UNIFORM DEFINITIONS, STANDARDS, AND INSTRUCTIONS FOR ADMINISTRATIVE COSTS FOR COORDINATING AGENCIES AND AREA AGENCIES ON AGING

(FY2013 Appropriation Bill - Public Act 200 of 2012)

May 15, 2013

Section 282: (1) The department, through its organizational units responsible for departmental administration, operation, and finance, shall establish uniform definitions, standards, and instructions for the classification, allocation, assignment, calculation, recording, and reporting of administrative costs by the following entities:

(a) Coordinating agencies on substance abuse, and the Salvation Army Harbor Light program that receive payment or reimbursement from funds appropriated under section 104.

(b) Area agencies on aging and local providers that receive payment or reimbursement from funds appropriated under section 117.

(2) By May 15 of the current fiscal year, the department shall provide a written draft of its proposed definitions, standards, and instructions to the House of Representatives and Senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director.

Michigan Department of Community Health

MDCH

Rick Snyder, Governor
James K. Haveman, Director

BUREAU OF SUBSTANCE ABUSE AND ADDICTION SERVICES AND AREA AGENCIES ON AGING

APPROPRIATION ACT SECTION 282(2) REPORT

FISCAL YEAR 2012 ACTIVITIES

Bureau of Substance Abuse and Addiction Services

The Bureau of Substance Abuse and Addiction Services (BSAAS) established uniform definitions, standards, and instructions regarding administrative costs for substance abuse coordinating agencies (CAs) effective starting fiscal year 2006. These were developed by a work group consisting of CA and department staff. Two major considerations were to maintain compliance with the federal Substance Abuse Prevention and Treatment Block Grant requirements, and to become functionally consistent with the department's requirements for mental health agencies.

Late in 2008, BSAAS received notice from the federal Center for Substance Abuse Treatment, the agency that administers the block grant, that CA administrative costs need not be counted against the block grant's 5% cap on annual spending for administration.

BSAAS has not established administrative definitions or standards specifically applicable to subcontractors. Most subcontractors are on purchase of service, fixed-rate contracts, and the bulk of state and federal funds administered by CAs are spent on such contracts. Procurement is based largely on unit costs, quality, and performance, and not on subcontractor administration costs or practices.

Requirements for reporting administrative costs are contained in the annual contract agreement between Michigan Department of Community Health (MDCH)/BSAAS and the CAs. Those requirements are in the following documents: Attachment 1) *Financial Reporting Requirements*, and Attachment 2) *Establishing Administrative Costs Within and Across the Coordinating Agency System*. The requirements include instructions for reporting administrative costs, including Access Management System costs, along with the reporting form. These documents are attached to this report.

Salvation Army Harbor Light (SAHL) is a service provider; as such, their administration costs are part of service delivery. BSAAS reviews the administrative costs requirements periodically.

Area Agencies on Aging

Uniform definitions and instructions for the classification, allocation, assignment, calculation, recording, and reporting of administrative costs by area agencies on aging are in Attachment 3.

Michigan Department of Community Health
Financial Reporting Requirements
Fiscal Year (FY) 2012

The reporting of revenues and expenditures will be accomplished via two avenues. For revenues and expenditures: an initial and a final Revenues and Expenditures Report (RER). For expenditures only: quarterly and final Financial Status Reports (FSRs).

The MDCH must allocate and manage state-administered funds in a way that assures compliance with all federal and state requirements, including SAPT Block Grant expenditure requirements.

Each CA will receive its initial FY allocation letter via EGrAMS. The letter will be available on-line after the initial FY Substance Use Disorder Services (SUDS) Agreement has been published in EGrAMS. Initial SUDS allocations are in compliance with all federal and state requirements at the beginning of the fiscal year.

1. REPORTING REVENUES AND EXPENDITURES

Revenues and Expenditures Report

The main purposes and applications of the RER include the following:

- Display revenue sources and expected amounts, and how these are budgeted at the start of a fiscal year;
- Enable management and monitoring of federal and state spending requirements; and
- Enable reconciliation of prepayments and expenditures on an annual basis.

2. ADMINISTRATIVE BUDGETS AND EXPENDITURES

CA budgets and expenditures for Administration must be reasonable, prudent, and commensurate with meeting the requirements of this Agreement, consistent with 2 CFR Part 225 (previously OMB Circular A-87) or 2 CFR Part 230 (previously OMB Circular A-122), as applicable.

The CA's Access Management System (AMS) is considered an administrative operation, and cannot be a direct service operation. To assure accurate classification of AMS expenditures, and in the interest of reporting consistency, AMS expenditures must be reported separately on the initial and final RER, on Page 3, in the indicated column.

All of the CA's administrative costs must be entered in the General Administration or the AMS column on page 3 of the RER. This includes costs for all CA personnel (Prevention Coordinators, Treatment Coordinators, etc.), information and data systems, financial audits, and other administrative costs.

If the Administration budget contains a central cost allocation amount or rate, this allocation must have been developed consistent with 2 CFR Part 225 (OMB Circular A-87, Attachment C). Payments are subject to recovery, based on audit findings.

