

ADMINISTRATIVE COSTS BY PIHPs, CMHSPs, AND CONTRACTED ORGANIZED PROVIDER SYSTEMS

(FY2007 Appropriation Bill - Public Act 330 of 2006)

April 1, 2007

Section 460: (1) The uniform definitions, standards, and instructions for the classification, allocation, assignment, calculation, recording, and reporting of administrative costs by prepaid inpatient health plans (PIHPs), CMHSPs, and contracted organized provider systems that receive payment or reimbursement from funds appropriated under section 104 of part 1 that are established by the department shall go into effect on October 1, 2006 and shall be fully implemented by September 30, 2007. (2) No later than October 30, 2006, the department shall provide a copy of the uniform definitions, standards, and instructions to the house of representatives and senate appropriations subcommittees on community health, the house of representatives and senate fiscal agencies, and the state budget director. (3) The department shall provide the house of representatives and senate appropriations subcommittees on community health, the house of representatives and senate fiscal agencies, and the state budget director with 2 separate progress reports on the implementation required under subsection (1). The progress reports are due on April 1, 2007 and July 1, 2007.

*Michigan Department
of Community Health*



Jennifer M. Granholm, Governor
Janet Olszewski, Director

Public Acts 154 of 2005 and 330 of 2006, Section 460 Report
Cost Allocation for the Public Mental Health System
April 1, 2007

Background:

The public mental health system is comprised of 46 community mental health services programs (CMHSPs) that manage services and supports for over 200,000 people with serious mental illnesses, serious emotional disturbance, and developmental disabilities. Eighteen of those CMHSPs are prepaid inpatient health plans (PIHPs) that manage the Medicaid specialty services and supports. The PIHPs are a combination of standalone CMHSPs and affiliations of smaller CMHSPs. Both CMHSPs and PIHPs have a variety of methods for delivering services: some contract out all services, while others have a mix of contractual services, and those that they deliver themselves.

CMHSPs are established and governed by the Michigan Mental Health Code (The Code). The Code mandates recipient eligibility for service, the required array of services, and recipient protections. In addition, The Code prescribes a number of administrative activities that are unique to the public mental health system, such as completing an annual community needs assessment, operating a recipient rights office, collaborating with local human service agencies, supporting a board of directors, maintaining local dispute resolution processes, and operating a quality improvement system. Other core administrative activities performed by CMHSPs, such as finance, payroll, human resources, billing/claims payment, and information technology are typical of most businesses.

PIHPs were established as part of Michigan's 1915(b) Medicaid managed care waiver for specialty services and supports. As such, they are considered managed care organizations by the federal Centers for Medicare and Medicaid Services (CMS) and must be compliant with the federal Balanced Budget Act of 1997 (BBA). The BBA mandates that the PIHPs are responsible for provider network management, service authorization and utilization management, claims payment, access management, customer services, appeal and grievance systems, information technology, quality management, risk management and compliance monitoring. As with CMHSPs and other businesses, PIHPs must perform certain core administrative functions as listed above.

CMHSPs and PIHPs subcontract some or all of service delivery and/or administrative functions to other entities: CMHSPs to large provider networks as well as to small "mom and pop" group homes; and PIHPs to CMHSP affiliates, substance abuse coordinating agencies (CAs), and large provider networks. Detroit-Wayne County Community Mental Health Agency was required by the 1915(b) waiver to competitively procure Medicaid service providers and as a result six managed comprehensive provider networks (MCPNs) won the bid. The (now five) MCPNs perform the BBA-mandated administrative functions listed

above and subcontract with providers to deliver services. Oakland County Community Mental Health Authority chose to take a similar approach by subcontracting with “core providers” that perform BBA-mandated administrative functions and subcontract with providers to deliver services. MDCH is designating as “prime subcontractors” CMHSP affiliates and CAs, Detroit Wayne’s MCPNs and Oakland “core providers.”

MDCH has been reporting CMHSP administrative costs in response to Section 404 for at least a decade. MDCH provided definitions of administrative functions that gave guidance in distinguishing between “board administration” and services. However, it allowed “program administration” to be added to the service costs. In 2004, MDCH required the PIHPs to report “Medicaid managed care administration” and provided guidance in distinguishing the functions of Medicaid managed care administration that had been developed by the Encounter Data Integrity Team (EDIT). MDCH found in both reports, CMHSP and PIHP, a wide degree of variability in reported percentage of total expenditures that were administrative. EDIT analyses of the reasons for the variability revealed accounting practices that, while they were in compliance with federal accounting standards, were very different across the state.

