1.0 General Report Overview

Effective October 1, 2017, the Michigan Department of Health and Human Services (MDHHS) has modified the functionality of the Financial Status Report (FSR) bundle. The modification to the FSR bundle is designed to increase reporting efficiency for the Community Mental Health Services Programs (CMHSPs) and the Prepaid Inpatient Health Plans (PIHPs). The FSR bundle will now allow FSR reporting specific to the needs of the reporting board. There are three FSR report types; CMHSP (Non-Medicaid reporting), PIHP (Medicaid/Affiliate CMHSP reporting) and Stand Alone (Detroit-Wayne, Oakland, Macomb). The selected FSR will only display the applicable report tabs, columns and rows.

Please note that the report tabs, columns and rows that are not applicable are hidden or relabeled to condense the FSR bundle. Additionally, the financial reporting instructions for each form within the FSR bundle have not been modified. All column, row, cell and formula references remain intact and should only be considered if applicable to the selected FSR.

The Financial Status Report (FSR) – Health Home Services is a 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 1115 and 1915(c)/(i) Waiver Program Contract (Medicaid Contract) with the Michigan Department of Health and Human Services (MDHHS) for the provision of Health Home Services. Section 2703 of the Affordable Care Act allows State Medicaid programs to develop Health Home services for Medicaid beneficiaries with chronic conditions. The FSR – Health Home Services summarizes the revenues and expenditures of the PIHP related to the provision of Health Home Services and will identify whether there is a net deficit prior to any redirection of funding to address a deficit.

Health Home services are authorized through a Medicaid State Plan Option that provides a comprehensive system of care coordination for Medicaid individuals with chronic conditions. Health home providers integrate and coordinate all primary, acute, behavioral health and long-term services and supports to treat the “whole person” across the lifespan. The health home services include:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient and family support
- Referrals to community and social support services

MDHHS designates Prepaid Inpatient Health Plans (PIHPs) to serve as the central point for directing patient-centered care, reducing avoidable health care costs (specifically preventing hospital admissions/readmissions and avoidable emergency room visits), providing timely post-discharge follow-up, and improving patient outcomes by addressing whole-person health care needs through provision of comprehensive, integrated

behavioral health (mental health and substance use disorder), medical, care coordination and management services.

Medicaid eligible adults with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) residing in an eligible county qualify for the provision of benefits described in the Health Home State Plan Amendment. Prepaid Inpatient Health Plans (PIHPs) and Medicaid Health Plans (MHPs) operating in an eligible county shall establish a care coordination agreement to assure service coordination and continuity of care for persons receiving services from both organizations, including persons with SMI or SED who qualify for MHP Complex Case Management services.

The Health Homes Behavioral Health (HHBH) benefit is managed on a full risk basis by the PIHP. PIHPs shall develop and establish contracts with CMHSPs/eligible Health Home Partners to ensure that the terms of the agreements between PIHPs and MHPs shall extend to CMHSPs/eligible Health Home Partners as applicable, particularly those terms for ensuring sharing of information and collaborating on mutually shared beneficiaries. A comparison will be made between revenue and expense to determine whether there is an overall surplus or deficit in funding. When a surplus in funding exists the unspent Health Home Services funds become local funds in the following fiscal year. When an overall deficit exists, the PIHP must report what funding will be used to cover the costs above the capitation received.

Per the approved CMS State Plan Amendment, the HHBH contract contains a Pay-for-Performance (P4P) withhold. The P4P distribution methodology can be found in the HHBH Handbook. MDHHS will calculate and distribute earned P4P within one year of the performance year (PY) (e.g., for FY22, the amount earned will be distributed by the end of FY23). Please note that the distribution of the P4P withhold in a measurement year (MY) will be based on a quarterly increase in enrollment.

The HHBH P4P withhold will be reported on a cash basis in the fiscal year following the MY/PY (e.g., for FY22, the earned HHBH P4P will be reported in the FY23 reporting period).

The FSR – Health Home Services will be utilized by the Michigan Department of Health and Human Services (MDHHS) as a tool to monitor the fiscal operations of the PIHP. In addition, this report will provide the basis for the annual contract reconciliation of the MDHHS/PIHP Health Home Services.

The PIHP/CMHSP shall comply with Generally Accepted Accounting Principles, along with any other federal and state regulations as defined in the PIHP Contract. All revenue and expenditures are required to be reported on an accrual basis of accounting, unless otherwise directed by MDHHS policy. 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 – Health Home Services must reconcile to the PIHP/CMHSP's general ledger.

The PIHPs with affiliate CMHSPs contracts for the provision of the Health Home Services will report summary level revenue and expenditure information in separate columns for each contract. The amounts reported by the PIHP should reconcile to the FSR – All Non-Medicaid – Section IC – PIHP to Affiliate Health Home Services Contracts for each affiliate CMHSP.