When there is a central cost allocation, the CA must also submit via EGrAMS, on CA letterhead, a Certificate of Cost Allocation Plan whenever a central cost allocation is introduced or is revised, or every two years, whichever is sooner. This Certificate of Cost Allocation Plan form is available electronically (in WORD) from the MDCH contract manager or use the format shown below:

(Printed On CA Letterhead)
Certificate of Cost Allocation Plan

This is to certify that I have reviewed the Cost Allocation Plan and to the best of my knowledge and belief:

(1) All costs included in this proposal to establish cost allocations or billings for October 1, 2011 through September 30, 2012 are allowable in accordance with the requirements of 2 CFR Part 225, "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 CFR Part 225 can be found at the following link: http://www.whitehouse.gov/sites/default/files/omb/assets/omb/fedreg/2005/083105_a87.pdf

(2) All costs included in this proposal are properly allocable to Federal awards on the basis of a beneficial or causal relationship between the expenses incurred and the awards 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.

I declare that the foregoing is true and correct.

CA Name: _____

Signature: _____

Name of Official: _____

Title: _____

Date of Execution: _____

This Certificate of Cost Allocation Plan should be used for certification of the CA's Cost Allocation Plan. This form must be signed by the Executive Director or Finance Director of the CA.

3. AMENDMENTS

A. State Agreement Funding Change

When there is either an increase or decrease in the CA's State Agreement allocation, an amendment must be processed via EGrAMS.

B. Allocation Revision Request

An Allocation Revision Request (ARR) is a request to transfer State Agreement funds between allocation categories, during the amendment application process. An ARR may only be used to move funds between Community Grant and Prevention and must not exceed the total State Agreement amount.

To request an ARR, the CA must contact its Contract Manager, via email, with the rationale supporting its ARR. Once the ARR has been approved, the Contract Manager will then initiate the amendment process in EGrAMS.

The MDCH will be receptive to approving ARRs, when 1) the CA can demonstrate that all applicable planning and agreement requirements can be achieved, perhaps through the use of other available resources, for all affected program and budget areas and 2) the MDCH can maintain compliance with federal and state requirements. With regard to redirection of Treatment funds, the CA must be able to demonstrate that treatment needs within the catchment area are fully met and that there is adequate capacity to meet drug court and offender re-entry initiatives as well.

The associated rationale for ARRs that reduce Prevention allocations will be closely monitored by the CA's Contract Manager. The SAPT Block Grant requires states to spend at least 20 percent of these federal funds on Prevention activities.

C. Budget Revisions

A Budget Revision involves moving State Agreement funds between budgets within each allocation category. As an example-- **Community Grant**: General Administration, AMS, Treatment, Women's Specialty, MIChild. A Budget Revision must not exceed the total allocation category or State Agreement amount. A Budget Revision can only be accomplished via an amendment.

ALL AMENDMENTS MUST BE INITIATED BY MDCH STAFF ONLY. CAs CANNOT INITIATE AMENDMENTS IN EGrAMS.

4. REVENUES AND EXPENDITURES REPORT (RER): Initial and Final

The fiscal year initial RER and final RER will be used to provide a standardized format for reporting the financial status of individual programs.

Reporting of revenues and expenditures must be consistent with Generally Accepted Accounting Principles (GAAP).

All amounts entered on the RERs must be whole dollars.

A. Initial RER

The fiscal year initial RER is submitted with the initial, fiscal year SUDS Agreement application in EGrAMS. No State Agreement allocation changes will be allowed during this initial SUDS Agreement processing phase.

In reviewing the fiscal year initial RER, the CA's Contract Manager will assess Local Match compliance, using the Match Computation table provided in Attachment B.1. If at least 10% match is not achieved, the initial SUDS Agreement application will be rejected in EGrAMS. Once the match criteria is met, the initial SUDS Agreement application and initial RER will need to be revised and resubmitted for approval via EGrAMS.

B. Final RER

The fiscal year, final RER is submitted as an 'Attachment' report in EGrAMS. The due date is listed in Attachment C-Required Reports.

Budgets on the final RER must be the same as those presented on the final fiscal year amendment.

All actual expenditures and revenues (including Medicaid, Adult Benefits Waiver [ABW], MI Child, Local, Fees and Collections, and Other Contracts and Sources) for the particular program must be reported on the final RER.

On the final RER, Community Grant expenditures for AMS, Treatment, Women's Specialty Services (WSS), Adult Benefits Waiver (Treatment) and MIChild are fungible, once required targets and match requirements are met.

The CA is granted limited discretion in moving State Agreement expenditures between allocated categories without prior approval by MDCH. Under this discretion, $50,000 is the annual, maximum net change.

In reviewing the fiscal year final RER, the CA's Contract Manager will assess Local Match compliance, using the Match Computation table provided in

Attachment B.1. If at least 10% match is not achieved, the fiscal year final RER will be rejected in EGrAMS, requiring revision and resubmission into EGrAMS.

5. QUARTERLY FINANCIAL STATUS REPORT--SUBMISSION FLEXIBILITY

The Financial Status Report (FSR) is used to provide a standardized format for reporting the financial status of individual programs. All expenditures and revenue for the State Agreement are reported on the FSR.

The FSR must be submitted to the Michigan Department of Community Health, Bureau of Finance through MI E-Grants, no later than the last day of the month following the end of each fiscal quarter. The fourth quarter FSR must be marked as final and is due sixty (60) days after the end of the Agreement.

➢ Deviation Allowance

Within the State Agreement, there are several allocation categories; i.e., Community Grant, Prevention, SDA and FASD.

When completing an FSR in EGrAMS, the system will allow a CA to post expenditures above the budgeted amount for that allocation category. The maximum allowance is $50,000, per allocation category. CAs have this reporting flexibility WITHIN each of the allocation categories but not BETWEEN each of the allocation categories.

As an example, if a CA wants to report $25,000 more in Treatment expenditures than the Treatment budget, EGrAMS will accept this. That would leave $25,000 available for a CA to use within the Community Grant allocation category.

