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Children, Families, Health and Human Services Interim Committee

HB 155: Provider Cost Reporting

August 26, 2022

Cost Reporting Requirements Under HB 155

HB 155 requires a plan for collection of cost data and reports.

Plan for Collecting Expenditure Data

- DPHHS, in collaboration with providers, consumers, and other stakeholders, shall develop a plan for collecting expenditure data from Medicaid-dependent providers of services that:
  - Assist and support the elderly and persons with mental illness, physical disabilities, and developmental disabilities;
  - Are administered by the department divisions responsible for overseeing services for the elderly and persons with mental illness, physical disabilities, or developmental disabilities.
- "Medicaid-dependent providers" means providers with more than half of their clients receiving services through the Medicaid program.

Purpose of the Plan

Enable DPHHS and the legislature to:

- Analyze the data;
- Determine the cost of providing services;
- Make sound judgments about whether the rates being paid for each service are too high, too low, or appropriate; and
- Make decisions about rates that are based on sound data and analysis.

Source: https://leg.mt.gov/bills/2021/billpdf/HB0155.pdf

Cost Reporting Requirements Under HB 155 (cont.)

HB 155 requires a plan for collection of cost data and reports.

Plan Requirements

- Identify Medicaid-dependent providers;
- Identify high-volume services based on the units of service and costs;
- Identify smaller providers who should be exempt from data reporting requirements;
- Determine a base year for data collection and identify the types of expenditures and the providers who are required to report data in order to make it possible to analyze data and make determinations about rate adequacy;
- Ensure that expenditure data reporting requirements are consistent across divisions of the department to the extent possible;
- Identify how often data should be collected for purposes of updating the base year expenditures; and
- Create a schedule prioritizing the order in which data is collected from various providers in order to transition to a point at which all applicable provider information will be available and updated regularly.

Plan Timeline

- The plan must be completed no later than July 1, 2022 and provided to the 2023 legislature.

Cost Reporting Provider Focus Group

Guidehouse and DPHHS collaborated with provider representatives to discuss the development and planning of a cost reporting program and solicit feedback on implementing a program. The figure below identifies the programs that should be included for cost reporting.*

Montana DPHHS Programs and Services

Adult Behavioral Health Programs (AMDD)
- HCBS for Adults with Severe Disabling Mental Illness (SDMI)
- Substance Use Disorder (SUD) Medicaid Providers
- Medicaid Mental Health Services
- Targeted Case Management

Developmental Services (DSD)
- Developmental Disabilities Program Waiver
- Targeted Case Management

Senior and Long Term Care (SLTC)
- Community First Choices
- Personal Attendant Services
- Big Sky Waiver
- Home Health Services

Children's Mental Health (CMH)
- Mental Health Center Services
- Therapeutic Youth Group Home Services
- Home Support Services and Therapeutic Foster Care Services
- Partial Hospitalization
- Psychiatric Residential Treatment Facility (PRTF)
- Targeted Case Management

*Note: The following programs were deemed out of scope for cost reporting either because the programs are non-Medicaid, or because they are provided by individual practitioners: Autism Treatment Services or Applied Behavior Analysis, SUD Non-Medicaid and Non-Medicaid for Crisis Stabilization & Crisis Intervention and Response, and Out-of-State PRTFs. Additionally, the following service providers are not included for the cost reporting plan: (a) Services maintained under the RBRVS are excluded (e.g., Physical Therapy, Occupational therapy services under the HHS program); (b) Schools and individual practitioners are excluded (e.g., Board Certified Business Analysts, Medication-Assisted Treatment practitioners).

Cost Reporting Plan for Implementation

The Cost Reporting Plan includes an implementation plan for introducing a cost reporting program and it is intended to fulfill legislature requirements under House Bill 155.

- The plan specifies the programs, services, and providers that should be included as well as excluded from cost reporting based on guidance in House Bill 155. It also includes information on suggested content for the cost reports, supplemental material to support cost reporting, and considerations to administer and operate cost reports.
- Guidehouse conducted a review of 10 peer states and other states with established cost reporting programs for Medicaid populations to provide additional insights into common and promising practices that may be considered by the Department.

