DEPARTMENT OF COMMUNITY HEALTH
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES ADMINISTRATION

ESTABLISHING ADMINISTRATIVE COSTS WITHIN AND ACROSS THE CMHSP SYSTEM

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I. INTRODUCTION AND OVERVIEW:

The public mental health system in Michigan is responsible for reporting administrative costs for a variety of purposes. In the past this has resulted in a number of different reporting models. As part of its pursuit of efficiencies, the MDCH Mental Health and Substance Abuse Services Administration is replacing these models by one methodology.

This methodology will satisfy the reporting requirements established by the Centers for Medicare and Medicaid Services for the management of the federal Medicaid Specialty services program, other Medicaid programs and the reporting requirements under the appropriation act for MDCH sections 440 and 460. This will create a single uniform method for identifying costs throughout the public mental health system.

This document presents guidelines for CMHSPs/PIHPs in identifying administrative functions and costs. The reports will be at the CMHSP level and provide for aggregation to the PIHP regions.

II. REPORTING PREMISE AND PRINCIPLES

The following premises and principles guide CMHSP efforts to identify Administration costs:

- CMHSP 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 CMHSP, 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.
- Differences in administrative costs are expected in that the nature of CMHSP and the PIHP arrangement varies; DCH reporting formats are intended to capture and account for these differences.
- Some CMHSPs/PIHPs are also direct service providers; as such, some of their administrative costs are incorporated in direct service expenditures.
- Some CMHSPs/PIHPs are also Coordinating Agencies and as such have some costs that are unique to this role.
- Some provider organizations have been delegated administrative functions by the CMHSP/PIHP. In order to provide comparability across PIHPs/CMHSPs, the costs of these delegated functions must be included in administrative cost information.

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 CMHSP/PIHP administrative cost reporting, using the functions identified in this 2010 document, at the CMHSP/PIHP total (gross) expenditure level, as well as net of service related administration.
- Provide sufficient information to describe and understand the CMHSP/PIHP administrative cost information
- Provide comparable administrative cost information by fund sources other than Medicaid specialty services
- Provide information about delegated administration costs of contract providers.

III. REPORTING AND MODELS OF PIHP-CMHSP-CA-PROVIDER RELATIONSHIP

There is great variation in the nature of the relationship between the PIHP, CMHSPs and service providers. Before identifying Administrative costs, the location of each management function identified in this document must be identified. In many arrangements, portions of some or all management functions are carried out by more than one administrative structure. It is important that the costs associated with the function be identified, regardless of where they are carried out. Specifically, service delivery entities may carry out Administrative functions (delegated administration from the CMHSP/PIHP), the cost of which should not be included as a service delivery cost.

It is important to remember that if the activity is reportable as a service (ie there is an appropriate procedure code) then the cost for that activity is not an administrative cost.

DELEGATION OF RESPONSIBILITY – PIHPs that have affiliated CMHSPs and Substance Abuse Coordinating Agencies (CAs) are required to include in their service and funding agreements a description of the PIHP Administrative functions that have been delegated to the entity (42CFR230).

CMHSPs/PIHPs may also delegate Administrative functions to non-CMHSP/CA contracted Manager and/or Provider entities through a contractual arrangement.

Sub-capitated entities may perform many Administrative functions which are carried out in both their interest and the interest of the PIHP. When there is no explicit delegation of responsibility by the PIHP, the sub-capitated entity and PIHP cooperatively allocate functions serving both interests.

The cost of all Administrative functions delegated by the PIHP to a Manager and/or Provider and/or CMHSP entity, must be included in the costs incurred directly by the PIHP to form the total Administrative cost reported by the PIHP.

PURCHASING - Some CMHSPs are purchasing administrative functions for non-Medicaid fund sources from a related CMHSP. For these arrangements, the providing CMHSP would treat the contract with the CMHSP as earned revenue, but it should include those costs in its administrative costs. The CMHSP that pays for the administrative services would include such costs as part of its cost report as part of the "delegated/purchased" section of the report.