Methodology

Act 154, Section 460 required that MDCH establish uniform definitions, standards, and instructions for the classification, allocation, assignment, calculation, recording and reporting of administrative costs by PIHPs, CMHSPs and contracted organized provider systems that receive funds appropriated under Act 154, Section 104, in consultation with representatives of the CMHSPs.

The Mental Health and Substance Abuse Administration staff selected representatives from the CMHSPs to join them and MDCH Budget and Finance staff in a “Cost Allocation Team.” The team considered several approaches, but chose one that, in the team’s opinion, was the least expensive and burdensome to implement. The team proposed that the approach be done in two phases: Phase I that began October 1, 2006 focuses on PIHPs, CMHSPs and their prime subcontractors. Phase II will target the remaining contracted organized provider systems and will begin October 1, 2007.

The team developed steps and instructions, a diagram and flow chart for allocating costs and sent a draft of the package to CMHSPs and PIHPs for comment. MDCH heard from 15 of the 46 CMHSPs and of those, seven supported the approach, seven were concerned about it, and one asked for clarification. MDCH staff met with CMHSP directors to understand their concerns. Primarily, CMHSPs were concerned that this approach would result in higher reported administrative costs, which would in turn be compared to Medicaid health plans and other human service agencies. In addition, PIHPs

were concerned that a higher administrative cost would result in lower Medicaid capitation rates.

The Cost Allocation Team revised documents to address the concerns raised. On October 5, 2006, MDCH issued a letter to executive directors and finance directors of PIHPs and CMHSPs announcing the implementation of the cost allocation process with definitions and cost allocation instructions to be used in conjunction with the Office of Management and Budget (OMB) Circular A-87 accounting standards; and the templates and instructions for reporting the administrative and direct service costs to MDCH. MDCH also invited executive directors to an informational session on October 31, 2006 and finance officers to a technical training on November 6, 2006.

Phase I cost allocation reporting requirements have been agreed to for the FY 2007 contracts between MDCH and CMHSPs and PIHPs. Those requirements are in Attachment A of this report. The requirements include due dates of January 31, 2007 for the first submission of cost allocation plans for FY 2007, and January 31, 2008 for the first annual Section 460 Report.

Phase II

Phase II, to commence October 1, 2007, applies a similar approach to the contracted organized provider systems. The Cost Allocation Team conducted a session on December 1, 2006 with CMHSPs, PIHPs and providers to learn about concerns and potential challenges for reporting administrative costs from the subcontracting providers. Since January 2007, the Cost Allocation Team has worked to identify the subcontracting providers for which MDCH will require reporting on administrative and direct service costs, and those who would be exempt from the process. Keeping the concerns about reporting burden in mind, the Cost Allocation Team decided to use information from the Internal Revenue Service (IRS) Form 990 that private non-profit organizations use to report program services expenses (Line 13) and management and general expenses (Line 14). For-profit and governmental entities would be required to submit a statement to the CMHSPs and PIHPs attesting to their administrative costs, using the definitions of administration and direct service costs that are contained in Phase I. The Cost Allocation Team proposes to exempt small sole proprietors from this reporting.

Proposed Phase II reporting requirements have been disseminated to the CMHSPs, PIHPs and provider associations for technical review and comment. The proposed Phase II requirements are in Attachment B of this report.

Next Steps

Technical comments received on the proposed Phase II will be considered when the Cost Allocation Team prepares the final requirements. These requirements

will be proposed in the spring of 2007 for addition to the FY 2008 contracts between MDCH and CMHSPs and PIHPs. Since Phase II reports will not be due until January 31, 2009, training on Phase II will take place in early 2008.

The Cost Allocation Team is currently reviewing the FY 2007 cost allocation plans received from the 46 CMHSPs and 18 PIHPs and, using specific criteria, will determine the adequacy and quality of the plans. The criteria are in Attachment C of this report. The Cost Allocation Team will follow up with, and provide technical assistance to, the CMHSPs and PIHPs who have submitted plans needing improvement. The Cost Allocation Team intends to provide training this summer to assist CMHSPs and PIHPs in preparing their cost allocations plans for FY 2008 that are due September 30, 2007.

