

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

(FY2007 Appropriation Bill - Public Act 330 of 2006)

**October 30, 2006**

**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**

**BOILERPLATE REPORT SECTION 460**  
**PUBLIC ACT 330 of 2006**

Cost Allocation for the Public Mental Health System  
October 30, 2006

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 CMH 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 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 to commence 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 the 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 October 31, 2006 and finance officers to a technical training on November 6, 2006. MDCH established a due date of January 31, 2008 for the first annual Section 460 Report. The final materials for Phase I follow in this document and in the templates for reporting.

#### Next Steps

Phase II, to commence October 1, 2007, will apply the same approach to the contracted organized provider systems. The Cost Allocation Team will develop a definition of the “organized provider systems” so that CMHSPs and PIHPs can distinguish them from providers for whom the cost allocation reporting would be inappropriate. In addition, the team will develop sample provider contract language that CMHSPs and PIHPs can use when negotiating new contracts in early 2007. A report on Phase II will be included in the April 1, 2007 report to the Legislature.

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
Cost Allocation Requirement for FY'07  
October 2006**

Background

Section 460 of P.A. 154 of 2005 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 and CMHSPs on the "Section 460 Report" by January 31<sup>st</sup> of each year are submitted by MDCH to the Legislature annually. In Attachments A and B to this document you will find in each Table One and Table Two. Attachment A, Table One contains all the PIHP Medicaid direct and administrative costs with an explanation that the Balanced Budget Act defines the administrative functions that a managed care organization must perform, whether a PIHP or MCO. Table One, to be sent to the Legislature, contains each of the 18 PIHP Medicaid direct service costs and administrative costs, and the aggregate prime subcontractors' Medicaid direct service costs and administrative costs. Table Two, to be used also for PIHP reporting to MDCH, contains the Medicaid direct costs and administrative costs for each PIHP's prime sub-contractors. Attachment B, Table One is the CMHSP non-Medicaid direct and administrative costs with an explanation that the Mental Health Code requires certain administrative functions (i.e., the historical "board administration"), 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. As with the PIHP attachment, Attachment Two Table One contains each of the 46 CMHSP non-Medicaid direct service costs and administrative costs, and the aggregate prime subcontractors' non-Medicaid direct service costs and administrative costs. Attachment B Table Two contains each CMHSP's non-Medicaid direct service costs and administrative costs for each of their prime sub-contractors.

While many of the administrative functions are derived from the BBA or Mental Health Code requirements, and are delegated by the PIHP and CMHSP to their prime sub-contractors, certain core functions, such as human resources, information systems, and executive director exist in PIHPs, CMHSPs and the prime subcontractors regardless of funding stream. The costs of these core functions must be allocated to the PIHP as

Medicaid administrative expenditures and to the CMHSP as non-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 and CMHSPs 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 and CMHSP 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 prior to the beginning of the 2007 calendar year. 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' and CMHSPs' annual independent audit will review actual cost allocations and compare to the prospective methodologies in the cost plans.

The remainder of this document 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; 5) a flow chart for allocation steps; 6) a question and answer document, version 1; and 7) PIHP and CMHSP Section 460 reports, templates, and instructions for completion.

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**  
**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.**

Other General Direct Services (not reported as encounters)  
Prevention (not individual-specific)  
Outreach (might include homeless projects)  
Crisis Intervention  
Peer Delivered (not reported as encounter)

Allocated Overhead (examples)  
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**

Staff (examples)  
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)

Line Items (examples)  
Legal, audit, consultation services  
Advisory councils and committees  
Accreditation & licensing fees  
Association membership fees  
County indirect  
Subscriptions  
Allocated Overhead (examples)  
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 1<sup>st</sup> 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.

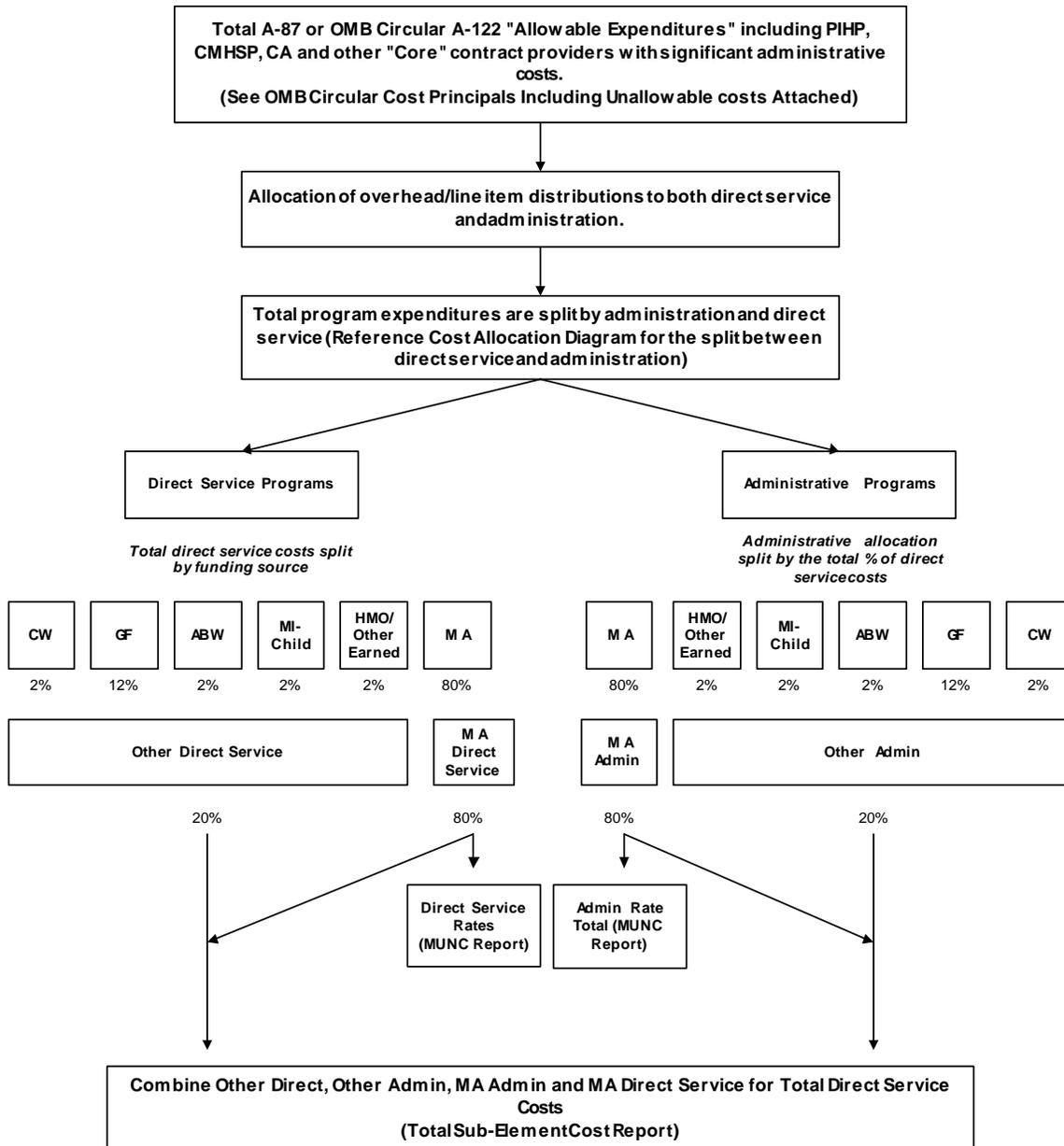
- Equipment attributable to other staff shall be included in administration.
  - The cost of training required for a specific covered service shall be reported as a direct service cost.
  - General training that is provided to staff across the service delivery system shall be included in administration.
  - 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 contact with consumers, these functions are considered facilitating, advocacy/assistance in protecting/asserting rights and/or “regulatory” functions and therefore classified, for the purpose of cost categorization, 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.

## 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).

## Steps for Allocation of Direct and Administrative Costs



**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**

**PIHP COST ALLOCATION MODEL: PHASE I, FY 2007**

*Technical Questions and Answers*

Version 1

**Note:** This document contains technical questions and answers. Some questions and comments submitted to MDCH were not technical, and were answered in other venues. A couple of questions received were unclear, are being pursued individually, and were not included here.

