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) and CRCS – Certified Behavioral Health Clinic (CCBHC) is a report of all activity for the 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 the Certified Community Behavioral Health Clinic (CCBHC) Demonstration services. Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA) requires states and their certified CCBHC sites to provide a robust set of coordinated, integrated and comprehensive services to all persons with any mental illness or substance use disorder diagnosis. The FSR and CRCS – CCBHC summarizes the revenues and expenditures related to the provision of the CCBHC services. The FSR and CRCS – CCBHC will identify whether there is a net surplus or deficit prior to any redirection of funding.

MDHHS utilizes a Prospective Payment System 1 (PPS-1) methodology in which CCBHC Demonstration sites receive a daily clinic-specific rate for providing approved CCBHC services to eligible Medicaid beneficiaries with a mental health and/or substance use disorder diagnosis. MDHHS operationalizes the PPS-1 through their contracted PIHPs, specifically those PIHPs that have CCBHC Demonstration sites within their service areas. PIHPs receive funds from MDHHS for CCBHC services in the Medicaid and Healthy Michigan Plan base capitation payment and a CCBHC supplemental payment. Base capitation is consistent with historical reimbursement methodology and reflects a portion of the PPS-1 payment. Supplemental payments were initially calculated as the PPS-1 rate less the portion of the PPS-1 rate included in the Medicaid and Healthy Michigan Plan base capitation. Supplemental payments are distributed monthly to PIHPs based on eligible beneficiaries enrolled in the CCBHC benefit plan.

PIHPs reimburse CCBHC Demonstration sites at clinic-specific PPS-1 rate for qualifying services to eligible Medicaid beneficiaries less any current payment already made for a discrete CCBHC service. Additionally, MDHHS will provide Quality Based Payments

(QBPs) that will reward CCBHC Demonstration sites based on attainment of CMS-defined quality metrics in a given performance year. The QBP distribution methodology can be found in the **CCBHC Handbook**.

> Note: MDHHS will calculate and distribute earned QBP within one year of the performance year. The CCBHC QBP will be reported in the Restricted Fund Balance Activity report on a cash basis in the fiscal year following the performance year (e.g., for FY22, the earned QBP will be reported in the FY23 reporting period). CCBHC QBP funding awarded must be distributed to the designated CCBHCs and shall be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system.

Per CMS guidelines, CCBHCs are entitled to the full PPS-1 rate per eligible daily visit and cost settling is not permitted. A comparison will be made between revenue and expense to determine whether there is an overall surplus or deficit in the PPS-1 funding. When a surplus in funding exists the unspent PPS-1 funds become local funds for the CMHSP/CCBHC. When an overall deficit exists, the funding used to cover the costs above the PPS-1 funding must be reported.

MDHHS will reconcile the supplemental payments annually based on actual utilization. The reconciliation will reflect the total expected cost of services (supplemental PPS-1 rate per eligible Medicaid and Healthy Michigan Plan daily visit) less the supplemental capitated payments received, inclusive of the retroactive payment activity received in the subsequent fiscal year.

The FSR and CRCS – CCBHC will be utilized by the (MDHHS) as a tool to monitor the fiscal operations of the PIHP and CMHSP/CCBHC. In addition, this report will provide the basis for the annual contract reconciliation and cash settlement of the CCBHC services.

The PIHP/CMHSP/CCBHC shall comply with Generally Accepted Accounting Principles, along with any other federal and state regulations as defined in the Medicaid Contract and Certified Community Behavioral Health Clinic Handbook. With the exception of the GF Contract - Special Fund Account – Section 226(a) of the Mental Health Code (MHC), 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 and CRCS – CCBHC must reconcile to the PIHP/CMHSP general ledger.

The PIHPs with affiliate CMHSP/CCBHC contracts for the provision of CCBHC services will report summary level revenue and expenditure information in separate columns for each contract. The amounts reported by the PIHP on the FSR and CRCS – CCBHC should reconcile to the FSR – All Non-Medicaid – Section IA – PIHP to Affiliate CCBHC Medicaid Contracts for each affiliate CMHSP.