[From Attachment 6.5.1.1. (Reporting Requirements) of the
2007 MDCH Contracts with CMHSPs and PIHPs]

SECTION 460 PIHP COST ALLOCATION REPORT

Background

Section 460 of Public Acts 154 of 2005 and 330 of 2006 required that the Michigan Department of Community Health develop methods and instructions for allocating administrative costs and reporting requirements for the Pre-Paid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs), and their sub-contractors. This document contains MDCH's response to the legislation and is reflective of the values of a public mental health system. The first phase of the activity, to commence October 1, 2006, involves PIHPs, CMHSPs, and their "prime subcontractors" defined as those entities from which administrative functions and/or direct services are purchased and which further sub-contract with other entities for administrative and/or direct services in fulfillment of their obligations to the contract. Prime subcontractors include the affiliate CMHSPs of the PIHPs, substance abuse coordinating agencies (CAs) that manage Medicaid services, Managed Comprehensive Provider Networks (MCPNs) and all other entities that meet the definition of prime subcontractor as defined in the Glossary of Terms. The second phase, to commence in FY'08 adds the major subcontracted providers of PIHPs, CMHSPs and prime sub-contractors.

The administrative cost data reported by PIHPs on the "Section 460 Report" by January 31st of each year are submitted by MDCH to the Legislature annually. Section 460 Compliance Report for Medicaid Managed Mental Health Supports and Services contains the PIHP Medicaid direct and administrative costs with an explanation that the **Balanced Budget Act defines administrative functions that a managed care organization must perform, whether a PIHP or HMO. The explanation will also indicate that** the Mental Health Code requires certain administrative functions with examples like recipient rights, community needs assessment and school-to-community transition services, that are unique to Michigan's public mental health system and therefore not comparable to other health care organizations. The Compliance Report contains each PIHP's Medicaid direct service costs and administrative costs for each of their prime sub-contractors.

While many of the administrative functions are derived from the **Balanced Budget Act or** Mental Health Code requirements, and are delegated by the PIHP to their prime sub-contractors, certain core functions, such as human resources, information systems, and executive director exist in PIHPs and the prime subcontractors regardless of funding stream. The costs of these core functions must be allocated to the PIHP as Medicaid administrative expenditures according to an allocation methodology that is consistent with Office of Management and Budget Circular A-87.

The Cost Allocation model in response to Section 460 uses A-87 as its foundation. PIHPs might also use the EDIT (Encounter Data Integrity Team) document titled "Establishing Managed Care Administrative Costs", June 20, 2005, to determine the administrative

functions that should be allocated to Medicaid administration regardless of whether they are delegated. The first step of the process requires that each PIHP develop a cost allocation plan and submit it to MDCH prior to the beginning of a fiscal year except for the FY'07 when it will be due **February 28, 2007**. It is expected that the cost plans indicate what has been delegated to another entity and what has not, and the methods being used to allocate costs. MDCH will review the plans, and may comment if a plan contains a questionable allocation methodology, but will not approve plans. The PIHPs' annual independent audit will review actual cost allocations and compare to the prospective methodologies in the cost plans.

The remainder of this section contains 1) steps for determining "allowable" expenditures per applicable state and federal regulations; 2) a diagram depicting where the line is drawn between direct service costs and administrative costs; 3) steps for allocating costs to either direct service and administration; 4) glossary of terms; and 5) a flow chart for allocation steps. Electronic templates for reporting will be issued by MDCH six weeks prior to the due date and are also located on the MDCH web site:

www.michigan.gov/mdch , click on Mental Health and Substance Abuse, then Reporting Requirements

Steps For Determining Allowable Costs Per State and Federal Regulations

For costs to be reported by pre-paid inpatient health plans (PIHPs) and community mental health services programs (CMHSPs) as allowable costs they must meet the standard for allowable costs in state and federal regulations. Substance abuse costs reported to PIHPs and CMHSPs must also meet standards for allowable costs. The state regulations are the Mental Health Code and PIHP or CMHSP contracts, and, as applicable, the Medicaid Provider Manual. For governmental units (PIHPs and CMHSPs) the federal standards are in Office of Management and Budget (OMB) Circular A-87. It is used in determining the allowable costs incurred by State and local governments under cost reimbursement contracts. For non-profits those federal standards are in OMB Circular A-122. It is used to establish principles for determining costs of grants, contracts and other agreements with non-profit organizations. Once costs are determined to be allowable then the PIHP or CMHSP can utilize the Cost Allocation Diagram to determine the classification of the costs between direct services and administration.

All other costs not allowable under any of these regulations should be reported as "expenditures not otherwise reported" on the applicable financial status report (FSR) and must have appropriate administrative costs allocated.

COST ALLOCATION DIAGRAM

Note: PIHPs, CMHSPs, and their prime subcontractors must define all allowable costs (either directly or through allocation) as either “Direct Service” or “Administration.” To be considered an allowable cost, the cost must meet the guidelines defined per OMB Circulars A-87 and 122, the Medicaid Provider Manual or the Mental Health Code.