1. What do you mean when you say that administrative costs should be “transparent?”
  - A. **Administrative costs should be disclosed at each level of service provision. Therefore, administrative costs for PIHPs, CMHSPs, MCPNs, and Prime Subcontractors (including any CAs that perform delegated administrative functions on behalf of PIHPs or CMHSPs) will be required to be reported on the “Section 460 Report” in Phase I (6-month report due June 30<sup>th</sup> and an annual report due January 31, 2008), and then other major subcontractors in Phase II.**
  
2. How will the Medicaid administrative costs that are reported on the Section 460 Report comport with the 15% cap on Medicaid administrative costs that CMS required in our 1915(b) waiver and that is mandated by the CMS rate-setting checklist?
  - A. **The 15% cap mentioned in the 1915(b) waiver is on the amount of savings that can be spent for administrative purposes. In order to use savings for administrative purposes, a PIHP would need to submit a reinvestment plan to MDCH (who in turn submits it to CMS) for approval. There is not a requirement to limit the general Medicaid administrative costs to 15% of total costs or revenue in either the waiver application or the CMS rate setting checklist.**
  
3. Will we no longer be breaking out managed care costs from the administrative costs?
  - A. **In order to comply with the legislative requirement you will be reporting total Medicaid and total non-Medicaid administrative costs. The federal Balanced Budget Act does not define administrative costs but rather defines administrative functions and the quality standards for managed care organizations. The Encounter Data Integrity Team (EDIT) created definitions for those functions in “Establishing Managed Care Administrative Costs.” That document will be useful as PIHPs and CMHSPs sort administrative functions**

**between Medicaid and Mental Health Code-mandated (or “Board”) administrative functions. However, EDIT’s attempt to use those definitions in a cost model, although created with good intention, lead to the need for the proposed administrative cost definitions and resulted in the public mental health system creating subsets or arbitrary indirect cost pools of total administrative costs. It is these indirect pools that resulted in the current cost reporting discrepancies.**

4. Will delegated functions between PIHPs and Affiliates still exist?
  - A. Yes they may. PIHPs are still required by the BBA and the MDCH/PIHP contract to perform certain managed care functions (e.g., customer services, quality management). PIHPs may still desire to delegate some or all required functions to affiliates but will not report separately on the cost of the delegated function.**
  
5. Isn’t this method out of compliance with A87? For example, the cost of a 2<sup>nd</sup> line supervisor who is involved in only one program such as a day program should not be allocated across all of administration.
  - A. No. The Office of Management and Budget Circular A-87 (OMB A-87) does not dictate any level of cost classification and indicates that there is no certain rule for classifying costs as either direct or indirect. To paraphrase and quote OMB A-87 requirements, “some costs may be direct with respect to a specific service or function but indirect with respect to federal awards or another final cost objectives...Therefore, it is essential that each item of cost be treated consistently in like circumstances either as direct or indirect”. MDCH is not dictating or advising that a particular method be used for allocating administrative costs to programs or to all of administration. Your cost allocation plan will describe how you will allocate the administrative costs. The model being presented is how you divide administrative costs from direct costs, and how you will report them both.**
  
6. Can you clarify or better define the line between administration and direct services?
  - A. This will be an ongoing process. As specific questions regarding classification of items are submitted to the MDCH review panel, it will provide us with the opportunities to clarify the line.**
  
7. Will there be sample cost allocation plans provided so that we get an idea of how much or how little detail you are looking for?

- A. MDCH will provide several samples, what is acceptable and unacceptable, and a general format for the prospective cost plans.**
8. Does the cost allocation plan include how a specific cost is to be allocated, such as buildings? For example, “buildings will be allocated based on square footage.”
- A. MDCH will not prescribe, but your plan should indicate how each cost is allocated.**
9. Will it be acceptable for one CMH to allocate building cost by square footage and another CMH to allocate building costs by FTEs using that building and another CMH to allocate building costs equally between three programs that use that building?
- A. If the allocation of indirect costs is in compliance with OMB Circular A-87 then it will be acceptable.**
10. We do a formal Cost Allocation Plan that is certified by using the prior year’s data to set the current year’s rates. Is that a completely separate process than what this proposal is referring to?
- A. Yes and no. It is separate but much of the allocations in that plan would be acceptable in this requirement. The additional step needed for compliance here would be to assign all costs to either service or administrative costs. This additional step could be included in the cost allocation plan that is currently being done or it could be done separately.**
11. Would Boards who provide direct services have two distinct processes, one for setting rates and one for this process?
- A. The Cost Allocation Model is not intended as a guide for first and third party or actuarial rate setting (if that is what the question is referring to). For first and third party rate setting purposes, (unless otherwise specified by grant or payer) all administration regardless of its definition is spread to the unit of service.**
12. Can we use our existing cost-finding process (which we believe puts us in compliance with applicable rules and cost-finding standards)?
- A. You would have to submit the detail of what that is for the MDCH review panel to make a judgment. If it meets the standards in A-87 and assigns costs to service and administration using the definitions in this proposal then it could be used.**
13. Under Administration, does it read “management/non-immediate supervisory staff” or “management/non-immediate and supervisory staff?”

- A. Management/non-immediate supervisory staff
14. Does staff cost (as part of direct services) include vacation or other leave, and time spent in training?  
A. Yes, if it is direct service staff.
15. Would all grant activity (whether or not included as encounters) fall under Direct Services?  
A. **Generally, grant activity that is not reported as encounters but provides direct service to consumers would fall under “Direct Services.” However, those activities that are not clearly direct service or administrative will need to be addressed by the MDCH review panel.**
16. If a subscription for a journal is ordered and used by a clinical program would that be a direct cost?  
A. **Yes, it would be considered a supply or material – allocated overhead to direct service cost.**
17. Where would direct-operated client transportation system fall?  
A. **Transportation is included in a number of the service descriptions/coverages for which encounters are reported – for example, community living supports, out-of-home habilitation, skill-building and supported employment. In these cases, transportation is an allowable part of a Direct Service. Disallowed transportation costs include transportation to medical appointments that is the responsibility of another entity. Other kinds of consumer transportation should be described and submitted to the MDCH review panel.**
18. Would our training center need to be broken out by training that is required of direct care personnel versus those required by all staff for cultural competence, infection control, CARF, etc?  
A. **Yes, a distinction is needed between what is specific to serving a consumer versus what is general to the job duties.**
19. Where would staff who do the financial interviews and do other functions (such as reimbursement or benefits advocacy) fall?  
A. **Administration**
20. Are the references to the Children’s Waiver made just to the fee-for-service Children’s Waiver rather than any Children’s Waiver services under capitation?  
A. **Children’s Waiver is a fee-for-service program; there are no Children’s Waiver services covered under the capitation to PIHPs.**

21. In what program bucket are administrative costs for the Children's Waiver, Habilitation Supports Waiver and new Children's SED waiver allocated?
- A. Habilitation Supports Waiver goes into the Medicaid bucket; Children's Waiver and new SED Waiver go into GF bucket.**
22. If an immediate supervisor has ten staff and only one staff directly provides services, are 1/10<sup>th</sup> of that supervisor's salary/benefits allocated to direct service?
- A. Only if there is documentation that the 1/10<sup>th</sup> of the supervisor's time is spent in direct supervision of the direct care worker.**
23. If a PIHP wants to include a 2<sup>nd</sup> or 3<sup>rd</sup> line supervisor, are they only allocating that portion of the supervisor's salary/benefits that was involved in direct provision or immediate supervision of direct providers of services?
- A. Only staff that directly provide a service that results in the reporting of a CPT or HCPCS code, or who directly supervise someone who does. If a 2<sup>nd</sup> or 3<sup>rd</sup> line supervisor performs one of those functions, and the proportion of his/her time is documented, then the requisite proportion of his/her costs may be allocated to direct service.**
24. What is the methodology expectation for staff that do two functions (direct and administrative based on the diagram) splitting costs between direct and administrative?
- A. A-87 ATTACHMENT A, section C. Basic Guidelines, 3. Allocable costs, says, "a. A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received." Therefore, the answer is yes, you will need to allocate these costs to both classifications and include these in the cost allocation plan. You should use a method that assigns the costs to each classification relative to the benefits received. The method used will also need to comply with OMB Circular A-87.**
25. Can staff that provide payroll services (finance and accounting staff) human resource functions, reimbursement functions and some information system capacity be allocated to direct services?
- A. No.**
26. Is payroll considered part of Human Resources?
- A. It depends on the organization's structure.**
27. Where does the Medical Director and Access fall?

**A. Typically the Medical Director and Access function would fall under Administration. However, if a direct service that results in a CPT or HCPCS code reported is provided by the Medical Director or Access staff or they directly supervise someone who does, then the appropriate portion of their costs would be allocated to Direct.**

28. Staff who provide direct intake services with clients report to a supervisor who also supervises UM and/or QI staff, would a % of supervisors' time spend with the direct intake service staff be part of the direct costs, and the rest of the supervisor's time be allocated to administration? Would the supervisor have to keep a time log?

**A. Intake is a Direct Service only if it is reported in the encounter data. Unless the supervisor has documentation they are doing direct care or direct supervision of direct care the cost would be administration. With adequate documentation it could be allocated. Some method, included in the cost allocation plan that is acceptable under A-87 would be required; a time log would be one.**

29. Even though Customer Services Staff (consumer representatives) are dealing directly with the clients they are considered Administration?

**A. Yes**

30. Where does the cost of a self-determination coordinator go? This position does linking and coordinating in order to place eligible individuals into the self-determination program, but does not provide direct services.