The PIHP/CMHSP must certify the accuracy and completeness of the FSR and CRCS – CCBHC and identify a contact person, phone number and email address that questions

regarding the submission should be directed to. Please refer to the Electronic Report Submission Guidance and Report Certification Form.

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 network180 for the Health Home Benefit, the file name should read **FYXX Year End Interim Northcare FSR Bundle MM-DD-YYYY.**

Note: The FSR and CRCS – CCBHC 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 Concurrent1115 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.

MI Health Link: MI Health Link is a new demonstration health care option authorized under Section 2602 of the Patient Protection and Affordable Care Act for Michigan adults, age 21 or older, who are enrolled in both Medicare and Medicaid (dual eligible).

Substance Use Disorder (SUD): A combination of the federal grant received by the State from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the general fund dollars appropriated by the legislature for the prevention and treatment of SUD.

Certified Community Behavioral Health Clinic (CCBHC): A new demonstration health care option authorized under Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA) and the federal Cares Act of 2020 for all persons with any mental illness or substance use disorder diagnosis.

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.

Designated Collaborating Organization (DCO): An entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC.

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.

PPS-1 Rate: The Certified Community Behavioral Health Clinic (CCBHC) Prospective

Payment System 1 (PPS-1) methodology in which CCBHC Demonstration Sites receive a daily clinic-specific rate for providing approved CCBHC services to eligible individuals with a mental health and/or substance use disorder diagnosis.

The Financial Status Report – CCBHC 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 and CRCS – CCBHC

1	Row for entry of the name of the PIHP or CMHSP for each column
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
291-292	Sub-total row identifying net surplus (deficit) by fund source
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 variance between revenues and expenditures.

The FSR and CRCS – CCBHC

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/CCBHs for the provision of the CCBHC Demonstration. The amounts reported by the PIHP should reconcile to the revenues, expenditures, redirection of funds, sub-totals and totals of the affiliate CMHSPs/CCBHCs.

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 FSR and CRCS - CCBHC. 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 – AC 310a (FROM) Medicaid – A301a, the “AC” refers to CCBHC, the 310a indicates that this row represents a redirection from another row, the “(FROM) Medicaid” describes that Medicaid funds are being redirected to CCBHC services, the “A 301a” indicates that the partner row (TO row) is row 301a on the FSR – Medicaid.

REDIRECTS – (TO) FROM – Each PIHP and CMHSP/CCBHC 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/HHP 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:

AC 310a FROM Medicaid A301a $10

This line is within the FSR – Medicaid and indicates that $10 is being received “FROM” the FSR – Medicaid to fund expenditures that exceed CCBHC Demonstration PPS-1 funding.

A 301a (TO) CCBHC AC310a ($10)

This line is within the FSR - Medicaid and indicates that $10 is being redirected “(TO)” the FSR and CRCS – CCBHC to fund the CCBHC PPS-1 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.

Row 1 – PIHP or CMHSP
The name of the Regional Authority / Reporting Board (column A) will auto populate based on what was entered on the FSR - Medicaid.

The name of the CMHSP/CCBHC will auto populate based on what was auto populated on the FSR – CCBHC Supplemental. As previously mentioned, the MDHHS may request, for select PIHPs, the reporting of prime sub-contractors.

Row AC – CCBHC Services – PIHP Use Only
This row is the label CCBHC SERVICES – PIHP ONLY. The rows immediately following will represent the revenues, expenditures and redirection of funding related to the provision of the CCBHC Demonstration.

Row AC 100 – Revenue
This row is the label REVENUE. The rows following will represent the revenues available to fund current year expenditures.

Row AC 101 – Revenue – Medicaid
This row is the label REVENUE – Medicaid. The rows immediately following will represent the CCBHC Medicaid revenues available to fund current year expenditures.

Row AC 102 – Medicaid CCBHC Base Capitation
Enter, in Column A, the amount of funding authorization associated to the CCBHC base portion of the CCBHC PPS-1 rate, less any CCBHC Medicaid consumer 1st & 3rd party collections and MI Health Link CCBHC revenue. The Medicaid CCBHC base funding is equal to the Medicaid base portion of the CCBHC Demonstration PPS-1 rate per eligible daily visit. **If the projected CCBHC supplemental rate is zero, the Medicaid base funding is calculated using the lesser of the Medicaid base rate and the PPS-1 rate.**

> Note: The FSR - CCBHC Supplemental will calculate the CCBHC Medicaid funding prior to a reduction for 1st & 3rd party collections and MI Health Link CCBHC revenue.

