

**Michigan Specialty Supports and Services**  
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

**ESTABLISHING MANAGED CARE  
ADMINISTRATIVE COSTS**

Revised June 20, 2005

Michigan Department of Community Health  
Mental Health and Substance Abuse Services Administration

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**TABLE OF CONTENTS**

I	Program Overview	2
II	Principles	3
III	Managed Care Administrative Components	
	A. Utilization Management	6
	B. Customer Services	8
	C. Provider Network Management	10
	D. Quality Management	12
	E. Financial Management	14
	F. Information Systems Management	15
	G. General Management	17

## I. Overview:

The Centers for Medicare and Medicaid Services (CMS) promulgated rules for the 1997 Balanced Budget Act that specifies requirements for the management of the federal Medicaid Program. These include explicit requirements regarding the process for determining capitation rates for a Managed Care program. These requirements are contained in the Code of Federal Regulations (CFRs).

Among the requirements are guidelines for separating administrative and service costs. In the process of setting capitation rates, these costs are evaluated separately and in Michigan, are then combined to create a single capitated rate for the Prepaid Inpatient Health Plan (PIHP).

For simplicity, the MDCH will use the same process for separating administrative and service costs in the Indigent ("General Fund") program. This will create a single uniform method for identifying costs throughout the public mental health system.

In order to establish the costs of providing treatment, supports and services, each PIHP network must submit financial information related to each service encounter delivered regardless of funding source in the form of an "aggregate net cost per unit." This aggregate net cost per unit is calculated by the PIHP by dividing the sum of the Medicaid costs in the PIHP's service area (including affiliates) for a procedure by the total units of the procedure delivered to Medicaid beneficiaries in the PIHP's service area (including the affiliates). This provides a single uniform system for identifying the costs of Medicaid treatment, supports and services. The total Medicaid expenditures and total units are reported on the PIHP's Medicaid Utilization and Net Cost Report at six and twelve months. The total CMHSP expenditures and total units are reported on the CMHSP total Sub-element Cost Report at twelve months. It is no longer required that a cost per unit be reported with the encounter data.

The second part of the data submission - administrative and other indirect costs attributable to managed care - are not to be reported in the encounter data. Instead, administrative costs are reported using the PIHP Medicaid Utilization and Net Cost Report and the CMHSP Total Sub-element Cost Report in accordance with guidelines that follow. Two reports of administration are submitted. One report covers Medicaid Administration only and is submitted by the PIHP. This report accumulates all Medicaid Managed Care Administration costs throughout the PIHP's structure. The second report is submitted by each CMHSP and incorporates all managed care administration for all fund sources for that CMHSP.

In the final development of Medicaid capitation rates, the funding for the administrative costs attributable to managed care will be added to the service rate to create a total capitation rate for each PIHP.

This paper presents guidelines for PIHPs and CMHSPs in identifying Managed Care administrative costs. These guidelines differ substantially from prior instructions regarding Board Administration. The changes are made to allow for compliance with Federal requirements, and establish a single system for reporting administration.

## II. Principles

The following principles guide PIHP and CMHSP efforts to identify Managed Care Administration costs:

1. **System Consistency:** The system is best served if CMHSPs follow, in good faith, common definitions for both services and management functions. At the same time, local differences in both service provision and management will result in different interpretation of guidance, at least in the short run. Reasonable variation will be tolerated. DCH anticipates that the costs per unit and the amount identified for PIHP Administrative functions will vary across the state but that over time this variation will be reduced. Managed Care Administration reported by CMHSPs may have greater variability because of regional differences in the delegation of Medicaid functions. The CMHSP cost report will provide several lines for reporting Managed Care Administration to help identify and explain this variation.
2. **Aggregate Net Cost Per Unit:** This amount for each procedure code will be based upon actual costs of Medicaid services within a PIHP area, adjusted for considerations of market rates or projections of unavoidable cost increases. This net cost per unit **includes** the indirect, overhead and management costs of delivering the service. However, it **excludes** the costs of managing the functions identified in #3 below.
3. **Managed Care Administrative Functions.** Managed care functions are categorized, for purposes of this document, into seven groups, as follows:
  - A. Utilization Management
    1. Access and Eligibility Determination
    2. Level of Care Assessment/Service Support Selection
    3. Authorization
    4. Utilization Review
    5. Care Management
  - B. Customer Services
    1. Information Services
    2. Coordination of Customer participation in Managed Care Activities
    3. Complaint, Grievance and Appeals Processes

