MILLIMAN CLIENT REPORT

PIHP and CMHSP Standard Cost Allocation Methodology

REVISED DRAFT

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I. Background

Milliman, Inc. (Milliman) has been retained by the State of Michigan, Department of Health and Human Services (MDHHS) to provide actuarial and consulting services related to the development of a behavioral health fee schedule for its behavioral health managed care program. The impetus behind this project, among other objectives, was to better understand the observed variation in benefit cost and administrative expenses reported by the ten prepaid inpatient health plans (PIHPs) responsible for managing the care of the behavioral health managed care program enrollees. To manage this benefit, the PIHPs contract with forty-six Community Mental Health Service Programs (CMHSPs) who often provide direct services to individuals (referred to herein as "direct-run services"), contract with network providers for service provision, and provide managed care administrative services.

One of the key observations identified from this project was that the differences in cost allocation methods employed by the CMHSPs may be significantly contributing to the variation in reported benefit unit cost and administrative expenses. These cost allocation methodology differences make it difficult to understand the actual variation in resources required to provide these benefits, particularly when the services are provided directly by a CMHSP (i.e., direct-run services), and when compared to the cost of services provided by contracted network providers. To support the development of a process for better consistency in cost allocation within the context of state and federal regulations, MDHHS convened a Standard Cost Allocation (SCA) Workgroup, which is being led by representatives of the CMHSPs. The purpose of this workgroup is to develop a standard cost allocation methodology and reporting tool that can be utilized by the CMHSPs and PIHPs to calculate and report the unit costs for services separately for CMHSP direct-run services and services delivered by contracted network providers. The SCA Workgroup is made up of financial officers of CMHSPs and PIHPs and representatives of MDHHS and Milliman.

As discussions with the SCA Workgroup progressed, it is clear that one of the key issues affecting the current unit cost reporting is inconsistency in the approach to report provider administrative costs versus other administrative costs, including both managed care administration and administration associated with the Michigan's Mental Health Code. Given this, the standard cost allocation methodology developed by the SCA Workgroup and outlined in this report provides guidance to the CMHSPs and PIHPs to achieve greater consistency in reporting provider administration versus other administration.

For purposes of this report, the term "cost" is used synonymously with the term "expense," a term that is defined in Generally Accepted Accounting Principles (GAAP). Under GAAP, expenses are recognized as actual or expected cash outflows that have or will eventually occur as a result of the entity's ongoing operations.[1] The methodology described herein is not to establish estimates of expenses (or costs) – rather, it is to establish a standard approach to allocating GAAP defined expenses incurred by the CMHSPs and PIHPs in providing the services and performing the administrative functions that are necessary under the behavioral health managed care program. Additionally, an outcome of this standard cost allocation methodology will be to support future PIHP Medicaid medical loss ratio (MLR) reporting required by the federal government as well as the Encounter Quality Initiative (EQI) reporting.

The purpose of this document is to summarize the standard cost allocation methodology developed by the SCA Workgroup, including definitions and foundational elements underlying the cost allocation framework. MDHHS, the SCA Workgroup, and Milliman have worked together since late 2019 to develop this information, which will form the basis for the standard cost allocation reporting requirement beginning October 2021. For additional background on the broader fee schedule project, please refer to the correspondence entitled *Behavioral Health Fee Schedule Development - Project Status* dated June 17, 2020.

[1] Financial Accounting Standards Board (FASB), Statement of Financial Accounting Concepts (SFAC) No. 6, Elements of Financial Statements

II. Executive Summary

Michigan's PIHP and CMHSP behavioral health entities currently employ a range of allowable cost allocation methodologies to calculate and report the unit cost of providing services. The SCA Workgroup has confirmed through analysis and discussion that the differences in cost allocation methodologies have contributed to significant variation in reported unit cost. The primary objectives of the SCA Workgroup in crafting the proposed standard cost allocation framework outlined in this report are to create greater consistency in reporting and to provide the ability to understand and explain future variation in the cost of providing these services.

Given these objectives, the SCA Workgroup has agreed that it will be necessary to find an appropriate balance between attaining a certain level of precision that may be attainable by some CMHSPs in exchange for more consistency in reporting across CMHSPs. For example, certain expenses, such as health insurance, can vary significantly by employee within a CMHSP. Instead of allowing these differences to persist across each CMHSP cost center and ultimately to the reported unit service cost, the SCA Workgroup proposes to allocate total health insurance costs evenly to all individuals who qualify for health insurance. Certain types of costs, like employee health insurance expenses, may be different at the service level depending on the circumstances of and decisions made by the employees providing those services. At the same time, variations created by differences in employee enrollment in different health insurance options may not be indicative of the differences in the resources required to provide services. As such, for purposes of allocating certain types of expenses, such as health insurance expenses, the SCA Workgroup proposes to apply broader allocation bases for purposes of a more uniform allocation across all services that benefit from the expense.

The remainder of this document outlines the standard cost allocation methodology, which comprises the following steps summarized below and explained in detail in Section III.

1. **Summarize adjusted trial balance for reporting period** – the summarized adjusted trial balance will require alignment and assignment of most expenses into standard expense categories, which in turn will be either directly assigned or allocated to standard cost centers, depending on the type of expenditure. The standard expense categories and cost centers represent the minimum level of detail required to be retained by the CMHSP. CMHSPs may retain additional levels of detail so long as that detail can be rolled-up into the prescribed standard categories. Some CMHSPs may "crosswalk" their entity's adjusted trial balance expense amounts to the pre-established standard expense categories and cost centers, retaining their CMHSP-specific detail, while other CMHSPS may make modifications to their internal accounting systems through updates to their standard chart of accounts and payroll systems for purposes of better aligning with the standard expense categories and cost centers.

   For example, Outpatient services is one of the standard clinical cost centers. If a CMHSP incurs clinical salaries and wages expenses for Outpatient services in multiple locations and wants to retain location splits for those Outpatient services for internal accounting purposes, the CMHSP can maintain its general ledger at a more granular level. However, for purposes of the standard cost allocation methodology, the assignment of the clinical salaries and wages for all Outpatient service locations must be rolled up to the single Outpatient standard cost center for consistency.

   The expenses recorded in the adjusted trial balance for each reporting period should include expenses associated with services funded by all payers and represent the ***gross*** cost of providing services (as opposed to the ***net*** cost).

   For contracted network provider services, Expense Category 10, there are no required clinical cost centers (although the cost centers for direct-run services may be used). The Service UNC tab should reflect what is included within the encounter data (i.e. so that entities can summarize their data warehouse to populate) for both fee-for-service (FFS) and non-FFS contracts. Additional reporting will be required in the EQI for non-FFS contracts to document the difference between the amount paid and included in encounters relative to the actual cost incurred for services at the provider and procedure code level.

As CMHSPs work through their trial balance to assign expenses, there may be items that do not fit into a single category. The SCA Workgroup is available to provide technical assistance to CMHSPs as needed.

2. **Direct assignment or standard allocation of expenses to standard cost centers** – for each reporting period, all adjusted trial balance expense amounts will either be directly assigned to standard cost centers (i.e. the general ledger account will map directly to the standard cost center to which the expense should be assigned) or allocated to the standard cost centers. If expenses in a standard expense category are being allocated, a prescribed basis for allocating expenses to the standard cost centers will be applied. In some instances, expenses are first accumulated into a Direct Allocation cost center as an interim step before being allocated to standard cost centers.

3. **Assignment of accumulated non-encounterable costs** – Following the direct assignment or allocation of the expense amounts in the expense categories to the standard cost centers, the next step in the methodology is to assign amounts that have been accumulated in non-encounterable cost centers to one of five prescribed administrative cost categories. From there, depending on the administrative cost category, accumulated amounts are further allocated to other clinical or administrative cost centers, as with business operations expenditures, or assigned to non-service-related functions, such as managed care administration. The assignment of non-encounterable standard cost center amounts to the five administrative cost categories is based on the administrative functions supported by the expenditures captured in the cost centers, consistent with state and federal rules regarding clinical and administrative cost reporting.

   Non-encounterable costs will not be allocated to contracted network provider services as part of the SCA methodology. It should also be noted that any revenues generated by the provision of administrative services to entities outside of the PIHP/CMHSP will be used to offset the expenditures that should be assigned to any of the five administrative categories.