Row AC 103 – Medicaid CCBHC Base Capitation - Affiliate Contracts- COLUMN A
This cell is formula driven and will offset the revenue distributed to each of the affiliates/CCBHCs recognized in columns B through H. The formula is *less the amounts reported in columns B through H.*

Row AC 103 – Medicaid CCBHC Base – Affiliate Contracts-COLUMNS B THROUGH H
Enter the amount of Medicaid CCBHC base funding distributed to each of the affiliate CMHSPs/CCBHCs of the PIHP.

Note: Per CMS guidelines, CCBHCs are entitled to the full PPS-1 rate per eligible daily visit and cost settling is not permitted.

Row AC 104 – Medicaid CCBHC Supplemental Revenue
This cell is formula driven and equals the amount of funding authorization associated to the Medicaid CCBHC supplemental capitated payments, inclusive of any open accruals. The formula is *plus CCBHC Supplemental Payment Funding thru 9/30 (2.c) plus CCBHC Supplemental Payment Funding after 9/30 (2.d), Medicaid column.*

Row AC 105 – Medicaid CCBHC Supplemental – Affiliate Contracts- COLUMN A
This cell is formula driven and will offset the revenue distributed to each of the affiliate CMHSPs/CCBHCs recognized in columns B through H. The formula is *less the amounts reported in columns B through H.*

Row AC 105 – Medicaid CCBHC Supplemental – Affiliate Contracts-COLUMNS B THROUGH H
The Medicaid CCBHC supplemental funding for distribution is equal to the CCBHC Demonstration PPS-1 supplemental rate per eligible daily visit for the Medicaid SUD/SMI consumers and the full PPS-1 rate per eligible daily visit for the Medicaid mild to moderate consumers.

Enter the amount of Medicaid CCBHC supplemental funding distributed to each of the affiliate CMHSPs/CCBHCs of the PIHP, less any CCBHC Medicaid consumer 1st & 3rd party collections and MI Health Link CCBHC revenue.

Note:
- The FSR - CCBHC Supplemental will calculate the CCBHC supplemental funding prior to a reduction for 1st & 3rd party collections and MI Health Link CCBHC revenue.
- Per CMS guidelines, CCBHCs are entitled to the full PPS-1 rate per eligible daily visit and cost settling is not permitted.

Row AC 106 – Medicaid CCBHC Supplemental Administration Revenue
The CCBHC supplemental capitated payments include funding for PIHP administration. Administrative funding is calculated as a percentage of the CCBHC supplemental capitation for a PIHP Region. The portion of the supplemental capitation attributable to administration is published in the State Fiscal Year CCBHC Supplemental Capitation Rate Development table distributed to each participating PIHP.

Column A, in this row, represents the amount of CCBHC administration funding authorization associated to the Mental Health and Substance Abuse Medicaid CCBHC supplemental capitated payments. This cell is formula driven. The formula is *CCBHC supplemental administration percentage for a PIHP Region times total Medicaid CCBHC supplemental capitated payments for that PIHP Region.*

Row AC 107 – MI Health Link CCBHC Consumers Revenue – Reporting Board
Enter, in Column A, the amount of funding authorization associated to the CCBHC Demonstration for the MI Health Link CCBHC consumers.

Note: The CCBHC MI Health Link revenue/expenditures reported in the FSR and CRCS – CCBHC should not be included in the FSR – MI Health Link.

Row AC 108 – MI Health Link CCBHC Consumers Revenue - Affiliate Contracts- COLUMN A
This cell is formula driven and will offset the revenue distributed to each of the affiliates/CCBHCs recognized in columns B through H. The formula is *less the amounts reported in columns B through H.*

Row AC 108 – MI Health Link CCBHC Consumers Revenue – Affiliate Contracts- COLUMNS B THROUGH H
Enter the amount of MI Health Link CCBHC funding distributed to each of the affiliate CMHSPs/CCBHCs of the PIHP.