- 4. Community Benefit
- C. Provider Network Management
  - 1. Network Development
  - 2. Contract Management
  - 3. Network Policy Development
  - 4. Credentialing and Privileging
- D. Quality Management
  - 1. Standards Setting
  - 2. Performance Assessment
  - 3. Regulatory Management/Corporate Compliance
  - 4. Managing Review Processes
  - 5. Quality Process Facilitation
  - 6. Research
  - 7. Provider Education and Training
- E. Financial Management
  - 1. Financial Operations and Risk Management
  - 2. Claims Management
- F. Information Systems Management
  - 1. DCH Contract Management Support
  - 2. Reporting
- G. General Management

Although this categorization is commonly used it is not intended that it describe the actual or ideal organizational structure of any PIHP or CMHSP. Nor is it intended to suggest that the identified sub-categories should be clustered organizationally according to this configuration.

**4. Medicaid Reporting and Models of PIHP-Provider Relationship:**

There is great variation in the nature of the relationship between the PIHP, CMHSPs and service providers. Before identifying Managed Care Administrative costs, the location of each management function listed above must be identified. In many arrangements, portions of some or all management functions are carried out by more than one administrative structure. It is important that the costs associated with all components of the function be identified, regardless of where they are carried out. Specifically, service delivery entities may carry out Managed Care Administrative functions, the cost of which should not be included as a service delivery cost (i.e., they should not be included as part of the 'allowable amount'). On the other hand, some service delivery agencies carry out management functions which are identical in nature to Managed Care Administrative functions as described in this document, but which should be included as service delivery costs. This paper identifies three circumstances under which such functions of service delivery entities should be included as Managed Care Administrative functions:

- **Delegation of Responsibility** – PIHPs that have affiliated CMHSPs and Substance Abuse Coordinating Agencies (CAs) acting in the capacity of CSSNs, are required to include in their service and funding agreements a description of the PIHP Administrative functions that have been delegated to the CSSN (42CFR230). PIHPs may also delegate Administrative functions to non-CSSN contracted Provider entities through a contractual arrangement. The cost of all Managed care Administrative functions delegated by the PIHP to a Provider entity, including a CSSN, must be added to the costs incurred directly by the PIHP to form the total Managed Care Administrative cost reported by the PIHP.
  - **Functions in the Interest of the PIHP** – All service delivery entities carry out some functions which are identical in nature to those described above as Managed Care functions. For example, all Health Care providers and management agencies are required to perform regulatory management functions; most service providers engage in customer service and utilization review activities, etc. When delegation of responsibility is not explicit, service provider entities in cooperation with the PIHP should identify as Managed Care Administrative functions, with associated costs, those activities which they carry out in the interest of the PIHP.
  - **Shared Risk Arrangements** – sub-capitated entities may perform many Managed Care Administrative functions which are carried out in both their interest and the interest of the PIHP. When there is no explicit delegation of responsibility by the PIHP, the sub-capitated entity and PIHP cooperatively allocate functions serving both interests; the costs, therefore, are allocated similarly.
5. **Level of Cost Detail for Medicaid Reporting** -- The PIHP Administrative rate component of the total Medicaid capitation rate will be based on the total cost of carrying out PIHP Administrative functions. The PIHP is expected to identify and establish a total cost for those functions carried out directly by the PIHP and to identify and establish total costs for functions carried out by service entities to which functions are delegated. Responsibility for and costs must be identified for those entities with which the PIHP has established a direct delegation relationship. Such entities should identify total costs for functions for which they have assumed responsibility regardless of whether they carry out the function directly or sub-delegate it.
6. **Isolating Medicaid Costs** – For purposes of establishing the Medicaid capitation rate, only PIHP Administrative costs related to services chargeable to Medicaid revenue will be utilized. For this purpose, when the PIHP functions are related to services in addition to Medicaid services, the PIHP should allocate the total cost of carrying out a function as a proportion of

Medicaid expenditures to total expenditures or via another standard cost allocation method.

