C. HB 155 Cost Reporting Plan

C.1. Introduction and Background

A cost report is a tool used by states in which providers are tasked with reporting the costs involved with rendering services.[10] As identified by the Centers for Medicare and Medicaid Services (CMS), "cost reports are most often used to gauge rate sufficiency by determining whether existing payment rates are sufficient to cover provider costs, establish payment rates, and identify unallowable costs."

Additionally, CMS's 2019 training on cost factors and rate assumptions emphasizes that states are required to explain the details of rate setting methods for each service. Some of the Federal guidance for rate setting methodologies include:

- §1902(a)(30)(A) of the Social Security Act: "Payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population."
- 1915(c) waiver program Technical Guide pages 252–254 CMS Review Criteria: States must describe "methods" that are employed to "establish provider payment rates" for "each" waiver service.
- 42 CFR 441.303(b) requires the state Medicaid Agency furnish CMS with sufficient information that includes: "A description of the records and information that will be maintained to support financial accountability."

During the 67th Montana State Legislative Session, **House Bill (HB) 155 Section 1** directed the Department, in collaboration with providers, consumers, and other stakeholders, to develop a plan for collecting expenditure data from Medicaid-dependent providers of services with the goal of completing the following objectives:

1. Assist and support the elderly and persons with mental illness, physical disabilities, and developmental disabilities;
2. Ensure services are administered by the Department divisions responsible for overseeing services for the elderly and persons with mental illness, physical disabilities, or developmental disabilities.
3. Enable DPHHS and the legislature to:
    a. analyze the data;
    b. determine the cost of providing services;
    c. make sound judgments about whether the rates being paid for each service are

[10] Centers for Medicare and Medicaid Services, Preventing Unallowable Costs (December 2019) Available online: https://www.medicaid.gov/sites/default/files/2019-12/preventing-unallowable-costs.pdf

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too high, too low, or appropriate; and

d. make decisions about rates that are based on sound data and analysis.

Additionally, HB 155 ensures the cost reporting plan includes the following components:

1. Identify Medicaid-dependent providers;
2. Identify high-volume services based on the units of service and costs;
3. Identify smaller providers who should be exempt from data reporting requirements;
4. 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;
5. Ensure that expenditure data reporting requirements are consistent across divisions of the Department to the extent possible;
6. Identify how often data should be collected for the purpose of updating the base year expenditures; and
7. Create a schedule prioritizing the order in which data is collected from various providers in order to transition to a point at which the information will be available regarding all applicable providers and will be updated on a regular basis.

In meeting the stakeholder engagement requirements of the legislation, the Department convened three rate study workgroups composed of provider financial and service delivery experts and stakeholders, as well as an overarching Steering Committee comprised of members, caregivers, advocates, providers, state agency staff, the Lieutenant Governor, and other executive and legislative stakeholders to provide additional subject-matter expertise and offer input throughout the study. Feedback received from these groups were vital to the development of rates consistent with the efficiency, accessibility, and quality of care standards federally required by federal Medicaid regulations, specifically, U.S.C. Section 1396(a)(30)(A)[11].

Montana's House Bill 155 requires a plan for ensuring rate adequacy and collecting cost data as well as the purpose and requirements of cost report planning.[12] Of note, these requirements are consistent with Federal requirements for cost surveying. The goal is to develop a cost reporting plan no later than July 2022 that can be delivered to the 2023 legislature. The details under House Bill 155 are outlined below.

C.1.1. Plan for Collecting Expenditure Data

- DPHHS, in collaboration with providers, consumers, and other stakeholders, shall

[11] Title 42, The Public Health and Welfare Available online: http://uscode.house.gov/view.xhtml?req=(title:42%20section:1396a%20edition:prelim)

[12] Montana House Bill 155, Plan for Collection of Cost Data Available online: https://leg.mt.gov/bills/2021/billpdf/HB0155.pdf

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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.

C.1.2. Purpose of Plan

The purpose of the Provider Rate Cost Reporting Plan is to 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.

C.1.3. Plan Requirements

The Provider Rate Cost Reporting Plan must:

- 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.

In response to requirements under House Bill 155, Guidehouse worked with DPHHS to develop a Cost Reporting Plan and collaborate with a focus group of provider representations to solicit their feedback on the plan. Section C.2., Cost Reporting Provider Focus Group highlights information regarding the Provider Focus Group and Section C.3., Cost Reporting Plan includes details on the methodology, plan, and recommendations for cost reporting.

