

**Community Mental Health Affiliation
of Mid-Michigan**

PROCEDURE #: 7.5	Page 1 of 6	SUBJECT: Capitation Payments and Budget Development
Related Policy(ies) #: 7.0		SUBJECT: Financial Management
Issuing Director: Director of Affiliation Operations		Original Effective Date: 07/10/08

REVISED DATE

08/19/08
02/10/09
03/17/09
09/14/09

Review Date(s)

I. PURPOSE:

The purpose of this procedure is: to describe the methodology by which the PIHP will make straight capitated payments to affiliates, to identify the conditions for using Medicaid Savings and/or ISF to ensure benefit stabilization throughout the Affiliation, and to outline the steps that the PIHP and affiliates will take to ensure fiscal stewardship across the Affiliation.

Guiding Principles:

Each process in this procedure takes into account the commitment by CMHAMM to adhere to the following principles:

- Autonomy is retained by each CMHSP within uniform standards and statutory and regulatory requirements.
- The PIHP will confirm that each CMHSP demonstrates financial stewardship through the use of a transparent system of on-going reporting, including reviews of actual to projected Medicaid expenditures, including projected lapse.
- The PIHP will ensure that the Affiliation has sufficient Risk Reserve.
- The PIHP is responsible for ensuring that Medicaid recipients, within the PIHP region, have access to medically necessary Medicaid services as indicated in 42CFR Sec. 438.206
- All current year Medicaid revenues and Medicaid savings as well as the Medicaid ISF must be projected to be spent before State General Funds (GF) are used to cover the costs of Medicaid services.

II. STANDARDS:

42 CFR Sec. 438.206 Availability of services:

(a) Basic rule. Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs.

(b) Delivery network. The State must ensure, through its contracts, that each MCO, and each PIHP and PAHP consistent with the scope of the PIHP's or PAHP's contracted services, meets the following requirements:

- Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.

In establishing and maintaining the network, each MCO, PIHP, and PAHP must consider the following:

- i. The anticipated Medicaid enrollment.
- ii. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO, PIHP, and PAHP.

III. **DEFINITION(S):** (if applicable)

A. Affiliate:

All members of the Community Mental Health Affiliation of Mid Michigan (CMHAMM), including the PIHP.

B. Spending plan:

General description of revenues and expenditures as it relates to Medicaid expenditures approved by the PIHP.

C. Budget:

Formal document of expenditures and revenues approved by a CMHSP Board of Directors that includes all funding streams and expenditures.

D. ISF:

Internal Service Fund: Medicaid funds held by the PIHP for the benefit of the CMHAMM for use on Medicaid related risk.

IV. **PROCEDURES:**

A. Affiliation spending plan preparation:

1. In June of each fiscal year, the PIHP will issue projected Medicaid funding for the upcoming fiscal year straight capitation based on the PIHP's best estimates of Medicaid revenue for the coming year. This information will be presented to each CMHSP in the form of projected funding exhibits that include estimated straight capitation payments and affiliation fees to reflect net Medicaid for the coming year for each affiliate.
2. Individual CMHSP's project the coming fiscal year's expenditures against estimated revenues. Proposed expenditures should be determined using the same set of variables for all affiliates. At a minimum, these variables should include those listed in attachment A. Where possible, affiliates should use as close to actual projected expenditures and increases based upon their individual experiences and history. The balanced spending plan should detail any planned program expansions or contractions that are included in the plan.
 - a. The rate of the economic increases to staff, fringe benefit costs, contractors, utilities and all other increases over costs incurred in the current year must be explicitly stated as part of each affiliate's spending plan submission to the PIHP. This spending plan must also use the methods outlined in the "Medicaid Allocation" section provided later in this document.
 - b. The CMHSP's will submit to the PIHP the coming fiscal year's balanced spending plan no later than July 15th. This spending plan may be submitted to the PIHP prior to individual CMHSP Board approval of a formal budget. The PIHP will

notify the CMHSP of their approval or disapproval of the plan no later than August 31st. The PIHP may disapprove a spending plan only if the plan does not meet Medicaid rules and regulations.