2.0 Report - Due Dates

Refer to the reporting grid incorporated in Schedule E of the Contract for identification of report due dates. Reporting requirements can be found on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

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 MDHHS-BHDDA-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 XX Year End Interim submitted from Northern MI for the Health Home Benefit, the file name should read **FYXX Year End Interim Northern MI FSR Bundle MM-DD-YYYY.**

Note: The FSR – Health Homes 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 1115 and 1915(c)/(i) Waiver Program Contract with selected PIHPs to manage the Concurrent 1115 and 1915(c)/(i) waiver and 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.

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.

GF Contract: MDHHS/CMHSP Managed Mental Health Supports and Services Contract.

PIHP: A CMHSP or Regional Authority that holds the Medicaid Managed Specialty Supports and Services Concurrent 1115 and 1915(c)/(i) Waiver Program Contract with MDHHS and acts as the Prepaid Inpatient Health Plan.

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

Regional Authority: An entity, jointly governed by the sponsoring CMHSPs, that has met the MDHHS 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 1115 and 1915(c)/(i) waivers or who is eligible for the Healthy Michigan Plan.

IPA: Insurance Provider Assessment Act. Public Act 175 of 2018 created the Insurance Provider Assessment Act. The legislation mandates that effective October 1, 2018, certain insurance providers are required to pay an assessment on certain paid health care revenue.

The FSR – Health Homes 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.

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

The following numbering / sequencing have been utilized in the FSR – Health Homes

100	Title row for revenue
101-189	Detail rows for reporting revenue
190	Total row for revenue
200	Title row for expenditures
201-289	Detail rows for reporting expenditures
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 retained surplus funding, and any redirections (TO) or FROM

Column A: Column A is to be used by the reporting Regional Authority or PIHP for the revenues, expenditures, redirection of funds, sub-totals and totals.

Column B through H: Columns B through H will be used by the PIHP to report summary level information of their contracts with affiliate CMHSPs for the provision of the Health Home benefit. The amounts reported by the PIHP should reconcile to the revenues, expenditures, redirection of funds, sub-totals and totals of the affiliate CMHSPs.

Column I: Column I is formula driven and represents the total revenues, expenditures and redirections entered in columns B through H.

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 Health Home benefit. 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. The redirection rows include at the end of the description a reference to the partner row.

For example – AG 332 (FROM) Local Funds M301.4 the "M" refers to the Local Funds section of the FSR All Non-Medicaid, the 301.4 represents the partner row of the FSR All Non-Medicaid redirection to row "AG 332".

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" sections will be the mechanism in which the PIHP/CMHSP will identify how any funding surplus or deficit was resolved by

category. 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.

Every "TO" redirection will have an offsetting "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:

AG 332 FROM Local Funds – M301.4 $10

This line is within the Local funds section and indicates that $10 is being received "FROM" the Local Funds section to fund Health Home Services expenditures that exceed Health Home Services funding.

M301.4 (TO) Health Home Services (AG 332) ($10)

This line is within the FSR - All Non-Medicaid – Local Funds section and indicates that $10 is being redirected "(TO)" the FSR – Health Home 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.

5.0 Instructions for Completion of the Report

The PIHP name, Fiscal Year, Submission Type and Submission Date have been brought forward from the FSR – Medicaid.

5.1 SECTION 1 – FINANCIAL STATUS REPORT – Health Homes

This section is the Financial Status Report for the Health Home benefit.

Row 1 – PIHP or CMHSP
The name of the Regional Authority / Reporting Board (column A) and the name of any affiliate CMHSP (columns B through H) will auto populate based on what was entered on the FSR - Medicaid. The MDHHS may request, for select PIHPs, the reporting of prime sub-contractors.

Row AG – Health Home Services – PIHP Use Only
This row is a title row for informational purposes only. The rows immediately following will represent, on an accrued basis, the revenues, expenditures and redirection of funding related to the Health Home Services.

Row AG 100 – Revenue
This is a title row for informational purposes only. The form will not allow any numbers in this row.

Row AG 101 – Revenue – Health Home
Column A, in this row represents the amount of funding authorization associated to the Health Home Services capitated payments, inclusive of any open accruals.

Note: The HHBH P4P withhold will be reported on a cash basis in the fiscal year following the MY/PY (e.g., for FY22, the earned HHBH P4P will be reported in the FY23 reporting period).

Row AG 115 – Revenue – Health Home Services - 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. The formula is *less the amounts reported in columns B through H.*

Row AG 115 – Revenue – Health Home Services – Affiliate Contracts- COLUMNS B THROUGH H
Enter the amount of Health Home Services funding distributed to each of the affiliate CMHSPs of the PIHP.

Note: The Health Home Contract amendment requires the PIHP shall: forward the entirety of all HHBH payments received from MDHHS (less any amount required to satisfy applicable Insurance Provider Assessment (IPA) tax and administrative costs) to the designated affiliate CMHSP/Health Home Partner.

