FY'19 *PRELIMINARY* PIHP MEDICAID UTILIZATION AND NET COST REPORT (MUNC)

This report provides preliminary FY19 service data for MDHHS management of PIHP contracts and rate-setting by the actuary. The PIHP must report information on **cases and units of service** as an aggregation of all Medicaid services provided in the service area by the CMHSPs and other contracted providers, including substance use disorder providers. **This preliminary report does not include cost information.**

The data set reflects and describes the support activity provided to or on behalf of Medicaid beneficiaries, **except** Children's Waiver, and Children's Serious Emotional Disturbance Waiver. The format is presented by procedure code, beginning with facility services reported by revenue code. Most of the activity reported here will also have been reported in the encounter data system. Refer to the PIHP/CMHSP Encounter Reporting Costing per Code and Code Chart on the MDHHS web site for a crosswalk between services and the appropriate codes.

Cases and units for 1915(c) HSW services provided to beneficiaries who are enrolled in the Habilitation Supports Waiver should be reported on the Specialty Medicaid Utilization and Net Cost Report (MUNC) for all Scopes and Coverages included in the specialty behavioral health benefit.

RULES FOR REPORTING

Instructions:

Submission Requirement for FY19 – Each regional entity must provide a report for each CMHSP in the region plus an aggregated report for the PIHP. These reports may be submitted in a single excel workbook with separate worksheets for the PIHP and each CMHSP.

I. Total units and cases per procedure code:

A. Enter the number of **units** per procedure code that were provided during the period of this report for Medicaid beneficiaries with mental illness, serious emotional disturbance, developmental disabilities and substance use disorders served by the PIHP (see exclusions). For most of the procedure codes, the total number of units should be consistent with the number of units for that procedure code that were reported to the MDHHS warehouse for all consumers. Follow the same rules for reporting units in this report that are followed for reporting encounters. Refer to the Behavioral Health HCPCS and Revenue Code Chart on the MDHHS web site and the Behavioral Health and Intellectual and Developmental Disability Supports Chapter of the Medicaid Provider Manual (also on the MDHHS web site).

B. PIHPs are to report EPSDT (Early Periodic Screening Diagnosis and Treatment) for some services that are provided to beneficiaries under age 21 on the date of service. All services provided under the Autism benefit are to be reported as EPSDT. Report

units of state plan, EPSDT, 1915(b)(3), and Habilitation Supports Waiver (HSW) in separate columns on the worksheet. Some procedures are reportable under more than one coverage. For example, supports coordination (T1016) is reportable as a 1915(b)(3) service, EPSDT and HSW. Care should be taken to report the appropriate number of units attributable to the coverage. **Note that all units for HSW services are to be reported under columns N and O including instances in which the consumer is under 21 on the date of service.**

C. For FY19 inpatient services for both provider types, IMDs and local psychiatric hospitals, are separated out to distinguish between costs with **bundled per diems and those with the physician costs excluded**. Within each of these rows, there are rows added to distinguish between level of payment responsibility:
    - a row for inpatient costs and units for which the PIHP/CMHSP makes 100% Medicaid payment for the inpatient encounter.
    - a second row for which the PIHP/CMHSP makes partial Medicaid payment for an inpatient encounter.

D. **Very important - Community inpatient and IMD services reported in rows 1-8 should not include the estimate of the use (days and consumers) for IBNR accruals for the current year.**

E. Inpatient units reported in rows 1 through 8 **should include** services that were provided during the reporting year but funded by prior year savings or carry-forward or by funds pulled **out** of the ISFs.

F. Inpatient units reported in rows 1-8 **should not include** accruals or adjustments for services provided in previous years.

G. Note that some procedures are reportable under only one column. An example is out-of-home prevocational service (T2015) that is only available to persons with a developmental disability who are enrolled in the Habilitation Supports Waiver.

H. Peer-support specialist services (H0038), Substance Abuse Peer Services (H0038 with HF), Developmental Disabilities Peer Mentor (H0046), and Drop-in centers (H0023), each have a row to report cases and units for those services reported as encounters. In addition, there is a row 251 for peer-delivered expenditures and drop-in center activities that were **not** captured by encounter data. It is important that the appropriate numbers are entered into the correct rows for these procedures for different types of peers. **Do not** aggregate the units and cases into one row.

I. Several codes have rows without modifiers as well as rows with modifiers: for example, 90849 (HS modifier used to distinguish when a beneficiary is not present), H0031 (HW modifier used to determine whether the assessment is a Supports Intensity Scale (SIS) assessment). It is important that the appropriate number of units

and cases are entered into the correct rows for these procedures. **Do not** aggregate the units and cases for the modified procedures into one row.

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

For this preliminary report, do not enter information into Sections II- XV.

Exclusions:

The units tied to the following expenditures **MUST BE EXCLUDED** from the preliminary Medicaid Utilization and Net Cost Report:

1. Local contribution to Medicaid.

2. Room and board

3. Services for Children's Waiver and Children with Serious Emotional Disturbance Waiver

4. Payments made into internal service funds (ISFs) or risk pools. 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.

5. Provider of administrative service organization (ASO) services to other entities, including PIHP/hub ASO activities provided to CMHSP affiliates/spokes for non-Medicaid services.

6. Write-offs for prior years.

7. Workshop production costs (these costs should be offset by income for the products).

8. Services provided in the state hospitals and Center for Forensic Psychiatry.

9. Mental health services delivered by CMHSP but paid for by health plan (MHP) contracts.

Additional Issues:

1. Report services that match 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. (i.e., report cases and units for services rendered, but those whose claims have not been adjudicated by the time of report).

2. The COFR PIHP should report services that are provided by another CMHSP/PIHP through an earned contract.