Row AC 109 – INTENTIONALLY LEFT BLANK

Row AC 110 - 1ST & 3RD PARTY COLLECTIONS - MEDICAID CCBHC CONSUMERS – AFFILIATE - COLUMNS B THROUGH H
The PIHP/CMHSP is the payer of last resort and has the responsibility to identify and seek recovery from all other parties for services provided to recipients. Enter, in columns B through H, the funding available to the affiliate CMHSP/CCBHC from 1st and 3rd party collections (consumer fee payments, insurances and Medicare) that are not included in the Special Fund Account authorized in Section 226a (PA423) of the Mental Health Code (MHC) or enrolled in the MI Health Link program. The 1st and 3rd party collections for the MI Health Link CCBHC enrollees are to be entered on row, AC 107 of the FSR and CRCS - CCBHC. The amount entered in this cell is for 1st and 3rd party collections associated to the cost of a person's 100% funded daily care or services.

Note: The amounts reported for affiliate 1st and 3rd party are for reporting purposes only and will not be included in the general ledger of the PIHP/CMHSP. These amounts will not be taken into consideration for the contract reconciliation and cash settlement.

Row AC 120 - SUBTOTAL – CURRENT PERIOD MEDICAID CCBHC REVENUE
These cells represent the total Medicaid CCBHC revenue available to fund current year expenditures. This cell is formula driven. The formula is the *sum of Medicaid CCBHC Base Capitation (AC 102), Medicaid CCBHC Base – Affiliate Contracts (AC 103), Medicaid CCBHC Supplemental Revenue (AC 104), Medicaid CCBHC Supplemental – Affiliate Contracts (AC 105), Medicaid CCBHC Supplemental Administration Revenue (AC 106), MI Health Link CCBHC Consumers Revenue- Reporting Board (AC 107), MI Health Link CCBHC Consumers Revenue – Affiliate Contracts (AC 108), Intentionally Left Blank (AC 109), 1st & 3rd Party Collections – Medicaid CCBHC Consumers – Affiliate Contracts (AC 110).*

Row AC 121 – Revenue – Healthy Michigan
This row is the label REVENUE – Healthy Michigan. The rows immediately following will represent the CCBHC Healthy Michigan revenues available to fund current year expenditures.

Row AC 122 – Healthy Michigan CCBHC Base Capitation
Enter, in Column A, the amount of funding authorization associated to the CCBHC portion of the Healthy Michigan base capitated payments, less any Healthy Michigan CCBHC consumer 1st & 3rd party collections. The Healthy Michigan CCBHC base funding is equal to the Healthy Michigan base portion of the CCBHC Demonstration PPS-1 rate per eligible daily visit. **If the projected CCBHC supplemental rate is zero, the Healthy Michigan base funding is calculated using the lesser of the Healthy Michigan base rate and the PPS-1 rate.**

> Note: The FSR - CCBHC Supplemental will calculate the CCBHC Healthy Michigan funding prior to a reduction for 1st & 3rd party collections.

Row AC 123 – Healthy Michigan CCBHC Base - Affiliate Contracts- COLUMN A
This cell is formula driven and will offset the revenue distributed to each of the affiliate CMHSPs/CCBHCs recognized in columns B through H. The formula is *less the amounts reported in columns B through H.*

Row AC 123 – Healthy Michigan CCBHC Base – Affiliate Contracts-COLUMNS B THROUGH H
Enter the amount of Healthy Michigan CCBHC base funding distributed to each of the affiliate CMHSPs/CCBHCs of the PIHP.

> Note: Per CMS guidelines, CCBHCs are entitled to the full PPS-1 rate per eligible daily visit and cost settling is not permitted.