**7. Indigent Fund and Models of PIHP Provider Relationship**

Some CMHSPs are purchasing managed care administrative functions for the indigent population from a related PIHP. For these arrangements, the PIHP should treat the contract with the CMHSP as an earned revenue, and not include those costs in its Indigent Fund administrative costs. The CMHSP that pays for the administrative services would include such costs as part of its Indigent Fund cost report.

Where a CMHSP has delegated administrative functions to a CSSN or other provider entity, these costs should be incorporated into the CMHSP administrative cost reporting. Similarly, CSSN administrative activities undertaken on behalf of the CMHSP should be reported as managed care administration. If CSSNs perform functions in both their own interests and the interests of the CMHSP, these costs would be included as managed care administration only if there is a specific delegation from the CMHSP.

8. **Cost Principles** -- In calculating both the aggregate net cost per unit (adjusted for market-related and other factors) and the Managed Care Administrative cost, the PIHPs and CMHSPs will use cost guidelines, including A-87 costing principles, as included in the relevant MDCH contract.

**III. Managed Care Administrative Functions**

The following core functions have been identified as managed care administration. The costs of these functions must be reported by PIHPs and CMHSPs, regardless of who carries them out. The terminology used below may not correspond with that used in individual PIHPs and CMHSPs; further, some entities may consider components or sub-components listed within these categories to belong elsewhere. Since creation of the Administrative component of the rate will not require reporting by category or component of each function, this is okay.

Since both CMHSPs and PIHPs use these guidelines for both Medicaid and Indigent Fund reports, the term Managed Care Entity is used in this paper to refer to the organizations holding the Medicaid and Indigent Funds contract, ie the PIHPs and CMHSPs.

**A. UTILIZATION MANAGEMENT**

Utilization Management (UM) is a set of administrative functions that pertain to the assurance of appropriate clinical service delivery. Through the application of

written policies and procedures, Utilization Management is designed to ensure (1) that only eligible beneficiaries receive specialty plan benefits; (2) that all eligible beneficiaries receive all medically necessary specialty plan benefits required to meet their needs and desires; and (3) that beneficiaries are linked to other Medicaid, Health Plan or other services when necessary.

The list of functional components below should be used as a guide as the Managed Care Entity locates this function and identifies the costs associated with it. Functional components may be performed by a managing entity, or delegated to an entity within the Managed Care structure. Further, functional components are likely to be distributed among several organizational components. Some components may not be carried out in some entities. Functional components that are carried out as part of a billable service encounter should not be included as a Managed Care Administrative function. Because UM is also a key function of an effective service provider, UM activities, carried out as a part of a provider's self-monitoring process (i.e., when carried out in the interest of the provider), should not be included in the cost of managed care functions, as indicated in Principle #4 above.

**Components** of utilization management include:

- **Access and Eligibility Determination.** This functional component includes both clinical and financial eligibility determination. Specifically, this includes:
  - development of access and eligibility policy and procedures,
  - initial contact with potential consumers,
  - collection of consumer specific information
  - services referral, including both inpatient and alternative emergency services and non-emergency initial referral
  - initial screening/first appointment,
  - verification of funding sources including determination Public Funding status and first and third part liability,
  - documentation and monitoring of activities.
- **Level of Care Assessment/ Service and Support Selection.** This component is the initial and ongoing interface between the consumer--clinical treatment and support team and the Managed Care Organization. This includes:
  - Determination of Medical Necessity,
  - Assessment of risk
  - Application of Service Intensity criteria
  - Continuing Stay review
  - Specialist review
  - Development of financial and clinical eligibility criteria, Level of Care criteria, Service Selection Guidelines, and Best practice Guidelines as well as procedures for applying them