- c. If a spending plan submitted by an affiliate includes plans for service expansion or operations strengthening initiatives, these plans must be described in narrative which accompanies the plan. These uses must meet Medicaid standards. The PIHP's review and approval of the affiliate's coming fiscal year's balanced spending plan will also include the review and approval of these expansion and strengthening initiatives.
- d. An affiliate with a projected deficit shall submit a spending plan with the assumption that no additional Medicaid funds are forthcoming. In such cases, the balanced spending plan, and the accompanying narrative may include contraction of services, change in practices, or use of the affiliate's fund balance. A plan that reduces services to consumers shall also include program details, timelines, as well as an analysis of the potential impact to consumers. The PIHP's review and approval of the affiliate's coming fiscal year's balanced spending plan will also include the review and approval of these contraction, change in practices, use of fund balance initiatives.
- e. If the PIHP determines that additional funds are available, either through rebasing, excess Medicaid savings, or lapse from another affiliate, it will allocate those funds, at its discretion, to strengthen the Medicaid services array available within the individual CMHSP, or across the Affiliation and notify the affiliates impacted by the adjustment. The affiliate will then submit a new spending plan that balances.

B. Spending Plan Monitoring:

1. Quarterly projections of variances for each affiliate are reviewed by the PIHP and the CMHSP using FSR (which is based on actual ledger balances) and additional information, in writing, from each CMHSP within the Affiliation. The PIHP and affiliates will meet to resolve any discrepancies relative to the projected variances.
2. Based on the discussion, above, and other information, the PIHP estimates the projected lapse for each CMHSP, if any. Each affiliate that projects a lapse is due its full payment up to the straight cap amount for their counties. Actual lapse will be re-directed at the time of cost-settlement by the PIHP, if necessary. The PIHP will allocate those funds, at its discretion, to strengthen the Medicaid services array available within the individual CMHSP, or across the Affiliation. The timing of the redistribution of lapse may be adjusted by the PIHP as cash-flow issues, on the part of the affiliate receiving redirected funds, necessitate.
3. The PIHP will utilize a process of its own design to distribute, via contract amendment, excess funds.
4. The PIHP will use, as the primary tools for spending plan monitoring, the 1st, 2nd and 3rd quarter Medicaid FSR. Additional supporting documents will include: quarterly budget documents as submitted to the CMHSP Board of Directors, reserve account contributions and use. Schedule of Residential (including CLS) and Inpatient budget to actual, and a written analysis of budget to actual contained in these documents. The CMHSP will submit, or allow access to supporting documents, including general ledger detail, for any items the PIHP determines is in need of clarification. The PIHP will prepare a preliminary Savings Summary for each quarter of the fiscal year based on the above findings.

5. If revenue or expense problems are noted, the following steps will be taken:
 - a. Affiliate CEO determines steps to take, date of implementation, and responsible party, if needed, to control expenditures. These steps can include:
 - i. Obtain additional information to determine causes, via discussions with key informants, gathering data
 - ii. Implement changes to control expenditures
 - iii. Recommend a budget revision to remain within capitated funding
 - b. Subsequent to Budget CEO Meeting, Affiliate submit to PIHP, in writing:
 - i. Revenue or expenditure problem
 - ii. Steps to be taken to address problem (including the request for a budget revision)
 - iii. Date of implementation for each step
 - iv. Responsible party for each step
 - v. If a budget revision is recommended, the rationale for the revision
6. Timelines for budget analysis for current fiscal year include:
 - a. January/February – Documents from B4, above, for prior year (year-end) and 1st quarter of current fiscal year, due to PIHP from CMHSP.
 - b. February – review Medicaid Savings balance after cost settlement of prior year activity is completed and establish target Medicaid savings balance for current fiscal year.
 - c. February – CEO and CFO meeting to review prior year (year end) and 1st quarter summary analysis of items contained in B4 above. Revise, if needed, Medicaid Savings balance estimates.
 - d. April/May – Documents from B4 above, for 2nd quarter, due to PIHP from CMHSP.
 - e. May – CEO and CFO meeting to review 2nd quarter summary analysis of items contained in B4 above. Revise, if needed, Medicaid Savings balance estimate. This savings estimate will also be used to determine the amount of savings available for use in balancing the coming year's budget.
 - f. July/August – Documents for B4 above, for 3rd quarter, due to PIHP from CMHSP.
 - g. August – CEO and CFO meeting to review 3rd quarter summary analysis of items contained in B4 above. Revise, if needed, Medicaid Savings balance estimate.
 - h. November – Documents for B4, above, for 4th quarter (preliminary year-end) due to PIHP from CMHSP.
 - i. November – Review Medicaid Savings balance, after preliminary cost settlement of current year activity is completed, to determine Medicaid availability for CMHSP's with a deficit.
7. Addressing Use of Medicaid Savings, Excess Current Medicaid and the Internal Service Fund:
 - a. Affiliates must notify the PIHP, both verbally and in writing, as soon as a projected deficit in Medicaid funding is anticipated. This should be in addition to quarterly monitoring through the FSR and other mechanisms. Affiliates who anticipate a Medicaid funding deficiency shall comply with the requirements of the PIHP including but not limited to changes in clinical and administrative practices, staffing patterns, as well as program and administrative structures.
 - b. Affiliates that overspend their funding allocation will receive the additional funds required after cost-settlement if they are available system wide or in the Medicaid Savings or ISF. During the fiscal year, the PIHP will monitor and ensure fiscal restraint by all affiliates, including the PIHP. In this regard the PIHP will take all necessary steps to ensure that the spending of each affiliate remains within the balanced spending plan developed by the affiliate and approved by the PIHP. These