EGrAMS will not allow a CA to exceed the total State Agreement amount. If the expenditures will be greater than the $50,000 Deviation Allowance, the CA will need to contact its Contract Manager and request an amendment to revise the budget(s).

6. NOTICE OF EXCESS OR INSUFFICIENT FUNDS (NEIF)—DUE JUNE 1

Coordinating agencies must notify the Department in writing and upload the notice to EGrAMS by June 1 if the amount of State Agreement funding may not be used in its entirety or appears to be insufficient.

The contract requires that the CA expend all allocated funds per the requirements of the SUD contract within the contract year OR notify the Department via the NEIF that spending by year-end will be less than the amount(s) allocated. This requirement applies to individual allocations, earmarks and to the total CA allocation. Of particular importance are allocations for

Prevention services and Women's Specialty Services (WSS), including the earmarked allocations for the Odyssey programs. The State must closely monitor these expenditures to ensure compliance with the Maintenance of Effort requirement in the federal SAPT Block Grant.

When it has been determined that a CA will not expend all of its allocated, WSS State Agreement funds (including the earmarked allocations for the Odyssey programs), these unspent funds must be returned to the Department for reallocation to other CAs who can appropriately use these funds for WSS programs within their CA regions within the current fiscal year. A CA's failure to expend these funds for the purposes for which they are allocated and/or its failure to notify the Department of projected expenditures at levels less than allocated may result in reduced allocations to the CA in the subsequent contract year.

7. REVENUES

For State Agreement allocation categories, Revenues are as listed in the CA's initial allocation letter and subsequent amendments in EGrAMS. Each CA will receive its initial FY allocation letter via EGrAMS. The letter will be available on-line after the initial FY SUDS Agreement has been published in EGrAMS.

For most other allocation categories, Revenues are estimates. In some cases, the CA may not be planning to expend all fiscal year Revenues.

On the final RER for the fiscal year, revenues and expenditures must be actual. It is understood that, for non-State Agreement allocation categories, total actual expenditures may be less than total Revenues.

8. INITIAL OR FINAL ANNUAL BUDGET PLAN

There are links and formulas within the RER form which will automatically populate all of the Composite Page, except for the Revenues Column (B).

On the final RER for the fiscal year, 1) Revenues and expenditures must be actual; and 2) Budgets must be the same as those presented in the final fiscal year amendment. It is understood that, for non-State Agreement sources, total actual expenditures may be less than total planned budgets.

9. REPORTING FEES AND COLLECTIONS

The MDCH/CA Agreement requires agencies to report actual fees and collections associated with services that the CA purchases. Expected revenues from fees and collections must be reported on the initial fiscal year RER. The final fiscal year RER must report actual revenues.

Some agencies reimburse providers net of co-pay amounts, whether or not the co-pays are actually collected by providers. Please do not report uncollected co-pay revenues. Report only the revenues actually earned.

Food stamp revenue, in conjunction with residency, should be reported in Fees and Collections—Section F on the initial and final RERs.

10. LOCAL MATCH—HOW TO BUDGET FEES/COLLECTIONS AND LOCAL FUNDS

Amounts for Local Match are reported in the initial and final RERs. Please be sure that the amounts entered meet Local Match criteria. The Substance Use Disorders Agreement (Attachment A) clarifies which fees and collections may count toward Local Match.

Please use the following worksheet to assist in computing the CA's Local Match percentage:

Match Computation – Must Be At Least 10%

a. GRAND TOTAL (RER Composite) $_____

b. LESS:

Section B. Medicaid subtotal	$_____
Section C. ABW Gross subtotal	$_____
Section D. MIChild subtotal $	_____
Section G. Other Contracts & Sources (incl. direct Federal) $	_____

c. TOTAL (Subtotal of b.) ($_____)

d. FUNDS SUBJECT TO MATCH (a. minus c.) $_____

e. MATCH FUNDS:

Section E. Local Subtotal $	_____
Section F. Fees & Collections Subtotal $	_____

f. TOTAL MATCH FUNDS (Subtotal of e.) $_____

g. MATCH PERCENTAGE (f/d * 100 = 00.00%) _____%

NOTE: At the beginning of the fiscal year, the CA will use the Annual Budget Plan amounts from Column C of the initial RER, when completing the Match Computation Table.

At the end of the fiscal year, the CA will use final, year-end expenditures from Column D of the RER, when completing the Match Computation Table.

11. MICHILD AND ABW SAVINGS

MIChild savings become Local funds in the fiscal year following the year in which the savings were earned. Savings should be entered in Section E. Local, Row 3-Other Local in the initial and final RER of the fiscal year following the year in which the savings were earned.

The MIChild savings must be expended consistent with requirements in this Agreement, pertaining to State Agreement funds, to support the CA's substance use disorders program.

The ABW savings should be treated according to the CA/Prepaid Inpatient Health Plan(s)' (PIHP) agreement(s).

12. POSTING MEDICAID REVENUES THAT ARE TRANSFERS FROM A PIHP

Some CAs receive increased Medicaid revenues in the form of transfers from a PIHP, usually late in the fiscal year. Assuming these are current year PEPM funds, these revenues and associated expenditures should be entered on the final RER-Composite Page/Revenues Column (B).