4. **Summarize direct-run clinical costs** – Expenses that are directly assigned or allocated are accumulated in the CMHSP direct-run clinical cost centers. The expenses are separated into the following components, which align with the independent rate models used to develop the behavioral health fee schedule:

   - Direct Staff Salaries & Wages
   - Employee Related Expenses
   - Supervisory Expenses
   - Transportation
   - Program Support
   - Provider Admin

   This step of the process also requires the CMHSPs to input the total clinical direct minutes associated with each cost center. The composite cost per minute is calculated as the total accumulated expenses for each cost center divided by the respective total clinical direct minutes.

5. **Apply provider group weighted cost per minute method to allocate pooled direct-run clinical cost center total costs to individual services** – This allocation step will be based on the total number of "weighted" direct minutes of service provided by the clinical staff attributable to each clinical cost center. Weighted minutes will be the actual direct minutes reported for the services attributable to the cost center (from Step 4), adjusted to reflect the wage differences for specified cohorts of clinical staff (referred to herein as "provider groups") that provide the services. In other words, this step takes the composite cost per direct minute for each cost center captured in the previous step, and applies a weighting based on the average total compensation of the provider groups performing services within the cost center. This step requires establishing standard weights for each provider group, which represents the total compensation, as well as identification of the provider group on the encounter using modifiers. **This method allows for services performed by a psychiatrist within a med clinic to have a higher unit cost than services performed by a nurse within that same med clinic without having separate cost centers for each provider group**.

6. **Reporting the network provider cost of providing clinical services** – reporting of network provider costs under the standard cost allocation methodology will reflect solely what is paid to the network provider to perform the services. Federal regulations prohibit CMHSPs from layering administrative costs onto network provider costs to perform the services. All administrative expenses incurred by the CMHSP will be identified as CMHSP direct-run provider administration or other administrative costs not included within network provider service unit cost. *Section III.3.c Accounting for offsetting revenues* describes the proposed approach, which will require CMHSPs to pay network providers for functions that the CMHSP may perform, and then "chargeback" the functions being performed for network providers. For purposes of this step, actual expenditures for network provider services, net of any offsets, should be directly assigned to each type of service.
7. **Reduce gross costs for coordination of benefits –** the final step of the standard cost allocation methodology is to determine the ***net*** cost associated with the Medicaid and General Fund behavioral health programs for both CMHSP direct-run and network provider clinical services. The coordination of benefits should be retained within each CMHSPs and PIHPs data warehouse at the individual claim level, separately for CMHSP direct-run and network provider clinical services.

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III. Standard Cost Allocation Methodology

1. CREATION OF SUMMARIZED TRAIL BALANCE

This section is split into the following sub-sections, which provide information to support the creation of the summarized trial balance:

- Defining standard expense categories and cost centers
- Determination of employee, CMHSP contractual staff, or network provider
- Threshold for documenting administrative time in cost centers
- Ability to retain CMHSP-specific granularity among expense categories and cost centers
- Contracted network provider services

a. Defining standard expense categories and cost centers

To successfully report costs using the standardized cost allocation methodology and template, it will be necessary for the CMHSPs and PIHPs to be able to accurately "crosswalk" their entity's adjusted trial balance expense amounts to a pre-established set of standard expense categories for each reporting period. From there, the expenses are then either directly assigned or allocated (using a prescribed allocation basis) to a pre-established set of standard cost centers. This new process may prompt some CMHSPs or PIHPs to make modifications to their internal accounting systems through updates to their standard chart of accounts and payroll systems for purposes of better aligning their adjusted trial balance expense amounts to simplify the reporting process under the new cost allocation methodology in future periods.

For example, one of the Standard Expense Categories – *Salaries and Wages, Clinical Direct Service Staff* - will be used to group all salaries and wages paid to employees whose primary responsibility is to provide direct "individual facing" services and supports to individuals receiving services. If an entity's accounting records do not separately identify salaries and wages paid to clinical direct service staff from the salaries and wages paid to administrative staff, it will be necessary to either manually split these expenses to be able to properly report them in the cost allocation template, or to update their accounting systems (e.g., standard chart of accounts and payroll system interface) so as to avoid a manual process each year. **The expectation for non-service-related (e.g. training and conference time, internal administrative meetings, etc.) time is that it gets spread to cost centers in proportion to service-related time spent**. We understand this will vary in implementation by CMHSP, depending on existing systems and processes.

All trial balance expense amounts should crosswalk to the set of standard expense categories, including those expenses attributable to the Certified Community Behavioral Health Clinic (CCBHC) demonstration and other special projects and grants. As CCBHC services are a subset of CMHSP services, no additional cost centers or expense categories are necessary.

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Figure 1 provides the list of expense categories to be used for the standard cost allocation methodology. The standard expense category definitions and examples to be included within each category are provided in Appendix 1.

FIGURE 1: LIST OF STANDARD EXPENSE CATEGORIES

STANDARD EXPENSE CATEGORY CODE	STANDARD EXPENSE CATEGORY DESCRIPTION
01	Salaries and Wages, Clinical Direct Service Staff
02	Salaries and Wages, Service Support Staff
03	Salaries and Wages, Clinical First- and Second- Line Supervision
04	Compensation, Contractual Clinical Direct Service Staff
05	Compensation, Contractual Clinical First- and Second- Line Supervision
06	Salaries and Wages, Administration
07	Federal and State Payroll Taxes and Fees
08	Employee Insurance and Other Fringe Expenses
09	Pension and Retirement Expenses
10	Network Provider Services, Clinical
11	Contracted Services, Administrative
12	Contracted Services, Other
13	Board of Directors Expenses
14	Travel Expenses, Client-related
15	Travel Expenses, Administrative
16	Clinical Program and Support Expenses
17	Facility and Equipment-Related Expenses
18	Vehicle Expenses
19	Other Expenses
20	Wages Paid to Individuals Receiving Services
21	Offsetting Revenues

Once expenses have been "mapped" to the Standard Expense Categories, they will then need to be either directly assigned or allocated to Standard Cost Centers. There are four broad categories of Standard Cost Centers, which are:

1. **Direct-run Clinical Cost Centers** – this category comprises 28 different cost centers intended to capture expenses incurred in the provision of service groupings. Service groupings are defined as groups of current procedural terminology (CPT) codes for services such as licensed residential, autism, and assertive community treatment (ACT). Appendix 2 provides a complete list of the 28 direct-run clinical cost centers and the corresponding CPT codes that should be used to map expenditures to each cost center. In some cases, the direct-run clinical cost center applicable for a given service is dependent on the provider group modifier rendering the service. This additional granularity was incorporated into the methodology in order to limit the number of cost centers that employees were required to track their direct and indirect time within.

2. **Non-encounterable Cost Centers** – this category includes 17 different cost centers intended to capture expenses incurred generally for administrative functions, such as Finance, General Administration, Grants, Utilization Management, and Fraud, Waste and Abuse. Each of these cost centers is described in more detail in the paragraphs below.

3. **Direct Allocation Cost Centers –** this category includes 4 different cost centers used to directly allocate costs from first- and second-line supervisors, facilities and equipment, salaries and wages for support staff, and vehicles. Expenses will be allocated to the direct-run clinical cost centers. Other than supervision, the other three cost centers can either be directly assigned (if the allocation is built into the CMHSPs accounting records) or the SCA model can be used to directly allocate expenses. If using the SCA model, these expense categories will be fully pooled into the cost center and then allocated based on the prescribed methodology.

4. **Excluded Service Cost Centers** – This category comprises three different cost centers intended to capture expenditures related to items or services that are not considered allowable under Medicaid regulations, including:

    - **Room and board expenditures**, which are all client-related facility and facility maintenance incurred for residential settings, client meals, and other personal expenses. Room and board expenditures are not allowable expenses for purposes claiming federal financial participation for Medicaid programs.

    - **Wages paid to individuals** that are receiving behavioral health benefits as part of their service plan, if they represent a subsidy or are intended to encourage an employer to hire the individual. For example, payments that are made to an employer to encourage or subsidize the employer's hiring of an individual receiving supported employment services, such as paying all or a portion of a wage rate for an individual employed in the community, is not considered an allowable cost under Medicaid programs.