steps may include requiring an affiliate who is projecting an over-expenditure of the balanced spending plan to change clinical and administrative practices, staffing patterns, as well as program and administrative structures.

- c. Any affiliate with a funding deficit, after cost settlement, will be required to submit a revised spending plan, for the recently closed out fiscal year, using available excess Medicaid , in the amount determined by the PIHP. The PIHP will allocate those funds, at its discretion, to strengthen the Medicaid services array available within the individual CMHSP, or across the Affiliation. If excess Medicaid is not available, this plan will detail the source of funding intended to be used. Additionally, a plan for addressing the causes of over-expenditure, in the subsequent fiscal year, must be submitted by the affiliate. Both the revised spending plan for the recently closed out fiscal year and the plan for addressing the causes of over- expenditure must be approved by the PIHP.
- d. An affiliate with projected excess Medicaid funding, in the current fiscal year, or with excess Medicaid funding in the recently closed fiscal year, as determined after cost settlement, can propose via a Medicaid Savings Reinvestment plan provided to the PIHP for the use of some or all of these excess funds for use, by the affiliate projecting or recording the excess Medicaid funds, in the subsequent fiscal year. The amount that can be included in such a Reinvestment Plan is limited to \$100,000 or 0.65% of an affiliate's annual Medicaid revenue, whichever is greater.

The PIHP will approve or disapprove of this Medicaid Savings Reinvestment plan, at its discretion, after considering any of a number of variables and principles, including: the specificity of the plans, including proposed uses and timeframes (the more specific, the better able the PIHP is to determine the value of the plans); the value of the requesting affiliate's plans, relative to other potential uses for these Medicaid funds, in the current or coming fiscal year; the assurance that the generation of these excess funds is not the result of unmet Medicaid need within the region served by the affiliate generating the funds; and the amount of excess funds reflected in the Reinvestment Plan, in relation to the annual Medicaid revenue of the affiliate projecting or generating these excess funds.

If approved, the use of these funds in an Reinvestment Plan will be reported, by the affiliate, and monitored, by the PIHP, in the same manner as all other Medicaid expenditures, as described in this document. If the funds addressed in the Medicaid Savings Reinvestment Plan are not used for the purpose outlined in the plan, including adherence to timeframes, the PIHP reserves the right to withdraw approval of the plans and reallocate all or a portion of the Medicaid funds delineated in the plans, from the affiliate which submitted the plan, to other uses and affiliates within the Affiliation.

C. Use, Allocation and Reporting of Medicaid Revenues and Expenses:

1. *Allocation of costs to Medicaid:* For the purpose of allocating the cost of services among funding sources, all affiliates will use a process that includes the following components:
 - a. Encounter based
 - b. Weighted to account for the differences in time and/or cost of procedure codes reported within the encounter data system
 - c. Allocation of expenditures to funding sources other than Medicaid when the cost of services for Medicaid consumers are not Medicaid eligible

This allocation, conducted quarterly, must draw upon the Medicaid Utilization Net Cost (MUNC) report, the Medicaid cost allocation plan, and the quarterly Financial Status Report (FSR) of each affiliate.