Row AG-190 – Total Revenue
These cells represent the total Health Home Services accrued revenue available to fund current year expenditures. These cells are formula driven. The formula is the *sum of Revenue – Health Home (AG 101) and Affiliate Contracts – Health Home Services (AG 115).*

Row AG 200 – Expenditure
This row is a title row for informational purposes only. The rows immediately following will represent the Health Home Service expenditures provided and authorized in the Contract.

Row AG 201 – Expenditure – PIHP Insurance Provider Assessment (IPA) Tax
Enter, in Column A, the amount of expenditures associated to the PIHP Insurance Provider Assessment (IPA) Tax.

Row AG 202 – Expenditure – Health Home
Enter the amount of expenditures related to the provision of services for consumers eligible through the Health Home Services as authorized in the Contract.

Row AG 204 – Surplus Health Home Funding - Retained

Surplus Health Home funding must be retained until the next Fiscal Year in order to ensure that all Health Home locations in the program have coverage for any deficit in the program. Per the MDHHS/PIHP contract the Health Home service is full risk, and under this full risk arrangement any remaining funds (after Health Home deficits are paid) convert to local revenue in the subsequent year.

Enter the amount of Health Home Services funding retained.

Note: The Health Home Contract amendment requires the PIHP shall:

- forward the entirety of all HHBH payments received from MDHHS (less any amount required to satisfy applicable Insurance Provider Assessment (IPA) tax and administrative costs) to the designated affiliate CMHSP/ Health Home Partner.

- ensure that its contract for the provision of Health Home service delivery with an affiliate CMHSP/Health Home Partner requires the CMHSP/Health Home Partner to account to the PIHP on Health Home expenditures, including how surplus became local and how deficits were covered.

ROW AG 290 - Total Expenditure
This row represents the total Health Home Services accrued expenditures. The cells in this row are formula driven. The formula is *the sum of Expenditure – PIHP Insurance Provider Assessment (IPA) Tax (AG 201), Expenditure –Health Home Services (AG 202), and Surplus Health Home Funding – Retained at Affiliate (AG 204).*

Row AG 295 - Subtotal Net Health Home Services Surplus (Deficit)
This cell represents the net Health Home Services surplus or deficit prior to any redirection of funds. The cell is formula driven. The formula is *Total Revenue (AG 190) less Total Expenditure (AG 290).*

Row AG-300 Redirected Funds (To) From
This row is the label Redirected Funds (To) From. Although this row indicates both "TO" and "FROM" for consistency within the FSR Bundle, the Health Home Services section does not allow for any redirection to any other program. The rows immediately following the label "Redirected Funds (To) From" will identify how the PIHP addressed any deficit in Health Home Services funding.

Row AG 315 – From Restricted Fund Balance – RES 1.f
This cell represents the amount of restricted fund balance being redirected to cover the costs associated to the provision of services to Medicare consumers enrolled in the Health Homes. The cell is formula driven. The formula is *less RES Fund Bal - Current Period Financing Health Homes Behavioral Health (1.f) Columns: PA2 and Performance Bonus Incentive Pool (PBIP).*

Row AG 325 – Information Only - Affiliate Total Redirected Funds – IC 390
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 consumers for Health Home Services. Enter the amount of redirected funding

used by the affiliate to fund all or a portion of the affiliate deficit in Health Home Services.

Row AG-330 - SUBTOTAL REDIRECTED FUNDS – ROWS 300 – 325
This cell represents the subtotal of redirected funds prior to any redirections for an overall funding deficit. The cell if formula driven. The formula is the *sum of FROM Restricted Fund Balance (AG 315) and Info Only – Affiliate Total Redirected Funds (AG 325).*

Row AG 332 – From Local Funds – M301.4
Enter the amount of local funds being utilized to fund all or a portion of the deficit in Health Home Services funding.

Row AG 335 – FROM Restricted Fund Balance – Risk Financing – RES 1.f
This cell represents the amount of restricted fund balance being utilized to fund all or a portion of the net Health Home Services deficit. This cell is formula driven. The formula is *less RES Fund Bal - Current Period Financing Health Homes Behavioral Health (1.f) Columns: PA2 – (Risk Financing) and Performance Bonus Incentive Pool (PBIP) – (Risk Financing).*

Row AG-390 - Total Redirected Funds
This cell represents the total of redirected funds associated to the Health Home Services. These cells are formula driven. The formula is the *sum of Affiliate Total redirected Funds (AG 325), FROM General Fund* (AG *331), FROM Local Funds (AG 332), and FROM Restricted Fund Balance – Risk Financing (AG335).*

Row AG 400 – Balance Health Home Services
These cells represent the net Health Home Services surplus or deficit after redirection of funds. There should never be a surplus/deficit, as any surplus/deficit in Health Home Services funding must be resolved. This cell is formula driven. The formula is Subtotal *Net Health Home Services Surplus (Deficit) (AG 295) plus Total Redirected Funds (AG 390).*

Note: Any amounts greater than zero will be reflected in cells (AG 204) Surplus Funding Retained and will represent the unspent balance of Health Home Services which will be converted to local funding as defined in the contract.

5.2 Row AH - REMARKS

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