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C.2. Cost Reporting Provider Focus Group

Guidehouse and DPHHS collaborated with volunteers from the Rate Workgroup to form the Cost Reporting Provider Focus Group ("focus group"). The purpose of the focus group was to discuss the development and planning of a cost reporting program and solicit feedback from provider representatives on implementing a program for DPHHS programs. Figure 21 includes the composition, role, and discussion topics for the focus group.

Figure 21: Cost Reporting Provider Focus Group

<table>
<tr><th colspan="3">Cost Reporting Provider Focus Group (43 members)</th></tr>
<tr><th>Behavior Health</th><th>Developmental Services</th><th>Senior and Long-Term Care</th></tr>
<tr><td colspan="3">Composition:
• Volunteers from the Rate Workgroups
• DPHHS staff</td></tr>
<tr><td colspan="3">Role:
• Assess cost reporting data points and provide feedback on the feasibility of reporting data.
• Provide advisory feedback on potential impacts of cost reporting on broader provider base including potential operational challenges.
• Participate in one focus group meeting for an open discussion on the cost reporting program.</td></tr>
<tr><td colspan="3">Discussion Topics:
• Background on cost reporting and federal requirements
• Review potential revenue, cost, and wage components included reporting
• Discuss considerations on administering and operating a cost reporting program, and common practices in other states
• Discuss feedback from providers on developing multiple cost reports and combining cost components</td></tr>
</table>

C.3. Cost Reporting Plan Details

The Cost Reporting Plan includes details that would assist DPHHS with designing and implementing a cost reporting program. 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 and the guardrails of the rate study. This plan also includes information on suggested content for the cost reports, supplemental material to support cost reporting, and considerations to administer and operate cost reporting.

Guidehouse conducted a review of 10 peer states and other states with established cost

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reporting programs for Medicaid populations to provide additional insights into common and promising practices that may be considered by DPHHS. States reviewed for cost reporting include California, Iowa, Minnesota, Missouri, Kentucky, Louisiana, Maryland, North Dakota, South Dakota, Wisconsin, and Wyoming. Additionally, Guidehouse reviewed federal guidance provided by CMS through recently published trainings for Medicaid HCBS programs and the State's guidance under House Bill 155 for cost surveying, rate setting, and reporting unallowable costs to assist with the cost reporting plan development.

C.3.1. Program Scope

Per House Bill 155, Medicaid programs are within scope for cost reporting. Therefore, provider organizations should be included in scope for cost reporting if they fall under one or more of the following programs.

1. Adult Behavioral Health Programs
    - HCBS for Adults with Severe Disabling Mental Illness
    - SUD Medicaid Providers
    - Medicaid Mental Health Services
    - Targeted Case Management
2. Children's Mental Health
    - 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
3. Developmental Disabilities
    - Developmental Disabilities Program Waiver
    - Targeted Case Management
4. Senior and Long Term Care
    - Community First Choices
    - Personal Attendant Services
    - Elderly and Physically Disabled - Big Sky Waiver
    - Home Health Services

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
- Out-of-State PRTFs

Additionally, the following service providers are not included for the cost reporting plan:

- Services maintained under the RBRVS are excluded (e.g., Physical Therapy, Occupational therapy services under the HHS program)

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- Schools and individual practitioners are excluded (e.g., Board Certified Business Analysts, Medication-Assisted Treatment practitioners)

C.3.2. Service and Provider Scope

This section includes services and providers that should be included and prioritized for cost reporting.

C.3.2.1. Providers and Services

Overall, 65 percent of providers receiving Medicaid reimbursement are included in the Cost Reporting Plan. Additional information on specific providers and services that are recommended to be included or excluded from the plan is highlighted below.

1. Medicaid-Dependent Providers: Nearly all providers within the programs in scope are identified as Medicaid-Dependent providers, as defined by House Bill 155, with the exception of Assisted Living Facilities (ALFs) and Private Duty Nursing providers. These providers were identified as providers primarily drawing funds outside Medicaid based on the revenue reported by providers that responded to the Montana DPHHS Cost and Wage Survey.

   Although most of these service providers are not Medicaid-dependent, DPHHS should consider encouraging providers to submit cost reports. For example, ALFs are high volume services that represent nearly a fourth of all Medicaid claims for the programs in scope, and the data collected from ALFs may assist the State with future rate review processes.

2. 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 (CCTS) under the Big Sky waiver is excluded since the service is utilized only by one provider and total reimbursement is minimal at $275.

3. Other Service Exclusions: Additionally, the following services are recommended to be excluded from cost reporting.
   - 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.

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- Services billed and reimbursed at the actual cost to the individual provider and are not based on a standardized rate. These services represent under 0.8 percent of total Medicaid system reimbursement.
  - 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.