1 Service and Provider Scope

- Inclusion of Medicaid-Dependent Providers
- Small Provider Exemption Service Exclusions
- Service Prioritization

2 Cost Reporting Data and Standardization

- **Cost Reporting Data**: Revenue, expenses, wages, supplemental pay, other service data, provider certification
- **Six Types of Cost Reports**: Assisted Living Facilities (ALFs), Case Management, Nutrition, Mental Health and Substance Use Disorder, Psychiatric Treatment Residential Facility, Waiver and Home Health Providers

3 Supplemental Material and Support

- **Checklist for Cost Reporting**: Document that serves as a checkbox exercise for providers during submission process
- **Instructions for Cost Reports**: Detailed instructions on cost reporting topics including unallowable cost guidelines
- **Provider Training and Informational Sessions**: Initial and ongoing provider education

4 Administration and Operation Considerations

- **Frequency of Cost Reporting**: Annual
- **Time Period for Data Collection**: Submit data for a 12-month fiscal year (FY)
- **Base Year for Data Collection**[1]
- **Cost Report Management and Staffing**: Estimated 4.25 FTEs[2]
- **Schedule for Cost Reporting and Monitoring:** Submit within 4 months after FY ends; audit each provider every 3 years

Note: (1) The start of the State's fiscal year after the Cost Reporting Plan is approved can serve as the first year for implementation; (2) Additional information about staffing is included on slide 8.

Service and Provider Scope

Medicaid-Dependent Providers means providers with more than half of their clients receiving services through the Medicaid program.

- Nearly all providers within the programs in scope are identified as Medicaid-Dependent providers, as defined by House Bill 155.
- Although a few providers are not Medicaid-dependent (e.g., Assisted Living Facilities) and may not be mandated to submit cost reports, the Department should consider encouraging the providers to submit cost reports.

Small Provider Exemption Criteria

- Providers with individual Medicaid reimbursement less than $120k or 0.03 percent of total system reimbursement are “small” providers that may be exempt from cost reporting.
  - These providers collectively represent 2.5 percent of total system reimbursement and 35 percent of total number of providers across programs.
  - All services are represented in the remaining 97.5 percent of claims are “large” providers with the following exceptions incorporated.
    - Nutrition (Meals) providers are included although rendered entirely by small providers to account for the service in cost reporting.
    - Consultative Clinic and Therapeutic Services (CSCT) under the Big Sky waiver is excluded since the service is utilized only by one provider and total reimbursement is minimal at $275.

Service and Provider Scope (cont.)

Other Service Exclusions

- **Transportation Services:** Standalone transportation services (mileage and trip) can be excluded from cost reporting since providers would account for transportation costs associated with service delivery as part of reporting program support costs for services.
- **Services Reimbursed at Cost:** Services that are billed and reimbursed at the actual cost to the individual provider and are not based on a standardized rate.
  - Specialized Medical Equipment and Supplies; Personal Emergency Response System (PERS); Environmental Accessibility Adaptations and Home Modification; Goods and Services; Dip Strip or Saliva Collection, Handling, and Testing; Health and Wellness.
  - These services represent under 0.8 percent of total Medicaid system reimbursement.

High-Volume Service Inclusion

- High volume services include below that represent 5 percent of total reimbursement across all programs may be prioritized for implementation:
  - Congregate Living, Personal Assistance Services (Personal Care, Medical Escort, Homemaker, Companion), Assisted Living Facilities (ALFs), Day Services, Supported Living, Psychiatric Treatment Residential Facilities (PRTFs), Case Management, Comprehensive School and Community Treatment (CSCT), Youth Group Homes (Therapeutic and Foster Care), Adult Group Homes (Behavioral, Adult Group, Mental, Intensive Mental).

Cost Report Management and Staffing

Cost reports are typically managed by state departments and staff responsible for auditing, budgeting, finance, and/or provider reimbursement processes.

- The staff resources needed to manage the six cost reporting programs are estimated to be 4.25 FTEs (3 auditor FTEs, 1 supervisor FTE, 0.25 SME supervisor FTE).
  - The estimate assumes each type of cost report would require approximately 0.7 FTEs to review, audit, and manage the provider cost reports.
  - A peer state serving provider populations similar to DPHHS's programs has a comparable staffing requirement for cost reporting.

