Get it Right the First Time: Cost Reporting as a CCBHC

National Council Member Regional Meetings
Think but don’t say FQBHC

- Paid for actual costs of providing services
- Have common scope of services
- Have common quality metrics
- A federal definition – commonality across state provider networks

H.R. 4302: passed March 2014

- $1.1 billion investment in behavioral health
- Certified Community Behavioral Health Clinic framework
- Two phases:
  - Planning grant phase
  - Demonstration phase
Behavioral health inside medical homes—deeply embedded in primary care team, prevention and early intervention, addressing behaviors as well as disorders

Behavioral health specialty centers of excellence, partnering with medical homes to provide high-value, whole-health care to people with complex conditions
Timeline

- **May-Aug 5, 2015**
  - Prepare Planning
  - Grant Applications

- **Oct 2015—Oct 2016**
  - Planning Phase

- **Jan 2017—Dec 2018**
  - Demonstration Phase
Application information

- Due August 5, 2015
- Awards up to $2 million
- Estimated number of awards: 25
- Planning phase: 1 year
- Key decision points (that can change):
  - Target Medicaid population
  - Select a PPS option
  - Design the site selection process for the planning phase
  - Determine EBPs to be required of CCBHCs
Planning Phase

- One year – October 2015 to October 2016
- Activities during the year:
  1. Solicit input
  2. Certify clinics (at least two, can be all)
  3. Establish a PPS
  4. Develop capacity to provide CCBHC services
  5. Develop or enhance data collection and reporting capability
  6. Prepare for participation in national evaluation
  7. Submit a demonstration proposal
- 8 selected states allowed no-cost extension to finish planning activities
Minimum Standards

Areas that an organization must meet to achieve CCBHC designation:

1. Staffing
2. Accessibility
3. Care coordination
4. Service scope
5. Quality/reporting
6. Organizational authority

*See MTM’s Certification Criteria Readiness Tool for detail
Care Coordination: The “Linchpin” of CCBHC

Partnerships (MOA, MOU) or care coordination agreements required with:

- FQHCs/rural health clinics, unless the CCBHC provides comprehensive healthcare services
- Inpatient psychiatry and detoxification
- Post-detoxification step-down services
- Residential programs
- Other social services providers, including
  - Schools
  - Child welfare agencies
  - Juvenile and criminal justice agencies and facilities
  - Indian Health Service youth regional treatment centers
  - Child placing agencies for therapeutic foster care service
- Department of Veterans Affairs facilities
- Inpatient acute care hospitals and hospital outpatient clinics
Care Coordination: The “Linchpin” of CCBHC

• CCBHC coordinates care across the spectrum of health services, including physical and behavioral health and other social services

• CCBHC establishes or maintains electronic health records (EHR)
  ✓ Health IT system is used to conduct population health management, quality improvement, reducing disparities, and for research and outreach
CCBHC Scope of Services

- Screening, Assessment, Diagnosis
- Pt. Centered Treatment Planning
- Outpatient MH/SA
- Targeted Case Management
- Primary Health Screening & Monitoring
- Armed Forces and Veteran’s Services

- Crisis Services*
  - Mobile Emergency
  - Crisis stabilization
- Peer Support
- Psychiatric Rehab

Delivered directly by CCBHC
Delivered by CCBHC or a Designated Collaborating Organization (DCO)
DCOs

- Formal relationship, not direct supervision
- Delivers services under “same requirements” – up for interpretation
- Payment included in PPS
- DCO encounter = CCBHC encounter
- CCBHC is clinically responsible
What a DCO can provide

- Targeted Case Management
- Primary Health Screening & Monitoring
- Armed Forces and Veteran’s Services

(All of it!)
PPS Rate Methodology

- Participating states will select 1 of 2 PPS rates
  1. FQHC-like PPS
     - Reimbursement of cost on daily basis
  2. CC PPS Alternative
     - Reimbursement of cost on monthly basis
     - Layered payments for clients with certain conditions
     - Outlier payments

- PPS Rate will include cost of DCO services
- Quality Bonus Payments
  ✓ Optional for FQHC-like PPS Option
  ✓ Required for Alternative PPS Option
Required Measures for Quality Bonus Payments:

1. Follow-Up after Hospitalization for Mental Illness (adult age groups)
2. Follow-Up after Hospitalization for Mental Illness (child/adolescents)
3. Adherence to Antipsychotics for Individuals with Schizophrenia
4. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
5. Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
6. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
Quality Measures

Eligible Measures for Quality Bonus Payments:
1. Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication
2. Screening for Clinical Depression and Follow-Up Plan
3. Antidepressant Medication Management
4. Plan All-Cause Readmission Rate
5. Depression Remission at Twelve Months-Adults

States may propose quality measures for QBP; however, CMS approval is required.
Costing and Rebasing

• Demonstration Year 1 Rates
  • Cost and visit data gathered during planning phase;
  • May include **estimated costs** for services/items projected for demo phase
  • Updated by Medicare Economic Index (MEI)

• Demonstration Year 2 Rates
  • Update of DY1 rates with MEI
  
  Or

  • Rebasing
CCBHCs and Other Provider Types

CCBHC PPS payments trump all
- FQHCs
- Clinics
- Tribal Facilities

Excluded services:
- Inpatient care
- Residential treatment
- Room and board expenses
State Options

1. Fully incorporate the PPS payment into the managed care capitation rate;
   or

2. Year-end reconciliation process to make a wraparound supplemental payment to ensure that the total payment is equivalent to CCBHC PPS.
Come to Hill Day 2015

October 5-6, 2015
Washington, D.C.
Influencing State Planning Year Decisions

National Council Regional Meetings
Medicaid Not Adequately Funding Behavioral Health Services

- Providers dependent on grants

- Grants funding has locked us into a defined scope of services, job titles, and job functions that will not exist in the new cost reporting world
Medicaid Funding Behavioral Health Services

• Cost-based reimbursed would allow providers to define the scope of services, job titles, and job functions as long as consistent with Medicaid cost principals

• A different way of thinking also creates:
  – Different partners
  – Different politics
  – Different optics
Opportunity to Create Different Partners

• Lessen burden on public safety
• Lessen burden on foster care system
• Lessen burden on health care system
• Allow for more integrated care
• Allow for technological and service expansion
Opportunity to Create Different Politics

• Expansion vs. Non-Expansion States
  – Federal Reimbursement is higher in expansion states

• Different partners create different political allies

• Increasing role of state politics

• All politics is local
Opportunity to Create Different Optics

- Externally communicating the opportunities of new partners and changing politics
- Internally updating staff and board identity
- Role of technology
Opportunity to Engineer Change

• Utilize technology to modernize systems
• Communication across systems
• Improve management of care
• Track systems
Communicating the Opportunity of Change
Certified Community Behavioral Health Center – Prospective Payment System Implementation - Cost Report
Overview
Steve Kohler
Todd H. Kevles
Cost Report Overview

- What is a cost report?
  - A series of forms that collect descriptive, financial, and statistical data to determine cost services dating back to 1957 and was developed by the American Hospital Association
  - Medicare implemented the model in 1966 to determine cost of services, and the basic cost allocation methodology remains today
  - Submitted annually for institutional providers
    - Not required for physicians or other non-institutional providers (e.g. Therapists)
Cost Report Overview

- What specific type of information is gathered?
  - Facility characteristics (ownership status, type of facility)
  - Statistical Information (Volume statistics by payer)
  - Financial Data, primarily P&L data, revenue and expense
  - Wage related data
Cost Report Overview

- Types of Facilities Submitting Cost Reports
  - Hospitals
  - Skilled Nursing Facilities
  - Home Health Care Agencies
  - Hospices
  - FQHCs
  - Other
Cost Report Overview

- How are they used?
  - Implementation of Prospective Payment Systems (PPS)
  - Annual measurement of wage index variations
  - Updating and monitoring of PPS performance
  - Determine financial health of institutions
  - Research purposes
  - Industry and federal reporting
Why is a Cost Report Important?
- The cost report is a financially report that identifies the cost, charges, and volume statistics related to healthcare treatment activities