13. ADULT BENEFITS WAIVER

A. Withholds of State Share Amounts

ABW per member per month gross payments for ABW SUD will be paid to PIHPs. The state portion of the gross will be calculated as a projection based on an estimate of annual member months per CA. The CA's fiscal year State Agreement allocation will be reduced by this projected amount and then paid to the PIHPs by the Department. The amount of the reduction may be adjusted during the fiscal year, if warranted, based on unanticipated changes in enrollment. The amount of each CA's reduction will be determined by the Department based on:

- the projected annual beneficiary count per county (or city, in the case of Detroit) that is within a CA region and also within a PIHP region, multiplied by
- the state share of the gross rate including use tax, multiplied by
- the PIHP's geographic factor.

B. How to Report ABW Revenues and Expenditures

If the CA has ABW expenditures, if any, in the General Administration (GA) or Access Management System (AMS) categories, these expenditures should be reported in the GA and/or AMS columns on Page 3 of the RER.

For ABW expenditures reported in Section C ABW (gross expenditures), state share does not have to be reflected in the Community Grant row, because the state share is included in the gross.

On Page 4 of the RER, the ABW column label reads "ABW Treatment." This is to clarify that only ABW expenditures for treatment services should be reported in this column, given that there may be ABW expenditures reported also for GA and AMS.

If the CA has expended all of its ABW funds (Gross) received from its PIHP(s) during the fiscal year, the CA may choose to use its Community Grant funds to purchase treatment services for ABW beneficiaries. Those expenditures would be reported on the RER, Page 4, Section A. ABW Treatment column, Community Grant row.

In order to allow for this possible action, each CA must set up a Community Grant/ABW (Treatment) budget during the completion of the initial SUDS application or subsequent amendment application. A minimum budget amount of $1 will suffice and allow EGrAMS to set up a budget associated with a line item for reporting these expenditures on quarterly FSRs and on the final fiscal year RER (Page 4, Section A. ABW [Treatment] column, Community Grant row).

C. How to Report Expenditures for WSS- and ABW-eligible Women

When a woman is eligible for both ABW and WSS funds, the woman's expenditures must be paid for with ABW funds.

Report these expenditures on the RER, page 3, Section C. ABW, Women's Specialty column, Rows 2 and 3—federal and state share respectively. This also applies to the Odyssey House WSS expenditures (see Page 5).

D. Use of State-administered Funds for ABW Enrollees

ABW funds (received from the CA's PIHPs) are first source for all services, both covered and optional, provided to ABW beneficiaries. Other funds provided through the MDCH/CA contract cannot be used for any services to ABW beneficiaries if ABW funds are available. "Available" includes ABW gross revenues (federal share and state share) received and not expended during the previous fiscal year. See the following paragraphs regarding CA/PIHP agreements.

If the CA has NOT been delegated by one or more PIHPs the responsibility to manage the ABW SUD program, the CA is prohibited from using any state-administered funds for covered treatment services to ABW beneficiaries. The CA may use state-administered funds for services that are discretionary under the

ABW program (examples: detoxification, residential), but ONLY if the PIHP(s) has adopted written policy that the PIHP(s) will NOT pay for these services. CAs are prohibited from using state-administered funds when other parties are financially responsible.

If the CA DOES have an agreement with one or more PIHPs, the first source for billing is ABW revenue received from the PIHP(s).

Any unexpended ABW Fund Balance remaining for the fiscal year should be treated according to the CA/PIHP(s)' agreement(s).

14. MIChild

On a monthly basis, MDCH will provide the CA with the federal share of MIChild funds as a per capita payment based upon a Per Enrolled Child Per Month (PECPM) methodology for MIChild covered services. In consideration for accepting the federal funding pushed to the CA, the CA agrees to redirect existing State General fund dollars to match the MIChild federal FMAP funds (Title XXI State Children's Health Insurance Program) and carry out the associated substance use disorder program requirements.

The PECPM rate and the federal fund source are updated, as needed, by the Department on an annual basis or as rates change. The PECPM funding is a per capita payment for medically necessary MIChild-covered services including outpatient, residential and inpatient services as authorized by the CA. If the MIChild capitation is not sufficient to serve the MIChild enrollees, use of state-allocated General Funds is allowed. Federal SAPT Block Grant funds may not be used for inpatient care.

15. EARMARKED FUNDS

Special, earmarked funds will be identified in the CA's initial fiscal year allocation letter and subsequent amendments, as shown in EGrAMS. Earmarked funds may include Odyssey House, Hispanic Services Program, Sacred Heart, or other identified programs. The CA must budget separately these special earmarked funds in the initial fiscal year SUDS Agreement application, the initial RER, subsequent amendments, and the final RER. When it has been determined that a CA will not expend all special, earmarked State Agreement funds (including the earmarked allocations for the Odyssey programs), these unspent funds must be returned to the Department.

If those unspent funds are Odyssey House (WSS) funds, the Department will reallocate the funds to other CAs who can appropriately use these funds for WSS programs within their CA regions within the current fiscal year.

16. WOMEN'S SPECIALTY SERVICES—REQUIRED TARGET

Each CA's Women's Specialty Services (WSS) funds are combined with the Community Grant allocation. For the purpose of assuring statewide compliance with the SAPT Block Grant minimum expenditure requirement for Women's Specialty Services, each CA is given a minimum expenditure target for these services, as stated in its initial fiscal year allocation letter in EGrAMS. All program/services objectives related to Women's Specialty Services remain in place.

The expenditure target can be reached through expenditures of a combination of SAPT Block Grant and state funds (Community Grant), State Disability Assistance, Medicaid state share, and ABW state share for specialty treatment services for eligible individuals. Eligible individuals are pregnant women, primary caregivers with dependent children, or primary caregivers attempting to regain custody of their children. Use of federal and state funds must be consistent with applicable SUDS Agreement requirements.

