FY'15 CMHSP TOTAL SUB-ELEMENT COST REPORT

This report provides the total service data necessary for MDCH management of CMHSP contracts and reporting to the Legislature. The data set reflects and describes the support activity provided to or on behalf of all consumers receiving services from the CMHSP **regardless of funding stream** (Medicaid, Healthy Michigan, MI Child, general fund, grant funds, private pay, third party pay, autism iSPA, contracts). 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.

Note: Services provided under the PIHP's substance use disorder function are NOT to be reported in this sub-element cost report.

RULES FOR REPORTING ON CMHSP TOTAL SUB-ELEMENT COST

Background:

MUNC

PIHPs report Medicaid managed care expenditures on the Medicaid Utilization and Aggregate Net Cost report (MUNC) as well as Medicaid benefit plan management. It is used by the state's actuary as a PIHP Financial Statement as well as in the analysis of the encounter data and costs The report is also used to compare the volume of units reported with the encounter data.

Healthy Michigan

PIHPs report Healthy Michigan managed care expenditures on the HMP Utilization and Aggregate Net Cost report (HMPUNC) as well as HMP benefit plan management. It is used by the state's actuary as a PIHP Financial Statement as well as in the analysis of the encounter data and costs. The report is also used to compare the volume of units reported with the encounter data.

MIChild

Starting in FY15, PIHPs report MiChild managed care expenditures on the MiChild Utilization and Aggregate Net Cost report (MiChildUNC), as well as MiChild benefit plan management. It is used by the state's actuary as a PIHP Financial Statement as well as in the analysis of the encounter data and costs. The report is also used to compare the volume of units reported with the encounter data.

PIHPs reported cases, units and costs for services covered under the state plan amendment for the Medicaid autism benefit. These costs are reported on the second tab of the MUNC report workbook. PIHPs are to use this sheet to document those services

included in the cost settlement process for Medicaid autism services. The information will also be used by the state's actuary in the analysis of expenditures for the 1915i state plan amendment.

Sub-element Cost Report
CMHSPs report expenditures for all funding streams on this Sub-Element Cost Report. It is used by MDCH to comply with the MDCH Appropriations Act Section 404 boilerplate requirements.

General Fund Utilization and Net Cost Report (GFUNC)
CMHSPs report their expenditures for general fund only on this General Fund Cost Report. This report enables MDHHS to know the services, cases, units and costs, and indirect activity and subsidies attributed to CMH general funds. It is used by MDHHS to respond to MDHHS Appropriations Act Section 406.

It is not currently intended that the Sub-element Cost expenditures match the Financial Status Report (FSR) expenditures. Each CMHSP should maintain documentation, however, as to the source of variance between the FSR and the sub-element cost report.

Instructions:

I. Total units, cases, and costs per procedure code:

A. Enter the number of **units** per procedure code that were provided during the period of this report for each disability group – individuals, with a developmental disability, adults with mental illness, and children with serious emotional disturbance. 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 PIHP/CMHSP Encounter Reporting Costing per Code and Code Chart on the MDHHS web site, the Mental Health and Substance Abuse Chapter of the Medicaid Provider Manual (also on the MDHHS web site). Report services for Persons with Developmental Disability (H), Adults with Mental Illness (I), and Children with Serious Emotional Disturbance (J) in separate columns on the spreadsheet.

B. Units, Cases and costs for those individuals who have both a mental illness and a developmental disability designation should be reported in only one column (H, I or J). Report these units, cases and costs based on the person's primary service designation. **Include costs and services for persons with MI/SA co-occurring conditions where revenues were used by the CMHSP to purchase or provide such services.**

C. Include costs and services that were funded by prior year savings or carry-forward or by funds pulled **out** of the ISFs.

D. Report information from State Psychiatric Hospitals.

E. 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.

F. Include cases, units and costs for Children's Waiver and the SED Waiver. Report Children's Waiver units and costs using the separate rows that have been added for Children's Waiver or in other related rows in the Developmental Disability columns. Report units and costs for the SED waiver in the related rows in the Children with Serious Emotional Disturbance columns.

G. Peer-delivered (H0038) has a row for units, costs, and cases that were reported in the encounter data, and a row for peer-delivered expenditures and drop-in center activities that were **not** captured by encounters data. **Do not** aggregate the units, cases and costs for these rows. Report the information for these rows separately.

H. Several codes have rows without modifiers as well as rows with modifiers: 90849 (HS modifier used to distinguish when a beneficiary is not present), H2016 and T1020 (TF and TG modifiers used to distinguish between the levels of service). 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.