Cost Reports Impact Reimbursement
- Today
- Future Reimbursement – Prospective Payment System Implementation; Monitoring; and rate adjustments
- Congressional / CMS policy and rate setting
Cost Report Fundamentals

- What can the provider community do with cost report data?
  - Use the data for management reporting
  - Use the data for market comparative purposes
  - Use the data to respond to Federal or State regulatory changes
  - Use the data to illustrate inequities in the current payment system – Prove financial harm, seek changes
CMS Experience with PPS

- Acute Care Hospitals – DRGs
- Outpatient Hospital – APCs
- Skilled Nursing Facilities – RUGs
- Inpatient Rehabilitation Facilities – IRF PPS
- Inpatient Psychiatric Facilities – Psych PPS
- Home Health Agencies – HHA PPS

- Each of the above systems are national, with geographical adjustment factors (Wage Index)
Possible Base Year PPS Rate Development

- Facility specific base year cost as it stands now would be utilized to develop a facility specific rate per visit. The base year rate would be updated, by the MEI (Medicare Economic Index) or other state determined factors.
- At this time, updates would not be provided for a change in services or service mix.
- Budgetary constraints can also impact future payment rates.
What does a PPS Offer?

- Predictability of Cash Flow and Receipts
- Shared Risk between the Payer and the Provider
- Offers Reward (Profit) where costs are less than reimbursement and Loss where cost exceeds the PPS payments
Preparing for the Cost Report

- Assemble your team
- Develop a plan and timetable
- Know the regulations (go to trainings)
- Compile all required records
- Keep in mind the cost data is based on accrual accounting
- Keep and provide all backup supporting statistical records
Getting it Right the First Time

- Why Get it Right?
  - You may have to live with the rate you establish
- When setting your rate consider:
  - Budgeting for growth
  - Potential new staffing requirements
  - New documentation or collaboration requirements
Getting it Right the First Time

- Be aware of cost ceilings:
  - Not allowed if it excludes reasonable and related costs

- Baseline PPS rates:
  - Improperly calculated the first time will never catch up to your actual cost even with inflation factors in place
Cost Report Overview

- Direct and Allowable Cost (as defined by regulations)
- Allocation of Overhead Cost
- Determination of Cost of Services (Cost per Unit)
- Determination of Cost of Services related to Medicaid Patients
- Provides for Cost Basis to Develop a Prospective Payment System (PPS)
Cost Report Overview

- Commonly Used Data in a Cost Report
  - General Ledger (Summary Trial Balance)
  - Payroll Register
  - Statistical Reports of Services by Payer with a detailed review required – Patient Census
  - Overhead Allocation Statistics
  - Other Specific Purpose Data
Cost Report Overview

- General Ledger – Summary Trial Balance
  - The General Ledger serves as the source document for initial reporting on the cost report
  - A properly established General Ledger will serve to categorize expense and revenue related to the specific departments / types of services provided that will ease the burden of completing the cost report without the need for post year-end analysis, or at least minimize it.
Cost Report Overview

- General Ledger – Trial Balance (cont’d)
  - With a properly detailed general ledger (accounts / departments / etc. mapping expenses to the cost report becomes easy, okay, easier.
  - With an overly simplistic general ledger, one which is constructed just with natural accounts, e.g. salary expense, benefit cost, supply expense, etc. and not on a cost center basis, be prepared for late hours for analysis and breakdown of expenses to meet the cost reporting requirements.
Cost Report Overview

- Direct Expense
  - Should be easily mapped to the cost report from the summary trial balance
  - Certain expenses may require reclassification from one department / cost center to another on an as-needed basis and should be supported by actual and auditable documentation. In some cases time studies may serve as the basis for expense reclassifications, where for example individuals may perform services over several cost centers and such cost are not broken down in the general ledger.
Cost Report Overview

- What are Overhead Costs?
  - Depreciation / Rent
  - Insurance
  - Interest Expense
  - Utilities
  - Housekeeping and Maintenance
  - Property Taxes
  - Administrative Salaries
  - Office Supplies
  - Legal
Cost Report Overview

- What are Overhead Costs? (cont’d)
  - Accounting
  - Insurance
  - Telephone
  - Fringe Benefit Costs, including Payroll Taxes
Cost Report Overview