Row AC 124 – Healthy Michigan CCBHC Supplemental Revenue
This cell is formula driven and equals the amount of funding authorization associated to the Healthy Michigan CCBHC supplemental capitated payments, inclusive of any open accruals. The formula is *plus CCBHC Supplemental Payment Funding thru 9/30 (2.c) plus CCBHC Supplemental Payment Funding after 9/30 (2.d), HMP column.*

Row AC 125 – Healthy Michigan CCBHC Supplemental – Affiliate Contracts- COLUMN A
This cell is formula driven and will offset the revenue distributed to each of the affiliate CMHSPs/CCBHCs recognized in columns B through H. The formula is *less the amounts reported in columns B through H.*

Row AC 125 – Healthy Michigan CCBHC Supplemental – Affiliate Contracts-COLUMNS B THROUGH H
The Healthy Michigan CCBHC supplemental funding for distribution is equal to the CCBHC Demonstration PPS-1 supplemental rate per eligible daily visit for the Healthy Michigan SUD/SMI consumers and the full PPS-1 rate per eligible daily visit for the Healthy Michigan mild to moderate consumers.

Enter the amount of Healthy Michigan CCBHC supplemental funding distributed to each of the affiliate CMHSPs/CCBHCs of the PIHP, less any CCBHC Healthy Michigan consumer 1st & 3rd party collections.

Note:

- The FSR - CCBHC Supplemental will calculate the CCBHC supplemental funding prior to a reduction for 1st & 3rd party collections.
- Per CMS guidelines, CCBHCs are entitled to the full PPS-1 rate per eligible daily visit and cost settling is not permitted.

Row AC 126 – Healthy Michigan CCBHC Supplemental Administration Revenue
The CCBHC supplemental capitated payments include funding for PIHP administration. Administrative funding is calculated as a percentage of the CCBHC supplemental capitation for a PIHP Region. The portion of the supplemental capitation attributable to administration is published in the State Fiscal Year CCBHC Supplemental Capitation Rate Development table distributed to each participating PIHP.

Column A, in this row, represents the amount of CCBHC administration funding authorization associated to the Mental Health and Substance Abuse Healthy Michigan CCBHC supplemental capitated payments. This cell is formula driven. The formula is *CCBHC supplemental administration percentage for a PIHP Region times total Healthy Michigan CCBHC supplemental capitated payments for that PIHP Region.*

Row AC 129 – INTENTIONALLY LEFT BLANK

Row AC 130 - 1ST & 3RD PARTY COLLECTIONS – HEALTHY MICHIGAN CCBHC CONSUMERS – AFFILIATE - COLUMNS B THROUGH H
The PIHP/CMHSP is the payer of last resort and has the responsibility to identify and seek recovery from all other parties for services provided to recipients. Enter, in columns B through H, the funding available to the affiliate CMHSP/CCBHC from 1st and 3rd party collections (consumer fee payments, insurances and Medicare) that are not included in the Special Fund Account authorized in Section 226a (PA423) of the Mental Health Code (MHC) or enrolled in the MI Health Link program. The 1st and 3rd party collections for the MI Health Link enrollees are to be entered on row, AC 107 of the FSR and CRCS - CCBHC. The amount entered in this cell is for 1st and 3rd party collections associated to the cost of a person's 100% funded daily care or services.

Note: The amounts reported for affiliate 1st and 3rd party are for reporting purposes only and will not be included in the general ledger of the PIHP/CMHSP. These amounts will not be taken into consideration for the contract reconciliation and cash settlement.

Row AC 140 - SUBTOTAL – CURRENT PERIOD HEALTHY MICHIGAN CCBHC REVENUE
These cells represent the total Healthy Michigan CCBHC revenue available to fund current year expenditures. This cell is formula driven. The formula is the *sum of Healthy Michigan CCBHC Base Capitation (AC 122), Healthy Michigan CCBHC Base – Affiliate Contracts (AC 123), Healthy Michigan CCBHC Supplemental Revenue (AC 124), Healthy Michigan CCBHC Supplemental – Affiliate Contracts (AC 125), Healthy Michigan CCBHC Supplemental Administration Revenue (AC 126), Intentionally Left Blank (AC 129), 1st & 3rd Party Collections – Healthy Michigan CCBHC Consumers – Affiliate Contracts (AC 130).*

Row AC 190 – Total Revenue
These cells represent the total CCBHC Demonstration accrued revenue available to fund current year expenditures. These cells are formula driven. The formula is the *sum of Subtotal – Current Period Medicaid CCBHC Revenue (AC 120) and Subtotal – Current Period Healthy Michigan CCBHC Revenue (AC 140).*

Row AC 200 – Expenditure
This row is a title row for informational purposes only. The rows immediately following will represent the CCBHC Demonstration expenditures provided and authorized in the Contract.