    - **Other expenses not allowed under Medicaid regulations** – includes any other costs based on federal Medicaid regulations are the not considered reasonable costs necessary to provide services to individuals eligible for the approved federal Medicaid waivers. Determinations of allowable costs must be consistent with 2 CFR § 200, and in principal, the term "reasonable" relates to the prudent and cost-conscious buyer concept that purchasers of services will seek to economize and minimize costs whenever possible. The term "necessary" relates to the necessity of the service. To be "necessary", it must be a required element for providing care to individuals as specified by the approved federal waivers.

    Note that expenses assigned to these excluded service cost centers will not be allocated further as part of the cost allocation methodology process.

Non-encounterable cost centers are used to capture expenses incurred by the PIHPs and CMHSPs related to the services that are not encounterable, high-level administrative functions, or groups of non-benefit activities. These cost centers are used when an employee's time does not directly support the direct provision of a clinical service. After non-encounterable expenses are accumulated in these cost centers, they will be allocated to either clinical services, managed care administration, or other administrative cost categories depending on the nature of the expenditures.

These non-encounterable cost centers comprise expenditures related to the typical administrative functions PIHPs and CMHSPs perform to fulfill their contractual obligations and are defined below.

Access Center – activities that support a beneficiary's initial access to supports and services as defined in MDHHS' policy on Access System Standards. Activities include welcoming through Access Centers, screening for crises, priority population management, determining coverage eligibility for public mental health or substance abuse treatment services, collecting information to reduce duplication of screening and assessments, making referrals to PIHP or CMHSP practitioners, making referrals to community resources outside the PIHP/CMHSP system, informing individuals of their rights, services and providers available, and administrative oversight responsibilities. Verification of coverage by providers at the point of care is considered a "front desk" function that would be allocated to general administration.

Care Coordination – activities to organize and manage beneficiary care, ensure each beneficiary has an ongoing source of care appropriate to his or her needs, and share information among all participants concerned with beneficiary care, including:

- Care management and coordination of services not encounterable as targeted case management
- Referrals, screening, and assessments

    - Fidelity assurance for the Supports Intensity Scale (SIS), Level of Care Utilization System (LOCUS), and SUD assessments
- Collaboration with Medical Health Plans (MHPs) to integrate physical health and behavioral health services
- Coordination of services provided by community and social support providers
- Linking beneficiaries to local community resources and social supports
- Person-centered planning process. As contracted network providers, the non-encounterable time of Independent Facilitators should be added to the cost of the services and included with the direct-run cost centers.

Customer Service – activities that provide information on the services and benefits available, how to access these services, and the various rights processes. Specific activities include:

- Customer Services Unit including customer service telephone line
- Customer Services Handbook
- Contractor website
- Translation and interpretation services
- Member education and outreach
- Other written and oral beneficiary materials and information

Finance – processes for managing revenues and expenditures in order to provide accountability, maximize financial resources, and maintain fiscal integrity. Components include:

- Budgeting, general accounting, and financial reporting
- Accounting
- Billing and collection
- 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
- Audits
- Third party liability

General Administration – functions necessary to manage and maintain business operations of the entity, including but not limited to:

- Executive leadership
- Office supplies
- Marketing
- Administrative support staff
- Accreditation expenses, dues, and memberships
- Telephone and other communications expenses
- Corporate compliance
- Legal expenses

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Grants – activities to support grants, applications, and other contractual obligations outside of the Mental Health Code and MDHHS required functions. Examples include grant manager salary and wages and other payer business activities.

Human Resources – a function that identifies, recruits, screens, hires, and trains personnel, as well as administers employee-benefit programs and employee relations.

Information Technology – health plan information technology functions including health information systems to collect, analyze, integrate, and report data. This includes processes designed to support management, administrative, and clinical decisions with the provision of data.

- Individual service record system
- Data collection
- Security and privacy
- User technical support

Mental Health Code/CMHSP Only Activities – non-encounterable obligations of the Michigan Mental Health Code (MHC), corresponding administrative rules, and the MDHHS-CMHSP Managed Mental Health Supports and Services contract to provide the behavioral health and disability services safety net. This cost center only reflects contract requirements that are unique to the CMHSP and are not required by other payers (i.e. not included as clinical services or in shared managed care administration). Additionally, this cost center only reflects CMHSP functions that are not encounterable services (i.e. 24-hour crisis and pre-admission screening costs are assumed to be included in the Crisis service cost center). Examples of these non-encounterable services are outlined below. For the full list of requirements, please see Appendix 3, "CMHSP Duties in Mental Health Code Corresponding Rules and CMHSP Contract."

- Administrative and operations
    - Mediation and dispute resolution
    - Creation of interagency agreements
    - Annual plan and needs assessments
    - Establish and maintain waiting lists
- Services for the community
    - Recipient rights process, including cost of trainers but excluding staff time receiving training which is charged to their direct service cost center
    - Advocacy activities
    - Family support subsidy
    - Prevention activities
- Services for medical institutions
    - Pre-release and post-release plans from hospitalizations
    - Coordination with hospitals for treatment
- School-to-community transition services
- Services for the Criminal Justice System
    - Jail diversion
    - Preparation of Court assessment reports
    - Petition for assisted outpatient treatment
    - Provide treatment recommendations for courts or serve individuals who are required by a court to receive outpatient treatment
    - Informed consent board
    - Emergency guardianship; guardianship appointment

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Other Managed Care Administration – any another responsibility identified in the MDHHS-PIHP contract not identified in another non-encounterable cost center. Examples include:

- Claims adjudication/processing (both IT system and CMHSP/PIHP staff)
- Beneficiary grievance and appeals
- Beneficiary surveys
- Encounter data

Provider Network – activities to maintain and continually evaluate an effective provider network adequate to fulfill contract obligations. Specific activities include:

- Provider communication (Provider dedicated call lines, provider newsletter, provider portal, etc.)
- Provider grievance and appeals process
- Provider directory
- Network development
- Contract management
- Access and availability monitoring, including linguistic and cultural competence
- Network provider credentialing

Utilization Management – activities to control costs and minimize risk while assuring quality care and appropriate clinical service delivery.

- Development and application of Clinical Practice Guidelines, Clinical Coverage Policies, and Authorization Protocols
- Prior authorization
- Utilization review

Other Healthcare Quality Improvement Activities – activities that support ensuring 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.

- Quality Assessment Performance Improvement Program (QAPI)
- Standard setting
- Conducting performance assessments
- Performance improvement projects
- External quality review

Fraud, Waste, and Abuse – activities related to program integrity, efforts to prevent and detect fraud, waste, and abuse, provider screening, and subcontractor disclosures. Included activities are provisions for internal monitoring and auditing including post-payment reviews, and record reviews.

Trainers Net Expense – Expenses related to training programs, including salaries and wages of trainers and training development personnel, and out-of-pocket training materials and programs. Note that to the extent that revenues are earned by trainers or training departments for programs provided to outside individuals or entities, expenses should be offset by revenues earned or received. The trainers' costs for training on activities required under the Mental Health Code should be mapped to the Mental Health Code non-encounterable cost center.

Medical Records – Time and expenses for the administrative work to organize and manage the medical records, e.g. release of records tracking, incorporation of external documents (i.e., external specialist records/test reports), chart archival/retrieval (for paper charts), etc.

Self-Directed Administration – activities that support a person's participation in their self-directed care arrangements including but not limited to providing information on principles of self-determination, ensuring service planning and delivery processes support self-determination, maintaining networks for provider choice, providing fiscal responsibility and accountability for public fund use, assisting with provider selection, supporting budget development

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by providing applicable rate ranges and budget maximums, authorizing budget agreements, supporting resource allocation according to individual budget, managing conflicts of interest, and selecting and making available qualified third-party entities to serve as fiscal intermediaries.

Supervision – Time and expenses for first- and second- line supervisors in the oversight and management of directly reporting ***clinical*** staff. Supervisory staff are those primarily responsible for supervising, hiring, and training the clinical staff that actually provide the billable services. Supervisor responsibilities may also include program planning and evaluation, advocacy, working with families, performance management and discipline, and working with community members.

b. Determination of employee, CMHSP contractual staff, or network provider

CMHSPs will be required to determine whether each individual rendering clinical services or acting in a supervisory capacity is an employee of the CMHSP, contractual staff of the CMHSP, or covered under a network provider agreement. Depending on which determination is made, the expenses associated with that individual will captured within different Standard Expense Categories. The following defines each of these three options and provides the Standard Expense Categories associated with each:

CMHSP employee: an employee is a person employed by the CMHSP receiving a salary or wage and a W-2 for tax purposes, and where the work performed by the person is under the control of the CMHSP (i.e., how and where the work is done). Clinical direct service staff and clinical supervisors who are employees of the CMHSP should have their expenses captured in either *Salaries and Wages, Clinical Direct Service Staff* or *Salaries and Wages, Clinical Supervision Staff*.