**A. If linking and coordinating is performed by a case manager/supports coordinator or assistant and is reported as a CPT or HCPCS code in the encounter data system then the costs of the case manager/supports coordination, clerical support and direct/first-line supervisor go into direct services. Otherwise the costs of self-determination coordinator go into Administration**

31. Where does the cost of a hospital liaison/residential placement coordinator go? This position does linking and coordinating to place individuals who qualify into appropriate residential placement, but does not provide direct services.

**A. If linking and coordinating is performed by a case manager/supports coordinator or assistant and is reported as a CPT or HCPCS code in the encounter data system, then the costs of the case management/supports coordination, clerical support and direct/first-line supervisor go into direct services. Otherwise the costs of hospital liaison go into Administration**

32. Where does the cost of a supported employment coordinator go? This position does linking and coordinating to secure employment opportunities to eligible individuals, but does not provide direct services.
- A. If linking and coordinating is performed by a case manager/ supports coordinator or assistant and is reported as a CPT or HCPCS code in the encounter data system, then the costs of the case management/supports coordination, clerical support and direct/first-line supervisor go into direct services. Otherwise the costs of supported employment coordinator go into Administration**
33. Would costs other than equipment associated with an electronic medical record (specifically software and in-house development specific to electronic record) also be considered allocated overhead to direct service?
- A. Yes, EMR applications (proprietary and “homegrown”), enhancements, and support are considered allocated overhead. In addition, a proportion of network server, router and help desk in support of EMR may be allocated overhead to direct service.**
34. If the computer equipment can be a direct cost, then why can't the IS staff be a direct cost using the same allocation as the computer equipment?
- A. Equipment and application costs used in the provision of services are a tool of providing the service. IS staff would be the technical support for making the computers work and be counted as administration unless it directly affects the direct service, is documented, and appears in the cost allocation plan.**
35. Will I have two amounts reported for each funding source (MA, GF, ABW, etc.) – direct service costs and administrative costs?
- A. Yes**
36. The CMHSP contracts with large residential providers to provide CLS/Personal care. They have administrative costs (e.g., accounting, human resources) as well as direct supervision. Will we need to separate out those administrative costs in Phase 1?
- A. If the large provider fits the definition of a prime sub contractor then, yes, you will need to separate out those administrative costs in Phase 1. If they don't meet that definition then the answer is no, not until Phase 2.**
37. Does this mean that CAs have to allocate Medicaid admin according to these rules and all other admin according to the directions we received from the Substance Abuse Bureau?

- A. These two requirements need to be reconciled. Under OMB circular A-87 the same method for allocating a cost should be used for all programs. Therefore, the method used to allocate administration to the Medicaid SA costs should be used to apply costs to the other SA costs.**
38. Substance abuse block grant is limited to an arbitrary 10%. How will that work (also with other programs where administrative cost are limited or prohibited)?
- A. OMB Circular A-87 Attachment A, section C. Basic Guidelines allocable costs says, “Any cost allocable to a particular Federal award or cost objective under the principles provided for in this Circular may not be charged to other Federal awards to overcome fund deficiencies, to avoid restrictions imposed by law or terms of the Federal awards, or for other reasons.” Therefore, the appropriate amount of administration must be assigned to each program/grant with out consideration of any restrictions imposed by the program or grant.**
39. Substance abuse AAR service benefit includes some activities, such as eligibility determination, that are identified as administrative functions in the Medicaid Provider Manual. Is it expected that the provider manual guidance no longer applies?
- A. Those functions that are not reportable as Medicaid encounters would be reported as Medicaid administration.**
40. Are there new encounter reporting requirements relative to what had been administrative costs – e.g., fiscal intermediary services are now reported as encounters – how does this affect CAs?
- A. There are no new encounter reporting requirements. Fiscal intermediary services are a new benefit under the 1915(b)(3)s for beneficiaries for whom it is medically necessary and who want to use a self-determination approach. It is unlikely to impact CAs.**
41. The document says that only administrative functions that are delegated by a PIHP to a CA are to be reported as MA costs. This raises the issue of what to do when admin functions are not delegated but have to be done at the CA level. Are these defined as program costs? Is it expected that the general guidance in this draft be used?
- A. Any costs that the CA has that are charged to the PIHP must be classified as service or administration based on the definitions in the Section 460 Report Cost Allocation Instructions.**

42. CA requirements classify all CA staff as admin (either program or general) while this document allows for classifying some PIHP and CMH activities as direct service?

A. **Yes it does.**

42. On the old FSRs the PIHP reported the QAAP tax on a separate line. In the new reporting format for PIHPs to report service and administrative expenses how will a PIHP report the QAAP tax?

**A. PIHPs will report the QAAP tax on a separate line in the Section 460 Report.**

**SECTION 460 COST ALLOCATION REPORT**  
**Informational Session for Executive Directors**  
**October 31, 2006**  
**Conference Rooms A& B, Constitution Hall, Lansing Michigan**  
Tentative Agenda

1:00 p.m.

- |                            |         |
|----------------------------|---------|
| I. Welcome                 | J. Webb |
| II. Purpose of the Session | J. Webb |

1:15 p.m.

- |                            |              |
|----------------------------|--------------|
| III. Intent of Section 460 | Rep. Caswell |
|----------------------------|--------------|

1:30 p.m.

- |  |           |
|--|-----------|
| IV. MDCH Response to Legislation               | P. Barrie |
| V. How MDCH Will Use Section 460 data          | P. Barrie |
| VI. Administrative Data for the Actuarial Work | P. Barrie |

2:00 p.m.

- |                            |  |
|----------------------------|--|
| VII. Questions and Answers |  |
|----------------------------|--|

2:15 p.m.

- |               |  |
|---------------|--|
| VIII. Adjourn |  |
|---------------|--|

**SECTION 460 COST ALLOCATION REPORT**  
Technical Training for PIHP and CMHSP Chief Financial Officers  
November 6, 2006  
Constitution Hall, Lansing

Tentative Agenda

**9:00 a.m.**

- I. Welcome, introductions and background

**9:15 a.m.**

- II. Steps for Allocating Costs

**9:45 a.m.**

- III. Section 460 Report Formats
  - a. How to fill in the blanks
  - b. Due Dates

**10:30 p.m.**

- IV. Cost Allocation Plans
  - a. Instructions
  - b. Examples
  - c. Due Dates

**11:30 a.m.**

- V. Answers to Written Questions

**11:50 a.m.**

- VI. Summary

**12:00 noon**

- VII. Adjourn

## **Submission Requirements for 460 Cost Allocation Plans**

### **A. *General.***

1. Section 460 of P.A. 154 of 2005 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.
2. Guidelines and illustrations of 460 cost allocation plans are adapted from a brochure published by the Department of Health and Human Services entitled "A Guide for State and Local Government Agencies: Cost Principles and Procedures for Establishing Cost Allocation Plans and Indirect Cost Rates for Grants and Contracts with the Federal Government."
3. This plan will be used to allocate the actual costs of the PIHP or CMHSP for the fiscal year ended 9/30/2007 between service and administrative costs for the 460 Cost Allocation Report.
4. Scope of the 460 Cost Allocation Plans for the 460 Cost Allocation Report: The 460 cost allocation plan shall be comprehensive and will include all costs of the applicable PIHP, CMHSP or Prime Subcontractor.

### **B. *Submission Requirements.***

1. Each PIHP or CMHSP will submit a plan to the Michigan Department of Community Health for each year in which it reports costs for the 460 Cost Allocation Report. The plan should include (a) a projection of the next year's allocated service and administrative cost (based on the budget projection for the coming year).
2. Prime subcontractors required to report service and administrative costs must develop a plan in accordance with the requirements described in this document and submit it to the applicable PIHP or CMHSP. All 460 cost allocation plans will be prepared and submitted prior to the beginning of each fiscal year in which reporting is required

**C. Documentation Requirements for Submitted Plans.** The documentation requirements described in this section may be modified, expanded, or reduced by MDCH on a case-by-case basis.

1. General. All proposed plans must be accompanied by the following: an organization chart sufficiently detailed to show operations including all the activities of the PIHP or CMHSP whether or not they are shown as benefiting from service and administrative functions; a copy of the Executive Budget to support the allowable costs of each service and administrative activity included in the plan; and, a certification (see subsection 3.) that the plan was prepared in accordance with OMB Circular A-87, contains only allowable costs, and was prepared in a manner that treated similar costs consistently among all the programs.

2. Allocated service and administrative costs. For each allocated service or administrative cost, the plan must also include the following: a brief description of the service and administrative function\*, an identification of the unit rendering the service and the operating programs receiving the service/benefit, the items of expense included in the cost of the service, the method used to distribute the cost of the service to benefited programs, and a summary schedule showing the allocation of each service to the specific benefited programs.

3. Required certification. Each 460 cost allocation plan will be accompanied by a certification in the following form:

**CERTIFICATE OF 460 COST ALLOCATION PLAN**

This is to certify that I have reviewed the 460 cost allocation plan submitted herewith and to the best of my knowledge and belief:

(1) All costs included in this proposal [identify date] to establish cost allocations or billings for [identify period covered by plan] are allowable in accordance with the requirements of OMB Circular A 87, "Cost Principles for State, Local, and Indian Tribal Governments," and the Federal award(s) to which they apply. Unallowable costs have been adjusted for in allocating costs as indicated in the cost allocation plan.

