

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BEHAVIORAL HEALTH AND DEVELOPMENTAL
DISABILITIES ADMINISTRATION**

**Establishing Administrative Costs Within and Across the
Prepaid Inpatient Health Plan (PIHP)**

**Establishing Administrative Costs
Fiscal Year 2015
Table of Contents**

	Page No.
1. Introduction and Overview	1
2. Reporting Premise and Principles	1
3. Reporting and Models of CA-Provider Relationship	2
4. Administrative Functions	2
A. General Management	2
B. Financial Management.....	3
C. Information Systems Management.....	3
D. Provider Network Management.....	5
E. Utilization Management.....	6
F. Customer Services.....	7
G. Quality Management	8

Establishing Administrative Costs Within and Across the PIHP

I. Introduction and Overview

Requirements for reporting Prepaid Inpatient Health Plan (PIHP) administrative costs focus most heavily on several considerations:

- Reporting must be made consistent with federal and state requirements and with updated interpretations of requirements (such as the clarification that SAPT Block Grant cap on spending for administration being applicable only to the state agency).
- Consistency of cost reporting should be improved, with PIHPs including and excluding the same cost items. For example, all PIHPs should include Prevention Coordinator costs as administration.
- Improved consistency of reporting will lead to increased fairness and accountability with respect to administrative costs and comparing costs.
- PIHPs are prohibited by Administrative Rule (R 325.14213) from providing direct services. So, by implication, PIHPs costs are all administrative. However, PIHPs as a group devote considerable resources to developing, creating, and coordinating regional services. They also work at increasing regional support, both material and moral, for Substance Use Disorders (SUD) services and for persons with SUDs and for reducing the costs of SUDs to the communities. While these are nominally administrative costs, PIHP will have the opportunity to report them as a sub-category of administration called Service Coordination.

II. Reporting Premise and Principles

The following premises and principles guide PIHP efforts to identify administration costs:

- PIHP administrative cost reporting is required to be consistent with A-87 principles recognizing that there are various methods by which A-87 compliance may be achieved.
- All organizations have administrative functions (and costs) irrespective of their status as a PIHP or direct service provider. These functions include: General Management, Financial Management, Information Systems, Provider Network Management, Utilization Management, Customer Services, and Quality Management. The methods by which administrative costs are allocated vary by organization.

Establishing Administrative Costs Within and Across the PIHP

As such, the intent of administrative reporting requirements is to:

- Provide greater transparency of administrative costs using definitions that are common to health care organizations.
- Provide comparable administrative cost information by fund sources other than Medicaid specialty services.

III. Reporting And Models Of PIHP - Provider Relationship

It is important to remember that if the activity is reportable as a service (i.e., there is an appropriate procedure code, as defined and included in the “*Substance Abuse Encounter Reporting: HCPCS and Revenue Codes*” document revised August 2011 from the SUD Services Policy Manual); then the cost for that activity is not an administrative cost

IV. Administrative Functions

The following seven (7) core functions have been identified as administration. The costs of these functions must be reported by PIHP, regardless of who carries them out. The terminology used below may not correspond with that used in individual PIHP; further, some PIHPs may consider components or sub-components identified within these categories to belong under a different category/function.

If activity can be reported as an encounter, then the cost is excluded from administration costs – this is particularly relevant for access activities.

It is also assumed that overhead expenses; such as, rent, travel, supplies, insurance, etc. are allocated in accordance with A-87. That is to say where such costs can be attributed to a direct service activity, it is included as overhead with that activity (i.e., as a cost attached to the service encounter). The administration costs would include its share of such expenses.

A. GENERAL MANAGEMENT

General Management consists of functions which do not fit elsewhere. Many of these are executive or leadership functions, including:

- The Chief Executive Officer (CEO) of the PIHP;
- The Chief Operating Officer (COO), or equivalent staff position reporting to the CEO;
- The PIHP Director;
- The Medical Director; and
- Human Resources office staff.