CMHSP contractual staff: CMHSP contractual staff are not W-2 employees of the CMHSP, but they also do not have a network provider agreement. The following provides guidance regarding whether these contractual staff can be considered "employees" for purposes of reporting, or whether the CMHSP needs to have a network provider agreement with the contractual staff. Clinical direct service staff and clinical supervisors who are contractual staff of the CMHSP should have their expenses captured in either *Compensation, Contractual Clinical Direct Service Staff* or *Compensation, Contractual Clinical Supervision Staff*.

To determine if a provider without a network provider agreement can be considered an employee of the CMHSP for purposes of the standard cost allocation methodology, EQI reporting, and MLR reporting, the provider must:

1) Use the CMHSP NPI number for billing/encounter submission, and
2) Perform work under the control and direction of the CMHSP, i.e., what will be done and how it will be done.

Relationships where the provider does not use the CMHSP NPI number, or the CMHSP has the right to control and direct only the result of the provider's work (i.e., not what will be done and how it will be done) would be indicative of an network provider relationship.

Network provider: any provider, group of providers, or entity that has a network provider agreement with a PIHP or CMHSP, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with the PIHP and/or CMHSP. A network provider is not a subcontractor by virtue of the network provider agreement. Clinical direct service staff and clinical supervisors who are employed by a network provider should be represented in the costs underlying the reimbursement paid by the CMHSP or PIHP to the network provider for rendering covered services. These expenses are captured in the *Network Provider Services, Clinical* expense category.

c. Threshold for documenting administrative time in cost centers

The costs in standard expense category *Salaries and Wages, Administration* are directly assigned to the non-encounterable cost centers. Some PIHP/CMHSP employees may be dedicated to one administrative function and all their salaries and wages will be directly assigned to the corresponding non-encounterable cost center. Other employees may support multiple administrative functions (or even have a mix of clinical and administrative

responsibilities), which will require their salaries and wages to be assigned to the appropriate cost centers as a percentage of time spent performing the different activities. Activities that account for five percent or less of an employee's total time are not required to be tracked or assigned to non-encounterable cost centers to focus efforts on splitting time associated with significant roles and responsibilities. Leaders of administrative staff should allocate their time based on the activities they directly perform as individuals, not based on the supervised staff's actual time allocation.

d. Ability to retain CMHSP-specific granularity among expense categories and cost centers

The standard expense categories and cost centers represent the minimum level of detail required to be retained by the CMHSP. CMHSPs may retain additional level of detail so long as that detail can be rolled up in a way that will allow direct mapping to the standard categories.

For example, Outpatient services is one of the standard clinical cost centers. If a CMHSP incurs clinical salaries and wages expenses for Outpatient services in multiple locations and wants to retain location splits for those Outpatient services for internal accounting purposes, the CMHSP can maintain its general ledger at a more granular level. However, for purposes of the standard cost allocation methodology, the assignment of the clinical salaries and wages for all Outpatient service locations must be rolled up to the single Outpatient standard cost center for consistency.

e. Contracted network provider services

For contracted network provider services, Expense Category 10, there are no required clinical cost centers (although the cost centers for direct-run services may be used). The Service UNC tab should reflect what is included within the encounter data (i.e. so that entities can summarize their data warehouse to populate) for both fee-for-service (FFS) and non-FFS contracts. This change will allow for MDHHS to have a better understanding of costs reported in the encounter data relative to the total cost of providing behavioral health services and key drivers of differences. A separate tab in the EQI template will be created to capture all adjustments to expenditures for non-FFS contract arrangements, including documentation of the contract type, the information included in encounters, and the actual expenditures incurred. There will be a separate row for each provider and procedure code. CMHSPs will need to begin collecting start/stop times for contracted services to support this reporting beginning 10/1/2022.

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2. DIRECT ASSIGNMENT OR STANDARD ALLOCATION OF EXPENSES TO STANDARD COST CENTERS

Figure 2 provides the basis for assigning the expenses in each standard expense categories to the standard cost centers. If the allocation basis shown below indicates a direct assignment of the expenses to one or more standard cost center, the related general ledger accounts will have to be set up in a way that will accommodate the direct mapping of adjusted trial balance expenses from each general ledger account in its entirety to the appropriate standard cost center.

FIGURE 2: ALLOCATION BASIS FOR EACH STANDARD EXPENSE CATEGORY

CODE	STANDARD EXPENSE CATEGORY DESCRIPTION	EXPENSE CATEGORY ALLOCATION BASIS
01	Salaries and Wages, Clinical Direct Service Staff	Direct assignment to DR clinical or excluded service cost center
02	Salaries and Wages, Service Support Staff	Allocated to cost centers based on S&W of selected cost centers **OR** direct assignment to DR clinical or excluded service cost center
03	Salaries and Wages, Clinical First- and Second- Line Supervision	Direct allocation to supervisor cost center
04	Compensation, Contractual Clinical Direct Service Staff	Direct assignment to DR clinical or excluded service cost center
05	Compensation, Contractual Clinical First- and Second- Line Supervision	Direct allocation to supervisor cost center
06	Salaries and Wages, Administration	Direct assignment to non-encounterable or excluded service cost center
07	Federal and State Payroll Taxes and Fees	Allocated to cost centers based on Salaries and Wages (this cost center is allocated, but required to be included within the trial balance)
08	Employee Insurance Expenses	Allocated to cost centers based on Salaries and Wages
09	Pension and Retirement Expenses	Allocated to cost centers based on Salaries and Wages
10	Network Provider Services, Clinical	Direct assignment to service code on Service UNC
11	Contracted Services, Administrative	Direct assignment to non-encounterable or excluded service cost center
12	Contracted Services, Other	Direct assignment to non-encounterable or excluded service cost center
13	Board of Directors Expenses	Direct allocation to General Administration
14	Travel Expenses, Client-related	Direct assignment to DR clinical or excluded service cost center
15	Travel Expenses, Administrative	Direct assignment to non-encounterable or excluded service cost center
16	Clinical Program and Support Expenses	Direct assignment to DR clinical or excluded service cost center
17	Facility and Equipment-Related Expenses	Allocated to cost centers based on Square Feet
18	Vehicle Expenses	Allocated to cost centers based on Mileage
19	Other Expenses	Direct assignment to non-encounterable or excluded service cost center
20	Wages Paid to Individuals Receiving Services	Direct allocation to wages paid to individuals receiving services cost center
21	Offsetting Revenues	Direct assignment to all cost centers

(1) Any expenses related to room and board functions for licensed residential services, such as repairs and maintenance, should be directly assigned to the Excluded Services: Room and Board cost center.

Please note that the following expense categories can either be directly assigned in the general ledger using the specified standard allocation basis ***or*** they can be allocated in the SCA model:

- 02 (salaries and wages, service support staff)
- 08 (employee insurance and other fringe expenses)
- 09 (pension and retirement expenses)
- 17 (facility and equipment-related expenses)
- 18 (vehicle expenses)

CMHSPs must select which option they choose for these expense categories using the drop-down in Column E the *Expense Category Summary* tab. If the assignment to cost centers used in the CMHSPs General Ledger for a given expense category is not consistent with the SCA methodology, these expenses will need to be allocated within the SCA model. If the assignment in the CMHSP General Ledger is consistent with the SCA Methodology, they can "directly assign" the expense category.

a. Capturing employee time to support direct assignment of salaries and wages

The most significant type of cost needing to be captured and directly assigned to cost centers is salaries and wages. CMHSPs need to internally track employee-related time to support direct assignment of salaries and wages to the individual cost centers. For example, if a CMHSP incurs salaries and wages expenses for clinical direct service staff (shown below as Standard Expense Category “01”) that provide direct-run services for unlicensed residential

(standard cost center 122) and respite (standard cost center 119), the salaries and wages related to providing both of those services should be accumulated in separate general ledger accounts so that the adjusted trial balance expenses can be directly mapped to the two standard cost centers.