Row AC 201 - MEDICAID CCBHC SERVICES - COLUMNS B THROUGH H
Enter the amount of expenditures related to the provision of services to Medicaid CCBHC consumers as authorized in the Medicaid Contract.

Row AC 202 - MI Health Link MEDICAID SERVICES - COLUMNS B THROUGH H
Enter the amount of expenditures related to the provision of services to MI Health Link CCBHC consumers as authorized in the Medicaid Contract.

> Note: The CCBHC MI Health Link revenue/expenditures reported in the FSR and CRCS - CCBHC should not be included in the FSR – MI Health Link.

Row AC 203 – HEALTHY MICHIGAN CCBHC SERVICES - COLUMNS B THROUGH H
Enter the amount of expenditures related to the provision of services to Healthy Michigan CCBHC consumers as authorized in the Medicaid Contract.

Row AC 204 – Surplus Funding Retained - COLUMNS B THROUGH H
Per CMS guidelines, CCBHCs are entitled to the full PPS-1 rate per eligible daily visit and cost settling is not permitted. A comparison will be made between revenue and expense to determine whether there is an overall surplus or deficit in the PPS-1 funding.

When a surplus in funding exists, the unspent PPS-1 funds become local funds for the CMHSP/CCBHC. Enter the amount of surplus retained at each affiliate CMHSP/CCBHC.

ROW AC 290 - Total Expenditure
This row represents the total CCBHC Demonstration accrued expenditures. The cells in this row are formula driven. The formula is *the sum of Expenditure – Medicaid CCBHC Services (AC 201), Expenditure – MI Health Link-Medicaid Services (AC 202), Expenditure – Healthy Michigan CCBHC Services (AC 203), and Surplus Funding Retained (AC 204).*

Row AC 291 - Subtotal Net Medicaid CCBHC Services Surplus (Deficit)
This cell represents the net Medicaid CCBHC Services surplus or deficit prior to any redirection of funds. The cell is formula driven. The formula is *Subtotal – Current Period Medicaid CCBHC Revenue (AC 120) less Medicaid CCBHC Services (AC 201) less MI Health Link – Medicaid Services (AC 202).*

Row AC 292 - Subtotal Net Healthy Michigan Plan CCBHC Services Surplus (Deficit)
This cell represents the net Healthy Michigan Plan CCBHC Services surplus or deficit prior to any redirection of funds. The cell is formula driven. The formula is *Subtotal – Current Period Healthy Michigan CCBHC Revenue (AC 140) less Healthy Michigan CCBHC Services (AC 203).*

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

Row AC 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 CCBHC Demonstration 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 CCBHC Demonstration funding.

> Note: CCBHC Demonstration policy does not require a PIHP to fund CCBHC service costs above the PPS-1 rate.

Row AC 310a – Intentionally Left Blank

Row AC 310b – Intentionally Left Blank

Row AC 325 – Information Only - Affiliate Total Redirected Funds – IA 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 CCBHC Demonstration services. Enter the amount of redirected funding used by the affiliate/CCBHC to fund all or a portion of the affiliate/CCBHC deficit in CCBHC Demonstration service costs.

Row AC 390 - Total Redirected Funds
This cell represents the total of redirected funds associated to the CCBHC Demonstration. These cells are formula driven. The formula is the *sum of From Medicaid (AC 310a), FROM Healthy Michigan* (*AC 310b), and Info only – Affiliate Total Redirected Funds (AC 325).*

