behavioral health services only covered by Medicaid should be reported to MDHHS under the behavioral health program, including the full cost of the service on the encounter. Behavioral health services covered by Medicare should be handled using the following approach:

- PIHPs should only report the Medicare reimbursed service cost to the ICO and not to MDHHS.
- If the Medicare reimbursement does not sufficiently cover the full cost of the service, the PIHPs should report an encounter (beginning in SFY 2022 if not already doing so) under the behavioral health program to MDHHS, including the Medicaid paid amount and the Medicare coordination of benefits amount, consistent with other dual eligible beneficiaries. Given there aren't any encounters in SFY 2020 for these services for some PIHPs, the MHL Medicaid costs and utilization for Medicare services should be reported on the MHL Medicare Service UNC tab.

49. How do you address a single hospital encounter/claim crossing a month boundary? Could have multiple fund sources/populations (switch from HMP to Medicaid, or GF to Medicaid) as a result? On your end, will you attribute the entire encounter to a FS based on the service "from date"? Sometimes inpatient encounters/claims crosses FY boundaries too.

Answer: In these instances, the entire encounter should be attributed to the month based on the "from date" of the encounter. We have reviewed these claims and the impact of doing this is minimal.

50. Will the MUNC be required for SFY 2020?

Answer: The EQI template will replace the MUNC, GFUNC, SECR, and ACR for SFY 2020 reporting.

51. There are times when the 820 payment goes to another region than who is servicing the consumer. How should this be handled?

Answer: We expect that a member's revenue and eligibility will be assigned according to the capitation payment or county of eligibility, although we expect encounters to be reported

by the CMHSP and PIHP that performed the service. We understand that in a small percentage of cases, these are not the same.

52. There are times when the fund source for a service needs to be overridden to GF when, for instance, the rules of the primary payer (Medicare, etc.) were not followed. Are those overrides essentially disregarded with this model?

Answer: We have added an additional override in the Incorporation of Master Eligibility File into Encounters, which states the following:

CMHSPs have stated that several fund source overrides have historically been made to comply with Medicaid billing rules. One reason for overrides is that Medicaid cannot pay for services when the primary payer billing rules are not followed. An example of this is Medicare does not pay for certain services rendered by Licensed Professional Counselors (LPCs). Therefore, Medicaid and Medicare dual eligible beneficiaries receiving certain services from an LPC need an override to transition funding to General Fund.

53. Do we need to make the choice to report gross or net on a PIHP wide basis? Will it mess things up if some CMHs in the PIHP report as gross while others report as net?

Answer: Our recommendation is for this decision to be made at the PIHP level and relayed to the CMHs which method each should report, so that all are consistent within the PIHP.

54. Should the Regional Entities be reporting TOTAL costs? We have a lot of grants that are essentially staffing grants (at the PIHP level and some of our providers) as well as other contracting that supports non-encounterable costs and could be supported under a MH grant or the SUD grant. If this is NOT intended to reflect total costs, the expectations of what is to be reported needs to be crystal clear. The Regional PIHPs have never had a SUBEL requirement, so instructions on reconciliation is essential.

Answer: The Regional PIHPs should be reporting total costs for the Medicaid behavioral health managed care program only. SUD block and other Grants should not be included in SFY 2020 reporting.

55. Will there be adds for FSR lines so everyone knows what they should be reconciling to?

Answer: When available, there will be communication to clearly document how the EQI and FSR templates should reconcile.

56. Where should the premium pay expenses be captured since this is in a different FSR section and is cost settled separately?

Answer: Premium pay (hazard pay) expenses should be included within the Service UNC tab. Total EQI expenses will likely reconcile to the sum of total Medicaid expenditures and hazard pay expenses. Additional specific instructions will be provided when available.

57. On the reconciliation tab, the reconciling items are not pulling into the total expenses.

Answer: For reconciling items to be included in the total expenses, the user must select a *Program* in Column B. This allows the reconciling item to be attributed to a particular *Program*.

58. How do we report any GF carryforward or shortage?

Answer: We recommend using reconciling items for this.

59. In the past, NL has recorded administration on grants as a 90/10 FY expense to the extent GF funding is available and then used additional Local if needed. The other grant expenses are falling into line 151 of the financial reconciliation under grants. There is no grant match available to GF for administration

Answer: We recommend using reconciling items for this.

60. Why are there General Fund expenses included within the Regional PIHP template?

Answer: We have included CMHSP General fund and Grant expenses within the Regional PIHP Service UNC tab to retain the exact number of rows and order of the CMHSP Service UNC tab. This will aid Regional PIHPs to the extent that they agree with CMHSP reporting on the Service UNC tab and just want to paste in the values from the CMHSP template. These expenditures are not included in total PIHP reported expenditures.

Limitations and Data Reliance

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

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

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

In performing this analysis, we relied on data and other information provided by MDHHS and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

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