FELDESMAN+TUCKER+LEIFER+FIDELL
1129 20th Street, NW
Suite 400
Washington, DC 20036
T. 202.466.8960
F. 202.293.8103
www.ftlf.com

MEMORANDUM

TO: Robert Sheehan, Chief Executive Officer
Community Mental Health Association of Michigan

FROM: Adam Falcone, Esq.

DATE: December 17, 2020

RE: Service/Encounter Costs for Community Mental Health Service Programs

---

In determining service/encounter costs, the Michigan Department of Health and Human Services ("MDHHS"), through its actuaries, has proposed to exclude certain costs incurred by a Community Mental Health Services Program ("CMHSP") when the CMHSP contracts for services from direct care providers. For example, if a CMHSP incurred costs for training for the direct care providers, furnishing vehicles to the direct care providers, and employing adjunct staff (e.g., nurses and case managers) when contracting for psychiatric care, MDHHS would exclude those costs from calculating service/encounter costs on the theory that such costs result from performing delegated managed care functions.

You have asked us to opine on whether it is appropriate for MDHHS, in determining service/encounter costs, to categorically exclude all of the CMHSP's own costs when the CMHSP contracts for services from a direct care provider.

For reasons explained in more detail below, we conclude that MDHHS's proposal would be inconsistent with federal Medicaid managed care regulations. Contracting with direct care providers to render services does not transform a CMHSP into a subcontractor or result in a CMHSP performing managed care functions when it supports and oversees the direct care providers. Consequently, MDHHS should only exclude costs from calculating service/encounter costs when those costs arise from a CMHSP performing specific managed care functions that have been delegated by the PIHP to the CMHSP.

1. Background

MDHHS contracts with Prepaid Inpatient Health Plans ("PIHPs") to manage Medicaid specialty mental health and substance abuse services and supports. PIHPs contract with CMHSPs for two distinct functions as follows.

- First, PIHPs contract with CMHSPs as a network provider to render Medicaid covered services. You have informed us that CMHSPs, in their network provider role, furnish

services directly through its own employees as well as indirectly under contracts with other direct care providers.[1]

- Second, PIHPs contract with CMHSPs to furnish some portion of the work or services that the PIHP has agreed to perform under its contract with MDHHS. These services are referred to as "delegated managed care functions" because the PIHP has delegated certain managed care functions to a CMHSP as a subcontractor to the PIHP.[2]

The question presented is whether all of the costs incurred by a CMHSP in its network provider role may be categorized as service/encounter costs without regard to whether a CMHSP furnishes those services directly through its own employees or through contracts with other direct care providers.

2. Legal Analysis

A. Definitions of Network Provider and Subcontractor

Federal Medicaid managed care regulations, codified at 42 C.F.R. Part 438, distinguish between a "network provider" and a "subcontractor" based on the function that each entity furnishes to the PIHP. A "network provider" is defined as "any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, or PAHP, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP, or PAHP." 42 C.F.R. § 438.2. In contrast, a "subcontractor" is defined as "an individual or entity that has a contract with an MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State." 42 C.F.R. § 438.2.

Three aspects of the above regulatory definitions bear on the issues presented. First, the definition of a network provider contains two requirements: (1) the provider or entity must have a network provider agreement with a MCO, PIHP or PAHP, or a subcontractor and (2) the entity must receive Medicaid funding to order, refer or render covered services. Applied here, that means that a CMHSP should be considered to be a network provider if it holds a network

[1] We have not reviewed network provider agreements between PIHPs and CMHSPs nor the professional service agreements between CMHSPs and direct care providers.

[2] Pursuant to 42 C.F.R. § 438.230(c)(1), if a managed care plan delegates any of its activities or obligations under its contract with the State to a subcontractor, then the delegated activities or obligations must be specified in a contract or written agreement. We have not reviewed the contracts between PIHPs and CMHSPs and therefore express no opinion on which managed care functions have been delegated by PIHPs to CMHSPs.

provider agreement and receives funds to order, refer or render services. CMHSPs undisputedly meet both of those requirements.

Second, nothing in the definition of network provider above requires a provider to furnish services directly to patients. The Medicaid managed care regulations define a "provider" as "any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services." 42 C.F.R. § 438.2. Many providers engage in the delivery of services by purchasing services of other providers through professional services agreements. Because CMHSPs are entities engaged in the delivery of services, and are legally authorized to do so by the State of Michigan, CMHSPs continue to meet the definition of a provider even when they purchase services from other direct care providers.