Expense category 03 is for staff supervisors and 05 is for contractual staff as supervisors. Both get allocated solely to cost center 301 and then spread to all clinical cost centers based on total directly assigned and allocated expenditures regardless of the cost center included within the trial balance. There is not a need to track individual clinical cost centers that supervisors are supervising, but that can be done in the CMHSP general ledger if the CMHSP opts to do so.

The SCA methodology relies on entities ability to capture salaries and wages into several Expense Categories and Cost Centers based on time spent. Service-related time should capture both direct time as well as indirect time related to service delivery. Indirect time not attributable to services should be allocated based on the sum of direct and indirect service-related time. Service-related time that does not include enough time to result in an encounter should be included in the cost center.

Please note that provider groups are required on encounter data but are not required to be tracked in the CMHSP general ledger.

b. Allocation of expenses

Note that while many of Standard Expense Categories above indicate direct assignment, expenses accumulated in some of the Standard Expense Categories indicate the need for an allocation to the appropriate Standard Cost Centers. The following describes the allocation basis for each Standard Expense Category requiring allocation, as well as the rationale for selecting the allocation basis. Each allocation basis option will be an input into the model that is required to be split by cost center.

- **02, Salaries and Wages, Service Support Staff:** The model functionality allows users to select *Direct* assignment of these expenses on the *Expense Category Summary* tab or to select *Direct Allocation*. If doing *Direct Allocation, s*ervice support staff-related expenses will be pooled and allocated to the cost centers that they support (defined by CMHSP inputs) based on the respective salaries and wages of those cost centers. If users select *Direct* assignment, these expenses should also be identified on the trial balance with the standard cost centers to directly assign.

- **08, Employee Insurance and Other Fringe Expenses**: Expenses related to this Category will be allocated to all other Standard Cost Centers based on the proportion of total salaries and wages from Categories 01, 02, 03, and 06 that have already been directly assigned. The model functionality allows users to select *Direct* assignment of these expenses that have been allocated within the general ledger or to use the SCA Model for allocation purposes.

  This allocation approach was selected to uniformly distribute these expenses across all eligible employees, and to avoid variation in the allocated results that would be attributable to decisions made by employees to participate in insurance programs and based on differences in types of insurance coverage (e.g., family, individual, etc.).

  While the SCA workgroup originally considered using “qualifying FTEs” as an allocation basis, this allocation approach was ultimately selected after careful consideration of language contained in 2 CFR 200.431(d) – Cost Objectives, which specifically references salaries and wages as the distribution basis for fringe benefits, and goes on to say that when the allocation method is used, separate allocations must be made to selective grouping of employees, unless the entity demonstrates that costs in relationship to salaries and wages do not differ significantly for different groups of employees. After considerable discussion with stakeholders, it became clear that the language in 2 CFR 200 was subject to differences in interpretation, which led the group to reconsider the allocation basis. Ultimately, the SCA workgroup determined that the all employee salary and wages allocation basis would be most consistent with 2 CFR 200, and that other approaches that could be applied under different interpretations would not result in materially different expense allocations.

- **09, Pension and Retirement Expense:** Expenses in this Category will be allocated to all other Standard Cost Centers based on the proportion of total salaries and wages from Categories 01, 02, 03, and 06 that have already been directly assigned. The model functionality allows users to select *Direct* assignment of

these expenses that have been allocated within the general ledger or to use the SCA Model for allocation purposes.

This allocation approach was selected to uniformly distribute these expenses across all employees, and to avoid adding variation to the allocated results based on legacy pension and retirement benefit obligations from prior years. For grants and/or other contracts that do not permit allocation adjustments, users may need to estimate the costs and make adjustments at the year end.

- **17, Facility and Equipment-Related Expenses:** Facility and Equipment-Related Expenses will be allocated based on the square footage of the space used by individuals that have been assigned to each of the cost centers. This approach is reasonable in that it assigns related expenses to Standard Cost Centers based on the usage of the facility and related equipment, which is consistent with appropriate matching of expenses to services provided or administrative functions. The model functionality allows users to select Direct assignment of these expenses on the Expense Category Summary tab or to select Direct Allocation on the *Expense Category Summary* tab. If doing *Direct Allocation,* square footage in each cost center should be input on the *CMHSP Inputs* tab to support the allocation. If users select *Direct* assignment, these expenses should also be identified on the trial balance with the standard cost centers to directly assign.

- **18, Vehicle Expenses:** The model functionality allows users to select *Direct* assignment of these expenses on the *Expense Category Summary* tab or to select *Direct Allocation*. If doing *Direct Allocation,* mileage traveled in each clinical cost center should be input on the *CMHSP Inputs* tab to support the allocation. If users select *Direct* assignment, these expenses should also be identified on the trial balance with the standard cost centers to directly assign.

Adjusted trial balance expenses for all other Standard Expense Categories will be directly assigned to cost centers because they were determined to either be unique to certain cost centers (e.g., clinical salaries and wages or clinical program and support expenses) and/or to have a material negative impact on the accuracy of reported cost if not directly assigned. The SCA Workgroup identified Standard Expense Categories to require direct assignment only if they believed it reasonably achievable for all CMHSPs and PIHPs capture that level of granularity in their general ledger to accommodate such direct assignment.

3. DETERMINING AND ALLOCATING NON-ENCOUNTERABLE COSTS

Following the direct assignment or allocation of the Standard Expense Category amounts to the Standard Cost Centers, the next step in the methodology is to assign the accumulated expenditures in each of the non-encounterable and supervisory cost centers to one of the administrative cost categories. The five categories are:

1) Shared managed care administration
2) Unique non-encounterable CMHSP only activities (e.g., Mental Health Code (MHC))
3) CMHSP direct-run provider administration
4) Business operations
5) Non-encounterable Grant expenses

At this point in the process, all accumulated expenditures in each of the non-encounterable cost centers will be assigned to only one of the Administrative Cost Categories. From there, pooled non-encounterable cost center amounts will be further allocated or assigned, depending on the nature of the administrative functions.

The paragraphs below provide the following information:

- Definitions for each of the five Administrative Cost Categories;
- How any offsetting revenues received as a result of certain non-encounterable cost center activities should be considered and accounted for;
- How each of the non-encounterable Cost Centers will be mapped to the administrative cost categories; and,
- The methodology that should be applied to allocate expenditures in the business operations category to clinical services and to the other administrative cost categories.

a. Definitions of the Administrative Cost Categories

The Administrative Cost Categories represent a function or group of activities/services within the PIHP and/or CMHSP to which non-encounterable costs must be assigned. The five Administrative Cost Categories that have been established for the purposes of Medicaid administration cost allocation are described in more detail below.

Shared managed care administration: administrative costs to fulfill the obligations of contracts to organize, arrange, coordinate clinical service delivery. Examples of these contracts include the MDHHS-PIHP contract, PIHP-CMHSP delegation agreement, MDHHS-CMHSP contract, and other health plan payer-PIHP/CMHSP contracts. Shared managed administration includes eligibility and coverage verification, utilization management, network development, contracted network provider training, claims processing, activities to improve healthcare quality, and fraud prevention activities. Three required sub-splits of shared managed care administration that will be needed to support Medicaid medical loss ratio (MLR) reporting include healthcare quality improvement; fraud, waste, and abuse; and all other managed care administration. Each of these components are further defined in *Section IV Medical Loss Ratio Reporting*. Costs defined as shared managed care administration should be excluded from the unit cost and are excluded from the independent rate models. Shared managed care administrative costs at the CMHSP level may benefit Medicaid beneficiaries, General Fund beneficiaries, and other third-party payer beneficiaries and shall be allocated proportionally based on accumulated expenditures to those programs/contracts. This allocation will be completed in the EQI template. PIHP managed care administrative costs will only be allocated to the Medicaid program. CMHSPs should review the delegation agreements with their affiliated PIHPs for additional guidance on what Medicaid managed care administrative activities they are responsible to provide. As stated above, other shared managed care administration may be allocated to other programs/contracts based on accumulated expenditures as applicable.

Unique non-encounterable CMHSP only activities (e.g., MHC): actual administrative costs to fulfill the non-encounterable obligations of the Michigan Mental Health Code, corresponding administrative rules, and MDHHS-CMHSP Managed Mental Health Supports and Services contract to provide the behavioral health and disability services safety net. These contract requirements are unique to the CMHSP and are not required by other payers (not included in shared managed care administration). Examples of these non-encounterable services include supporting the recipient rights process, mediation and dispute resolution, school-to-community transition services, jail diversion, prevention, and advocacy activities. Please note that this only encompasses CMSHP functions that are not also required under the contracts (e.g. MDHHS-PIHP Medicaid managed care contract). Additionally, this cost category only reflects CMSHP administrative functions that are not encounterable services (i.e. 24-hour crisis and pre-admission screening costs are assumed to be included in the Crisis service cost center).