(2) All costs included in this proposal are properly allocable to service or administrative costs on the basis of a beneficial or causal relationship between the expenses incurred and the categories to which they are allocated in accordance with applicable requirements. Further, the same costs that have been treated as indirect costs have not been claimed as direct costs. Similar types of costs have been accounted for consistently.

(3) All costs included in this proposal are allocated to service or administration and reported in compliance with the Michigan Department of Community Health Cost Allocation Requirement for [identify period covered by plan].

I declare that the foregoing is true and correct.

Governmental Unit: \_\_\_\_\_

Signature: \_\_\_\_\_

Name of Official: \_\_\_\_\_

Title: \_\_\_\_\_

Date of Execution: \_\_\_\_\_

**SECTION 460 CMHSP COST REPORT**  
**INSTRUCTIONS FOR COMPLETION**

CMHSPs will use Table 2 of the Direct Service/Administrative Cost Report (Appendix C) for reporting in compliance with Section 460 of Public Act 154, 2005. Please refer to the Requirement for Allocating Administrative Costs for details and definitions of terms.

To complete Table 2:

1. Enter CMHSP name and enter an X in the box to indicate six-month or annual report.
2. Enter in row 1, col. B the cost of the total non-Medicaid direct services that the CMHSP provided directly (not via Prime Subcontractor or other Subcontracted Provider).
3. In row 1, col. E, enter the cost of the non-Medicaid administration for the CMHSP (less the administrative costs of the Prime Subcontractor or other Subcontracted Provider).
4. Cols. H, I, J, and K will self-calculate.
5. In Rows 2 through 14, enter in the Col. A the names of the Prime Subcontractors.
6. In Rows 2 through 14, Col. C, enter the cost of the total non-Medicaid direct services that each Prime Subcontractor provided directly.
7. In Rows 2 through 14, Col. F enter the costs of non-Medicaid administration for the Prime Subcontractor (less the administrative costs for any other Subcontracted Provider).
8. Rows 2 through 14, Cols. H, I, J and K will self-calculate
9. Row 15, Col C and F will automatically calculate the costs of the total non-Medicaid direct services and total non-Medicaid administration for the Prime Subcontractors (total of rows above)
10. Row 16, Col. D, enter the total costs for non-Medicaid direct services and administration performed by Subcontracted Providers as delegated by the CMHSP and/or the Prime Subcontractors.
11. Row 16, Cols. H and J will self calculate.
12. Row 17, cells will automatically fill with totals from Rows 1, 15 and 16, and Col. H, I, J, and K will self-calculate
13. Row 18, enter the amount of Local Contribution to State Medicaid Match allocated to non-Medicaid services and non-Medicaid administration. Cols. H, I, J and K will self-calculate.
14. Row 19, cells will automatically add rows 17 and 18.

**SECTION 460 PIHP COST REPORT**  
**INSTRUCTIONS FOR COMPLETION**

PIHPs will use Table 2 of the Direct Service/Administrative Cost Report (Appendix D) for reporting in compliance with Section 460 of Public Act 154, 2005. Please refer to the Requirement for Allocating Administrative Costs for details and definitions of terms.

To complete Table 2:

15. Enter PIHP name and enter an X in the box to indicate six-month or annual report.
16. Enter in row 1, col. B the cost of the total Medicaid direct services that the PIHP provided directly (not via Prime Subcontractor or other Subcontracted Provider).
17. In row 1, col. E, enter the cost of the Medicaid administration for the PIHP (less the administrative costs of the Prime Subcontractor or other Subcontracted Provider).
18. Row 1, Cols. H, I, J, and K will self-calculate.
19. In Rows 2 through 14, enter in the Col. A the names of the Prime Subcontractors.
20. In Rows 2 through 14, Col. C, enter the cost of the total Medicaid direct services that each Prime Subcontractor provided directly.
21. In Rows 2 through 14, Col. F enter the costs of Medicaid administration for the Prime Subcontractor (less the administrative costs for any other Subcontracted Provider).
22. Rows 2 through 14, Cols. H, I, J and K will self-calculate
23. Row 15, Col C and F will automatically calculate the costs of the total Medicaid direct services and total Medicaid administration for the Prime Subcontractors (total of rows above)
24. Row 15, Cols. H, I, J and K will self-calculate.
25. Row 16, Col. D, enter the total costs for Medicaid direct services and administration performed by Subcontracted Providers as delegated by the PIHP and/or the Prime Subcontractors.
26. Row 16, Cols. H and J will self calculate.
27. Row 17, cells will automatically fill with totals from Rows 1, 15 and 16, and Col. H, I, J, and K will self-calculate
28. Row 18, enter the amount of Quality Assurance Assessment Tax (QAAP) allocated to Medicaid services and Medicaid administration. Cols. H, I, J and K will self-calculate.
29. Row 19, cells will automatically add rows 17 and 18.

Michigan Department of Community Health  
Section 460 Compliance Report  
Direct Service / Administrative Cost for the Community Mental Health Service Programs  
Non-Medicaid Managed Mental Health Supports and Services  
October 1, 2006 - September 30, 2007

CMHSP	Non-Medicaid Direct Services				Non-Medicaid Administration				Total Non-Medicaid Costs			
	CMHSP	Prime Sub-Contractors	Sub-Contract Providers	Total	CMHSP	Prime Sub-Contractors	Sub-Contract Providers	Total	Total Direct Services	Total Administration	Total Costs	Percent Admin.
Allegan				\$ -				\$ -	\$ -	\$ -	\$ -	0.00%
Ausable Valley				-				-	-	-	-	0.00%
Barry				-				-	-	-	-	0.00%
Bay Arenac				-				-	-	-	-	0.00%
Berrien				-				-	-	-	-	0.00%
Clinton-Eaton-Ingham				-				-	-	-	-	0.00%
CMH for Central Michigan				-				-	-	-	-	0.00%
Copper Country				-				-	-	-	-	0.00%
Detroit-Wayne				-				-	-	-	-	0.00%
Genesee				-				-	-	-	-	0.00%
Gogebic				-				-	-	-	-	0.00%
Gratiot				-				-	-	-	-	0.00%
Hiawatha				-				-	-	-	-	0.00%
Huron				-				-	-	-	-	0.00%
Ionia				-				-	-	-	-	0.00%
Kalamazoo				-				-	-	-	-	0.00%
Lapeer				-				-	-	-	-	0.00%
Lenawee				-				-	-	-	-	0.00%
Lifeways				-				-	-	-	-	0.00%
Livingston				-				-	-	-	-	0.00%
Macomb				-				-	-	-	-	0.00%
Manistee-Benzie				-				-	-	-	-	0.00%
Monroe				-				-	-	-	-	0.00%
Montcalm				-				-	-	-	-	0.00%
Muskegon				-				-	-	-	-	0.00%
Newaygo				-				-	-	-	-	0.00%
Network 180				-				-	-	-	-	0.00%
North Country				-				-	-	-	-	0.00%
Northeast				-				-	-	-	-	0.00%
Northern Lakes				-				-	-	-	-	0.00%
Northpointe				-				-	-	-	-	0.00%
Oakland				-				-	-	-	-	0.00%
Ottawa				-				-	-	-	-	0.00%
Pathways				-				-	-	-	-	0.00%
Pines Behavioral				-				-	-	-	-	0.00%
Saginaw				-				-	-	-	-	0.00%
Sanilac				-				-	-	-	-	0.00%
Shiawassee				-				-	-	-	-	0.00%
St. Clair				-				-	-	-	-	0.00%
St. Joseph				-				-	-	-	-	0.00%
Summit Pointe				-				-	-	-	-	0.00%
Tuscola				-				-	-	-	-	0.00%
Van Buren				-				-	-	-	-	0.00%
Washtenaw				-				-	-	-	-	0.00%
West Michigan				-				-	-	-	-	0.00%
Woodlands				-				-	-	-	-	0.00%
<b>State-wide Total</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -	0.00%

Included in  
Direct for  
Phase 1

Michigan Department of Community Health

Section 460 Compliance Report

Direct Service / Administrative Cost for the Community Mental Health Service Programs

Non-Medicaid Managed Mental Health Supports and Services

October 1, 2006 - September 30, 2007

CMHSP	Non-Medicaid Direct Services				Non-Medicaid Administration				Total Non-Medicaid Costs			
	CMHSP	Prime Sub-Contractors	Sub-Contract Providers	Total	CMHSP	Prime Sub-Contractors	Sub-Contract Providers	Total	Total Direct Services	Total Administration	Total Costs	Percent Admin.