- DPHHS currently has a combined total of 1.25 FTE where cost reporting is some portion of a position across multiple divisions. These positions are required to do work on programing not included in this provider cost reporting plan. This cost reporting plan would require 4.25 positions to do complex analysis for the recommended cost reporting.

Recommendations for Cost Reporting

The Department should consider the following for implementing the Cost Reporting Plan and introducing a cost reporting program.

- **Conduct a pilot cost reporting program that prioritizes services and programs that span all programs.**
  - The Department should consider conducting a pilot cost reporting program during the first year of implementation
  - Consider cost reports that include services spanning all divisions and high-volume services
- **Engage with providers during implementation of the cost reporting plan.**
  - Engagement with provider representatives to solicit feedback will assist with developing holistic cost reporting material (e.g., customized templates, instructions) and ease the implementation process for both the Department and the providers
- **Consider developing a comprehensive web-based portal for cost reporting.**
  - A one-stop-shop web portal for providers to submit cost reporting data
  - Potential advantages include reduced administrative burden, and increased accuracy and efficiency
- **Establish protocols to protect provider cost reporting data.**
  - Cost reporting data submitted to the Department maybe subject to public disclosure under the right to know provision of the Montana constitution and implementing statutes
  - The Department should consider implementing protocols to de-identify provider identification details before transmitting the information to protect a provider's identity if the information is ever disclosed

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Questions

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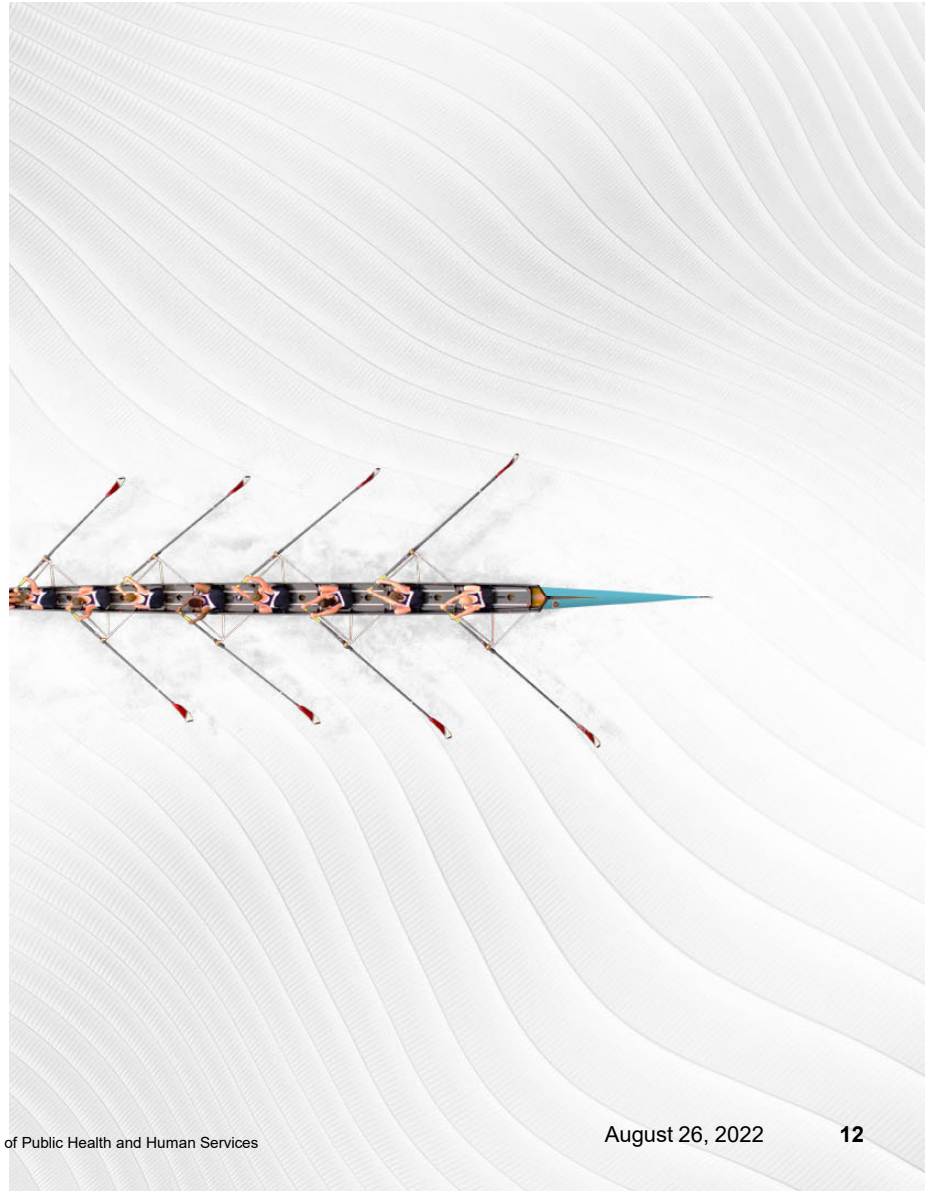