MDCH extends the five federal requirements to primary caregivers attempting to regain custody of their children or at risk of losing custody of their children due to a substance use disorder. These individuals are a priority service population in Michigan and; therefore, the five federal requirements shall be made available to them.

Attainment of the expenditure target and program/services objectives is a contract performance requirement. The target can be amended by mutual agreement. MDCH will not approve budget revisions or amendments that appear to create risk of failing to meet the Women's Specialty Services Maintenance of Effort.

If an CA reports Medicaid and ABW funds for WSS on the initial and final RERs, the CA must post both Medicaid and ABW federal and state shares for WSS—not just the Medicaid and ABW state shares.

The federal and state Medicaid and ABW Federal Medical Assistance Percentages (FMAP) percentages for each fiscal year will be updated, as needed, by MDCH on an annual basis or as rates change.

As a check, when adding both Medicaid and ABW federal and state shares for WSS (budgets or expenditures), the total amount multiplied by the current-year state or federal Medicaid and ABW FMAP percent must be the amount posted in the CA's RER budget and final RER expenditures.

EXAMPLE:

FUND SOURCE	BUDGET	FINAL EXPENDITURES
B. Medicaid		
1. Current Year PEPM (Federal & State)		
2. Federal share only for WSS	$87,107	$69,383
3. State share only for WSS	$44,594	$35,520
4. Reinvestment Savings		
B. Subtotal	$131,701	$104,903

$131,701 x .3386 = $44,594 (state share for WSS budget)
$104,903 x .3386 = $35,520 (state share for WSS expenditures)

17. PREVENTION ALLOCATION

For FY2012, the Prevention allocation is 100% federal SAPT Block Grant. There are no separate allocations for Tobacco Vendor Education or Non-Synar Tobacco Retailers Inspections. CAs are expected to use their Prevention allocations to meet tobacco-related performance objectives and to accomplish other Prevention plans developed through the Annual Plan Guidelines.

18. SUD TREATMENT ADMINISTRATION MINI REPORT (Bottom of Page 3)

On the bottom of Page 3 is a mini report labeled "SUD Treatment Administration." This report contains links/formulas which automatically populate all three cells. The information provided here is needed by the Department in order to complete the annual SAPT Block Grant application.

19. HOW TO REPORT GENERAL ADMINISTRATION

On Page 3, in Column C, enter expenditures charged to CA General Administration for each of the applicable funding sources (Column A). "Administration" includes the seven administrative functions listed and defined in the document entitled, "Establishing Administrative Costs Within and Across the CA System" (Attachment B.3). General Administration does not include AMS. (See below.)

The Administrative Rules for the Substance Use Disorders Service Program prohibit CAs from providing services. Any activity or function that is carried out within the CA or that is allocated to the CA is considered an administrative activity or function, and expenditures must be reported as such. For example, all CA personnel expenditures for employees and contractors are administrative expenditures, including expenditures for Prevention Coordinators, Treatment Coordinators, and others.

If a CA purchases administrative functions from a vendor or subrecipient, these contractual expenditures must be reported as CA administration. This would include audit services, data reporting functions, building maintenance, and so forth. Refer to the document entitled, "Establishing Administrative Costs Within and Across the CA System" (Attachment B.3). The administrative costs of service providers, whether vendors or subrecipients, are not counted as CA administrative costs.

20. HOW TO REPORT ACCESS MANAGEMENT SYSTEM (AMS)

On Page 3, in Column E, enter expenditures charged to AMS functions for each applicable fund source (Column A). AMS functions are as described in *Treatment Policy #07 – Access Management System*, which may be found in the SUD Services Policy Manual. All AMS functions are administrative. The AMS column (category) can be considered a subcategory of Administration, for RER purposes.

AMS budget and expenditures must be reported in AMS/Column E, whether the functions are carried out within the CA, by another entity, by a contractor, or by a combination of these.

If a CA purchases AMS functions through a contractor, and if the contractor also provides direct services under the contract, expenditures associated with AMS functions are to be reported in AMS/Column E on the RER. Expenditures associated with services are to be reported in the appropriate services category column(s).

21. HOW TO COMPLETE THE MDCH ADMINISTRATION AND SERVICE COORDINATION REPORT

This report has a sub-category of Administration called "Service Coordination." This captures the work and funds that CAs apply to activities that are administrative, but that may engender more direct benefit to the community. Service Coordination does not involve the delivery of direct services. Service Coordination may include activities conducted by CA employees or by contractors, but only includes activities that otherwise would be categorized as administration.

Examples of Service Coordination:

- collaborative planning with community stakeholders;
- work with community coalitions;
- development of new services and supports (such as recovery services);
- developing media campaigns;
- sustaining and expanding promising practices and methods; and

- providing consultation and technical assistance regarding services.

22. DISTRIBUTION

The initial RER (submitted with initial FY EGrAMS application) and final RER (submitted as an attachment in EGrAMS) should be prepared and distributed as follows:

One Copy - An electronic or printed copy of each RER should be retained by CA.

One Copy - Submitted electronically via EGrAMS at **http://egrams-mi.com/dch**.

Submission of the RERs shall be in accordance with the instructions in Attachment C-Required Reports.

23. RETENTION

All RERs should be retained for a period complying with the retention policies established in the SUDS Agreement.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
Final Year-end Reporting

1. FINAL REVENUES AND EXPENDITURES REPORT (RER)

The final RER is due by January 31 following the end of the fiscal year. The form must be marked "FINAL" on the Face Page.

The final RER will be used for final cost settlement purposes.