- Documentation and monitoring of activities
- **Authorization.** This component is the process of linking LOC and Service Selection processes to payment processes. It includes
  - Notification of authorization, or denial of request, to the consumer and provider
  - Documentation of decision in IS linking to claims processing
  - Development of authorization policy and procedure
  - Documentation and monitoring of activities
- **Utilization Review.** This component provides review/monitoring of individual consumer records, specific provider practices and system trends. Review of activities of both the managing entity and the provider network are included. It includes review and monitoring to determine appropriate application of Guidelines and Criteria in the following areas:
  - LOC determination
  - Application of Service Selection Criteria
  - Application of Best Practice Guidelines
  - Consumer outcomes
  - Over-Utilization/under Utilization
  - Review of Outliers
  - Development of review criteria and processes for individual consumer records
  - Development of procedures for system level data review
  - Policy and procedures regarding use of review documents
  - Documentation and monitoring of component activities
- **Care Management.** This component recognizes that some consumers represent such service or financial risk to the organization that closer monitoring of the individual case is warranted. Responsibilities include:
  - Development of selection criteria for consumers for care management. E.g., out of area consumers, inpatients, etc.
  - Policy and procedure detailing role of the managing entity and provider
  - Documentation and monitoring of component activities

## **B. CUSTOMER SERVICES**

The Customer Services function encompasses activities directed at the entire population of the Board's service area, including non-treatment/support services to consumers. Although most CMHSPs have a dedicated Customer Services Division/Department, customer services functions are frequently implemented outside this dedicated unit. 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 managed care administrative functions. The test of whether the function is performed in the interest of the provider or Managed Care Entity (Principle # 4 on page 4 above) should be applied.

The Recipient Rights function is to be included as a managed care administrative function and its costs attributed to both Medicaid (PIHP) and Indigent (CMHSP) administration. Recipient Rights functions are mandated by the State Mental Health Code and had previously been excluded from these guidelines for PIHP administration. However, these functions are also mandated in the PIHP contracts and are performed on behalf of Medicaid recipients. In some situations they fulfill the responsibilities for handling grievances and appeals required under Federal law. Therefore they are now to be included as Managed Care administration.

The following list of components will assist in locating functions which may be carried out within a central organization or delegated directly to a service provider entity. Both the list and the labeling of components is intended to be assistive. Managed Care Entities may not carry out some functions, may label them differently, or may delegate them elsewhere.

- **Information Services.** This component includes activities directed to the general population of the service area as well as to consumers of treatment and support services. These include
  - General orientation of new and potential consumers to the benefits available from the organization, as well as methods of accessing services. Potential consumers include the community at large.
  - Development and dissemination of informational brochures; coordinating community and stakeholder input and disseminating of specialized information about benefit plans, service providers and treatment and support practices. This includes development of culturally sensitive and/or alternative communication systems.
  - Operation of a telephone line and web site(s) in order to provide information about benefit plans and to respond to general inquiries.
  - Outreach activities to identify and establish communication with underserved groups.
  - Marketing and Public Relations activities
- **Coordination of Customer Participation in Managed Care Activities.** This component includes
  - Development of policy and a program 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.
  - Coordination of selection processes
  - Training and orientation of customers, including consumers, to participate actively in Advisory Groups, task forces, working committees and other management related groups.

- **Customer Complaint, Grievance and Appeals Processes.** Both formal and informal grievance and appeal mechanisms are coordinated as part of the Customer Services function. This includes
  - Process to collect, store and analyze reports from consumers and other persons regarding problems in the delivery system
  - Investigation and management of informal complaints
  - Investigation and management of all formal grievances and appeals
  - Operation of the CMHSP Recipient Rights Office.
  - Administrative Fair Hearings conducted by MDCH.
  - Formal tracking and coordination of Complaint Management processes, across the entire network.
  - Informal means used by the Managed Care Entity to resolve complaints from consumers about providers
- **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 focuses on activities designed to promote wellness and Healthy Communities, such as
  - 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.

