Michigan Department of Health and Human Services
Local Public Health Department
Full Cost Reimbursement
Cost Report Instructions

INTRODUCTION

The term full cost reimbursement means the full cost of providing Medicaid services as determined by information provided on the Michigan Medicaid Cost Report for Local Public Health Departments (LHDs). Full cost is offset by the amounts the LHD receives from Medicaid Fee-for-Service and Medicaid Health Plan payments; other commercial third party insurers; and quarterly payments, initial and final settlements provided by Michigan Department of Health and Human Services (MDHHS). Reporting within this cost report follows the Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (2 CFR 200 Subpart E). A combination of local and state general funds provides the basis for full cost reimbursement and is used for claiming federal financial participation. MDHHS will reimburse those covered services provided by LHD, other than dental services, which include preventive, diagnostic, therapeutic, rehabilitative or palliative services that are furnished by a public facility that is not part of a hospital but is organized and operated to provide medical care to outpatients.

LHDs receive full cost reimbursement for the following services:

- Breast and Cervical Cancer Control Program Services
- Child and Adolescent Health Centers
- Communicable Disease Services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Family Planning Clinic Services
- Hearing and Vision Screening
- Immunizations
- Maternal Infant Health Program (MIHP) Services
- Blood Lead Services

To receive full cost reimbursement qualified providers must supply the MDHHS Hospital and Clinic Reimbursement Division (HCRD) with a Michigan Medicaid Cost Report, which would include the referenced services listed above.

PROGRAM DEFINITIONS

Group 1- Medical Services

Breast and Cervical Cancer Control Program Services - (Direct services only) The Breast and Cervical Cancer Control Program (BCCCP) covers uninsured low-income women of all ages especially, but not limited to, women aged 40-64. Covered services include: Clinical breast exams, Pap smears, Pelvic exams, Screening mammogram, and appropriate referral to community providers for follow-up of abnormalities. It does not include case management services.

Child and Adolescent Health Centers - Child and Adolescent Health Centers and Programs (CAHCPs) provide medical services on behalf of the Medicaid Health Plans (MHPs) to school-aged children. Behavioral Health Services are covered if they are billable Medicaid services (e.g. not substance abuse services).

Communicable Disease Services- Communicable diseases are HIV/AIDS, tuberculosis, and vaccine-preventable communicable diseases as well as Sexually Transmitted Diseases (STD).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - Federal regulations require state Medicaid programs to offer early and periodic screening, diagnosis, and treatment (EPSDT) services to Medicaid eligible beneficiaries younger than 21 years of age. The intent of EPSDT is to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by screening services. Accordingly, EPSDT well child visits and any needed follow-up services are covered by Medicaid.

Maternal Infant Health Program (MIHP) Services - The MIHP is to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. Services are intended to supplement regular prenatal/infant care and to assist providers in managing the beneficiary's health and well-being. MIHP services are preventive health services provided by an agency that is certified by the Michigan Department of Health and Human Services (MDHHS). MIHP services are provided by a licensed social worker and a registered nurse.

Group 2- Procedure Clinics

Hearing and Vision Screening - Objective hearing screening and objective vision screening may be performed on eligible Medicaid children from age three through six years of age by qualified LHD staff. LHDs may provide objective hearing and/or vision screening services and accept referrals for screening from physicians and from Head Start agencies. This includes all services and associated costs – total service count is for the entire population served but can only bill for Medicaid preschool-aged children from age three through six years of age.

Group 3- Vaccines

Immunizations – Those costs incurred by the LHD for administering vaccines needs to be reported, including Vaccines for Children (VFC) costs or value of those costs. The value of the VFC reported in the Expense portion also needs to be included in the Federal Revenue so it can be offset.

Group 4- Enhanced Funding

Family Planning - A family planning clinic or a primary care provider can provide family planning services. Family planning clinics are limited to providing only family planning services. Family planning services are defined as any Medicaid covered contraceptive service, including diagnostic evaluation, drugs, and supplies, for voluntarily preventing or delaying pregnancy. Covered services include an office visit for a complete exam, pharmaceuticals, supplies and devices when such services are provided by or under the supervision of a medical doctor, osteopath, or eligible family planning provider.

Group 5- Limit Procedure Clinic

Blood Lead and Hemoglobin Services - A LHD can provide blood lead and hemoglobin draws in compliance with Medicaid policy and established procedure code limitations. The LHD must instruct the laboratory completing the blood lead analysis to send all blood test results to the child's Primary Care Physician (PCP) and health plan, if enrolled in managed care. Should a positive test be found, the LHD must collaborate with the PCP to assure the appropriate follow-up care is provided.