CMHSP direct-run provider administration: actual costs attributable to direct provision of Medicaid clinical services by CMHSP employees. These costs are supportive of provider functions and may be included with incurred claims. Examples include administrative costs for direct service provider training.

Business operations: actual administrative costs that support and are allocated across all services and payers. These costs are difficult or impossible to split by function and include (but are not limited to) business operations personnel, insurance, and facility overhead.

Non-encounterable Grant expenses: expenses related to any functions performed by CMHSPs associated with Grant funding that is not already captured in a service encounters should be captured in this administrative cost center. An example includes the grant manager salary.

b. Accounting for offsetting revenues

For Medicaid covered services provided by a contracted network provider, PIHPs may only include in incurred claims the amount that the CMHSP or PIHP actually pays the provider/supplier for providing Medicaid covered services. Managed care rules defining MLR standards at 42 CFR 438.8 state that incurred claims must include the direct claims paid to providers and must exclude expenses for administrative services. Where the CMHSP performs an administrative function, such as eligibility and coverage verification, claims processing, utilization review, or network development, expenditures and profits on these functions would be considered a non-claims administrative expense and should not be counted in reported incurred claims (i.e. in the unit cost of services). The CMCS Informational Bulletin on Medical Loss Ratio (MLR) Requirements Related to Third Party Vendors dated May 15, 2019 outlines an

exception to this rule, applicable when a CMHSP, through its own employees, provides Medicaid covered services directly to enrollees. In this circumstance, the entire portion of the amount the PIHP pays to the CMHSP that is attributable to the CMHSP's direct provision of Medicaid covered services should be included in incurred claims, even if such amount includes reimbursement for the CMHSP's own administrative costs related to the direct provision of Medicaid covered services.

Where the PIHP/CMHSP provides services to network providers, those services must be accounted for separately from the accounting for member clinical services and the costs borne by the PIHP/CMHSP cannot be layered into the unit cost of providing the service. For example, if the CMHSP provides EHR functionality to a network provider, a separate agreement and accounting process provides for "billing" for the EHR services. This approach is consistent with the CMS direction to exclude administrative costs from the cost of care provided by network providers. Allocation of expenditures that have been mapped to the Business Operations Category.

c. Mapping Non-encounterable Cost Centers to Administrative Cost Categories

Figure 3 provides a mapping of each Non-encounterable Cost Center to one of the corresponding Administrative Cost Categories.

FIGURE 3: MAPPING OF NON-ENCOUNTERABLE COST CENTER TO ADMINISTRATIVE COST CATEGORY

NON-ENCOUNTERABLE COST CENTER DESCRIPTION	ADMINISTRATIVE COST CATEGORY
Access Center	Shared managed care administration - all other managed care administration
Care Coordination	Shared managed care administration - healthcare quality improvement activities
Customer Service	Shared managed care administration - all other managed care administration
Finance	Business operations
General Administration	Business operations
Grants	Non-encounterable Grant expenses
HR	Business operations
IT	Business operations
Mental Health Code/CMHSP Only Activities	Unique non-encounterable CMHSP only activities (e.g., MHC)
Other Managed Care Administration	Shared managed care administration - all other managed care administration
Provider Network	Shared managed care administration - all other managed care administration
Utilization Management	Shared managed care administration - all other managed care administration
Other healthcare quality improvement activities	Shared managed care administration - healthcare quality improvement activities
Fraud, waste, and abuse	Shared managed care administration - fraud, waste, and abuse
Trainers Net Expense	CMHSP Direct-Run Provider Administration
Medical records	CMHSP Direct-Run Provider Administration
Self-Directed Administration	Shared managed care administration - all other managed care administration

d. Allocation basis for certain non-encounterable cost centers

After mapping the expenses associated with non-encounterable cost centers to the administrative cost categories, certain non-encounterable cost centers require further allocation (those identified as business operations or CMHSP direct-run provider administration). The following outlines the allocation basis for each of the five cost centers identified as business operations and the three cost centers identified as CMHSP direct-run provider administration.

Finance: costs are allocated to each functional area (all other cost centers) based on the percentage of the total expenses directly assigned or allocated to each cost center. This presumes the greater the size of the functional area, the greater the consumption of financial services.

General Administration: costs are allocated to each functional area (all other cost centers) based on the percentage of the total expenses directly assigned or allocated to each cost center. This presumes the greater the size of the functional area, the greater the consumption of general administrative services.

HR: costs are allocated based on number of FTEs attributed to each cost center. This allocates HR related support proportionately based on employee count as a proxy for utilization volume. HR support is proportionally distributed based on number of staff in each program.

IT: costs are allocated based on number of FTEs attributed to each cost center. This allocates hardware, software, and technical support services across all employees with the assumption that every employee has some level of technical infrastructure support.

Trainers Net Expense: costs are allocated based on FTEs attributed to each direct-run clinical cost center. This allocates the trainers cost, after netting any revenues from training provided to network providers, to the direct-run clinical cost centers.

Supervision: costs are allocated based on direct service clinical salaries and wages. This allocates the supervisory costs to the direct-run clinical cost centers.

Salaries and Wages, Service Support Staff for Allocation: costs are allocated based on the salaries and wages of CMHSP identified cost centers if the user selects *Direct Allocation* on the *Expense Category Summary* tab for this Expense Category.

Facility and Equipment Related Expenses for Allocation: costs are allocated based on the square footage input for each cost centers if the user selects *Direct Allocation* on the *Expense Category Summary* tab for this Expense Category.

Vehicle Expenses for Allocation: costs are allocated based on the mileage input for each cost center if the user selects *Direct Allocation* on the *Expense Category Summary* tab for this Expense Category.

The methodology outlined above is intended to further allocate expenses to the cost centers they support. The business operations costs will be allocated based on the primary functions of the CMHSP. CMHSPs who do not contract with network providers to perform services and only employ staff that are considered clinical (direct service and supervisory staff) or business operations (i.e. the four cost centers outlined above) will allocate all of their business operations expenses to provider administration. In contrast, CMHSPs who only contract with network providers to perform services and employ staff that are identified in non-encounterable cost centers will allocate all business operations expenses to the administrative cost categories, excluding for direct-run provider administration.

4. SUMMARIZE DIRECT-RUN CLINICAL COSTS

Following the separation of direct-run provider administrative expenses from other administrative cost category expenses in the prior step, the template accumulates all expenses into either the CMHSP direct-run clinical cost centers or the administrative cost categories. The CMHSP direct-run clinical cost centers are separated into the following components, which align with the independent rate models used to develop the behavioral health fee schedule:

- Direct Staff Salaries & Wages
- Employee Related Expenses
- Supervisor
- Transportation
- Program Support
- Provider Admin

Figure 4 provides a listing of the expense categories and cost centers that are either fully or partially (depending on allocation) included within each component of the CMHSP direct-run clinical cost centers. Please note that expense categories allocated to non-encounterable cost centers are not included in the figure below, but rather they are implicitly included within non-encounterable cost centers they were allocated to (e.g. Board of Directors expenses are included in General Administration).

FIGURE 4: COMPONENTS OF THE CMHSP DIRECT-RUN CLINICAL COST CENTERS

EXPENSE CATEGORY/COST CENTER	COMPONENT OF UNIT COST

Salaries and Wages, Clinical Direct Service Staff	Direct Staff Salaries & Wages
Compensation, Contractual Clinical Direct Service Staff	Provider Admin
Federal and State Payroll Taxes and Fees	Employee Related Expenses
Travel Expenses, Client Related	Transportation
Clinical Program and Support Expenses	Program Support
Vehicle Expenses	Transportation
Employee Insurance Expenses	Employee Related Expenses
Pension and Retirement Expenses	Employee Related Expenses
Facility and Equipment-Related Expenses	Provider Admin
Finance	Provider Admin
General Administration	Provider Admin
HR	Provider Admin
IT	Provider Admin
Trainers Net Expense	Provider Admin
Medical Records	Provider Admin
Supervision	Supervisory Expenses
Salaries and Wages, Service Support Staff for Allocation	Provider Admin
Facility and Equipment Related Expenses for Allocation	Provider Admin
Vehicle Expenses for Allocation	Transportation

The final step to in summarizing the direct-run clinical cost centers is to calculate the composite cost per minute for each cost center. Total employee minutes, summarized from the electronic health record (EHR) for each direct run clinical cost center, will be used to determine the composite cost per minute for each direct-run clinical cost center. The composite cost per minute is calculated as the total expenses divided by the total minutes.