### **C. Provider Network Management**

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

Utilizing Principle #4 on page 4 above, PIHP network management functions carried out by a CSSN or other Service Provider vis-à-vis its sub-contractors or practitioners is a Managed Care Administrative function if such activities are performed in the interest of the Managed Care Entity. PIHPs which are CMHSPs that operate services directly must include such a service provider function as if it were a contracted provider regardless of whether a contract actually exists.

Provider Network Management consists of the following components:

- **Network Development** -- This is the process of identifying member service needs and procuring sufficient providers to meet those needs. Activities include:
  - Needs Assessment, including analysis of the demographic characteristics of the community, the customers and the current and past consumer population. Needs assessment should include analysis of the historic patterns of services and projection of demand for services
  - Analysis of current network capacity to meet projected need and development of a "gap assessment" which identifies procurement needs.
  - Development of an annual network plan.
  - Procurement of providers using a process which meets Federal and State standards and addresses identified program needs and required/desirable provider characteristics.
  - Development of agreements with alternative payors or related agencies with a goal of coordinating care (such as with DHS, MRS and Schools)
  - Recruitment of specialized supports such as staff or contracted interpreters, translators and bi-lingual/bi-cultural clinicians
  - Training for network providers concerning performance expectations.
  
- **Contract Management** consists of the following activities:
  - Development of provider contract language including boilerplate language, payment models, performance expectations, operating expectations, dispute resolution processes, sanctions, incentives, etc.
  - Negotiation of contracts
  - Monitoring Providers for compliance with all aspects of the contract.
  - Conducting reviews for evidence of abuse and/or fraud.
  - Sanctioning providers, through Plans of Compliance or other means
  - Managing the comprehensive review process as part of contract renewal.
  - Managing contracts for consumer services with non-panel providers

- **Network Policy Development** -- This includes development of standards for participation in the provider panel. For Managed Care Entity whose service delivery system operates through affiliated CSSNs or other service providers, standards for sub-contracting are included in this area. Operating and performance expectations are also included through this Policy Development function.
  
- **Credentialing, Privileging and Primary Source Verification:** These functions are part of network management although frequently carried out by staff participating in QM functions. These functions are carried out at both service delivery and Administrative levels. The Managed Care Entity must, at least, verify the credentialing done at the service delivery level. Further, the Managed Care Entity must perform these function vis-à-vis Utilization Management and other management staff.
  - **Credentialing** is the process of validating the qualifications of a licensed practitioner or facility to provide services in a health care network or its components.
  - **Primary Source Verification** is the process of independently contacting the organization responsible for issuing a credentialing requirement to verify the report of a practitioner or facility.
  - **Privileging** is the process of reviewing specific education, training, and experience to determine the consumer populations and/or service modalities the practitioner or facility will be approved to provide.

#### **D. Quality Management**

The Quality Management function encompasses activities directed at ensuring that standards of staff, program and management performance exist, that compliance with them is assessed and that ongoing improvements are introduced and assessed.

CMS regulations require the PIHP to develop an overall Quality Assessment and Performance Improvement Program (QAPIP) for its organization and its provider network. Specifications for the QAPIP are detailed both in the CFRs and the MDCH Contract. The QAPIP includes the development of an annual QI Plan that includes those specific developmental and improvement activities to improve the overall effectiveness of the PIHP network's clinical and administrative practices.

Virtually all service provider organizations have Quality Management programs. Some components of these organizations are mandated for all providers (such as regulatory management or corporate compliance); others are maintained in the interest of the provider. Unless specifically delegated by the Managed Care Entity or manifestly operated in its interests, these activities of provider

organizations should not be identified as Managed Care Administrative functions or included in the costing process.