COST REPORT PREPARATION

The following definitions and instructions are uniform across all groups and programs unless directly specified otherwise. All reporting within this cost report should follow the Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards in 2 CFR 200 Subpart E.

EXPENSES

1) **Salaries and Wages:**
    a. **Direct Medical Staff**: Include the salary and wage for direct medical providers such as physicians, CNS, CNP, blood lead investigators, technicians and first line medical practitioner supervisors to the extent the supervisor is providing care. This includes the compensation for all permanent and part- time employees related to those who provide the direct health care related services and are assigned directly to the program.
    b. **Direct Supporting Staff**: Include the compensation for all permanent and part time employees supporting the health care services when they can be directly allocated to the program. This does not include contractual services, professional fees or personnel hired on a private contract basis. Consulting services, vendor services, professional fees or personnel hired on a private contracting basis should be included in "Other Expenses." Contracts with secondary recipient organizations such as cooperating service delivery institutions or delegate agencies should be included in Contractual (Sub-contract) Expenses.

2) **Fringe Benefits:**
    a. **Direct Medical Staff**: Include the fringe benefits related to the staff reported in line 1a above. This includes costs for social security, retirement, insurance and other similar benefits. These expenses must meet the provisions of 2 CFR

§200.431 to be considered allowable.

b. **Direct Supporting Staff**: Include the fringe benefits related to the staff reported in line 1b above. This includes costs for social security, retirement, insurance and other similar benefits. These expenses must meet the provisions of 2 CFR §200.431 to be considered allowable.

3) **Capital Expense for Equipment:** This category includes expenditures for budgeted stationary and movable equipment used in carrying out the objectives of each program element, project or service group. Capital expenditures means to acquire capital assets or expenditures to make additions, improvements, modifications, replacements, rearrangements, reinstallations, renovations, or alterations to capital assets that materially increase their value or useful life. (2 CFR §200.13) Capital expenditures for special purpose equipment are allowable as direct costs, provided that only items with a unit cost of $5,000 or more are reported in this category. Small equipment items costing less than $5,000 are properly classified as Supplies and Materials or Other Expenses. Capital assets means tangible or intangible assets used in operations having a useful life of more than one year which are capitalized in accordance with Generally Accepted Accounting Principles (GAAP) (2 CFR 225 § 200.12). This category also includes capital outlay for purchase or renovation of facilities. Please refer to the 2 CFR §200.13 Capital Expenditures and 2 CFR § 200.436 Depreciation.

4) **Contractual (Subcontracts/Sub recipient):** Use for expenditures applicable to written contracts or agreements with secondary recipient organizations such as cooperating service delivery institutions or delegate agencies which provide direct allocable services to the program (2 CFR § 200.413). Any costs associated with contracts or agreements with secondary recipient organizations reported on this line may not be captured under any other line or within any indirect allocation plan. Services which may be directly allocated under separate lines should be done so. Refer to 2 CFR Appendix IV to Part 200. Payments to individuals for consulting or contractual services, or for vendor services are to be included under Other Expenses. Specify subcontractor(s) address, amount by subcontractor and total of all subcontractors.

5) **Supplies and Materials:** Use for all consumable items and materials including equipment-type items costing less than $5,000 each. This includes office, printing, janitorial, postage and educational supplies; medical supplies; contraceptives and vaccines; tape and gauze; prescriptions and other appropriate drugs and chemicals. Supplies and equipment for medical direct services can be claimed at the direct rate. Include those supplies and materials for direct related patient care only. Federal Provided Vaccine Value should be reported and identified in the “Less: Federal Revenue” category- do not combine with supplies.

6) **Travel:** Travel costs of permanent and part-time employees assigned to each program element. This includes costs of mileage, per diem, lodging, meals, registration fees and other approved travel costs incurred by the employee. These costs must be directly related to patient care and the training necessary to provide patient care. Travel of private, non-employee consultants is allowed if not part of the contract and should be reported under Other Expenses. Travel logs must be maintained by the facility and provided upon request for audit review. See 2 CFR §200.474 for complete description of allowable costs for travel.

7) **Communication Costs:** These are costs for telephone, Internet, telegraph, data lines, websites, fax, email, etc. when related directly to the operation of the program element. Include only those costs directly allocable. Any costs included in determination of indirect cost allocation plans may not be charged under this center and should be reported under line 11 'Indirect Expenditures'. There must be maintained a cost allocation plan which clearly demonstrates the method used to charge the expenses to the program. This plan must be made available upon request. Refer to 2 CFR Appendix IV to Part 200. Also, any communication costs associated with County-City Central Services must be reported under the County-City Central Services and not directly charged to Communication.