Budgets on the final RER must be the same as those presented on the final amendment for the year.

Final, year-end expenditures can be more than the corresponding budget, within the $50,000 Discretionary Revision Allowance.

On the final RER, Community Grant expenditures for AMS, Treatment, Women's Specialty Services (WSS), Adult Benefits Waiver (Treatment) and MIChild are fungible, once required targets and match requirements are met.

The CA is granted limited discretion in moving State Agreement funds between allocated categories without prior approval by MDCH. Under this discretion, $50,000 is the annual, maximum net change.

2. RECONCILIATION OF FINAL REPORTS

Financial information must be consistent and reconcile between the following final year-end reports:

a. Legislative Report;

b. Primary Prevention Expenditures by Strategy Report;

c. Revenues and Expenditures Report (Final), including:

1. ABW Year-end Balance Worksheet;
2. MIChild Year-end Balance Worksheet; and
3. Administration and Service Coordination Expenditures Report.

d. Substance Use Disorder Services Entity Inventory Report

The CA is required to liquidate all accounts payable and encumbrances by December 31 (see definitions below).

Exceptions may be granted for one-time obligations that cannot be liquidated within this time period. However, should this be the case, an additional fifteen

(15) days may be provided if a written request for an extension, with the reason why additional time is needed, is submitted by the due date of the final RER. Please submit such requests to the CA's contract manager.

Failure to meet these final reporting deadlines may result in the State's inability to reimburse the full amount of the State's share of the gross expenditures.

In addition to submitting initial and final RERs, other financial information will be requested to assist MDCH in properly closing the State's fiscal year (September 30). This information will help ensure sufficient funds have been reserved by the State to make reimbursement for the Agreement in the State's upcoming fiscal year. The additional financial information required will include an estimate of open commitments and obligations incurred as of September 30, but not yet paid. The MDCH/Accounting Division will provide detailed instructions for reporting additional financial information by mid-August of each year.

3. DEFINITIONS

Accounts Payable - Obligations for goods or services received, which have not been paid for as of the end of the agreement period.

Encumbrances - Commitments at the end of the agreement period related to unperformed (executory) contracts for goods and services.

Note: If an agreement does not end on September 30, it is still necessary to estimate accounts payable as of September 30.

All inquiries regarding financial reporting issues should be directed to the Expenditure Operations Section of the MDCH/Accounting Division.

References:
Michigan Department of Management and Budget
- Guide to State Government (1210.27)
- Year-End Closing Guide

Federal OMB Circular A-102 (Revised & DHHS Common Rule).

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

Establishing Administrative Costs Within and Across the Coordinating Agency (CA) System

December 2010

Table of Contents

Page No.

I. Introduction and Overview

Requirements for reporting coordinating agency (CA) administrative costs are revised based on the findings and recommendations of a 2010 work group consisting of CA and State staff. Revisions focused most heavily on several considerations:

- Reporting must be made consistent with federal and state requirements and with updated interpretations of requirements (such as the clarification that SAPT Block Grant cap on spending for administration being applicable only to the state agency).

- Consistency of cost reporting should be improved, with CAs including and excluding the same cost items. For example, all CAs should include Prevention Coordinator costs as administration.

- Improved consistency of reporting will lead to increased fairness and accountability with respect to administrative costs and comparing costs.

- CAs are prohibited by Administrative Rule (R 325.14213) from providing direct services. So, by implication, CAs costs are all administrative. However, CAs as a group devote considerable resources to developing, creating, and coordinating regional services. They also work at increasing regional support, both material and moral, for Substance Use Disorders (SUD) services and for persons with SUDs and for reducing the costs of SUDs to the communities. While these are nominally administrative costs, CA will have the opportunity to report them as a sub-category of administration called Service Coordination.

II. Reporting Premise and Principles

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

- CA administrative cost reporting is required to be consistent with A-87 principles recognizing that there are various methods by which A-87 compliance may be achieved.

- All organizations have administrative functions (and costs) irrespective of their status as a CA or direct service provider. These functions include: General Management, Financial Management, Information Systems, Provider Network Management, Utilization Management, Customer Services, and Quality Management.

- The methods by which administrative costs are allocated vary by organization.

- Differences in administrative costs are expected in that the CA organizational status varies; Michigan Department of Community Health (MDCH) reporting formats are intended to capture and account for these differences.

- Some CAs are also Community Mental Health Services Program/Prepaid Inpatient Health Plans (CMHSPs/PIHPs) and as such have some costs that are unique to this status.

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

- Provide greater transparency of administrative costs using definitions that are common to health care organizations.

- Provide comparable administrative cost information by fund sources other than Medicaid specialty services.

III. Reporting And Models Of CA-Provider Relationship

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

IV. Administrative Functions

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

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

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

A. GENERAL MANAGEMENT

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

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

Other General Management activities and costs include:

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

B. FINANCIAL MANAGEMENT

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

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

C. INFORMATION SYSTEMS MANAGEMENT

Information Systems (IS) include processes designed to support management, administrative and clinical decisions with the provision of

data and information and to support the accountability and information requirements of funders, regulatory bodies, consumers and communities.

Components include hardware, software, specific applications and their integration, network configuration and connectivity. Telecommunications equipment, software, and management are often included. Information Technology (IT) refers to the hardware and connectivity - including individual workstations, laptops, servers, routers, and management of IS networks. Managing security requirements for access to the network is also included in IT. Information systems also include the development and running of electronic health records.

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

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

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

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

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

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

- MDCH reporting requirements, including the costs of reporting demographic, encounter, cost and performance indicators to MDCH by the CA. Administrative costs in performing reporting requirements may also include the costs associated with data validation and correction.