DIRECT SERVICES	
All contract or directly operated services and supports reported as encounters to MDCH data warehouse (the cost of these include face-to-face activities and collateral activities performed on behalf of beneficiary). Note that fiscal intermediary services are now reported as encounters.	
<u>Other General Direct Services</u> (not reported as encounters) Prevention (not individual-specific) Outreach (might include homeless projects) Crisis Intervention Peer Delivered (not reported as encounter)	<u>Allocated Overhead (examples)</u> Building costs (including building security) Utilities Travel/vehicles Clerical Equipment (furniture, telephone, personal computer – cabling, server, router, software) Medical records – electronic or otherwise Supplies Training on specific service Immediate/First-line supervisors
ADMINISTRATION	
All functions and activities that are not “direct services” above	
<u>Staff (examples)</u> Executive Director Management/ non-immediate supervisory staff Human resources staff Budget, Finance and Accounting staff Reimbursement staff Training staff Customer Services staff Recipient Rights staff Utilization Management staff Quality Improvement staff Information system staff (+ network mgmnt, help desk, security)	<u>Line Items (examples)</u> Legal, audit, consultation services Advisory councils and committees Accreditation and licensing fees Association membership fees County indirect Subscriptions <u>Allocated Overhead (examples)</u> Building costs Utilities Travel/vehicles Clerical Equipment (personal computer, furniture, fax, telephone) Supplies Training & conferences related to administrative functions

See Steps for Allocating Administrative Cost for additional details.

Steps for Allocating Administrative Costs

Note: These steps, along with the flow chart attached, are provided as guides when developing a cost allocation plan. In Phase I, to commence October 1, 2006, these steps apply to PIHPs and CMHSPs. Substance abuse coordinating agencies (CAs) and the PIHPs' and CMHSPs' prime subcontractors -those entities from which administrative functions are purchased and/or direct services are purchased and further sub-contract with other entities for administrative and/or direct services in fulfillment of their obligations to the contract shall follow steps three through six and report their administrative costs by program type to the PIHPs or CMHSPs with which they contract.

Phase II, to commence October 1, 2007, requires that similar steps be applied to the subcontractors of PIHPs, CMHSPs, CAs and core providers or prime subcontractors. A determination will be made, in preparation for Phase II, of the materiality of the administrative costs of small subcontractors and/or the relative amount of Medicaid payments that are made to subcontractors. In addition, Phase II will need to address the issue of subcontractors that are community and private hospitals.

Phase I

1. Determine allowable costs under the applicable state and federal regulations.
2. PIHP and CMHSP must identify the methodologies to be used in their cost allocation plans. The cost allocation plans for the PIHP drives their affiliate CMHSP cost allocation plans for Medicaid purposes and determination. The methodologies must meet federal Office of Management and Budget (OMB) Circular A-87 (A87) standards. The cost allocation plan shall be submitted to MDCH by a specified date prior to the start of the fiscal year (except for year one).
3. Identify all costs that are direct service costs; the remaining costs are administrative costs. (See diagram)
4. Allocate overhead costs to direct service or administrative costs.
5. Allocate direct costs by program (Medicaid, GF, etc)
6. Allocate administration costs by program (Medicaid, GF, etc) utilizing the cost allocation methodologies identified in Step 2.
7. Report direct service and administrative costs to MDCH on the Section 460 report, Table 2, to be provided.
8. Independent audit shall verify that costs were allocated correctly and according to the cost allocation plan.

Commentary on the steps

1. The applicable state and federal regulations include, but are not limited to, the Michigan Mental Health Code, the service definitions in the Michigan Medicaid Provider Manual, the contract between MDCH and the PIHPs and CMHSPs, and federal OMB circulars.
2. MDCH is not dictating the methodologies for allocating costs.
 - The allocation methods used must meet A-87 standards.