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Appendix

Cost Reporting Standardization

DPHHS should consider designing and implementing the six types of cost reports outlined below.

Cost Report Type	Services Included
Assisted Living Facilities (ALFs)	Assisted Living Facilities and Adult Foster Care (BSW) Assisted Living (DD) Assisted Living Facilities and Adult Foster Care (SDMI)
Case Management	Targeted Case Management – Adult Behavioral Health Targeted Case Management – Development Disability Targeted Case Management – Youth Case Management (SDMI) Case Management (BSW)
Nutrition	Nutrition – Meals (BSW) Nutrition – Meals (BSW) Meals (DD)
Psychiatric Treatment Residential Facility (PRTFs)	In-State PRTFs

Cost Reporting Standardization (cont.)

Cost Report Type	Services Included
Mental Health and Substance Use Disorder	• **Mental Health**: PACT, Community Based Psychiatric Rehabilitation and Support (CBPRS), Day Treatment, Peer Support, Adult Foster, Adult Group Homes (Behavioral, Adult Group, Mental, Intensive Mental), Youth Group Homes (Therapeutic and Foster Care), Youth Day Treatment, Comprehensive School and Community Treatment (CSCT), Home Support Services, Peer Support • **Substance Use Disorder** (excluding Medication-Assisted Treatment Services): SUD Intensive Outpatient, SUD Clinically Managed (ASAM 3.5), SUD Medically Monitored (ASAM 3.7), SUD Partial Hospitalization (ASAM 2.5), Peer Support
Waiver and Home Health Providers	• **Big Sky Waiver**: Supported Employment, In-Home and Personal Assistance Service, Private Duty Nursing, Respite, Day Services, Residential Habilitation • **Development Disability Waiver**: Supported Employment, In-Home and Personal Assistance Services, Private Duty Nursing, Respite, Congregate Living, Supported Living, Day Services, Adult Foster • **Severe Disabling Mental Illness Waiver**: Supported Employment, In-Home and Personal Assistance Services, Private Duty Nursing, Respite, Day Services, Residential Habilitation • **Community First Choice and Personal Attendant Services**: Self-direct and Agency-directed – Personal Assistance and Nursing services • **Home Health Services**: Home Health Aide, Specially Trained Attendant

Cost Reporting Data

Each cost report should include one or more of the following reporting areas:

Cost Reporting Area	Description
1. Revenue:	Total revenue of the provider organization across programs with the exception of a few cost reports that encompass multiple programs and would require program-specific reporting.
2. Expenses:	Total costs of the provider organization for services rendered under each program. •Cost per Service: •Unallowable Costs:
3. Wages and Supplemental Pay:	Wages and supplemental pay for each direct care, direct care supervisor, and direct care contractor position in the provider organization.
4. Other Service Data:	A few cost reports may include additional information like census data and statistics pertinent to individual services.
5. Audit and Certification Statement:	Each template should include a certification page that requires a chief decision maker (e.g., CEO/CFO/Accounting Manager) to verify or acknowledge that the submitted cost report does not contain any unallowable costs and the data is accurate.