I. Rows have been added for services provided through the 1915(i) state plan amendment for the Medicaid autism benefit. The Sub-Element contains a row for each autism assessment service listed in the Autism Worksheet. There is one row each for Applied Behavioral Intervention, Early Intensive Behavioral Intervention, and Home Care Training to Home Care Clients. The sub-element does not contain a separate row for each provider level for these services. The units, cases and costs across the various provider types are to be aggregated into each service row for these three services.

J. If room and board is reported as encounters (S9976) to the warehouse, enter the cases, units and costs here. If room and board was not reported as encounters, report it in Row VI.D., "Other Costs Details, Room and Board."

K. A row for pharmacy is included to report drugs, including injectibles, and other biologicals. Do not report "enhanced pharmacy" cases and costs in this row, but rather under T1999.

L. A row for "All Other Costs" has been added to report other procedure codes that are not included in the rows above. These are typically non-mental health activities provided to individual consumers for which CMHSPs use general funds.

M. Enter the **unique number of cases** per procedure code. This number should reflect the unduplicated number of consumers who were provided the service during the reporting period. Record cases, unit, and costs under "Column J" if the child has a mental illness and is less than age 18 at the time the service was provided.

N. Enter the **total expenditures** per procedure code (see exclusions below) by each population group.

O. Rows for Substance Abuse procedure codes are included. If the CMHSP is providing these services or contracting with a provider for these services then the unique number of cases, number of units, and total costs should be entered into these lines. Cases should only include those consumers who are in at least one of the eligibility groups – individuals with a developmental disability, adults with mental illness, or children with serious emotional disturbance. Note that the Sub-element report no longer collects information on substance abuse services provided to individuals who are not in one of these eligibility groups. **Do not include units and costs for services managed/provided via the PIHP SUD function.**

II. Total MH/DD Cases and Costs:

Enter in the appropriate columns the unduplicated number of cases for each population group. The total service costs will automatically calculate in column K.

III. Prevention – Indirect Service Model

In row III, column K, enter the total expenditures (staff, facility, equipment, staff travel, contract services, supplies and materials) for indirect prevention activities. Indirect prevention activities include Health Fair participation, visiting classrooms, speaking at events, and similar activities aimed at informing stakeholders about mental illness or developmental disabilities and where they can go for help.

IV. MH/DD Medicaid Administration by PIHP for CMHSP Member:

Report costs incurred on your CMHSP's behalf by your regional PIHP. CMHSPs that are also a PIHP should report "zero" (Detroit, Macomb, Oakland).

V. MH/DD Administration by CMHSP:

Enter in column K the total expenditures for managed care administration performed by the CMHSP for all its services. For member CMHSPs this includes Medicaid managed care administration for activities delegated by the PIHP region and also includes non-Medicaid managed care administration. The CMHSP should also include costs where the PIHP region provides administrative service organization activities for the CMHSP member for non-Medicaid services paid for by the member.

IV. Other Costs Details:

a. Michigan Rehabilitation Services (MRS), MRS Cash Match.

b. GF used to subsidize PASARR and not reported in encounters or claims).

c. Contracts and grants **only reported expenses beyond the grant revenue**. One row each for:

   i. DCH grants.

   ii. Non-DCH Grants, earned contracts (including COFR).

   iii. CMHSP, as subcontractor to the PIHP for the substance use disorder function. GF subsidy expensed for substance abuse services.

   iv. Categorical funds.

d. Room and board not reported as S9976.

e. Laboratory procedures.

f. Local match for Forensic Center.

g. Jail diversion.

h. Department of Human Services Worker for eligibility determination

i. Transportation (not reported as encounter or claim).

V. All Other Costs:

In column K report all service related costs that cannot be included in any of the service lines, or Other Costs Details rows, above and cannot be charged to Medicaid. ***Please provide an itemized listing of "all other costs" in the Comments box.***

Grand Total Expenditures:

Formula in cell will automatically calculate the sum of all costs included in this report.

Exclusions:

The following expenditures **MUST BE EXCLUDED** from the CMHSP Sub-Element Cost Report:

1. Local contribution to Medicaid.

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

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. (Is this exclusion consistent with the language in V. above???

4. Services provided by CMHSP for another CMHSP/PIHP through an earned contract (the COFR CMHSP should report these costs, NOT the providing CMHSP).

5. Write-offs for prior years.

6. Workshop production costs these costs should be offset by income for the products.

7. Medicare payments for inpatient days (where CMHSP has no financial responsibility).

8. Services provided in the Center for Forensic Psychiatry.

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

Additional Issues:

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

2. Spend-down is captured separately on the Medicaid Utilization and Net Cost Report but does not need to be separated out on this report.