- The allocation methods may not be changed during the fiscal year unless a material defect is discovered or the law or organization is changed affecting the validity of the methodology.
 - A cost allocation plan due date in late December 2006 or early January 2007 shall be established by MDCH for the Phase I. Future year allocation plans are due on a date established by MDCH, but no later than October 1st of the year.
 - MDCH may review the cost allocation plan to assure it is complete and meets A-87 standards; and will keep the plan on file for future reference.
3. The “direct service” costs are those associated with the covered services that are reported via CPT or HCPCS codes as encounters.
- Direct service also includes services provided face-to-face to mental health consumers or prospective mental health consumers such as outreach, crisis intervention, prevention, and peer-delivered that do not result in encounter reporting.
 - Note that fiscal intermediary service is now a covered service and should be reported in the encounter data system and counted as a direct service cost.
 - The direct service costs include:
 - Staff salary/benefits for the time performing the face-to-face activity and the ancillary activities conducted on behalf of the consumer (progress notes, phone calls, etc.)
 - Salary/benefits of the **immediate** supervisor of the staff providing the service.
 - Only if there is documented evidence that the second or third line supervisor is performing a duty that is normally the duty of a direct care provider or his/her immediate supervisor may they be included as direct services.
 - Materiality is a factor in determining whether to include the staff salary/benefits for a second or third line supervisor, clinical director, etc.
 - A panel of experts established by MDCH will provide a ruling where there are local questions about whether a cost is direct service or administrative.
 - If electronic medical records are used, these shall be reported as direct service
4. Allocate the overhead costs using the methodologies identified in Step 2.
- Equipment shall be allocated to include the personal computers, telephones, fax, and office furniture used by the direct service staff and the clerical staff to direct services.
 - Equipment attributable to other staff shall be included in administration.
 - The cost of training required for a specific covered service shall be reported as a direct service cost.
 - General training that is provided to staff across the service delivery system shall be included in administration.
 - Building costs, including rent and utilities, shall be allocated to direct services and administration.

- All other costs that are not determined to be direct service costs, or allocable overhead to direct service activities, are administrative costs.
 - While Recipient Rights, Customer Services, and some of Utilization Management and Quality Improvement may include direct service to consumers, these functions are not considered to be the primary business of the public mental health system but are “regulatory” functions and therefore classified as administrative costs.
5. Using the allocation method identified in Step 2, allocate the entire direct service costs by program: Medicaid, Children’s Waiver, GF, Adult Benefits Waiver (ABW), MI-Child, HMO/Other Earned Contract, SA Block Grant, for example.
 6. Using the allocation method identified in Step 2 allocate the administrative costs by program: Medicaid, Children’s Wavier, GF, Adult Benefits Waiver (ABW), MI-Child, HMO/Other Earned Contract, SA Block Grant, for example. CMHSPs shall-separately identify non-Medicaid direct service costs and administration on the new Section 460 Report, Table 2. CMHSPs that are affiliates report their Medicaid administrative costs to their PIHP.
 7. The PIHP shall aggregate and report the Medicaid administrative costs from their affiliates, the substance abuse coordinating agencies, and their core providers or prime subcontractors on the new Section 460 Report, Table 2 Substance abuse coordinating agencies must report to PIHPs their direct and administrative Medicaid costs as allocated in this manner. CA Medicaid administrative costs may not be allocated to direct Medicaid service costs.
 8. The annual independent audit shall review how the administrative and direct service costs were separated and will verify that the methodologies identified in the cost allocation plan were used and that there is evidence to support the allocation of costs was done in compliance with A87 using those methodologies.

SECTION 460 COST ALLOCATION REPORT

GLOSSARY

1. Administrative costs: For purposes of reporting on the Section 460 Cost Allocation report, these are costs of running the PIHP/CMHSP programs that do not meet the classification of direct service costs. These will include both directly assignable costs and those that are not readily assignable. For reporting purposes “Administration” also includes a share of the allocated overhead costs.

2. Allocated Overhead
 - These are costs that can be allocated to a particular cost objective or activity in accordance with the benefit received.
 - Allocated Overhead included in “Direct”
 - In general, these are the minimum requirements for an employee to perform their duties – for example: space, equipment and transportation (if necessary to access clientele)
 - Allocated Overhead included in “Administration”
 - Other costs such as human resources, legal counsel and the executive staff are not strictly required for an employee to perform their duties – therefore they are not allocated, but 100% included in “Administration”
 - Examples of costs that may be included in allocated overhead
 - Building Rent
 - Utilities
 - Telephones
 - Personal Computers
 - Training
 - Specific clinical-type training would be included as “Direct”
 - General training, such as a seminar on HIPAA would be included as “Administration”