8) **County/City Central Services:** These are costs associated with central support activities of the local governing unit allocated to the local health department in accordance with 2 CFR, part 200 Subpart E Appendix V, which addresses County Central Service Allocation Plans. These costs at a County level; such as County Administrator, motor pool, purchasing, accounting, HR, and other related services; are provided on a centralized basis and allocated to benefitting departments including the health department. Include only those costs directly allocable. Any costs included in determination of indirect cost allocation plans may not be charged under this center and should be reported under line 11 'Indirect Expenditures'. There must be a cost allocation plan maintained which clearly demonstrates the method used to charge the expenses to the program. This plan must be made available upon request. Refer to 2 CFR Appendix IV to Part 200.

9) **Space Costs:** These are costs of building space necessary for the operation of the program. 2 CFR § 200.413 Direct Costs makes consistent the guidance that administrative costs may be treated as direct costs when they meet certain conditions to demonstrate that they are directly allocable to a Federal award. Include only those costs directly allocable. Any costs included in determination of indirect cost allocation plans may not be charged under this center and should be reported under line 11 'Indirect Expenditures'. There must be a cost allocation plan maintained which clearly demonstrates the method used to charge the expenses to the program. This plan must be made available upon request. Refer to 2 CFR Appendix IV to Part 200.

10) **All Others:** These are costs for all other items purchased exclusively for the operation of the program element and not appropriately included in any of the other categories including items such as repairs, janitorial services, consultant services, vendor services, equipment rental, insurance, Automated Data Processing (ADP) systems, etc. Include only those costs directly allocable. Any costs included in determination of indirect cost allocation plans may not be charged under this center and should be reported under line 11 'Indirect Expenditures'. There must be a cost allocation plan maintained which clearly demonstrates the method used to charge the expenses to the program. This plan must be made available upon request. Refer to 2 CFR Appendix IV to Part 200.

11) **Indirect Expenditures:** Use to distribute costs of general administrative operations that have not been directly charged to individual programs. The Administrative Overhead (O/H) expenditures distribute administrative costs to each program element, project or service grouping. A sample of your indirect cost rate determination must be included as support for your cost report filing.

12) **Other Cost Distribution:** Use to distribute various contributing activity costs to appropriate program areas based upon activity counts, time study supporting data or other reasonable and equitable means. An example of Other Cost Distributions is nursing supervision. The distribution process permits costs reflected in a single program element to be subsequently distributed, perhaps only in part, to other programs or projects as appropriate. Include only those costs directly allocable. Any costs included in determination of indirect cost allocation plans may not be charged under this center and should be reported under line 11 'Indirect Expenditures'. There must be maintained a cost allocation plan which clearly demonstrates the method used to charge the expenses to the program. This plan must be made available upon request. Refer to 2 CFR Appendix V to Part 200.

13) **Total Expenses**: Calculate the sum of the expenses listed.

14) **Federal Revenue**: Includes any revenue related to this program from a Federal Agency or Grant. Required match amounts must be included as revenue as well. Medicaid funds may not be used to match other Federal programs, nor can other Federal revenue be used as Medicaid match. Exception clause for Group 3 "Vaccine Program" include value of VFC vaccines as Federal Revenue.

15) **Net Expenses for Allocation**: Calculate as total expenses less federal revenue (line 13-14).

DETERMINATION OF RATE

1) **Total Services**: These group definitions stated below are for the total facility:

Group 1: Total visits are defined as a face to face billable service which relates to procedures listed under this group in the LHD database. All services performed during the face to face visit will be excluded from any other group. Example: Blood draw during a communicable disease program office visit will not be included in Group 5 services.

Group 2: Any services administered for vision and/or hearing screens

Group 3: Vaccines may be counted by the administration fees associated with the covered vaccines.

Group 4: Total visits are defined as a face to face billable service which relates to procedures listed in the LHD database and are billed under the Family Planning Clinic enrolled NPI. All services performed during the face to face visit will be excluded from any other group. Example: Blood draw during a communicable disease program office visit will not be included in Group 5 services.

Group 5: Blood Lead Services that are billable units for the procedures listed under this group in the LHD database.

2) **Total Rate per Service**: Calculate as "Net Expenses for Allocation" divided by "Total Services" (line 15-16)

Under "Group 2- Hearing and Vision"

2.1) Hearing and Vision direct billing for 3-6 year olds

2.2) Hearing and Vision Medicaid billed services - Include directly charged costs for units billed for Medicaid recipients aged 3-6.