Row AC 400 – Balance CCBHC Services
These cells represent the net CCBHC Demonstration PPS-1 surplus or deficit after redirection of funds. A balance in column A and column M will represent the MDHHS cost settlement with the PIHP/Regional Entity. There should never be a balance reflected in columns B through H. Any amounts less than zero should be resolved utilizing the redirect section. Any amounts greater than zero will be reflected in cells (AC 204) Surplus Funding Retained and will represent the unspent balance of the CCBHC Demonstration PPS-1 services. The surplus funds will convert to local funding as defined in the contract. This cell is formula driven. The formula is Subtotal *Net CCBHC Benefit Services Surplus (Deficit) (AC 295) plus Total Redirected Funds (AC 390).*

5.1 SECTION 2 – CCBHC Supplemental Contract Reconciliation and Cash Settlement

This section represents the "cash" settlement of the CCBHC supplemental funding. This section will compare the total CCBHC Supplemental capitated payments that the PIHP has received, both prior to 9/30 and after 9/30, to the total CCBHC PPS-1 Supplemental funding required to fund the CCBHC Demonstration eligible consumer daily visits to determine the cash settlement of the CCBHC Demonstration.

When the CCBHC supplemental capitated payments are greater than the CCBHC PPS-1 supplemental funding required, there will be an amount due MDHHS. When the CCBHC supplemental capitated payments are less than the CCBHC PPS-1 supplemental funding required, there will be an amount due the PIHP.

Column: Medicaid
This column represents the Medicaid CCBHC Supplemental cash settlement. The total Medicaid CCBHC supplemental capitated payments are compared to the CCBHC PPS-1 supplemental funding required to cover Medicaid CCBHC eligible daily visits for the fiscal year being settled.

Column: HMP
This column represents the Healthy Michigan CCBHC Supplemental cash settlement. The total Healthy Michigan CCBHC supplemental capitated payments are compared to the CCBHC PPS-1 supplemental funding required to cover Healthy Michigan CCBHC eligible daily visits for the fiscal year being settled.

Column: Total
This column represents the total CCBHC Supplemental cash settlement activity. The total CCBHC supplemental capitated payments are compared to the CCBHC PPS-1 supplemental funding required to cover CCBHC eligible daily visits for the fiscal year being settled.

Row 2 a. – Medicaid Supplemental Revenue / HMP Supplemental Revenue
This cell represents the Medicaid/HMP CCBHC PPS-1 supplemental revenue required to fund CCBHC eligible daily visits. The cells in this row are formula driven. The *formula* is *less Medicaid CCBHC Supplemental - Affiliate Contracts – column A (AC 105) and Healthy Michigan CCBHC Supplemental - Affiliate Contracts – column A (AC 125).*

Row 2 b. – Subtotal
This row represents the total CCBHC PPS-1 supplemental revenue required for CCBHC eligible daily visits for the fiscal year being settled. The cells are formula driven. The formula is *the sum of Medicaid column - Medicaid Supplemental Revenue and HMP column - HMP Supplemental Revenue (2.a).*

Row 2 c. – Supplemental Payment Funding thru 9/30
Enter the amount of Medicaid/Healthy Michigan CCBHC supplemental capitated payments received by the PIHP as of 9/30.

Row 2 d. – Supplemental Payment Funding after 9/30
Enter the amount of Medicaid/Healthy Michigan CCBHC supplemental capitated payments received by the PIHP after 9/30 for the fiscal year dates of service being settled.

Row 2 e. – Administration
This row represents the CCBHC supplemental capitated revenue associated to CCBHC Demonstration administration for the fiscal year being settled. The cells are formula driven. The formula is *plus Medicaid column - Medicaid CCBHC Supplemental Administration Revenue - column A (AC106) and HMP column - Healthy Michigan CCBHC Supplemental Administration Revenue – column A (AC 126).*

Row 2 f. – Subtotal – Supplemental
This row represents the net CCBHC supplemental capitated revenue for the fiscal year being settled. The cells are formula driven. The formula is *the sum of Supplemental Payment Funding thru 9/30, Supplemental Payment Funding after 9/30 less Administration – Medicaid column and HMP column.*

Row 2 g. – MDHHS Cash Settlement (Due MDHHS) / Due PIHP
This row represents the total amount due the MDHHS or PIHP. The cells are formula driven. The formula is *less Subtotal – Supplemental (2.f) plus Subtotal (2.b).*

Row AD - 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.