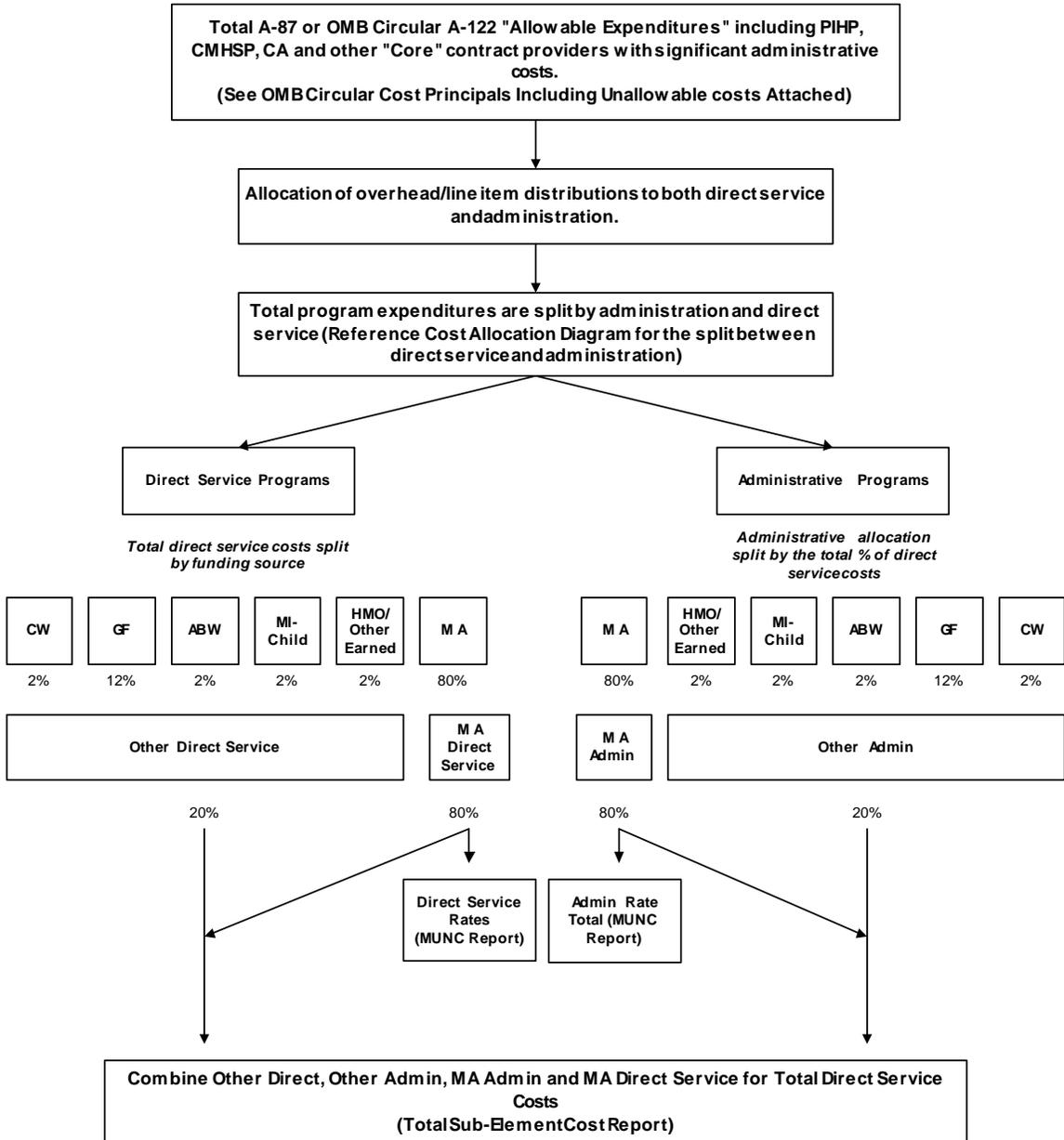
3. Allowable expenditures: The expenditures allowed by the state and federal regulations.

4. Cost allocation plan
 - For this reporting purpose a cost allocation plan should, at a minimum, include:
 - For each different allocation basis, include:
 - A description of the cost or service to be allocated. This may require inclusion of an organization chart, a chart of account or other supporting documentation
 - Projected costs to be allocated
 - A detailed description of the method used to allocate costs
 - A summary or pro-forma presentation of the allocation to each activity or program.