The CMHSP non-Medicaid administrative costs are borne by the 46 CMHSPs when they carry out the responsibilities associated with operating a local public mental health system and administering the direct services provided by them or purchased by them from prime sub-contractors. For purposes of this report, the administration is defined as those responsibilities that lie above front line supervision. These responsibilities include: finance, payroll, human resources, billing/claim payment and information technology. The CMHSP non-Medicaid administration also includes responsibilities mandated by the Michigan Mental Health Code such as community needs assessment, governance, compliance, quality improvement systems, local dispute resolution processes, recipient rights, and collaboration/coordination with local public human service agencies - responsibilities that are not typical of health care systems or private human service organizations.



# Section 460 Cost Allocation Report

## Technical Training for Chief Financial Officers and Key Accountants

November 6, 2006

# Section 460 Cost Allocation Report

Judy Webb, Director

MDCH – Division of Quality Management &  
Planning

John P. Duvendeck, CPA, Manager

MDCH - Contract Management Section

Teresa Simon, Manager

MDCH – Mental Health & CSHCS Support

# Purpose and Intent of Section 460 Report

- Section 460 of Public Acts 154 and 330 mandated that MDCH develop methodology for CMHSPs, PIHPs and their subcontractors to allocate costs, and instructions for reporting those costs
- The intent of the Legislature was to seek clear and accurate information about the public mental health system after finding that the Section 404 (“Boilerplate”) report presented wide and unexplainable variations in service and administrative costs across the state

# Legislative Intent

- There are assumptions that once PIHPs and CMHSPs compare their data resulting from this report they will learn from one another about ways to improve the efficiency of their operations
- It is the wish of the Legislature that savings will result from such improvements and that those savings will be moved into services

# Legislative Promise

- Responding to concerns about the likely higher reported CMHSP and PIHP administrative rates being compared to those of Medicaid Health Plans and other health care agencies, Representative Caswell has committed to introducing boilerplate indicating that the information should not be used for such purposes.



# Section 460 Report

- MDCH developed the approach we will describe today in concert with a small group of representatives from the CMHSPs, and after exploring several other, more complicated, approaches
- We are going forward with this approach – in other words – it's not negotiable
- We have drawn an arbitrary line between direct service costs and administrative costs that you might find arguable – but is not negotiable either

# Section 460: Phase I

- Today's session focuses on the first phase of this activity that addresses cost allocation requirements for PIHPs, CMHSPs and their prime sub-contractors
- In the coming months the Cost Allocation Team will work on Phase II that addresses cost allocation requirements for other major subcontractors with the intent that work will be completed by March 2007

# Section 460 Reporting

- This is an annual report to the Legislature – due from PIHPs and CMHSPs each June 30<sup>th</sup> (prime subcontractors will submit their reports to their PIHPs or CMHSPs)
- A six month report will be submitted for at least 2006 & 2007 to work out any “bugs”
- PIHPs & CMHSPs will be required to submit to MDCH cost allocation plans prior to each fiscal year (prime subcontractors will submit their plans to their PIHPs or CMHSPs)

# Plan for the Day

- Agenda
- Write your questions on 3X5 cards and we will either:
  - Answer at the end of the session, if time allows, or
  - Answer and post on the MDCH web site in Q and A Version, 2
- Revised reporting materials will be handed out at the end of the session, and will be posted on the MDCH web site

# Finally,

- We want this to work! So, technical assistance will be available!

# Section 460 Cost Allocation Report

Advisory committee:

Jim House, CMH for Central Michigan

Tom Elzinga, network180

Eric Kurtz, WCHO

Leon Karnovsky, Summit Pointe

Dave Short, Consultant

# Section 460 Cost Allocation Report

- Cost allocation diagram
- PIHP & CMHSP responsibilities
- Steps for allocating costs
- Section 460 report forms
- Due dates
- Sample cost allocation plan
- Technical guidance

# Section 460 Cost Allocation Report

## 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)	<u>Allocated Overhead</u> (examples)
Prevention (not individual-specific)	Building costs (including building security)
Outreach (might include homeless projects)	Utilities
Crisis Intervention	Travel/vehicles
Peer Delivered (not reported as encounter)	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</u> (examples)	<u>Line Items</u> (examples)
Executive Director	Legal, audit, consultation services
Management/ non-immediate supervisory staff	Advisory councils and committees
Human resources staff	Accreditation & licensing fees
Budget, Finance and Accounting staff	Association membership fees
Reimbursement staff	County indirect
Training staff	Subscriptions
Customer Services staff	<u>Allocated Overhead</u> (examples)
Recipient Rights staff	Building costs
Utilization Management staff	Utilities
Quality Improvement staff	Travel/vehicles
Information system staff (+ network mgmnt, help desk, security)	Clerical
	Equipment (personal computer, furniture, fax, telephone)
	Supplies
	Training & conferences related to administrative functions

# Section 460 Cost Allocation Report

- Per the Cost Allocation Diagram, MDCH is prescribing how costs are to be defined between Direct Services and Administration
- MDCH will provide ongoing support through a technical panel for decisions regarding whether a cost may be included as Direct Services or Administration

# Section 460 Cost Allocation Report

- MDCH is not prescribing how allocated overhead amounts are allocated between Direct Services and Administration
- Each PIHP and CMHSP will need to use professional judgment to determine the allocation basis between Direct Services and Administration for those overhead amounts to be allocated

# Section 460 Cost Allocation Report

There are eight steps in the process

Step 1 - Determine allowable costs under the applicable state and federal regulations. For example OMB Circular A-87, attachment A ,General Principles for determining allowable costs

# Section 460 Cost Allocation Report

Step 2 - PIHP and CMHSP must identify the methods to be used in their cost allocation plans. The methods must meet federal Office of Management and Budget (OMB) Circular A-87 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).

# Section 460 Cost Allocation Report

Step 3 - Identify all costs that are direct service costs; the remaining costs are administrative costs. (See diagram)

Step 4 - Allocate overhead costs to direct service or administrative costs.

# Section 460 Cost Allocation Report

Step 5 - Allocate direct costs by funding source (Medicaid, GF, etc)

Step 6 - Allocate administration costs by funding source (Medicaid, GF, etc) utilizing the cost allocation methodologies identified in Step 2.

# Section 460 Cost Allocation Report

Step 7 - Report direct service and administrative costs to MDCH on the Section 460 report

Step 8 - Independent audit shall verify that costs were allocated correctly and according to the cost allocation plan.

# Section 460 Cost Allocation Report

- The 460 cost allocation reports include sections for reporting
  - Cost of the PIHP or CMHSP
  - Prime subcontractor costs
  - Other subcontractor costs
- Costs will be reported as
  - Direct service costs
  - Administrative costs

# Section 460 Cost Allocation Report

- Prime subcontractors are
  - CMHSP affiliates
  - Substance abuse coordinating agencies
  - Detroit-Wayne's Managed Comprehensive Provider Networks (MCPNs)
  - Oakland's core providers
  - Other agencies that meet the prime subcontractor definition

# Section 460 Cost Allocation Report

- Review the CMHSP and PIHP report forms
- The following slides are 460 reports for
  - CMHSP form
  - PIHP form

Michigan Department of Community Health

Section 460 Compliance Report

Direct Service / Administrative Cost Detail Report for the Community Mental Health Service Programs

Non-Medicaid Managed Mental Health Supports and Services

CMHSP: \_\_\_\_\_

Fiscal Year: \_\_\_\_\_

Reporting Period:  Six Month Report  Annual Report

(A) Contractor(s)	Non-Medicaid Direct Service			Non-Medicaid Administration			Non-Medicaid Total Costs			
	(B) CMHSP	(C) Prime Sub-Contractors	(D) Sub-Contract Providers	(E) CMHSP	(F) Prime Sub-Contractors	(G) Providers	(H) Total Direct Services	(I) Total Administration	(J) Total Costs	(K) Admin.
<b>1. CMHSP PROVIDED</b>							\$ -	\$ -	\$ -	
<b>2. Prime Sub-Contractor(s)</b>							-	-	-	
3.[Name]							-	-	-	
4.							-	-	-	
5.							-	-	-	
6.							-	-	-	
7.							-	-	-	
8.							-	-	-	
9.							-	-	-	
10.							-	-	-	
11.							-	-	-	
12.							-	-	-	
13.							-	-	-	
14.							-	-	-	
<b>15. Sub-Total Prime Sub-Contractor(s)</b>		\$ -			\$ -		\$ -	\$ -	\$ -	
<b>16. Other Sub-Contractor(s)</b>						included in Direct for Phase 1	\$ -	included in Direct for Phase 1	\$ -	
<b>17. Total without Local Contribution to State Medicaid Match</b>	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	0%
<b>18. Local Contribution to State Medicaid Match</b>							\$ -	\$ -	\$ -	
<b>19.Total with Local Contribution to State Medicaid Match</b>	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	

**Michigan Department of Community Health**

**Section 460 Compliance Report**

**Direct Service / Administrative Cost Detail Report for the Prepaid Inpatient Health Plans  
Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Programs**

