

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

This report provides FY19 service data for MDHHS management of PIHP contracts and rate-setting by the actuary. The PIHP must report information on **cases, units and costs 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.

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, units and costs 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. (See last page of these instructions for list of 1915(c) HSW services for FY19.)

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, 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 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 and costs attributable to the coverage. **Note that all units and costs 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.**

For FY19 there are two rows to report IBNR/Accrual costs for inpatient services in the reporting year but for which there has not been an adjudicated claim at the time the MUNC report is compiled. One row for each of PT68 (Column I of row 10) and for PT73 (Column I of row 11) is added to include the reporting of the accrued cost in the MUNC.

- E. Inpatient units reported in rows 1 through 11 **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 1-11 **should not include** accruals or adjustments for services provided in previous years.
- G. There are two rows to report Hospital Reimbursement Adjustment (HRA) expenditures. Report HRA expenditures separately for IMDs (PT68) in Column I of row 12 and for community inpatient (PT73) in Column I of row 13. The amounts in these cells should sum to FSR row A204.
- H. 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.
- I. 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, cases and costs into one row.

- J. 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, 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.
- K. 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.
- L. Enter the **total Medicaid expenditures** per procedure code (see exclusions below) by State Plan Services, EPDST Services, 1915(b)(3) Services, and HSW Services. The sum of the Medicaid expenditures will automatically calculate in Column Q.
- M. In Column R, the net cost per unit will be automatically calculated by dividing the total expenditures in Column Q by the total units in Column P.

II. Total Medicaid MH/DD/SUD Cases and Costs

In Column II. G enter the total unduplicated cases served during the period. ***This total should not be the sum of the rows above, but rather a unique count of all Medicaid beneficiaries who received services reported above.*** MDHHS is using cost/case as a metric and it is critical that you report accurate, unduplicated counts of cases served. The sums of the costs per Columns I, K, M, and O will be automatically calculated.

III. Total Medicaid MH/IDD Cases and Service Costs

In Column III. G, enter the total unduplicated MH/IDD cases served during the period. ***This total should not be the sum of the rows above, but rather a unique count of all Medicaid beneficiaries who have mental illness or developmental disability and have received services reported above.*** The sums of the MH/IDD costs per Columns I, K, M, and O will be automatically calculated.

IV. Medicaid Benefit Plan Administration MH/IDD

Enter cost of Medicaid benefit plan administration performed by the PIHP (including administrative functions delegated to CMHSP affiliates and/or provider networks) for the MH/IDD benefit. Refer to the Administration's "CMHSP/PIHP Administration

Cost Reporting Instructions” for determining the Medicaid benefit plan administrative costs to be entered in row IV, Column Q. The document can be found on the MDHHS web site at:

https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

V. Total Medicaid MH/IDD Costs

The service costs and benefit plan administration costs will be summed in row V, column Q.

VI. Total Medicaid Substance Abuse Cases and Service Costs

In row VI, Column G, enter the total unduplicated Medicaid beneficiaries who received substance use disorder services during the period. *This total should not be the sum of the rows above, but rather a unique count of all Medicaid beneficiaries who received at least one substance abuse service reported above.* The sum of the costs for Medicaid SUD services will be automatically calculated in Columns I, K, M and O. Note, that the costs in row II will equal the costs in row III plus the costs in row VI. However, the cases in row II may be less than the sum of the cases in rows III and VI as some individuals may receive both MH/IDD as well as SUD services.

VII. Enter the cost of Medicaid benefit plan administration performed by the PIHP for the Substance Use Disorder benefit in Column Q.

VIII. Total Medicaid SUD Costs

The sum of the total SUD costs and the Medicaid benefit plan administrative costs in Column VIII. Q will automatically calculate.

IX. Medicaid Redirected to MIHealth Link

Only the four PIHPs that are participating in the MIHealth Link pilot should enter costs here. All other PIHPs should enter zero (\$0) dollars.

- A. Enter the total MIHealth Link expenses covered by Medicaid that are NOT shown on the service rows above.
- B. Enter the total MIHealth Link expenses redirected from Medicaid ISF that are NOT shown in the above service rows.

X. Total Medicaid MH/DD/SUD Service and benefit plan Administrative Costs

The sum of the service and administrative costs as well as Medicaid dollars redirected to MIHealth Link will automatically calculate in Row X, Column Q.

XI. Spend-down

- A. Enter in Column Q the amount of general fund expended for spend-down that needs to be deducted from the amount above; OR
- B. Enter in Column P the amount of general fund expended for spend-down that has already been deducted from the amount above.

Note: Do not include general fund if spend-down was **NOT** met. Determine whether spend-down has been met on a month-to-month basis.

XII. Medicaid MH/DD/SA Net Expenses

Spend-down expenditures in Column Q will automatically be deducted from total expenses to yield net expenses.

XIII. Reconciling items to the Financial Status Report (FSR)

Enter the following in Column Q

- A. Current period ISF contributions (deposits) to ISF FSR Row A203
- B. Insurance Provider Assessment (IPA) Tax from FSR Row A201
- C. Prior year adjustments included in costs on the PIHP FSR not included in the MUNC encounter rates
- D. Other. Adjustments needed to reconcile costs on the MUNC report to the Medicaid costs on the FSR. For each amount reported also provide a short description of the type of cost/adjustment, such as dental services not on the MUNC and IBNR included in the FSR. If more than three rows are needed, please attach a detailed listing for amounts included on row D.
- E. Total reconciling items to Financial Status Report Sum of XIII A, B, C, and D.

XIV. Adjusted MUNC report Medicaid costs: This is the sum of rows XII and XIII e.

XV. Financial Status Report (FSR):

- A. PIHP that are not participating in the MIHealth Link pilot are to enter Medicaid expenses from FSR row A290.

- B. PIHPs that are participating in the MIHealth Link pilot are to enter Medicaid the sum of expenses from FSR rows A290, and AK310.

Exclusions:

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

Services covered under the Habilitation Supports Waiver:

HSW Procedure Code	Notes
E1399	
H0043	
H0045	
H2014	
H2015	
H2016	
H2023	
S5111	
S5151	
S5160	
S5161	
S5165	
S5199	
S9123	
S9124	
T1000	
T1005	
T1016	No longer a HSW service effective 10/1/19
T1999	
T2015	
T2028	
T2029	
T2036	
T2037	
T2039	
T5999	
T2025	New HSW service effective 10/1/19
S5116	New HSW service effective 10/1/19
T2027	New HSW service effective 10/1/19