5. Cost centers: "Cost objective" means a function, organizational subdivision, contract, grant, or other activity for which cost data are needed and for which costs are incurred.
6. Cost pools: is the accumulated costs that jointly benefit two or more programs or other cost objectives.
7. Direct service cost: For purposes of reporting on the Section 460 Cost Allocation report, these are all contract or directly operated services and supports reported with CPT or HCPCS codes as encounters to MDCH data warehouse (the cost of these include face-to-face activities and collateral activities performed on behalf of beneficiary). Other "general" Direct Services not reported as encounters include Prevention (not individual-specific), Outreach (might include homeless projects), Crisis Intervention, Peer Delivered or Drop-in Centers (not reported as encounters).
 - Examples of direct costs
 - Employee costs directly identified and devoted to providing services that result in a reportable encounter
 - Materials acquired, consumed or expended specifically to provide direct services reported as an encounter
8. Indirect service cost: Allocated Overhead
9. Indirect administrative costs: Allocated Overhead
10. Prime subcontractor: those entities to which administrative functions and/or direct services are delegated and which sub-contract with other agencies. The entities' responsibilities may be limited to a particular geographic area or a population within the PIHP's service area, or the CMHSP's catchment area. The entities may (depending upon the delegation agreement) include CMHSP affiliates, "core providers", substance abuse coordinating agencies, and Managed Comprehensive Provider Networks (MCPNs).

SECTION 460 COST ALLOCATION REPORT

Steps for Allocation of Direct and Administrative Costs



SECTION 460 COST ALLOCATION REPORTING
Phase II: Cost Allocation And Reporting
By Subcontractors Of PIHPs, CMHSPs And Prime Subcontractors
Draft Version 2.0, 3/02/07

Phase II of the Section 460 Cost Allocation Process focuses on certain subcontractors who provide **direct mental health services to the consumers** of PIHPs, CMHSPs and their prime subcontractors (as defined in Phase I). Phase II does not require a prospective cost allocation plan for subcontractors, but does require that PIHPs and CMHSPs submit a sub-schedule to their annual year-end cost allocation report that contains the information required herein. In order to reduce the data-collecting burden for PIHPs and CMHSPs, this report was designed to utilize existing information to the extent available. For example, for non-profit providers, information from the Internal Revenue Service 990 form, that they are required to submit annually, will be used. Other providers will complete an attestation statement annually. Contractors who declare on the attestation statement that they are “sole proprietors” are exempt from distinguishing between direct service costs and administrative costs. The PIHPs and CMHSPs should list them on the sub-schedule as sole proprietors and may report all revenues going to them as direct service costs. State facilities are not included in this Phase II reporting.

Targeted Sub-Contractors

PIHPs and CMHSPs shall report on the Section 460 Cost Allocation sub-schedule according to the following:

1. **Non-profit organizations:** report total payments from the PIHP, CMHSP or prime subcontractor to the organization for direct services, then the amounts from line 13 and line 14 from the organization’s IRS Form 990.
2. **For profit and governmental units:** report total payments from the PIHP, CMHSP or prime subcontractor to the organization for direct services, then the amount of direct service expenditures and administration provided in their annual attestation. These entities are to be instructed to use the Section 460 Cost Allocation definition of direct service costs and administrative costs.
3. **Sole proprietors:** report as direct service costs the total payments from the PIHP, CMHSP or prime subcontractor to the proprietor for direct services.

Definitions:

1. Direct mental health services: those covered services that are reported via CPT or HCPCS codes as encounters. They also include services provided face-to-face to mental health consumers or prospective mental health consumers such as outreach, crisis intervention, prevention, and peer-delivered that do not result in encounter reporting.
2. For-profit corporations: may include residential, day program, home health, hospitals, private clinical service providers, private universities and colleges, etc.
3. Governmental units: include transportation authorities, intermediate school districts, public universities and community colleges
4. Non-profit organizations or corporations: typically those organizations that have 501c.3 status and report on the IRS 990 form. They include supports services providers, some community hospitals, housing/residential service providers, day programs, sheltered workshops, employment service organizations, etc.
5. Sole proprietors and partnerships: include practitioners (e.g., clinicians, professionals), some fiscal intermediaries, and some group home operators (e.g., “mom-and-pop”).

ABC COMMUNITY MENTAL HEALTH SERVICES PROGRAM
Contractor Attestation Statement
For Services Provided in the Fiscal Year Ended _____

COMPANY XYZ
123 Main Street
Anywhere, Michigan 12345

Tax ID Number 123-45-6789

Our records indicate that you received \$ [PIHP insert amount] for the provision of direct care services to our community mental health consumers during the fiscal year October 1, 200X and September 30, 200X. We are requesting confirmation of your tax status and additional financial information to comply with the State of Michigan reporting requirements.

Please indicate your tax status:

- _____ Sole proprietor [No further financial information is required in this statement]

- _____ Partnership \$ _____
Please identify the total amount of revenue received from us that was used for "direct services" to our community mental health consumers as defined in the attached Cost Allocation Diagram.