It is recognized that there will be duplication of reporting by the affiliate CMHSPs and PIHPs. This will be taken into account by MDCH when reporting the aggregation of CMHSP administrative costs.

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IV. ADMINISTRATIVE FUNCTIONS

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

Each CMHSP will be providing a narrative describing a) organizational and delegation arrangements, and b) cost allocation – including by function as well as by cost accounts within the General Ledger. This narrative will help provide background on what was reported in each function as well as provide guidance to MDCH for improving reporting consistency.

It should be noted that while previous efforts for reporting administration costs made a distinction between PIHPs/Medicaid and CMHSPs, this 2010 document focuses on CMHSPs and includes all of their fund sources.

It is also important to note that these descriptions cover the functions and activities at a total (gross) level. The MDCH report format provides for subsequent assignment of some of those costs to service provision.

Reminder: 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 A87, i.e., where such cost 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 CEO of the CMHSP/PIHP.
- The Chief Operating Officer (COO), or equivalent staff position reporting to the CEO.
- The PIHP Director. In some affiliations the PIHP has a position that is the director of the regional PIHP.
- The Medical Director.
- Human Resources office

Other general management activities and costs include:

- Activities to organize an affiliation governance structure and management structure
- Administrative support to executive office
- Legal support
- CMHSP Board of Directors costs
- Memberships and dues
- 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 the processes for managing revenues and expenditures in order to provide accountability to management and funders, to maximize financial resources, and maintain fiscal integrity. Because financial management is also a key function of an effective CMHSP as a service provider, financial management activities, carried out as a part of a provider's internal management process, will be included as a total (gross) administrative cost and then deducted in the MDCH form when a portion of that cost is assigned to services.

Critical components of financial management include:

- Budgeting, General Accounting (AR, AP, 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
- Audits

The following costs, when centralized, are to be considered as part of total (gross) administration expenditures, and then deducted as administrative costs attributable to CMHSP direct services:

- Billing and collecting from first and third party payors

C. INFORMATION SYSTEMS MANAGEMENT

Information Systems includes 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 management of IS Networks. Managing security requirements for access to the network is also included in IT. More recently, information systems also includes the development and running of electronic health records.

Information Systems within the CMHSP system usually fall into two (2) categories: General Management and Service Support.

GENERAL MANAGEMENT: Information System general management functions are those which support all other Administrative functions.

SERVICE SUPPORT: Information System Management functions which support the direct provision of services and supports, including electronic health records (development and operating).

Information system costs and cost allocation are handled in a variety of ways across the CMHSPs. As such, there may not a consistent way to ascribe costs within general management vs service supports. In the narrative the CMHSP should describe what it has reported as Total (gross) Information system costs and what is has shown as those IS costs attributable to services.

The following are examples of CMHSP general management IS activities/costs:

- hardware, software and other devices for collection, storage, retrieval and reporting to the state: 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
- MDCH/Management Reporting including the costs of reporting demographic, encounter, cost and performance indicator to MDCH by the CMHSP. Administrative costs in performing reporting requirements may also include the costs associated with data validation and correction.

D. PROVIDER NETWORK MANAGEMENT

The Provider Network Management function 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 CMHSP. 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, network management activities frequently 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: Needs Assessment, Analysis of current network capacity to meet projected need and development of a "gap assessment" which identifies procurement needs, Procurement of providers, Development of agreements with alternative payors or related agencies with a goal of coordinating care (such as with DHS, MRS, nursing homes, and Schools).
- **CONTRACT MANAGEMENT** – Activities include: Development of provider contract language, Negotiation of contracts, Monitoring Providers for compliance with all aspects of the contract (note – audits of providers performance included under Quality Management), Conducting reviews for evidence of abuse and/or fraud, Sanctioning providers through Plans of Compliance or other means, training network providers concerning performance expectations, 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 network management although frequently carried out by staff participating in QM or UM functions. These functions are carried out at both service delivery and Administrative levels. The CMHSP must, 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, Utilization Management 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 Medicaid, Health Plan or other services when necessary.

