Getting Paid as a CCBHC: Cost Reporting Principles
Agenda

• What would you like to learn about today?
• Overview of the CCBHC PPS
• Components of the CCBHC cost report
• Cost reporting strategies
CCBHC Demonstration Timeline

April 1, 2014
Congress enacts the Protecting Access to Medicare Act
PAMA § 223 establishes CCBHC Demonstration

October 19, 2015
SAMHSA awards planning grants to 24 States

October 31, 2016
States apply for CCBHC demonstration; CMS to select 8 States

2017-2019
States conduct two-year CCBHC Demonstration Project
CCBHC Demonstration Stakeholders

**Providers**
Become certified as CCBHCs and operate in accordance with State and Federal Rules

**Demonstration**
Tests effectiveness of the CCBHC model for Medicaid community-based behavioral health services

**SAMHSA**
Develops guidance on CCBHC program requirements and on States’ CCBHC certification processes

**States**
Develop CCBHC PPS, certify at least two CCBHCs, and implement demonstration

**CMS**
Provides guidance to States on the development of the CCBHC PPS
Reimbursement based on costs of serving CCBHC consumers, *not* on fee schedule

- PPS rate is unique to each CCBHC
- Rate based on allowable costs of furnishing all CCBHC services ("basket" of CCBHC services)
- Same rate is paid for each qualifying unit of service ("visit"), *regardless of the intensity of services provided*
Reimbursement under a PPS methodology
  - Bears *rational relationship* to provider’s costs of providing CCBHC basket of services
  - Likely will *not* result in reimbursement that precisely equals costs for a given year
  - Is not subject to cost settlement

PPS creates incentive to contain costs so that costs of care do not outpace inflation
CCBHC PPS Implementation – States’ Responsibilities

Determine the clinic-specific PPS rate for Demonstration Year 1 by collecting **base year** cost reports identifying all allowable costs and visit data relating to CCBHC services.

**Develop actuarially sound rates** for payments made through managed care systems, or develop capacity to make **supplemental payments for CCBHC services provided through managed care**

**Prepare to collect CCBHC cost reports** reflecting Demonstration Year 1 and 2 costs **no later than 9 months** after the end of each demonstration year.

**Design and implement billing procedures** to support the collection of data necessary to determine PPS payments (including quality bonus payments, if applicable) and to evaluate the demonstration.
A state must choose one methodology for the uniform per-clinic rate used to pay for CCBHC services delivered by a clinic. The rate methodology options include:

- Daily visits (CC PPS-1)
- Unique patient visit months (CC PPS-2)
Establishing a Base Year Rate: Daily Visit Option (CC PPS-1)

- CC PPS-1 is a per-clinic rate that applies uniformly to all CCBHC services rendered by a CCBHC

- Base PPS rate = \[
\frac{\text{Total annual allowable CCBHC costs}}{\text{Total number of CCBHC daily visits per year}}
\]
Establishing a Base Year Rate: Unique Monthly Visit Option (CC PPS-2)

- CC PPS-2 is a per-clinic rate that applies uniformly to all CCBHC services rendered by a certified clinic

- Base PPS rate =

- If it chooses PPS-2, State must
  - implement a separate PPS rate for specific populations based on clinical condition
  - implement a quality bonus payment system
  - create a system for “outlier payments”
Trending the PPS Rate Forward

- Costs per qualifying visit established by base period cost report are adjusted by the Medicare Economic Index (MEI) to yield Demonstration Year 1 (DY1) PPS rate.
- DY1 rate will be updated for DY2 by (at State option):
  - the MEI or
  - a “rebasing” of the PPS rate (new cost report reflecting DY1 costs)
Where to Find Guidance

- **CMS guidance** with detailed description of PPS methodology was issued in 2015 as appendix to Request for Applications for CCBHC planning grants

- CMS issued **cost report guidance** and a model cost report template in January 2016
  - States may choose to use this model or develop their own
Cost Report Basics

• 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 Basics

• 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
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.
PPS Benefits

• 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
Cost Report Preparation

• 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
Get It Right!

• 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
Preparing for the Cost Report

• 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 Essentials

- 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
The CCBHC Cost Report

- Costs must adhere to:
  - 45 Code of Federal Regulations (CFR) 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for the U.S. Department of Health and Human Services (HHS) Awards, and
  - 42 CFR 413 Principles of Reasonable Cost Reimbursement
The CCBHC Cost Report

- CCBHC records must be:
  - Detailed
  - Orderly
  - Complete, and
  - AVAILABLE for REVIEW or AUDIT
The CCBHC Cost Report

• Supporting documents must be maintained for all costs reported;
  – Cost report package and source documentation (e.g. invoices, patient records, cancelled checks) must adhere to federal and state record retention requirements.
The CCBHC Cost Report

- Accrual basis of accounting required
- All information requested in the cost report tabs must be furnished
- Failure to complete applicable tabs properly will result in rejection and return to the CCBHC for correction and re-submission
The CCBHC Cost Report

• Part 1 – Provider Information Tab
  – Basic information Gathered

• Part 2 – Provider Information For Clinics Filing Under Consolidated Cost Reporting
  – Must be completed for each site included in the consolidation
    • If more than 1 satellite exists, create a new tab
Trial Balance Tab

• Purpose:
  – Record amounts from the trial balance expense accounts
  – Perform necessary reclassifications and adjustments to adhere to Medicare and Medicaid cost principals
  – Record estimates of anticipated changes in costs
The General Ledger

• 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.
The General Ledger

- 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.
Trial Balance Tab

• Cost elements of an expense category maintained separately must be reconciled to the worksheet expense
• Working Trial Balance must be submitted with Cost Report
• MATERIALS ARE SUBJECT REVIEW or AUDIT
Direct CCBHC Expenses

• Key Column Descriptions
  – Column 4 – Reclassifications
  – Column 6 – Adjustments
  – Column 8 – Anticipated Costs
Anticipated Costs

• What are “Anticipated Costs”?  
  – Costs you expect to incur to meet the expectations of operating as a CCBHC!