- _____ Non-Profit (501.c.3 "Tax Exempt") organization, that is required to report on the IRS Form 990 annually. [No further financial information is required in this statement]

- _____ Governmental Entity \$ _____
Please indicate the total amount of revenue received from us that was used for "direct services" to our community mental health consumers, as defined in the attached Cost Allocation Diagram.

- _____ For-profit, not sole proprietor \$ _____
Please indicate the total amount of revenue received from us that was used for "direct services" to our community mental health consumers, as defined in the attached Cost Allocation Diagram.

I certify that I am authorized to sign on behalf of the above named entity and that this is an accurate statement of direct expenditures for the reporting period. Appropriate documentation is available and will be maintained to support this disclosure.

Signature _____ Date _____

Printed Name _____ Title _____

COST ALLOCATION DIAGRAM

Note: PIHPs, CMHSPs, their prime subcontractors, and for-profit providers must define all allowable costs (either directly or through allocation) as either “Direct Service” or “Administration.” To be considered an allowable cost, the cost must meet the guidelines defined per OMB Circulars A-87 and 122, the Medicaid Provider Manual or the Mental Health Code.

DIRECT SERVICES

ALL CONTRACT OR DIRECTLY OPERATED SERVICES AND SUPPORTS REPORTED AS ENCOUNTERS TO MDCH DATA WAREHOUSE (THE COST OF THESE INCLUDE FACE-TO-FACE ACTIVITIES AND COLLATERAL ACTIVITIES PERFORMED ON BEHALF OF BENEFICIARY). NOTE THAT FISCAL INTERMEDIARY SERVICES ARE NOW REPORTED AS ENCOUNTERS.

<p><u>Other General Direct Services</u> (not reported as encounters)</p> <p>Prevention (not individual-specific)</p> <p>Outreach (might include homeless projects)</p> <p>Crisis Intervention</p> <p>Peer Delivered (not reported as encounter)</p>	<p><u>Allocated Overhead (examples)</u></p> <p>Building costs (including building security)</p> <p>Utilities</p> <p>Travel/vehicles</p> <p>Clerical</p> <p>Equipment (furniture, telephone, personal computer – cabling, server, router, software)</p> <p>Medical records – electronic or otherwise</p> <p>Supplies</p> <p>Training on specific service</p> <p>Immediate/first-line supervisors</p>
---	---

ADMINISTRATION

All functions and activities that are not “direct services” above	
<p><u>Staff (examples)</u></p> <p>Executive Director</p> <p>Management/non-immediate supervisory staff</p> <p>Human resources staff</p> <p>Budget, Finance and Accounting staff</p> <p>Reimbursement staff</p> <p>Training staff</p> <p>Customer Services staff</p> <p>Recipient Rights staff</p> <p>Utilization Management staff</p> <p>Quality Improvement staff</p> <p>Information System staff (+ network mgmnt, help desk, security)</p>	<p><u>Line Items (examples)</u></p> <p>Legal, audit, consultation services</p> <p>Advisory councils and committees</p> <p>Accreditation and licensing fees</p> <p>Association membership fees</p> <p>County indirect</p> <p>Subscriptions</p> <p><u>Allocated Overhead (examples)</u></p> <p>Building costs</p> <p>Utilities</p> <p>Travel/vehicles</p> <p>Clerical</p> <p>Equipment (personal computer, furniture, fax, telephone)</p> <p>Supplies</p> <p>Training and conferences related to administrative functions</p>

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
MENTAL HEALTH AND SUBSTANCE ABUSE ADMINISTRATION

CRITERIA FOR REVIEW - SECTION 460 COST ALLOCATION PLANS
March 2007

Review of Cost allocation plan submitted by: [CMHSP or PIHP]
For the fiscal year ended September 30, 2007
Reviewer:
A. Organizational Items that must be included in the cost plan:
1. Signed certification
2. Organization chart
3. General narrative describing the organization
4. PIHP or CMHSP
5. Affiliation or standalone
6. Identifies counties served
7. Description of relationship to the county
8. Any direct/indirect county charges in costs
9. Description of the accounting system
10. Description of how staffing costs are handled
11. Description of the Substance Abuse Coordinating Agency arrangement
B. Cost allocation components that must be included:
1. Basis of allocation
2. Projected costs and/or an approved budget
3. Schedule of costs for the 460 report
4. Descriptions of services provided
C. Section on allocated services or administrative costs must include:
1. Cost centers
2. Each cost center's expense items
3. Programs receiving services
4. Distribution methods used
5. Summary of the allocations
6. Methods for assigning costs to funding sources
7. Schedules of costs assigned to funding sources