**PIHP:** \_\_\_\_\_

**Fiscal Year:** \_\_\_\_\_

**Reporting Period:**  Six Month Report  Annual Report

(A) Contractor(s)	Medicaid Direct Service			Medicaid Administration			Medicaid Total Costs			
	(B) PIHP	(C) Contractors	(D) Providers	(E) PIHP	(F) Contractors	(G) Providers	(H) Total Direct Services	(I) Total Administration	(J) Total Costs	(K) Admin.
<b>1. PIHP Provided</b>							\$ -	\$ -	\$ -	
<b>2. Prime Sub-Contractor(s)</b>										
3. [Name]							-	-	-	
4.							-	-	-	
5.							-	-	-	
6.							-	-	-	
7.							-	-	-	
8.							-	-	-	
9.							-	-	-	
10.							-	-	-	
11.							-	-	-	
12.							-	-	-	
13.							-	-	-	
14.							-	-	-	
<b>15. Sub-Total Prime Sub-Contractor(s)</b>		\$ -			\$ -		\$ -	\$ -	\$ -	
<b>16. Other Sub-Contractor(s)</b>						included in Direct for Phase 1	\$ -	included in Direct for Phase 1	\$ -	
<b>17. Total without Quality Assurance Assessment Tax</b>	\$ -	\$ -	\$ -	\$ -	\$ -	included in Direct for Phase 1	\$ -	\$ -	\$ -	0.00%
<b>18. Quality Assurance Assessment Tax</b>							\$ -	\$ -	\$ -	
<b>19. Total with Quality Assurance Assessment Tax</b>	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	

# Section 460 Cost Allocation Report

- Due Dates
- Cost allocation plan Phase I - 2/28/2007
- Six month 460 Cost Allocation Report 6/30/2007
- Final 460 Cost Allocation Report 1/31/2008
- Cost allocation plan Phase II – 9/30/2007

# Section 460 Cost Allocation Report

- Sample 460 Cost allocation plan titled “Mini-ways PIHP”
  - Follows model in OMB Circular A-87 implementation guide
  - Designed as PIHP with prime sub contractor
  - Model is to illustrate the application of the principals
  - It is not intended to be a comprehensive model

# Section 460 Cost Allocation Report

- You will use the cost allocation plan twice for each year
- The initial plan you submit to MDCH will utilize budget amounts
- To prepare the 460 report utilize actual general ledger amounts
- Retain both the initial plan and plan used to prepare the 460 report

# Section 460 Cost Allocation Report

## Outline of cost allocation plan requirements

- The projected costs for the fiscal year
- Organization chart sufficiently detailed to show operations
- Schedule showing totals reported on the 460 reports
- Certification that the plan was prepared in accordance with OMB Circular A-87

# Section 460 Cost Allocation Report

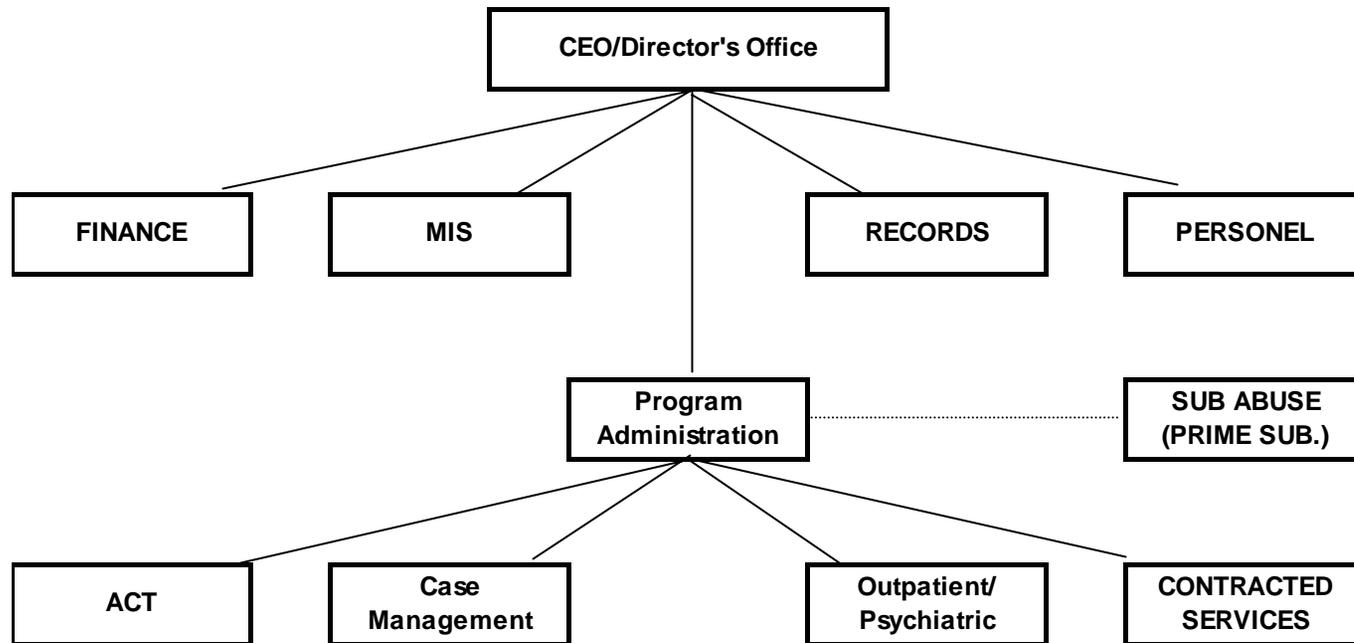
## Outline of cost allocation plan requirements

- For each allocated service or administrative cost
  - Description of the service and administrative function
  - Identification of the unit rendering the service
  - Programs receiving the service/benefit
  - Items of expense included in the cost of the service
  - Method used to distribute the cost of the service
  - Summary schedule of the service allocation to the specific benefited programs

# Section 460 Cost Allocation Report

- The following “Mini-ways PIHP” model is a sample. In practice, these schedules and narratives should be sufficiently detailed to provide explanations of the functions and benefits associated with the costs being allocated

# Mini-ways PIHP



Mini-ways CMH provides services for Small County. Although it is one of the smaller CMH's in the state, it has all the essential services as the organizational chart shows.

# Mini-ways Total Board Expenditures – General ledger

Mini-Ways Board Expenditures		
		Full Year Plan
<i>*Italic = Allocated Line Item Expense</i>		
	Salaries & Wages	\$1,954,557
	Fringe Benefits	802,242
	Office Supplies	15,000
*	<i>Communications</i>	110,000
	Staff Travel	60,000
*	<i>Building or Building Rental</i>	325,397
	Contracted Services	11,500,000
	Sub Abuse CA	<u>500,000</u>
	General Ledger Total	\$15,267,196

# Mini-ways Board Expense by Reporting Unit

<b>REPORTING UNIT</b>	<b>Base Cost</b>
<b>BUILDING</b>	<b>\$325,397</b>
<b>COMMUNICATIONS</b>	<b>110,000</b>
<b>CEO/ Director's Office</b>	<b>716,620</b>
<b>FINANCE</b>	<b>305,072</b>
<b>MIS</b>	<b>92,462</b>
<b>RECORDS</b>	<b>115,657</b>
<b>PERSONNEL</b>	<b>67,609</b>
<b>CLINICAL ADMINISTRATION</b>	<b>361,272</b>
<b>CASE MANAGEMENT</b>	<b>626,394</b>
<b>OUTPATIENT</b>	<b>328,858</b>
<b>ACT</b>	<b>217,855</b>
<b>CONTRACTED SERVICES</b>	<b>11,500,000</b>
<b>SUBSTANCE ABUSE C/A</b>	<b><u>500,000</u></b>
	<b>\$15,267,196</b>

# The Mini-ways Building



Mini-ways leases a single building for all its operations

# Mini-ways Building Allocation Schedule

Reporting Unit	Full Time Equivalents	Per Cent	Allocation
CEO/Director's Office	11	27.50%	\$89,484
Finance	4	10.00%	32,540
MIS	1	2.50%	8,135
Records	1	2.50%	8,135
Personnel	1	2.50%	8,135
Program Administraton	4	10.00%	32,540
<b>Sub Total Admin Services</b>			<b>178,969</b>
Case Management	11	27.50%	89,484
Outpatient-Psychiatric	4	10.00%	32,540
ACT	3	7.50%	<u>24,404</u>
<b>Sub Total Direct Services</b>			<b>146,428</b>
<b>TOTAL</b>	<b>40</b>	<b>100.00%</b>	<b>\$325,397</b>

Building costs are allocated to programs on the basis of FTE's.

# Mini-ways Communications



Mini-Ways communications line item includes purchased/leased hardware (T-1, Computers, etc), software and all local and long distance phone charges.