D. PROVIDER NETWORK MANAGEMENT

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

Provider Network Management consists of the following components:

- **Network Development** - This is the process of identifying consumer services and supports needs and procuring sufficient providers to meet those needs. Activities include: 1) needs assessment; 2) analysis of current network capacity to meet projected need and development of a "gap assessment" which identifies procurement needs; 3) procurement of providers; and 4) development of agreements with alternative payors or related agencies with a goal of coordinating care, such as with Department of Human Services (DHS), Michigan Rehabilitation Services (MRS), nursing homes, and schools.

- **Contract Management** - Activities include: 1) development of provider contract language; 2) negotiation of contracts; 3) monitoring providers for compliance with all aspects of the contract (NOTE – audits of providers' performance included under Quality Management); 4) conducting reviews for evidence of abuse and/or fraud; 5) sanctioning providers through Plans of Compliance or other means; 6) training network providers concerning performance expectations; and 7) managing contracts for consumer services with non–panel providers.

- **Network Policy Development** - This includes development of standards for participation in the provider panel. Operating and performance expectations are also included through this policy development function.

- **Credentialing, Privileging And Primary Source Verification** - These functions may be part of Provider Network Management although frequently carried out by staff participating in Quality Management (QM) or Utilization Management functions. These functions are carried out at both service delivery and administrative levels. The CA must, at least, verify the credentialing done at the service delivery level (direct run and contracted practitioners, contracted provider staff).

E. UTILIZATION MANAGEMENT

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

Utilization Management consists of the following components:

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

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

- **Utilization Management Protocols -** This component is the development and monitoring of clinical and authorization protocols to be used for determining level of care (LOC) and service selection process. This includes protocols for: 1) determination of Medical Necessity, 2) LOC assessments; 3) service intensity or selection criteria; 4) Continuing Stay review; and 5) services requiring specialist review, best practice guidelines.

- **Authorization -** This component is the process of linking LOC and service selection processes to payment processes.

- **Utilization Review -** It should be noted that there may be overlap between UM and Utilization Review (UR). This component provides review/monitoring of individual consumer records, specific provider practices and system trends. Review of activities of the provider

network is included. It may include: 1) review and monitoring to determine appropriate application of guidelines and criteria (LOC, service selection, authorization, best practice); 2) consumer outcomes; 3) over-utilization/under utilization; 4) review of outliers; 5) development of procedures for system-level data review; 6) policy and procedures regarding use of review documents; and 7) documentation and monitoring of UM/UR activities.

F. CUSTOMER SERVICES

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

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

Customer Services consist of the following components:

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

- **Customer Complaint, Grievance And Appeals Processes -** Both formal and informal grievance and appeal mechanisms are coordinated as part of the Customer Services function. This component includes:

  - Investigation and management of informal issues and grievances (Customer Services);
  - investigation and management of all formal grievances, appeals, and complaints, including local dispute resolution (Due Process, Recipient Rights);
  - Administrative Fair Hearings conducted by MDCH; and
  - formal tracking and coordination of Complaint Management processes, across the entire network.

- **Community Benefit -** This component consists of activities directed at the population of the entire service area, or sub-groups of that population, rather than at identified individuals. It includes:

  - community collaborative activities. It focuses on activities designed to promote wellness and Healthy Communities as well as coordinated human services delivery systems of care;
  - provision of specialized educational and informational services to at-risk groups;
  - community emergency and group trauma services;
  - partnership arrangements with community organizations to provide a specialty health service perspective on issues of concern to the general population or sub-groups served by the organization;
  - outreach activities and screening of the general population, or identified sub-groups, for health conditions such as depression, eating disorders, etc.;
  - cross training of, and specialized consultation with, school, jail, police, fire, church and other service personnel;
  - participation in community planning bodies, including the Human Services Coordinating Council, Indian Health Centers and other groups;
  - Jail Diversion; and
  - System of Care initiatives.

G. Quality Management

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

Virtually all service provider organizations have QM programs. Some components of these QM activities are mandated for providers (such as regulatory management or corporate compliance, and accreditation). Unless specifically delegated by the CA or operated in the CA interests, these activities of provider organizations should not be identified as administrative functions or included in the costs.

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

Quality Management consists of the following components:

- **Standard Setting** - This component includes review, analysis and recommendations concerning standards and measurement methodologies in the following areas essential to a continuous, quality improvement orientation:

  - choice of accrediting body;
  - best practice guidelines;
  - assessment tools; and
  - performance expectations for both clinical and management programs

- **Conducting Performance Assessments** - This component includes both routine, periodic performance assessment and specially designed evaluation activities. Performance assessments and evaluations, as used here, are generally analyses of data submitted as part of regular management information requirements or as part of a special study. The results of both periodic and special performance assessments are provided to the CA's leadership team on a regular basis as part of the management decision-making process. Results of selected periodic assessments are made available to consumers and the community.

- **Regulatory Management/Corporate Compliance** - This component includes review of performance and clinical source documents and summary data conducted, or overseen, by CA staff for compliance with regulations of outside bodies, including the State of Michigan, Center for Medicare and Medicaid Services (CMS) and other federal regulatory bodies. Activities include:

  - developing a compliance plan that focuses on regulations dealing with healthcare fraud and abuse;
  - maintaining current inventory of regulations;
  - conducting prevention activities;
  - providing direction to contractors regarding their responsibilities;
  - taking action when non-compliance issues are revealed; and
  - establishing a compliance-friendly environment.