5. APPLY PROVIDER GROUP WEIGHTED COST PER MINUTE METHOD

After calculating the composite cost per direct minute from Step 4, the standard cost allocation methodology applies the provider group weighted cost per minute method to attribute pooled direct-run clinical cost center total costs to individual services. This approach does not change the total costs in each cost center that are applied to the corresponding services, but instead more appropriately reflects the actual underlying cost differences of each provider grouping for the services.

a. Develop provider group standard weight

As part of the fee schedule project, MDHHS will be collecting salary and employee related expense information on an annual basis to support the development of a statewide standard weight for each provider grouping. The standard weight development and its application is be embedded within the standard cost allocation template for consistent application across all CMHSPs. Figure 5 provides an example of what how the provider group standard weight will be developed.

FIGURE 5: PROVIDER GROUP STANDARD WEIGHT DEVELOPMENT

PROVIDER GROUP	MODIFIER	SALARY	EMPLOYEE RELATED EXPENSES (ERE)	SALARY + ERE	STANDARD WEIGHT
P&S Doctors	AF	$222,056	$47,373	$269,430	2.69
P&S Bachelor's	TD	$64,088	$27,939	$92,027	0.92
MHP Bachelor's	HN	$55,152	$26,487	$81,639	0.82

Note: The standard weight is calculated as the salary + ERE divided by 100,000

b. Identification of provider group on encounter data

The most critical component of this methodology is the ability to capture the provider grouping related to the provider who performed the service on the encounter data for all non-team-based services using modifiers. Appendix 2 includes a column that identifies whether each service is considered a team-based service. The SCA Workgroup has ensured that all team-based services are captured within standard cost centers separately from non-team-based services. Figure 6 provides a listing of each provider grouping along with the corresponding modifier that should be included on all encounters that the rendering provider performs individually (i.e. non-team-based). Team-based services would not include a provider group modifier (except for ACT, which MDHHS would like for providers to include on encounters for informational purposes). Appendix 4 provides a listing of all job titles included within the provider qualifications document and their corresponding provider group and modifier.

FIGURE 6: LIST OF PROVIDER GROUPS AND MODIFIERS

MODIFIER	PROVIDER GROUP
AE	Registered Dietitian
AF	Psychiatrist – MD/DO
AG	Physician – MD/DO
AH	Clinical Psychologist
HM	Less than Bachelor's Level Education
HN	Bachelor's Level Education
HO	Master's Level Education
HP	Doctoral Level Education
SA	Physician Assistant
TD	Registered Nurse
TE	Licensed Practical Nurse
WP	Trained Parent
WQ	Independent Facilitator
WR	Peer Recovery Coach
WS	Certified Peer Specialist
WT	Youth Peer Specialist
WU	DD Peer Mentor

c. Calculation of the provider group weighted cost per minute

Figure 7 illustrates an example calculation of the provider group weighted cost per minute within a single CMHSP direct-run clinical cost center. The composite provider group standard weight (1.11 in this example) will be calculated for each cost center. Each provider group standard weight is divided by this factor within each cost center to ensure that the total cost allocated to services is equal to the total costs accumulated in that respective cost center. The provider group weighted cost per minute is equal to the composite cost per minute for the cost center multiplied by the budget neutral provider group standard weight. The total cost attributable to each provider group within a given cost center is calculated as the direct minutes adjusted for group size multiplied by the provider group weighted cost per minute.

FIGURE 7: CALCULATION OF THE PROVIDER GROUP WEIGHTED COST PER MINUTE

SERVICE	PROVIDER GROUP[1]	DIRECT MINUTES[1]	COST PER MINUTE	PROVIDER GROUP STANDARD WEIGHT	BUDGET NEUTRAL STANDARD WEIGHT	PROVIDER GROUP WEIGHTED COST PER MINUTE	COST
Service 1	Doctors	54,000	$2.58	2.69	2.42	$6.24	$336,787
Service 1	P&S Bachelor's	54,000	$2.58	0.92	0.83	$2.13	$115,034
Service 1	MHP Bachelor's	43,200	$2.58	0.82	0.73	$1.89	$81,639
Service 2	P&S Bachelor's	54,000	$2.58	0.92	0.83	$2.13	$115,034
Service 2	MHP Bachelor's	59,400	$2.58	0.82	0.73	$1.89	$112,254
Service 3	MHP Bachelor's	75,600	$2.58	0.82	0.73	$1.89	$142,868
Service 4	MHP Bachelor's	37,800	$2.58	0.82	0.73	$1.89	$71,434
Total/Composite		**378,000**	**$2.58**	**1.11**	**1.00**	**$2.58**	**$975,051**

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Note:
1.) The direct minutes by provider group will be identified within the EHR and will be input into the template by the CMHSP. It will be adjusted within the Service UNC to account for the group size.

d. Application of the provider group weighted cost per minute

After the provider group weighted cost per minute is determined for each direct-run clinical cost center and provider group combination, it will be applied to the direct minutes adjusted for group size that will be included on each row within the Service UNC tab of the EQI template. These costs comprise the CMHSP direct-run ***gross*** cost. Section 7, below, describes the approach for calculating the net cost.

6. REPORTING THE NETWORK PROVIDER COST OF PROVIDING CLINICAL SERVICES

As a final step in the process of determining the gross cost of clinical services, the actual network provider costs that are representative solely what is paid to the network provider to perform the services will be assigned to each service. As described previously, federal regulations prohibit CMHSPs from layering administrative costs onto network provider costs to perform the services. All administrative expenses incurred by the CMHSP will be identified as CMHSP direct-run provider administration or other administrative costs not included within network provider service unit cost.

Note that there will be instances where services are provided through contractual arrangements with network providers that "bundle" services together or are provided under sub-capitated contractual arrangements. In these instances, network provider contracts will require modification to require that network providers can report actual services and related payments for the services at the individual service level.

Section III.3.c Accounting for offsetting revenues describes the requirement for CMHSPs to pay network providers for functions that the CMHSP may perform, and then "chargeback" the functions being performed for network providers. For purposes of this step, actual expenditures for network provider services, net of any offsets, should be directly assigned to each type of service.

Network provider utilization and costs under fee-for-service (FFS) arrangements will be reported on the *Service UNC* tab of the EQI template and will require a summary from each CMHSPs data warehouse. For network provider non-FFS arrangements (e.g. net cost contracting or case rates), utilization and costs reported on the *Service UNC* tab of the EQI template should reflect what is submitted into MDHHS' data warehouse (i.e. actual utilization and the estimated cost). A separate tab will be added for non-FFS arrangements to document the difference between the estimated cost and actual cost for each provider and service.

7. COORDINATION OF BENEFITS APPLICATION

The final step of the standard cost allocation methodology is to determine the ***net*** cost associated with the Medicaid and General Fund behavioral health programs for both CMHSP direct-run and network provider clinical services. The coordination of benefits should be retained within each CMHSPs data warehouse at the individual claim level, separately for CMHSP direct-run and network provider clinical services. Offsetting COB amounts should be applied to determine and report net costs related to these programs.

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IV. Medical Loss Ratio Reporting

The medical loss ratio (MLR) is measure of the percentage of premium dollars that each Medicaid managed care plan spends on clinical claims and quality improvement activities. For each reporting year, States must require each Medicaid managed care plan to submit an MLR report that includes at least the total incurred claims, expenditures on quality improving activities, expenditures on fraud prevention activities, non-claims costs, premium revenue, taxes and fees, and expenditure allocation methodologies. States are responsible to ensure managed care plans are properly identifying and classifying costs across these categories.[2] The formula for the Medicaid MLR calculation is below.

$$\frac{\text{incurred claims + activities that improve health care quality}}{\text{adjusted premium revenue – taxes and fees}}$$

Incurred claims: direct claims paid to providers (including under capitated contracts) for services covered under the contract, unpaid claims liabilities, provider withholds and incentive/bonus payments, and claim payments recovered from fraud reduction efforts (not to exceed the amount of fraud reduction expenses which must not include fraud prevention activities). Non-claims costs must be excluded with the exception of administrative costs attributable to direct provision of Medicaid covered services by CMSHP provider employees, which may be included with incurred claims.[3][4] Unpaid claims liabilities, incentives, and bonuses paid to providers should not be included in the encounter data and can be reported on the Other Expense tab of the EQI template. These expenditures should be included in incurred claims for the purposes of the MLR calculation.