# Mini-ways Communications Allocation Schedule

Reporting Unit	Full Time Equivalents	Per Cent	Allocation
CEO/Director's Office	11	27.50%	\$30,250
Finance	4	10.00%	\$11,000
MIS	1	2.50%	\$2,750
Records	1	2.50%	\$2,750
Personnel	1	2.50%	\$2,750
Program Administrator	4	10.00%	<u>\$11,000</u>
<b>Sub Total Admin Services</b>			<b>60,500</b>
Case Management	11	27.50%	\$30,250
Outpatient-Psychiatric	4	10.00%	\$11,000
ACT	3	7.50%	<u>\$8,250</u>
<b>Sub Total Direct Services</b>			<b>49,500</b>
<b>TOTAL</b>	<b>40</b>	<b>100.00%</b>	<b>\$110,000</b>

Communication costs are allocated to activities on the basis of FTE's

# Mini-ways Management Information Systems

The MIS department is responsible for the development, planning, testing, maintenance, supervision, and purchase of MIS related software, hardware, and network functions.

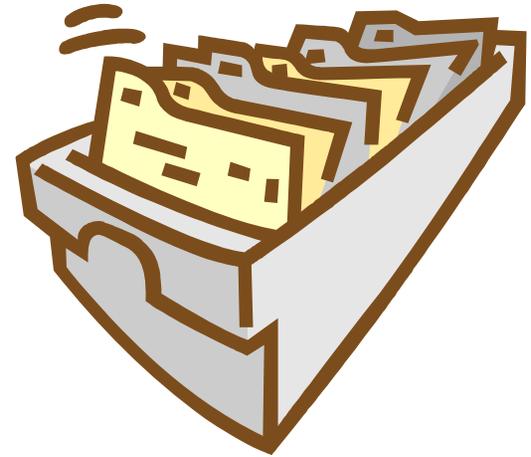
MIS can be allocated to both administrative and clinical programs for the 460 Report.

# Mini-ways MIS Allocation Schedule

Reporting Unit	PC Terminals	Per Cent	Allocation
CEO/Director's Office	11	27.50%	\$28,420
Finance	5	12.50%	12,918
Records	1	2.50%	2,584
Personnel	1	2.50%	2,584
Program Administraton	4	10.00%	<u>10,335</u>
<b>Sub Total Admin Services</b>			<b>\$56,841</b>
Case Management	11	27.50%	28,420
Outpatient-Psychiatric	4	10.00%	10,335
ACT	3	7.50%	<u>7,751</u>
<b>Sub Total Direct Services</b>			<b>\$46,506</b>
<b>TOTAL</b>	<b>40</b>	<b>100.00%</b>	<b>\$103,347</b>

MIS costs are allocated to programs based on the number of terminals or PC's.

# Mini-ways Medical Records Dept.



The Mini-Ways Medical Records Department is responsible for organizing, and securing all hard copy consumer records. Costs for the Records Department includes all allocated costs for communications, building, and Management Information Systems.

All functions of the Records Department benefit the clinical operations only and are therefore allocated to only clinical program costs.

# Mini-ways Medical Records Program Costs

	<b>FULL YEAR PLAN</b>
<b>Salaries &amp; Wages</b>	<b>\$71,623</b>
<b>Fringe Benefits</b>	<b>35,700</b>
<b>Office Supplies</b>	<b>1,667</b>
<b><i>Communications</i> *</b>	<b>2,750</b>
<b>Staff Travel</b>	<b>6,667</b>
<b><i>MIS</i> *</b>	<b>2,584</b>
<b><i>Building &amp; Rental</i> *</b>	<b><u>8,135</u></b>
<b>TOTAL</b>	<b>\$129,126</b>

# Mini-ways Medical Records Allocation Schedule

Reporting Unit	Clinical Open Cases	Per Cent	Allocation
CEO/Director's Office	0	0.00%	\$0
Finance	0	0.00%	0
MIS	0	0.00%	0
Records	0	0.00%	0
Personnel	0	0.00%	0
Program Administraton	0	0.00%	<u>0</u>
Sub Total Admin Services			\$0
Case Management	300	69.00%	\$89,097
Outpatient-Psychiatric	100	23.00%	29,699
ACT	35	8.00%	<u>10,330</u>
Sub Total Direct Services			\$129,126
<b>TOTAL</b>	<b>435</b>	<b>100.00%</b>	<b>\$129,126</b>

Medical Record costs are allocated to clinical programs only based on the number of open cases by program.

# Mini-ways Finance



- Finance Department Performs the Following Functions :
  - Maintains General and Subsidiary Ledgers
  - Develops Budgets
  - Develops Risk Management Plan
  - Analyses Efficiency and Effectiveness of Operations

# Mini-ways Finance Costs

<b>*Italic = Allocated Line Item Expense</b>	<b>Full Year Plan</b>
<b>Salaries and Wages</b>	<b>\$230,000</b>
<b>Fringe Benefits</b>	<b>66,738</b>
<b>Office Supplies</b>	<b>1,667</b>
<b>*<i>Communications</i></b>	<b>11,000</b>
<b>Staff Travel</b>	<b>6,667</b>
<b>* <i>Building</i></b>	<b>32,540</b>
<b>* <i>MIS</i></b>	<b><u>12,918</u></b>
<b>Total Expense</b>	<b>\$361,530</b>

For the 460 report, Finance is considered administration only and program costs are not allocated to other program units.

# Mini-ways ACT Program

The Mini-Ways ACT program is a direct clinical service that bundles all clinical costs associated with serving the consumers enrolled in the program. The ACT personnel costs consist of a psychiatrist, nurse, social workers and in some cases peer or other non-professional supports. Costs for the Mini-Ways ACT Program includes all allocated costs for communications, building, Records and Management Information Systems.

# Mini-ways ACT Program Costs

<b>*Italic = Allocated Line Item Expense</b>	<b>Full Year Plan</b>
<b>Salaries and Wages</b>	<b>\$147,481</b>
<b>Fringe Benefits</b>	<b>62,042</b>
<b>Office Supplies</b>	<b>1,666</b>
<b>*<i>Communications</i></b>	<b>8,250</b>
<b>Staff Travel</b>	<b>6,666</b>
<b>* <i>Building</i></b>	<b>24,405</b>
<b>* <i>MIS</i></b>	<b>7,751</b>
<b>*<i>Records</i></b>	<b><u>10,395</u></b>
<b>Total Expense</b>	<b>\$268,656</b>

ACT costs are considered 100% direct service.

# Mini-ways Contracted Services

<b>Contracted Services</b>	<b>Full Year Plan</b>
Residential Services	9,500,000
Skill Building	1,500,000
Health/Clinical Services	<u>500,000</u>
<b>TOTAL</b>	<b>\$11,500,000</b>

In addition to directly operated services, Miniways purchases services from subcontractors. During "Phase 1" these costs are all counted as Direct Services.

# Mini-ways Prime Subcontractor

<b>Substance Abuse Services</b>	
<b>Administrative Services</b>	<b>\$50,000</b>
<b>Direct Services</b>	<b><u>450,000</u></b>
<b>General Ledger Expense Item</b>	<b>\$500,000</b>

Mini-ways provides Medicaid funding for Substance Abuse Services through the Otherways Substance Abuse Coordinating Agency. Otherways has provided Mini-ways with an estimate of their administrative load based on the DCH 460 model.

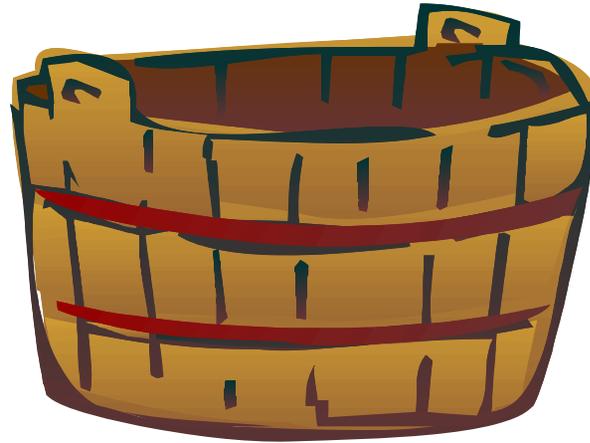
# Mini-ways Summary of Allocations

	Base Cost	Building	Communi- cations	MIS	RECORDS	TOTAL
<b>BUILDING</b>	325,397	(325,397)				0
<b>COMMUNICATIONS</b>	110,000		(110,000)			0
<b>CEO/ Director's Office</b>	716,620	89,484	30,250	28,420		864,774
<b>FINANCE</b>	305,072	32,540	11,000	12,918		361,530
<b>MIS</b>	92,462	8,135	2,750	(103,347)		0
<b>RECORDS</b>	115,657	8,135	2,750	2,584	(129,126)	0
<b>PERSONNEL</b>	67,609	8,135	2,750	2,584		81,078
<b>CLINICAL ADMINISTRATION</b>	361,272	32,540	11,000	10,335		415,147
<b>SUBSTANCE ABUSE C/A</b>	50,000					<u>50,000</u>
<b>TOTAL ADMINISTRATION</b>						1,772,529
<b>CASE MANAGEMENT</b>	626,394	89,483	30,250	28,420	89,045	863,592
<b>OUTPATIENT</b>	328,858	32,540	11,000	10,335	29,686	412,419
<b>ACT</b>	217,855	24,405	8,250	7,751	10,395	268,656
<b>CONTRACTED SERVICES</b>	11,500,000					11,500,000
<b>SUBSTANCE ABUSE C/A</b>	450,000					<u>450,000</u>
<b>TOTAL DIRECT SERVICES</b>						13,494,667
<b>TOTAL EXPENSE</b>	15,267,196	0	0	0	0	15,267,196