- **Managing Outside Agency Review Processes -** This component includes ensuring that source material is complete and available for reviews by outside bodies, including:

  - Accrediting bodies;
  - MDCH certification reviews and financial audits;
  - External Quality Review (EQR);
  - licensing bodies; and
  - non-MDCH payer audits and reviews: CMS, Auditor General, Office of Inspector General (OIG), etc.

- **Research** – This component consists of research activities, including management of a research committee.

- **Quality Process Facilitation -** This component consists of activities aimed at continuous improvement of the processes by which agency and contractor business is conducted. It includes facilitation of activities related to management processes and technical assistance/facilitation of activities in contract agencies.

- **Provider Education And Training And Quality Management Oversight -** This component includes activities related to ensuring that contractors have and carryout their own quality management plan, as well as ensuring that a Quality Improvement Culture is developed and maintained within all clinical and management arenas.

Area Agencies on Aging
Definition of Administrative Costs

Allowable costs, as defined in the Office of Management and Budget (OMB) Circulars A-87 and A-122, are eligible for reimbursement. The expenditure reports for Allowable costs are submitted on quarterly and final Financial Status Reports (FSR) in either a "Services" category or as "Administration" as defined below:

1. Services are defined as face-to-face activity with a client.
    a. Contracts for client services, such as:
        i. Adult Day Care
        ii. Legal Services
        iii. Elder Abuse
        iv. Long-Term Care Ombudsman/Advocacy
        v. Meals
        vi. Training
        vii. Outreach
        viii. Case Management
    b. Provision of the following services directly by the area agency, if authorized by the Office of Services to the Aging, including required waivers:
        i. Adult Day Care
        ii. Elder Abuse
        iii. Long-Term Care Ombudsman Advocacy
        iv. Meals
        v. Training for clients – presenting classes and workshops
        vi. Outreach
        vii. Transportation, including dispatch-related services
        viii. Case management, including all or an allocated portion of the immediate supervisor, if applicable
    c. Applicable allocated overhead
        i. A portion of the facility occupancy charges (rent, utilities...) if a portion of the facility is dedicated to direct client services – such as the site for Adult Day Care, classrooms, on-site meal programs...
        ii. Information technology, if it is associated with direct services, such as offering computer classes at your location or maintaining client data bases for the delivery of services
        iii. Equipment, if it is associated with direct services
        iv. Supplies, if associated with direct services
2. Administration – all functions and activities that are not "services" as defined above.
    a. Area Agency on Aging Staff
        i. Executive Director

   ii. Management and most supervisory staff, may exclude some or all of the food service manager, case management manager and any other first line supervisor
   iii. Human resources staff
   iv. Budget, finance and accounting staff
   v. Ombudsman – except the direct face-to-face time with a client may be considered a direct service.
   vi. Information technology system staff
b. Miscellaneous expenditures
   i. Facility occupancy charges (rent, utilities...) if the facility is only used for administrative activities
   ii. Advisory boards and councils
   iii. Staff training and conferences related to administrative functions
   iv. Memberships and subscriptions
   v. Indirect charges from local units
   vi. Contracted administrative activities, such as payroll services
c. Applicable allocated overhead
   i. Facility occupancy charges (rent, utilities...) if a portion of the facility is used for direct services in addition to administrative activities, otherwise it is 100% administrative
   ii. Equipment, if a portion of the equipment is used for direct services in addition to administrative activities, otherwise it is 100% administrative
   iii. Supplies, if a portion of the supplies are used for direct services in addition to administrative activities, otherwise it is 100% administrative

The above are not intended to be an all-inclusive listing of all expenditures, but reflect the major categories that define what should be reported as "administrative costs". All allocated costs must be allocated using an applicable, quantifiable allocation basis – i.e., occupancy charges should be allocated using square footage, case management supervisor should be allocated based on quantifiable activities of their subordinates.

Most subcontractors and local providers are on purchase of service, fixed rate contracts and the majority of state and federal funds administered by area agencies on aging are spent on such contracts. Procurement is based largely on unit costs, quality, and performance, and not on subcontractor administrative costs or practices. Thus, 100% of these costs would be considered as "Services".

Area Agency on Aging Standards

The Michigan OSA operating standards for service programs and operating standards for area agencies on aging comprise operating guidelines to be followed

by area agencies on aging in Michigan. State wide operating standards are adopted by the Michigan commission on services to the aging (MCSA). Standards are classified by name, number and a statement for each standard is presented along with its intent. The major reference authority for each standard is identified as a statute, regulation, rule, or CSA policy. Indicators of compliance are required components of area agency operations.

Budgeting Allocation & Assignment

Area Agency on Aging budgets and expenditures for administration must be reasonable, prudent, and commensurate with operating standards and OMB circular A-87 and A-122 as applicable. To assure accurate classification of budgets and for reporting consistency, area agency on aging budgets are submitted on an Annual Implementation Plan (AIP) Grant Budget form. These AIP Grant Budget forms are reviewed for properly allocable awards in accordance with applicable requirements. AIP grant budget amendments are required throughout the fiscal year at designated times to ensure accuracy with increases or decreases to funding amounts. It is a performance requirement that area agencies on aging expense all allocated funds per requirements or notify OSA that spending by year-end will be less than the amounts allocated. This requirement applies to individual allocations and earmarks.

The area agency on aging administration costs are reported on FSR expenditure reports and are reviewed on a quarterly and final basis to ensure that minimum and maximum requirements are being met in addition to on-site fiscal assessments. A closeout process is performed at the end of the year and a compliance statement is issued.