Components of Quality Management include:

- **Standard Setting.** This component includes review, analysis and recommendations concerning standards, and measurement methodologies in the following areas essential to a continuous quality improvement orientation
  - Choice of accrediting body
  - Research based Best Practice Guidelines, including analysis of create vs. purchase options, management of a stakeholder input process and training of providers and Utilization Management staff
  - Clinical pathway protocols and other authorization criteria
  - Credentialing standards and procedures
  - Establishing methods to establish eligibility for services, such as selecting standard assessments, diagnostic tests, medical necessity criteria, ASAM criteria etc.
  - Performance expectations for both clinical and management programs
- **Conducting Performance Assessments.** This component includes both routine, periodic performance assessment and specially designed evaluation activities. Performance assessments and evaluations, as used here, are generally analyses of data submitted as part of regular management information requirements or as part of a special study. The results of both periodic and special performance assessments are provided to the PIHP's leadership team on a regular basis as part of the management decision-making process. Results of selected periodic assessments are made available to consumers and the community.
- **Regulatory Management/Corporate Compliance.** This component includes review of financial and clinical source documents and summary data conducted, or overseen, by Managed Care Entity staff for compliance with regulations of outside bodies, including the State of Michigan, CMS and other federal regulatory bodies. Activities include:
  - Developing a compliance plan that focuses on regulations dealing with healthcare fraud and abuse.
  - Maintaining current inventory of regulations and conducting prevention activities.
  - Providing direction to contractors regarding their responsibilities
  - Ensuring that compliance issues are adequately addressed in vendor contracts
  - Establishing a compliance friendly environment
  - Taking action when non-compliance issues are revealed.

- **Managing Outside Agency Review processes.** This component includes ensuring that source material is complete and available for reviews by outside bodies, including
  - Accrediting bodies
  - DCH Certification reviews and financial audits
  - Licensing bodies
  - Non-DCH payer audits and reviews (CMS, Auditor General, OIG, etc.)
- **Research.** Research activities, including management of a Research Committee.
- **Quality Process Facilitation.** This component consists of activities aimed at continuous improvement of the processes by which agency and contractor business is conducted. It includes facilitation of activities related to management processes and TA/facilitation of activities in contract agencies.
- **Provider Education and Training and Quality Management Oversight.** This component includes activities related to ensuring that contractors have and carryout their own quality management plan, as well as ensuring that a Quality Improvement Culture is developed and maintained within all clinical and management arenas. Thus, activities include routine, periodic education and training activities and education/training activities designed to address special issues revealed by performance assessments, audits, compliance reviews or other means. Training of service delivery staff to meet program requirements is not a Managed Care Administrative function (examples include Group Home Training, PCP training, etc.).
- **Development of an Annual Quality Improvement Plan.** This Plan establishes specific goals for the coming year, consistent with the Managed Care Entity Strategic Plan and identifies monitoring mechanisms and timeframes with respect to their achievement.

## **E. Financial Management**

Financial Management consists of the processes for managing revenues and expenditures in order to provide accountability to management and funders, maximize financial resources and maintain fiscal integrity. Because financial management is also a key function of an effective service provider, financial management activities, carried out as a part of a provider's internal management process (i.e., when carried out in the interest of the provider), should not be included as a Managed Care Administration cost. The test included in Principle #4 on Page 5 above should be applied.

Critical components of financial management include:

- Budgeting, General Accounting (AR, AP, etc.), and Financial Reporting

- Service unit and Client-centered Cost analyses and Rate-setting may be done as a Managed Care Administrative function. Alternatively, the Managed Care Entity may set standards for rates, which are then developed as a service delivery function.
- 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

Consistent with Principle #4 above, the following functions may be directly identified and allocated as a Managed Care administrative function costs:

- Managing typical general accounting processes of the Managed Care Entity.
- Processing bills from external provider agencies, payments, reconciliation, appeals and all other functions related to payments to external service providers
- Receiving and reconciling managed care contract revenues
- Budget and financial analysis and reporting related to managing within capitated, sub-capitated or other risk-based funds
- Managing unspent funds within the risk corridor for alternative services
- Planning to contain risk, including actuarial analysis

The following costs are to be considered Service Management Costs, and should not be factored into the health plan *administrative costs*, but included in the allowable amounts rate development:

- Billing and collecting third party payors
- For fee for service Medicaid hub and spoke arrangements, billing the PIHP
- Ability to pay determinations
- On-site eligibility verification
- Obtaining and recording local matching contributions

Remaining financial management costs which cannot be directly allocated must be separated using an indirect cost allocation method.