# Mini-ways Allocating to Funding Sources



General Fund



Medicaid



Other

# Mini-ways Allocation Results

ALLOCATION OF ADMIN AND DIRECT COSTS BY FUND SOURCE  
SLIDE 2

	TOTAL	MEDICAID	GENERAL FUND	OTHER	CMHSP TOTAL
<b>DIRECT SERVICES</b>					
* 1. Direct Run (Provided) Service - PIHP / CMHSA	1,544,667	1,235,734 80%	231,700 15%	77,233 5%	308,933 20%
2. Prime Sub-Contractors Sub Abuse CA	450,000	450,000 100%	- 0%	- 0%	- 0%
16. Contracted Serv / Other Sub-Contractors	11,500,000	9,200,000 80%	1,400,000 12%	900,000 8%	2,300,000 20%
TOTAL DIRECT SERVICES BY FUNDING SOURCE	13,494,667	10,435,734	1,631,700	977,233	2,608,933
* Indicates the line on the 460 report					

<b>ADMINISTRATIVE COSTS</b>					
1. PIHP / CMHSA Provided:	1,722,529				
Direct Assignment to Funding Source:					
Fee for Service Billing costs	(55,000)			55,000	55,000
Amount to be allocated:	1,667,529	1,334,023 80%	250,129 15%	83,377 5%	333,506 20%
Sub total PIHP /CMHSP Provided:	1,722,529	1,334,023	250,129	138,377	388,506
2. Prime Sub-Contractors	50,000				
Direct Assignment to Funding Source:					
Sub Abuse CA	(50,000)	50,000			
Amount to be allocated:	-	- 100%	- 0%	- 0%	- 0%
Sub total Prime Sub Contractors:	50,000	50,000	-	-	-
16. Other Sub-Contractors	Phase 2				
Direct Assignment to Funding Source:					
Amount to be allocated:					
TOTAL ADMIN COST BY FUNDING SOURCE	1,772,529	1,384,023	250,129	138,377	388,506

# Mini-ways Allocation to Funding Sources

- Direct Service Costs are actual expenses by funding source (i.e. MA, GF, ABW, other) based on consumers eligibility.
- These direct service program totals (i.e. all agency direct service expenditures by funding source) are then used to calculate the percentages to allocate administration when using an accumulated cost method.
- For Direct Services, the breakdown / percent of Medicaid versus General Fund versus Other was calculated for each of the 3 areas indicated: Line 1. Direct Run, Line 2. Prime Sub-Contractor, Line 16. Contracted Service Other Sub-Contractors. When the Administrative Costs were allocated between funding sources, each area was viewed separately. Within each area, those administrative costs that could be directly assigned to a particular funding source were deducted and directly assigned. Then the remaining amount was allocated based on the corresponding percentage calculated in Direct Services for that area.

# Mini-ways Allocation to Funding Sources

- Administrative costs, in this example, have been allocated to funding sources based on the following
  - The costs of billing fee for service (\$55,000), which are included within the Finance department's costs, have been identified as relating entirely to other funding sources. Therefore, these costs have been assigned 100% to the other funding sources.
  - Coordinating Agency administrative costs have been identified as relating entirely to Medicaid covered services. Therefore, these costs have been assigned as 100% Medicaid.
  - The remaining administrative costs cannot be directly assigned to a funding source. Therefore, these costs have been allocated across all funding sources based on actual direct expenditures and an accumulated cost method

**Section 460 Compliance Report**

**Direct Service / Administrative Cost Detail Report for the Prepaid Inpatient Health Plans  
Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Programs**

**PIHP: Mini-ways**

**Fiscal Year: October 1, 2006 September 30, 2007**

**Reporting Period:**  **Six Month Report**     **Annual Report**

(A) Contractor(s)	Medicaid Direct Service			Medicaid Administration			Medicaid Tot	
	(B) PIHP	(C) Prime Sub-Contractors	(D) Sub-Contract Providers	(E) PIHP	(F) Prime Sub-Contractors	(G) Sub-Contract Providers	(H) Total Direct Services	(I) Total Administration
<b>1. PIHP Provided</b>	\$ 1,235,734			\$ 1,334,023			\$ 1,235,734	\$ 1,334,023
<b>2. Prime Sub-Contractor(s)</b>								
3. Sub Abuse CA		450,000			50,000		450,000	50,000
4.							-	-
5.							-	-
6.							-	-
7.							-	-
8.							-	-
9.							-	-
10.							-	-
11.							-	-
12.							-	-
13.							-	-
14.							-	-
<b>15. Sub-Total Prime Sub-Contractor(s)</b>		\$ 450,000			\$ 50,000		\$ 450,000	\$ 50,000
<b>16. Other Sub-Contractor(s)</b>			\$ 9,200,000			Included in Direct for Phase 1	\$ 9,200,000	Included in Direct for Phase 1
<b>17. Total without Quality Assurance Assessment Tax</b>	\$ 1,235,734	\$ 450,000	\$ 9,200,000	\$ 1,334,023	\$ 50,000	Included in Direct for Phase 1	\$ 10,885,734	\$ 1,384,023
<b>18. Quality Assurance Assessment Tax</b>							\$ -	\$ -
<b>19. Total with Quality Assurance Assessment Tax</b>	\$ 1,235,734	\$ 450,000	\$ 9,200,000	\$ 1,334,023	\$ 50,000		\$ 10,885,734	\$ 1,384,023

**Michigan Department of Community Health**

**Section 460 Compliance Report**

**Direct Service / Administrative Cost Detail Report for the Community Mental Health Service Programs**

**Non-Medicaid Managed Mental Health Supports and Services**

**CMHSP: Mini-Ways**

**Fiscal Year: October 1, 2006 to September 30, 2007**

**Reporting Period:**  Six Month Report  Annual Report

(A) Contractor(s)	Non-Medicaid Direct Service			Non-Medicaid Administration			Non-Medicaid Total Costs			
	(B) CMHSP	(C) Contractors	(D) Providers	(E) CMHSP	(F) Contractors	(G) Providers	(H) Services	(I) Total Administration	(J) Total Costs	(K) Admin.
<b>1. CMHSP PROVIDED</b>	\$ 308,893			\$ 388,506			\$ 308,893	\$ 388,506	\$ 697,399	
<b>2. Prime Sub-Contractor(s)</b>										
3.[Name]							-	-	-	
4.							-	-	-	
5.							-	-	-	
6.							-	-	-	
7.							-	-	-	
8.							-	-	-	
9.							-	-	-	
10.							-	-	-	
11.							-	-	-	
12.							-	-	-	
13.							-	-	-	
14.							-	-	-	
<b>15. Sub-Total Prime Sub-Contractor(s)</b>		\$ -			\$ -		\$ -	\$ -	\$ -	
<b>16. Other Sub-Contractor(s)</b>			\$ 2,300,000			included in Direct for Phase 1	\$ 2,300,000	included in Direct for Phase 1	\$ 2,300,000	
<b>17. Total without Local Contribution to State Medicaid Match</b>	\$ 308,893	\$ -	\$ 2,300,000	\$ 388,506	\$ -		\$ 2,608,893	\$ 388,506	\$ 2,997,399	13%
<b>18. Local Contribution to State Medicaid Match</b>							\$ -	\$ -	\$ -	
<b>19. Total with Local Contribution to State Medicaid Match</b>	\$ 308,893	\$ -	\$ 2,300,000	\$ 388,506	\$ -		\$ -	\$ 388,506	\$ 2,997,399	

# Section 460 Cost Allocation Report

## Technical guidance

- **Section 460 of P.A. 154 of 2005 and P.A. 330 of 2006**
- **MICHIGAN DEPARTMENT OF COMMUNITY HEALTH Cost Allocation Requirement for FY'07, report forms, instructions, submission requirements, question and answer document and this power point at [http://www.michigan.gov/mdch/0,1607,7-132-2941\\_38765---,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2941_38765---,00.html)**
- **OMB Circular A-87 at [http://www.whitehouse.gov/omb/circulars/a087/a87\\_2004.html](http://www.whitehouse.gov/omb/circulars/a087/a87_2004.html)**
- **IMPLEMENTATION GUIDE FOR OFFICE OF MANAGEMENT AND BUDGET CIRCULAR A-87 (sample allocation plan in attachment C section 4.6.1) at <http://www.hhs.gov/grantsnet/state/asmbc10.pdf#search=%22A%20guide%20for%20State%2C%20Local%20and%20Indian%20Tribal%20Governments%22>**
- **OMB Circular A-122, Cost Principles for Non-Profit Organizations at [http://www.whitehouse.gov/omb/circulars/a122/a122\\_2004.html](http://www.whitehouse.gov/omb/circulars/a122/a122_2004.html)**

# Section 460 Cost Allocation Report

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