- Reclassifications of Expense
  - Most common reclassification of expense relates to salary cost. When salary expense in maintained in one general ledger account, analysis is required to properly report salary expense by cost center
    - Actual time spent or auditable time studies
Cost Report Overview

- Adjustments to Expense
  - Recovery of Expense (revenue received)
  - Investment Income
  - Elimination of Expenses Under Regulation
    - Related Party Transactions (reduced to the cost of the related party)
    - Non-Allowable Expenses
Time Studies and the Cost Report

- Why do a time study?
  - Allows you to accurately attribute costs to the correct cost center
  - Identifies how much administrative time is dedicated to those duties versus directly program related duties
  - Reduces your administrative costs
Square Footage and the Cost Report

• Allows you to accurately attribute costs to the correct cost center based on the amount of square footage is in a particular building.

• Rent and Utilities costs are most commonly distributed this way in a shared building

• Example: Building Square Footage: 1,000sqft
  - Outpatient department = 600sqft of building
  - Partial Program=400sqft of building
  - The result is a 60/40 split of costs of rent and utilities
Administrative Costs

- What does your state allow for administrative cost ceilings?
- What is the potential impact of your administrative rate?
Direct and Indirect Costs

- **What is a direct cost?**
  - They can be traced directly to a department. I.e. outpatient staff that only work in that department. This allows that cost to only be used in determining the cost of outpatient services.

- **What is indirect cost?**
  - Costs that can’t be directly traced to a department.
    (i.e. Rent)
Cost Allocation Plans

- Why have a cost allocation plan?
  - Allows you to assign costs to cost centers based on the following examples:
    - Number of Active Employees;
    - Number of Visits;
    - Square Footage Occupied;
    - Salaries and Wages of Units Supervised;
    - Direct Assignment
Cost Report Overview

- Allocation of Overhead
  - As it stands now, overhead will be allocated on a simplified basis by taking total allowable overhead expenses divided by direct patient related cost (reimbursable and non-reimbursable services) and then applying that percentage times reimbursable expenses to determine the allocation of overhead cost to such services
  - This cost allocation model could overstate allocations of overhead to non-reimbursable services
Cost Report Overview

- Determination of Cost Associated with the Medicaid Program

- As it stands now, the cost will be determined based upon the overall average per visit cost (unduplicated patient visits, that is only 1 visit per day is counted regardless of the number of services.)
Cost Report Overview

- Basic Cost Report Flow
  - Expenses (Summary Trial Balance of Expenses)
  - Reclassifications (Placing expenses in the correct cost center)
  - Adjustments (Generally recovery of expense and elimination of non-allowable cost)
  - Overhead Allocations (Non-Direct expense allocated to service cost centers)
  - Rate Determination (Base year per visit cost)
Interest Expense

- Allowable if:
  - Supported by evidence of an agreement that funds were borrowed and the payment interest and repayment of the funds are required
  - Identified in your accounting records
  - Related to the reporting period in which the costs are incurred.
  - Necessary and proper for the operation, maintenance, or acquisition of your facilities
Interest Expense (cont)

- Non-Allowable if incurred as a result of:
  - A judicial review
  - Interest assessment on a determined Medicare overpayment
  - Interest on funds borrowed to repay an overpayment
Depreciation

- Depreciation is that amount which represents a portion of the depreciable asset’s cost or other basis which is allocable to a period of operation.
- Depreciation on buildings and equipment is an allowable cost.
Depreciation must be:

- Identifiable and recorded in accounting records
- Based on the historical cost of the asset as defined by 104.10, or in the case of donated asset, the lesser of the fair market value or net book value at the time of donation
Depreciable Assets

- Buildings – Defined in 104.2
- Building Equipment – Defined in 104.3
- Major Moveable Equipment – Defined in 104.4
- Minor Equipment – Defined in 104.5
- Land Improvements – Defined in 104.7
- Leasehold Improvements – Defined in 104.8
Cost Related to Patient Care

- Program Regulations and Instructions
  - Expense Recoveries
  - Non-Allowable Cost
  - Related Party Transactions
Sample Cost Report Preparation

- Discuss Cost Report Examples
Questions