

## **FY'19 PRELIMINARY PIHP HEALTHY MICHIGAN UTILIZATION AND NET COST REPORT**

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 Healthy Michigan 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 Healthy Michigan 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.

**For individuals enrolled in the Habilitation Supports Waiver (HSW), cases and units for non-1915(c) HSW services provided to beneficiaries while covered by Healthy Michigan Plan should be reported on the Healthy Michigan Utilization and Net Cost Report.**

### **RULES FOR REPORTING ON THE HEALTHY MICHIGAN REPORT**

#### 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 Healthy Michigan beneficiaries with mental illness, serious emotional disturbance, developmental disabilities or 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, the Behavioral Health and Substance Abuse Chapter of the Medicaid Provider Manual (also on the MDHHS web site).
- B. For this Healthy Michigan report, PIHPs are to report services provided under the mental health/IDD benefit (Columns G and H) separately from those services provided

under the substance use disorder benefit (Columns K and L). PIHPs are to report the cases and units for services provided by a provider agency licensed and accredited as a substance abuse treatment program under the columns for HMP-PIHP Substance Use Disorder Benefit. Examples of such services are substance abuse individual assessment, substance abuse outpatient care, and substance abuse residential services.

In addition, the Health Michigan plan introduced many new services to the substance use disorder service array. Examples of such services and supports include community living support, personal care, support and service coordination and skill building. The cases and units for these services provided to an individual with a substance use disorder are also to be reported under the columns for HMP-PIHP Substance Use Disorder Benefit.

- C. For FY19 inpatient services for IMD and community inpatient hospitals are separated out to distinguish between costs with **bundled per diems and those with the physician costs excluded**. Under 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% HMP payment for the inpatient encounter
  - a second row for which the PIHP/CMHSP makes partial payment with HMP dollars 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 costs reported in rows 1-8 **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. Rows 12 and 13 have been intentionally left blank.
- 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. **Do not** aggregate the units and cases into one row.
- I. Several codes have rows without modifiers as well as rows with modifiers: 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 Healthy Michigan cases** per procedure code in Column G for those receiving services under mental health benefit and in column K for those receiving services under the substance use disorder benefit. These number should reflect for each benefit the unduplicated number of Healthy Michigan beneficiaries who were provided the service during the reporting period.

**\*\*For this preliminary report, do not enter information into Sections II- XII.\*\***

Exclusions:

The units tied to the following expenditures **MUST BE EXCLUDED** from the Healthy Michigan report.

1. Local contribution to Healthy Michigan.
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 Healthy Michigan 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-Healthy Michigan 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. (ie. 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.