2. *Use of full accrual:* Each affiliate must use full accrual accounting in the completion of the FSRs which are submitted to the PIHP.
3. *Withdrawal from and contribution to reserve accounts/ISFs:* For the purpose of charging or crediting costs associated with a reserve account or internal service fund to current year Medicaid the following guidelines will be followed:
 - a. In no case will the amount charged to Medicaid be in excess of actual costs incurred unless supported by a certified actuarial analysis
 - b. All allocation methods and calculations must be pre-approved by the PIHP
4. *Increased costs incurred, via management decisions:* Before implementing changes that will incur greater Medicaid costs, the management of the affiliate considering such changes must review those changes with the PIHP. Those changes would include increases in staffing levels as well as increases in staff salaries not contained in the original proposed spending plan. The purpose of such a review is to ensure that the Medicaid funds to be used for such increases are not needed by other affiliates to meet the needs of Medicaid recipients. In most cases, those affiliates making such changes which do not result in use of Medicaid funds in excess of the affiliate's straight capitation payments will be given broader discretion than those affiliates whose proposals would cause them to spend above their straight capitation payments.

V. APPLICATION:

This procedure applies to all CMHAMM CMHSP's and providers.

VI. MONITOR AND REVIEW:

The PIHP Director and Finance will monitor these functions. The Director of Affiliation Operations reviews this policy annually. External review will include MDCFH and CMS site visits and annual financial audits.

VII. RELATED POLICIES AND PROCEDURES:

CMHAMM Policy	7.0	Financial Management
CMHAMM Procedure	7.1	Financial Management
CMHAMM Procedure	7.3	Risk Management ISF
CMHAMM Procedure	7.4	Habilitation Supports Waiver – Finance

Attachment A:

STEADY STATE BUDGET ASSUMPTIONS:

The steady state budget is the preliminary planning budget, holding operations constant, that represents: the estimated cost in the coming year, reflecting the trends expected for that year, to continue the level of services that CMH is providing this year, and the estimated revenue in the coming year, reflecting expected trends for that year.

The steady state budget is built using a number of assumptions. If information, that could be used to revise the assumptions, becomes available after the Preliminary Steady State budget is issued, the PIHP will notify the affiliates of such changes. The following is an example of the areas the PIHP will issue general guidelines for the affiliates to be used in initial budget preparation.

Expenses:

1. Cost increases that are required by contract or other regulatory or infrastructure arrangements (i.e. DEA certification, CARF requirements, foster care licensing, DCH contractual arrangements, software agreements, Corporate Compliance, HIPAA, etc.) that extend into FY 2008.
2. Adjust debt service payments based on facilities, vehicles, or other assets purchased/constructed or paid in full in FY 2007 or FY 2008
3. Inpatient expenditures, reflecting new rates
4. Projected cost of fringe benefit rate increases reflecting trends from the previous five years
5. MERS retirement based on actuarial valuation
6. Staff wages will reflect step increases and negotiated increases
7. Paralleling the residential wage increase, contracts with organizational service providers, with the exception of inpatient contracts, will receive a 3% increase. All other contract expense lines (i.e. liability insurance and vehicle costs) will be based on prior year actual or insurance carrier estimates. For all other total-cost contracts, a 0% increase will be assumed contingent upon negotiations with contractors.
8. Include any other known cost increases that will have a substantial impact on the budget (i.e. costs related to transition children from Child Waiver Program to CMH system; residential placements; loss of grant funding; residential type A contract increases due to difficulty of care, etc.).
9. General Insurance increases to reflect prior trends or insurance carrier estimates when available
10. Setting the Loss Reserve Provision at zero

Revenues:

1. Medicaid Revenue: Refer to the funding exhibit issued in June to determine the PIHP's estimate for Medicaid revenues
2. General Fund Revenue: No increase in state General Fund dollars
3. Fees (third party reimbursements and SSI) adjusted to reflect trend over last fiscal year
4. County contributions based on FY 2007 funding
5. Funding changes for current grants/contracts and new grants/contracts