Because UM is also a key function of an effective service provider and is required for accreditation, UM activities, carried out as a part of a contracted provider's self-monitoring process (i.e., when carried out in the interest of the provider), should not be included in the cost of CMHSP/PIHP administrative functions.

COMPONENTS of utilization management include:

- **ACCESS AND ELIGIBILITY DETERMINATION.** This functional component includes both clinical and financial eligibility determination. PLEASE note, some of the Access activities may be reported as an encounter as were provided face-to-face with the person. These costs are excluded from Administration. It is recognized that the CMHSPs differ in how their access points are established as well as the scope of functions covered by those staff, resulting in variance in what will be reported for this administrative function. The narrative should describe the CMHSP access arrangement.

  Activities include: development of access and eligibility policy and procedures, initial contact with potential consumers (when not reported as an encounter), initial screening (when not reported as an encounter), collection of consumer specific information, verification of funding sources including determination of Public Funding status and first and third part liability, 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 and service selection process. This includes protocols for: Determination of Medical Necessity, Level of care assessments, Service intensity or selection criteria, Continuing Stay review, 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 is overlap between UM and UR depending on how the CMMHSP is organized.** This component provides review/monitoring of individual consumer records, specific provider practices and system trends. Review of activities of both the CMHSP and the provider network are included. It may include: Review and monitoring to determine appropriate application of Guidelines and Criteria (Level of care, service selection, authorization, best practice), Consumer outcomes, Over-Utilization/under Utilization, Review of Outliers, Development of procedures for system level data review, Policy and procedures regarding use of review documents, Documentation and monitoring of UM/UR activities.
- **CARE MANAGEMENT. This is primarily a SA activity due to case management not being a covered Medicaid service.** This component recognizes that some consumers represent such service or financial risk to the organization that closer monitoring of the individual case is warranted.

F. CUSTOMER SERVICES

The Customer Services function encompasses activities directed at the entire population of the CMHSP's service area, including all services and supports to consumers. Most CMHSPs 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 many CMHSPs have begun using certified peers to provide customer services. As such, the peer costs when providing that activity should be included as an administrative cost.

Customer Services components include

- **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. These include: general orientation to CMHSP 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, outreach activities to identify and establish communication with under-served groups
- **CONSUMER EMPOWERMENT AND PARTICIPATION IN CMHSP 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. 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 includes:
  - 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.
  - 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
  - System of Care initiatives

G. QUALITY MANAGEMENT

The Quality Management function encompasses activities directed at ensuring that standards for staff, program and management performance exist, that compliance with them is assessed and

that ongoing improvements are introduced, monitored and assessed with respect to their outcomes.

MDCH requires the CMHSP/PIHP to develop an overall Quality Assessment and Performance Improvement Program (QAPIP) for its organization and its provider network. The QAPIP includes the development of an annual QI Plan that includes those specific developmental and improvement activities to improve the overall effectiveness of the PIHP network's clinical and administrative practices.

Virtually all service provider organizations have Quality Management 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 CMHSP/PIHP or operated in the CMHSP/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 CMHSPs in Utilization Management. Please describe in the narrative and identify to which function these costs were assigned.

Components of Quality Management include:

- **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, 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 PIHP'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 CMHSP/PIHP staff for compliance with regulations of outside bodies, including the State of Michigan, 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. Establishing a compliance friendly environment.
- **MANAGING OUTSIDE AGENCY REVIEW PROCESSES.** This component includes ensuring that source material is complete and available for reviews by outside bodies, including: Accrediting bodies, DCH Certification reviews and financial audits, EQR, Licensing bodies, Non-DCH payer audits and reviews (CMS, Auditor General, OIG, etc.)
- **RESEARCH.** 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 TA/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 carryout their own quality management plan, as well as ensuring that a Quality Improvement Culture is developed and maintained within all clinical and management arenas.
- **DEVELOPMENT OF AN ANNUAL QUALITY IMPROVEMENT PLAN.** This Plan establishes specific goals for the coming year, consistent with the CMHSP Strategic Plan and DCH QAPIP requirements and identifies monitoring mechanisms and timeframes with respect to their achievement.