Establishing Administrative Costs Within and Across the PIHP

Other General Management activities and costs include:

- Activities to organize an affiliation governance structure and management structure;
- Administrative support to executive office;
- Legal support;
- PIHP Board of Directors' costs;
- Memberships and dues; and
- Management and technical consultants provided general assistance to the Managed Care Entity. If the consultant's activities are directed at one of the other administrative functions, the cost should be included with that function.

B. FINANCIAL MANAGEMENT

Financial Management consists of: 1) the processes for managing revenues and expenditures in order to provide accountability to management and funders; 2) maximizing financial resources; and 3) maintain fiscal integrity. Financial Management is also a key function of an effective PIHP as a service provider. Critical components of financial management include:

- Budgeting, General Accounting (Accounts Receivable, Accounts Payable, etc.), and financial reporting;
- Revenue analysis;
- Expense monitoring and management;
- Service unit and consumer-centered cost analyses and rate-setting;
- Risk analysis, risk modeling, and underwriting;
- Insurance and re-insurance, management of risk pools;
- Purchasing, administrative contracts, and inventory management;
- Supervision of audit and financial consulting relationships;
- Claims adjudication and payment; and
- Audits.

C. INFORMATION SYSTEMS MANAGEMENT

Information Systems (IS) include processes designed to support management, administrative and clinical decisions with the provision of data and information and to support the accountability and information requirements of funders, regulatory bodies, consumers and communities.

Components include hardware, software, specific applications and their integration, network configuration and connectivity. Telecommunications equipment, software, and management are often included.

Information Technology (IT) refers to the hardware and connectivity - including individual workstations, laptops, servers, routers, and

Establishing Administrative Costs Within and Across the PIHP

management of IS networks. Managing security requirements for access to the network is also included in IT. Information systems also include the development and running of electronic health records.

Information systems within the PIHP system usually fall into two (2) categories: General Management and Service Support and Coordination.

General Management: Information System General Management functions are those which support all other administrative functions.

Service Support and Coordination: Information System Management functions support the direct provision of services and supports, including electronic health records (development and operating).

Information System costs and cost allocations are handled in a variety of ways across the PIHPs. As such, there may not a consistent way to ascribe costs within General Management vs. Service Support and Coordination.

The following are examples of PIHP General Management IS activities/costs:

- hardware, software and other devices for collection, storage, retrieval and reporting to the state which include demographic, service encounter, and performance indicators;
- capacity to collect, verify, store and analyze fund source eligibility information;
- the system for authorizing services to provider agencies;
- the system of enrolling both network organizations and professionals into the software for credentialing and claims payment purposes;
- the system for managing and processing claims for services across the provider network;
- the system for processing payment to service providers;
- systems to collect, analyze and act on data regarding the quality of services;
- confidentiality and security sub-systems intended to protect integrity of data;
- collecting information necessary to demonstrate compliance with the contract or with performance standards; and
- MDCH reporting requirements, including the costs of reporting demographic, encounter, cost and performance indicators to MDCH by the PIHP. Administrative costs in performing reporting requirements also may include the costs associated with data validation and correction.

D. PROVIDER NETWORK MANAGEMENT

Provider Network Management encompasses activities directed at ensuring that qualified providers in sufficient number and variety are available to permit meaningful consumer choice and that the provider network is in compliance with regulatory requirements and the performance expectations of the PIHP. Providers include both organizations and individual professional practitioners providing clinical services or paraprofessionals providing supports to consumers. Although most providers are part of the provider panel, Provider Network Management activities may include off-panel provider management as well. All organizations and practitioners providing specialty supports and services to consumers are considered part of the network.