• Discussion of Anticipated Costs
Expense Line Descriptions

• Key Line Descriptions
  – Part 1A- CCBHC Staff Costs
  – Part 1B- CCBHC Staff Costs Under Agreement (these are your DCO costs)
  – Part IC – Other Direct Expenses
Indirect Costs

• Part 2A – Site Costs
• What are Overhead Costs?
  – Depreciation / Rent
  – Insurance
  – Interest Expense
  – Utilities
  – Housekeeping and Maintenance
  – Property Taxes
  – Administrative Salaries
  – Office Supplies
  – Legal
  – Accounting
  – Insurance
  – Telephone
  – Fringe Benefit Costs, including Payroll Taxes
Direct Costs for Non-CCBHC Services

- **Part 3A - Direct Costs for Services other than CCBHC Services**
  - This is the subtotal of direct costs for non-CCBHC services “COVERED” by Medicaid “EXCLUDING” overhead and “SPECIFY” in the comments tab.

- **Part 3B - Non-Reimbursable Costs**
  - Is the subtotal of direct costs for Non-CCBHC services “NOT REIMBURSABLE” by Medicaid and “SPECIFY” in comments tab.
Trial Balance Reclassifications Tab

• Reclassifies expenses to determine proper cost allocation
  – Must be identifiable in accounting records
  – Use when expenses apply to more than 1 expense category
• Example Staff Psychiatrist
• Narrative must support reclassification of expense
Trial Balance Adjustment Tab

- Used to Adjust Expenses in the Trial Balance
- Made on the basis of cost or revenue
- If an adjustment is made on the basis of cost the provider may not adjust the expense on the basis of cost in future cost reporting periods
- If total direct and indirect cost can be determined use cost as the basis of the adjustment ....revenue as basis if not
Common Adjustments

- Investment income on restricted and unrestricted funds
- Home office costs
- Services provided by National Health Service Corps
- Depreciation Expense
Unallowable Costs

• Found in 45 CFR 75
• Examples
  – Related Party Transactions
  – Bad Debts
  – Certain Advertising and Public Relations Costs
Anticipated Costs Tab

• Additional costs for services needed to be a CCBHC
• Costs expected to increase as a result of offering CCBHC services
• Costs should support Medicaid and Non-Medicaid patients
• Allowed only in year demonstration year 1
Indirect Cost Allocation Tab

• Used to identify the method used for calculating allocable indirect costs to CCBHC services using:
  – Indirect rate approved by a cognizant agency
  – A 10% rate
  – Calculated indirect cost allocable to CCBHC
  – Other method
Allocation Descriptions Tab

• Used to describe calculations and methods that support the allocation methodology
• Additional documentation supporting allocations must be kept on file
• Allocation of direct costs must be detailed
  – Time Study
• Home office adjustments
Time Studies

• 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
Daily Visits Tab

- PPS-1 only
- Visits by one patient to multiple locations on the same day may only be counted 1 time.
- Unique visit days directly from the CCBHC
- Unique visit days from DCO
- Anticipated unique visits
Monthly Visits Tab

- Used for PPS-2
- Patient Demographics Consolidated
  - Patient visits to multiple locations counted 1 time
- Categorize costs according to whether monthly outlier threshold and whether they were allocated to certain conditions
Services Provided Tab

• Used to record FTE’s and # of services provided for CCBHC services for each type of practitioner
• This should be the units of service not days
• Must provide:
  – CCBHC staff services
  – CCBHC services under agreement
  – Services by site
Additional Tabs

• Comments Tab- used for considerations
• PPS-1 Rate Tab –auto populated
  – * Enter applicable Medicare Economic Index (MEI)
• PPS-2 Rate Tab
• Certification Tab
  – Must be an officer or other authorized administrator
    • CEO or CFO
Closing Thoughts

✓ The base period cost report is the foundation of your rate going forward. Prepare it carefully and with proper assistance.

✓ Ensure that a consistent standard for “visits” is used for
  ✓ Cost report preparation and
  ✓ Billing Medicaid.

✓ Carefully monitor rules/processes for updating CCBHC rates between DY1 and DY2.
Closing Thoughts

✓ Costs relating to designated collaborating organization (DCO) contracting will be included in the CCBHC’s base period cost report (likely on anticipated basis).
  ✓ Structure relationships with DCOs carefully, with input of counsel where needed.
✓ Cost-related reimbursement should not be an obstacle to CCBHCs’ participation in payment reform activities such as ACOs, health homes, and value-based payment!
Questions??

Steve Kohler, Practice Director
McBee Associates, Inc.
StevenKohler@McBeeAssociates.com

Susannah Vance Gopalan, Partner
Feldesman Tucker Leifer Fidell LLP
sgopalan@ftlf.com