Non-claims costs: expenses for administrative services that are not incurred claims, not expenses for activities that improve health care quality, nor taxes and licensing/regulatory fees. Non-claims costs include amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management and amounts paid (including to providers) for professional or administrative services that are not compensation or reimbursement for State plan services provided to enrollees.[5]

Activities to improve health care quality: an expense category within shared managed care administration that must be calculated and reported separately as part of the federal medical loss ratio (MLR) reporting requirements under 42 CFR §438.8 and are included with incurred claims as part of the MLR formula numerator. Activities to health care quality are managed care plan (and their delegate) expenditures on activity that meet requirements of 45 CFR 158.150(b), and:

- Improve health quality.
- Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.
- are directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.
- are grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

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[2] Electronic Code of Federal Regulations 42 CFR §438.8. Retrieved June 17, 2020, from https://www.ecfr.gov/cgi-bin/text-idx?SID=2378d19656d7b0f814166fd27783d4c3&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_18

[3] Electronic Code of Federal Regulations 42 CFR §438.8. Retrieved June 17, 2020, from https://www.ecfr.gov/cgi-bin/text-idx?SID=2378d19656d7b0f814166fd27783d4c3&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_18

[4] CMCS Informational Bulletin, May 2019. Retrieved June 1, 2020, from https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051519.pdf

[5] Electronic Code of Federal Regulations 42 CFR §438.8. Retrieved June 17, 2020, from https://www.ecfr.gov/cgi-bin/text-idx?SID=2378d19656d7b0f814166fd27783d4c3&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_18

These activities must be primarily designed to:

- Improve health outcomes and reduce health disparities
  - Direct interactions between the plan, providers, and enrollees to improve health outcomes including case management, care coordination, chronic disease management, and medication and care compliance initiatives
  - Identify and address ethnic, cultural, and/or racial disparities
  - Accreditation fees directly related to quality of care activities
- Prevent hospital readmissions
  - Comprehensive discharge planning programs
  - Patient-centered education and counseling to prevent hospital readmissions
- Improve patient safety, reduce medical errors, and lower infection and mortality rates
  - Identify and use of best clinical practices to avoid harm
  - Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions
- Implement, promote, and increase wellness and health activities
  - Wellness assessments, coaching programs, public health education campaigns, rewards/bonuses/incentives, and health promotion activities
- Enhance the use of health care data to improve quality, transparency, and outcomes, and support meaningful use of technology

Excluded expenditures and activities are:

- Cost containment expenses
- Activities that can be billed or allocated by a provider for care delivery and are reimbursed as clinical services
- Establishing and maintaining a claims payment system
- Retrospective and current utilization review
- Fraud prevention activities
- Provider network development and credentialing
- Marketing[6]

Fraud prevention activities: managed care plan expenditures on activities related to program integrity, efforts to prevent and detect fraud, waste, and abuse, provider screening, and subcontractor disclosures. These expenditures must not include expenditures for fraud reduction, which are included in incurred claims. The final managed care rule permits inclusion of fraud prevention activities in the numerator of the MLR as adopted for the private market under 45 CFR part 158.[7] As the private market has not yet incorporated fraud prevention activities into its MLR regulations, fraud prevention activities are excluded from the Medicaid MLR calculation. However, under 42 CFR 438.8, States must still require managed care plans to submit in their annual MLR reporting the expenditures related to fraud prevention activities as compliant with 42 CFR 438.608:

- Administrative and management arrangements or procedures to detect and prevent fraud, waste, and abuse
  - Compliance program
  - Provision for prompt reporting of all overpayments identified or recovered
  - Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstance affecting eligibility

[6] Electronic Code of Federal Regulations 45 CFR § 158.150. Retrieved June 17, 2020, from https://www.ecfr.gov/cgi-bin/text-idx?SID=74b6e90a79d4a58368b780617f4eae2e&mc=true&node=pt45.2.158&rgn=div5#se45.2.158_1150

[7] Electronic Code of Federal Regulations 42 CFR §438.8. Retrieved June 17, 2020, from https://www.ecfr.gov/cgi-bin/text-idx?SID=2378d19656d7b0f814166fd27783d4c3&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_18

- Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program
- Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis
- Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.
- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 §455.23

- Provider screening and enrollment requirements[8]

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[8] Electronic Code of Federal Regulations 42 CFR §438.608. Retrieved June 17, 2020, from https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b0f12ce8b200971a9069ad8bdbbe21f3&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1608

V. Foundational Elements

The following sections describe the foundational elements and basis for the administrative cost allocation process created and agreed to by MDHHS, the SCA Workgroup, and Milliman.

CONSISTENCY OF TERMS AND PROCESSES

- The standard allocation methodology represents a process for directly assigning or allocating the actual costs incurred by the PIHPs and CMHSPs
- The definitions and recognition of expenses and costs will be consistent with definitions prescribed by GAAP
- Definitions of clinical costs and administrative costs will be consistently applied
- Standard administrative cost centers will be consistently applied
- Standard administrative cost centers should delineate between managed care administration, provider administration, and general administration
- Clear standards for the identification of directly allocable and indirect costs will be applied.
- The standard cost centers will allow for consistent reporting of Medicaid managed care administrative costs across all PIHPs and CMHSPs.
- Allocation methods must be consistent with federal rules promulgated in the Code of Federal Regulations (CFR) at 2 CFR 200, and all other federal and State regulations and requirements.
- Methods determined must be dynamic and responsive to potential future changes in delegated administrative responsibilities.
- Resulting methodologies must result in reasonable and reliable reporting of the costs of providing clinical and administrative services and must reasonably attribute costs relative to the benefit provided.

APPLICATION OF FEDERAL STATUTES AND REGULATORY GUIDANCE

- The federal statutes and regulatory guidance governing Medicaid managed care outline the cost allocation principles and medical loss reporting requirements that both PIHPs and CMHSPs must follow
- MDHHS-PIHP contracts and PIHP-CMSHP delegation agreements outline contract deliverables, program requirements, and performance standards each entity is obligated to meet as well as define the managed care administrative functions and expectations

TREATMENT OF PROVIDER ADMINISTRATIVE COSTS

- Administrative costs attributable to a CMHSP's employed providers' direct provision of Medicaid covered services may be included as part of their billable services and reported in total incurred claims.
- CMHSP costs to perform administrative functions not attributable to its employed providers' direct provision of Medicaid covered services cannot be included in clinical costs or incurred claims and instead must be classified as non-claims administrative expenses (shared managed care administration).
- CMHSP costs to administer and oversee contracted provider networks providing Medicaid covered services must be reported as non-claims administrative expenses (shared managed care administration).
- CMHSP costs attributable to provision of Medicaid clinical services by contracted network providers that are not shared managed care administration shall be assigned to a temporary cost center for monitoring and reporting while solutions are developed to move the costs to a permanent administrative cost center. While these costs may be key to provider functions, they may not be included with incurred claims per CMS guidance.

REPORTING CHANGES

MDHHS will no longer require PIHPs to report administrative costs as one of the seven administrative function cost categories as described in the document "Establishing Administrative Costs Within and Across the PIHP System." Instead, PIHPs will reports costs as one of the five administrative cost centers and temporary cost centers and as required to fulfill the MLR calculation and reporting rules. CMHSPs must report their costs and all underlying data needed to the PIHP for MLR calculation and reporting.

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VI. Limitations and Data Reliance

The services provided for this project were performed under the signed contract between Milliman and MDHHS approved September 13, 2019.

The information contained in this letter, including the appendices, has been prepared for the State of Michigan, Department of Health and Human Services and their consultants and advisors. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for MDHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. In performing this analysis, we relied on data and other information provided by MDHHS and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

This work is not complete. Final results and recommendations may vary significantly from this draft document based on additional findings and information gathering.

This information is being shared for discussion purposes only.

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