Provider Network Management consists of the following components:

- **Network Development** - This is the process of identifying consumer services and supports needs and procuring sufficient providers to meet those needs. Activities include: 1) needs assessment; 2) analysis of current network capacity to meet projected need and development of a “gap assessment” which identifies procurement needs; 3) procurement of providers; and 4) development of agreements with alternative payers or related agencies with a goal of coordinating care, such as with Department of Human Services (DHS), Michigan Rehabilitation Services (MRS), nursing homes, and schools.
- **Contract Management** - Activities include: 1) development of provider contract language; 2) negotiation of contracts; 3) monitoring providers for compliance with all aspects of the contract (NOTE – audits of providers’ performance included under Quality Management); 4) conducting reviews for evidence of abuse and/or fraud; 5) sanctioning providers through Plans of Compliance or other means; 6) training network providers concerning performance expectations; and 7) managing contracts for consumer services with non–panel providers.
- **Network Policy Development** - This includes development of standards for participation in the provider panel. Operating and performance expectations are also included through this policy development function.
- **Credentialing, Privileging And Primary Source Verification** - These functions may be part of Provider Network Management although frequently carried out by staff participating in Quality Management (QM) or Utilization Management functions. These functions are carried out at both service delivery and administrative levels. The PIHP must,

Establishing Administrative Costs Within and Across the PIHP

at least, verify the credentialing done at the service delivery level (direct run and contracted practitioners, contracted provider staff).

E. UTILIZATION MANAGEMENT

Utilization Management (UM) is a set of administrative functions that pertain to the assurance of appropriate clinical service delivery. Through the application of written policies and procedures, UM is designed to ensure: 1) that only eligible beneficiaries receive plan benefits; 2) that all eligible beneficiaries receive all medically necessary plan benefits required to meet their needs; and 3) that beneficiaries are linked to other services when necessary.

Utilization Management consists of the following components:

- **Access And Eligibility Determination** - This functional component includes both screening for clinical eligibility and financial eligibility determination

Activities include: 1) development of access and eligibility policy and procedures; 2) initial contact with potential consumers (when not reported as an encounter); 3) initial screening (when not reported as an encounter); 4) collection of consumer-specific information; 5) verification of funding sources including determination of public funding status and first and third part liability; and 6) service referral, setting up first appointment if determined eligible.

- **Utilization Management Protocols** - This component is the development and monitoring of clinical and authorization protocols to be used for determining level of care (LOC) and service selection process. This includes protocols for: 1) determination of Medical Necessity, 2) LOC assessments; 3) service intensity or selection criteria; 4) Continuing Stay review; and 5) services requiring specialist review, best practice guidelines.
- **Authorization** - This component is the process of linking LOC and service selection processes to payment processes.
- **Utilization Review** - It should be noted that there may be overlap between UM and Utilization Review (UR). This component provides review/monitoring of individual consumer records, specific provider practices and system trends. Review of activities of the provider network is included. It may include: 1) review and monitoring to determine appropriate application of guidelines and criteria (LOC, service selection, authorization, best practice); 2) consumer outcomes; 3) over-utilization or under -utilization; 4) review of outliers; 5) development of procedures for system-level data review; 6) policy and

Establishing Administrative Costs Within and Across the PIHP

procedures regarding use of review documents; and 7) documentation and monitoring of UM/UR activities.

F. CUSTOMER SERVICES

The Customer Services function encompasses activities directed at the entire population of the PIHP's service area, including all services and supports to consumers. Some PIHPs have centralized these functions. Virtually all service providers provide customer services functions, as a part of the service delivery process, which should not be included in the cost of administrative functions.

It should be noted that some PIHPs have begun using certified peers to provide customer services. As such, when providing that activity, the peer costs should be included as an administrative cost.

Customer Services consist of the following components:

- **Information Services** - This component includes activities directed to the general population of the service area as well as to consumers of treatment and support services. This component includes:
 - general orientation to PIHP services (community meetings, informational brochures);
 - consumer handbook;
 - operation of a telephone line and web site(s) in order to provide information about benefit plans and to respond to general inquiries; and
 - outreach activities to identify and establish communication with under-served groups.
- **Consumer Empowerment And Participation In PIHP Planning And Monitoring Activities** - This component includes:
 - development of policy and implementation of activities designed to engage consumers, and other stakeholders, including members of the general public, in decision-oriented activities throughout the organization, including its provider network; and
 - training and orientation of stakeholders, especially consumers, to participate actively in advisory groups, task forces, working committees and other management related groups.
- **Customer Complaint, Grievance And Appeals Processes** - Both formal and informal grievance and appeal mechanisms are coordinated as part of the Customer Services function. This component includes:

Establishing Administrative Costs Within and Across the PIHP

- Investigation and management of informal issues and grievances (Customer Services);
 - investigation and management of all formal grievances, appeals, and complaints, including local dispute resolution (Due Process, Recipient Rights);
 - Administrative Fair Hearings conducted by MDCH; and
 - formal tracking and coordination of Complaint Management processes, across the entire network.
- **Community Benefit** - This component consists of activities directed at the population of the entire service area, or sub-groups of that population, rather than at identified individuals. It includes:
 - community collaborative activities. It focuses on activities designed to promote wellness and Healthy Communities as well as coordinated human services delivery systems of care;
 - provision of specialized educational and informational services to at-risk groups;
 - community emergency and group trauma services;
 - partnership arrangements with community organizations to provide a specialty health service perspective on issues of concern to the general population or sub-groups served by the organization;
 - outreach activities and screening of the general population, or identified sub-groups, for health conditions such as depression, eating disorders, etc.;
 - cross training of, and specialized consultation with, school, jail, police, fire, church and other service personnel;
 - participation in community planning bodies, including the Human Services Coordinating Council, Indian Health Centers and other groups;
 - Jail Diversion; and
 - System of Care initiatives.

G. QUALITY MANAGEMENT

The Quality Management (QM) function encompasses activities directed at ensuring that 1) standards for staff, program and management performance exist; 2) compliance with them is assessed and 3) ongoing improvements are introduced, monitored and assessed with respect to their outcomes.

Virtually all service provider organizations have QM programs. Some components of these QM activities are mandated for providers (such as regulatory management or corporate compliance, and accreditation). Unless specifically delegated by the PIHP or operated in the PIHP

Establishing Administrative Costs Within and Across the PIHP

interests, these activities of provider organizations should not be identified as administrative functions or included in the costs.

Some of the components identified below may reside in some PIHPs in UM.

Quality Management consists of the following components:

- **Standard Setting** - This component includes review, analysis and recommendations concerning standards and measurement methodologies in the following areas essential to a continuous, quality improvement orientation:
 - choice of accrediting body;
 - best practice guidelines;
 - assessment tools; and
 - performance expectations for both clinical and management programs
- **Conducting Performance Assessments** - This component includes both routine, periodic performance assessment and specially designed evaluation activities. Performance assessments and evaluations, as used here, are generally analyses of data submitted as part of regular management information requirements or as part of a special study. The results of both periodic and special performance assessments are provided to the CA's leadership team on a regular basis as part of the management decision-making process. Results of selected periodic assessments are made available to consumers and the community.
- **Regulatory Management/Corporate Compliance** - This component includes review of performance and clinical source documents and summary data conducted, or overseen, by PIHP staff for compliance with regulations of outside bodies, including the State of Michigan, Center for Medicare and Medicaid Services (CMS) and other federal regulatory bodies. Activities include:
 - developing a compliance plan that focuses on regulations dealing with healthcare fraud and abuse;
 - maintaining current inventory of regulations;
 - conducting prevention activities;
 - providing direction to contractors regarding their responsibilities;
 - taking action when non-compliance issues are revealed; and
 - establishing a compliance-friendly environment.

Establishing Administrative Costs Within and Across the PIHP

- **Managing Outside Agency Review Processes** - This component includes ensuring that source material is complete and available for reviews by outside bodies, including:
 - Accrediting bodies;
 - MDCH certification reviews and financial audits;
 - External Quality Review (EQR);
 - licensing bodies; and
 - non-MDCH payer audits and reviews: CMS, Auditor General, Office of Inspector General (OIG), etc.
- **Research** – This component consists of research activities, including management of a research committee.
- **Quality Process Facilitation** - This component consists of activities aimed at continuous improvement of the processes by which agency and contractor business is conducted. It includes facilitation of activities related to management processes and technical assistance/facilitation of activities in contract agencies.
- **Provider Education And Training And Quality Management Oversight** - This component includes activities related to ensuring that contractors have and carry out their own quality management plan, as well as ensuring that a Quality Improvement Culture is developed and maintained within all clinical and management arenas.