## **F. Information Systems Management**

Information Systems Management includes processes designed to support management, administrative and clinical decisions with the provision of data and information and to support the accountability and information requirements of funders, regulatory bodies, consumers and communities. Components include hardware, software, specific applications and their integration, network

configuration and connectivity. Telecommunications equipment, software, and management are often included. Information Technology (IT) refers to the hardware and connectivity—including individual workstations, laptops, phone systems, mobile personal assistants (such as Palm Pilots), servers, routers, and management of both Local and Wide Area Networks (LANs and WANs). Managing security requirements for access to the network is also included in IT.

Information Systems within the behavioral healthcare system usually fall into two (2) categories: Managed Care and Practice Management. **Managed Care** Information System Management functions are those which support all other Managed Care Administrative functions.

**Practice Management** Information System Management functions which allow providers to deliver clinical services and manage the interests of the provider agency. Related Practice Management costs to be borne by the provider include all IS Practice Management software, and related hardware, telecommunication and staffing costs pertaining to provider service delivery, and the submission of claims and data into the payor or fund source. These costs are not Managed Care Administrative costs.

In this context, include the portions of the following IS systems that are not related to practice management functions as managed care administrative costs:

- hardware, software and other devices for collection, storage, retrieval and reporting of demographic, service encounter, sub-element cost and performance indicators
- the system for authorizing services to provider agencies
- the system of enrolling both network organizations and professionals into the managed care 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 and its effectiveness
- systems to collect, analyze and act on data regarding the quality of services
- confidentiality and security sub-systems intended to protect integrity of data
- capacity to collect, verify, store and analyze eligibility information
- system for exchanging eligibility information between the managed care entity, affiliates and providers
- collecting information necessary to demonstrate compliance with the contract or with performance standards, such as establishing service penetration rates
- MDCH/Management Reporting including the costs of reporting demographic, encounter, cost and performance indicator to MDCH by the

PIHP. Administrative costs in performing reporting requirements may also include the costs associated with data validation and correction.

Information Management functions can be either Managed Care or Provider Administration, depending on which entity's interests are served. The following are examples of items which are not Managed Care Administrative functions:

- hardware, software and personnel for collection, storage, retrieval and submission to payors of demographic, service encounter, sub-element cost and performance indicators
- systems to collect, analyze and act on data regarding the quality of services, when this information is used by the provider to strengthen its own capability
- confidentiality and security sub-systems intended to protect integrity of the provider's data
- capacity to connect to the Managed Care Entity's eligibility system
- ability to bill for services
- internal management reports the provider may create for its payer reports or own internal operations.

## **G. General Management**

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

- The CEO of the managed care organization (PIHP). The CEO of the Managed Care Entity may also be the CEO of a Provider entity, in which case costs must be allocated between the two functions.
- The Chief Operating Officer (COO), or equivalent staff position reporting to the CEO. The COO may be dedicated to the Managed Care Entity or have divided responsibility to management of the provision of service.
- The Managed Care Entity's Medical Director. The Medical Director provides overall leadership to such functions as: Clinical Policies/Protocols; Development of Treatment Guidelines and Level of Care Criteria; Access, Eligibility, Triage and Authorization Line protocols; and the Utilization Management and Utilization Review processes.
- Oversight of delegated functions is considered a Managed Care Administrative function.

Other general management activities include:

- Activities to organize an affiliation governance structure
- Activities to organize an affiliation's management structure, including meetings of the PIHP with its CMHSPs, CA, or network providers.
- Activities to organize and maintain any management sub-workgroup structures, where the Managed Care Entity is providing lead staff direction/assistance.

Identifying Managed Care Administrative Costs (Revised 6-20-05)

- Administrative support.
- Legal support
- Management and technical consultants provided assistance to the Managed Care Entity.
- Other associative and staffing costs in managing a specialty health plan and a regional provider network.