Third, the regulatory definitions of "network provider" and "subcontractor" make clear that that a network provider is not a subcontractor by virtue of the network provider agreement. *See* 42 C.F.R. § 438.2 (containing similar statements under the definition of "network provider" and "subcontractor"). For that reason, even if a network provider purchases services from other providers in the rendering of covered services, that act alone would not qualify the entity to be a subcontractor. Consequently, CMHSPs do not become subcontractors simply as a result of contracting with other direct care providers.

Based on the foregoing, we conclude that CMHSPs qualify as network providers when they render covered services directly using their own employees and that they continue to qualify as network providers when they indirectly render covered services under contracts with other direct care providers. Because rendering covered services are not managed care functions, all of the CMHSPs' own costs of supervising and supporting other direct care providers should be included in determining service/encounter costs. In contrast, when CMHSPs perform delegated managed care functions on behalf of a PIHP, they would qualify as subcontractors, and those costs should be excluded from calculating service/encounter costs.

B. Medical Loss Ratio Standards

In its analysis of service/encounter costs, MDHHS appears to have relied upon the standards for the calculation and reporting of a medical loss ratio ("MLR") applicable to Medicaid managed care organizations (MCOs), including PIHPs ("MLR Standards").[3] *See* 42 C.F.R. § 438.8. The MLR is the ratio of the numerator to the denominator, with the numerator comprised of the sum of the managed care plan's incurred claims, the managed care plan's expenditures for activities

[3] An analysis of whether the MLR standards are applicable here are beyond the scope of this memorandum. We note, however, that the MLR standards are intended to address how payments made to providers and subcontractors should be characterized for the purpose of meeting MLR requirements. If MDHHS is using these standards for a different purpose, then the State may wish to consider looking to another source for guidance, such as cost principles applicable to the PIHP contracts.

that improve health care quality, and fraud prevention activities, 42 C.F.R. § 438.8(d)-(e), and the denominator comprised of the adjusted premium revenue, 42 C.F.R. § 438.8(f).

Under the MLR Standards, the definition of "incurred claims" includes "[d]irect claims that the MCO, PIHP, or PAHP paid to providers (including under capitated contracts with network providers) for services or supplies covered under the contract and services meeting the requirements of § 438.3(e) provided to enrollees." 42 C.F.R. § 438.8(e)(2)(i)(A). The definition of "incurred claims" specifically excludes "[a]mounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee." 42 C.F.R. § 438.8(e)(2)(v)(A)(3).

In applying the above regulatory provisions here, MDHHS has suggested that any costs incurred by CMHSPs for supervision and support of direct care providers should be excluded from service/encounter costs because they arise from the performance of professional or administrative services, i.e., delegated managed care functions. That view, however, overlooks the fact that CMHSPs incur the supervision and support costs in the course of furnishing covered Medicaid services to enrollees as a network provider, not in the course of furnishing delegated managed care services as a subcontractor.

Alternatively, MDHHS has pointed to MLR guidance issued by the Centers for Medicare and Medicaid Services ("CMS") to assist states when a managed care plan uses a third-party vendor in a subcontracted arrangement. *See* Memorandum from Chris Traylor, Deputy Administrator and Director Center for Medicaid and CHIP Services, "Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors", May 15, 2019 ("Traylor Memorandum"). In calculating incurred claims for Medicaid covered services, the Traylor Memorandum explains that, in general, a Medicaid managed care plan may only include the amount that the subcontractor actually pays the medical provider or supplier for providing Medicaid covered services to enrollees. *Id.* at 3. An exception applies, however, when a subcontractor, through its own employees, provides Medicaid covered services directly to enrollees. *Id.* at 4.

Reliance on the Traylor Memorandum is also misplaced because that guidance applies to subcontractors. Federal Medicaid managed care regulations state clearly that providers are not subcontractors by virtue of having a network provider agreement. If that were not the case, then each time a provider purchased services from another provider in the course of rendering services, the managed care plan would be required to identify the portion of the provider's payment for administrative function (such as oversight and support of the subcontracted provider) and exclude the related expense from the calculation of incurred claims. To avoid that result, providers are not automatically deemed subcontractors when they contract with other providers in rendering covered services.

3. Conclusion

CMHSPs contract with PIHPs as both a network provider in rendering covered services and a subcontractor in performing delegated managed care functions. To identify administrative costs that might be excluded from service/encounter costs, MDHHS must first identify the specific managed care functions delegated to the CMHSPs. Only in the performance of those specific functions would CMHSPs qualify as subcontractors. Once those functions are known, MDHHS may then identify costs incurred by CMHSPs for performing delegated managed functions, and exclude such costs from service/encounter costs.

Please let me know if you have any further questions.