2.3) Hearing and Vision Rate with Add-on - Calculate add-on rate by dividing direct billing

costs by the Medicaid units billed (line 17.1- 17.2) then include this amount to the Total Rate per Service.

Information Only- Source of Match Funds

1) **State Portion** - The local match that the LHDs are responsible for. Family Planning is 10% and the Other Medicaid programs is the difference between the total cost and the federal share (Federal Medical Assistance Percentage-FMAP)

2) **1st, 2nd and 3rd party fees only** - 1st party fees are from private payers such as: patients, 2nd party fees are received from organizations, private or public who might reimburse services for a group or under a special plan and 3rd party fees are funds projected to be received from private insurance carriers such as Medicare.

3) **Local Funds- Other** - Enter all local support received either from a project or service group. This may include local property tax and/or other local revenues.

4) **Other- Private Grants, Donations** - Enter any funds received from private grants or donations made to the health department.

5) **Total Revenue** - Calculated as the sum of all State and Local Match funding (line 18 through line 21)

All counties must comply with (42 CFR 433.54) regarding bona fide donations. A bona fide donation means a provider-related donation (as defined in 42 CFR 433.52) is one in which a donation is made to the State or unit of local government that has no direct or indirect relationship to Medicaid payments made to, the health care provider, any related entity providing health care services, or other providers furnishing the same class of items or services as the provider or entity . *(44 CFR 433.52 provider-related donation is a donation or other voluntary payment (in cash or in kind) made directly or indirectly to a State or unit of local government by or on behalf of a health care provider to the State's Medicaid plan)*

Programs

Medicaid XIX - This Title XIX population is reimbursed using the Federal Medical Assistance Program (FMAP) provided by CMS for that fiscal year. The health departments are paid this Federal portion only and the remaining difference is considered a local match.

Family Planning - This Title XIX population is reimbursed at a federal share of 90% and also uses a separate fund source.

HMP Expansion - This Title XIX benefit plan provides health care to adults 19-64 years of age, not covered by or eligible for Medicaid with family incomes at or below 133% of the Federal Poverty Level (FPL) and who are not enrolled in Medicare. Eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology such as:

MAGI I: T-XIX HMP Newly Eligible 100% Federal
MAGI D: T-XIX Old Eligible 19-20 Year Old FMAP
MAGI R: T-XIX Old Eligible Disabled Institutional FMAP
MAGI Q: T-XIX Old Eligible Disabled Non-institutional FMAP
MAGI P: T-XIX Old Eligible PCR FMAP

Healthy Kids Expansion - This fee for service (FFS) benefit plan Title XXI covers children ages 16-18 from 100% Federal Poverty Level (FPL) up to 160% of the FPL. The benefits plan is funded by the Children's Health Insurance Program (CHIP) and benefits mirror FFS Medicaid.

MI-Child - This FFS benefit plan Title XXI is for low income uninsured children who are under the age of 19 years old.

Reimbursement

1) **Rate by Group:** The rate calculated on cost determination line 17 (or 17.3 for Procedure Clinics).

2) **Total Medicaid FFS:** Total count of services defined by group for the Medicaid Fee for Service (FFS) population from your provider records. All lines will be assigned in this order:
   - If a Family Planning (FP) indicator then assigned to Group 4
   - If procedure code is in Group 2, 3 or 5 then it will be assigned to the applicable group
   - If neither of these apply then always Group 1

3) **Total Health Plan Services:** Total count of services defined by group for the Medicaid Health Plan populations from your provider records.

4) **Medicaid Payments:** All Medicaid Fee for Service Payments received by group.

5) **Health Plan Payments:** All Health Plan Payments received by group.

6) **Copay, TPL and Patient Pay:** Payments received from beneficiary copay, other insurance and all patient pay amounts as reported for Medicaid claims included in this filing.

7) **Est Gross Amount Due (From):** This is a calculated amount. Multiply line 1 times the sum of lines 2 and 3, less the amounts reported on lines 4 through 6.

8) **Blended FMAP:** A blended or estimated Federal Match rate (FMAP) may be applied to provide estimated net amount due to (from) provider.

9) **Est Net Amount Due (From):** This is a calculated amount. Multiply line 7 times line 8.

10) **Total All Programs:** Sum of all amounts calculated in line 9.

Completed cost reports are due to the Hospital and Clinic Reimbursement Division (HCRD) 5 months after the close of the facility's fiscal year end. An extension can be granted if requested within 30 days prior to the official due date.

If you have any questions relating to the Michigan Medicaid Cost Report please contact the Hospital and Clinic Reimbursement Division at (517) 335-5330.