Appendix B includes a detailed list of services excluded for cost reporting.

C.3.2.2. Service Prioritization

DPHHS should consider prioritizing a subset of cost reports for initial implementation, as highlighted further in Section C.4.1. This section includes high volume services based on the SFY2021 Medicaid claims that DPHHS may prioritize in tandem with the cost reports proposed in Section C.3.3 for a pilot implementation. High volume services spanning all programs (greater than 5 percent of total reimbursement) highlighted below are included for cost reporting.

- 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)

C.3.3. Cost Reporting Data Reporting and Standardization

CMS provides guidance on cost surveying processes for HCBS rate setting applicable to DPHHS programs. Typically, cost surveys and reports include basic provider data (e.g., name, contact information, address, number of individuals served, area served, total revenue and expenditures) and fiscal year for the data reported. Cost surveys may also include cost data grouped by specific theme or category dependent on the state's goals and catered to match those goals accordingly. In some cases, states also require providers to submit Audited Financial Statement (AFS) from an independent Certified Public Accountant (CPA).

Table 76 below includes examples of cost reporting areas and data points captured in other states' Medicaid cost reports that are common to varied programs and populations.

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Table 76: Example Cost Reporting Information

Cost Reporting Area	Example Data Points	State Examples
Salaries and Wages for Direct Care and Administrative Staff	Staff Numbers, Direct Care Hours, Administrative Hours, Wages, Total Hours, Gross Salaries/Wages	IA, LA, SD, ND
Administrative Costs	Supplies, Legal Fees, Accounting Fees, Telephone and Communications, Seminars, Subscriptions	IA, LA, SD, ND, MO, CA
Program Support Costs	Program Supplies, Activity Costs, Staff Training	IA, SD
Property, Equipment, and Rental Expenses	Equipment Repair or Purchase, Auto Rental, Rent, Start-Up	IA, LA, SD, ND
Assets, Liabilities, and Equity	Investments and Other Assets, Accrued Taxes, Capital Stock, Insurance, Other Liabilities	IA, SD, MO
Fringe Benefits	Social Security Contributions, Health Insurance, Workers Compensation, Unemployment Insurance, Retirement/Pension	MD, ND, SD
Transportation and Vehicle Costs	Public Transportation, Private Driver Services, Natural Supports (transportation from family, friends, etc.), Vehicles, Vehicle Maintenance, Vehicle Depreciation, Vehicle Insurance	MD, ND
Revenue	Medicaid Program Revenue, Private Pay, Consumer Fees, Grants, Contributions, Rental Assistance, SUD Revenue (e.g., Substance Abuse Prevention and Treatment Block Grant)	CA, IA, LA, ND, SD
Census Data / Other Metrics	ALFs: Occupancy data; Case Management: Caseload metrics; PRTFs: Number of beds	CA, MN, SD
Certification of Cost Report	Agency information, audit details, accounting basis, signature of administrator and preparer	IA, LA, SD, ND, MO, CA

DPHHS cost reports may include one or more of the following reporting areas. Appendix B provides a detailed view of the data that can be captured under each of these areas including feedback provided by the Cost Reporting Provider Focus Group and information gathered from other states.

1. **Revenue**: Total revenue of the provider organization.
    a. Revenue would be helpful is understanding if providers are getting their costs covered and whether there may be any duplicating payments which would be unallowable.
2. **Expenses**: Total costs of the provider organization for services provided under each program.

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   a. Cost per Service: Costs components tend to vary from service to service. For example, the place of service delivery would impact the total cost of delivering services. Services that are provided in a facility may have different costs from those provided in the community. Therefore, capturing costs by each service would assist with developing rate assumptions in future rate setting efforts.
   b. Unallowable Costs: Unallowable costs are costs submitted for federal Medicaid reimbursement that do not comply with HCBS waiver program federal requirements. Sometimes, these costs are inappropriately included in the rate determination process or may fail to be identified in the billing validation process, resulting in unallowable Medicaid reimbursement. Common unallowable costs include room and board costs, thirty party liable costs or costs supported by external organization, and costs that are unrelated to member care. Therefore, it is imperative to design the cost report to capture unallowable costs separately. Appendix B highlights how DPHHS may isolate 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 other 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 the submitted cost report does not contain any unallowable costs and the data is accurate.

DPHHS should consider designing and implementing the six cost report templates outlined below. These distinct reports group similar services and providers for standardization yet allow for customization of cost reporting areas based on the nature of services, providers, and rate models. The Cost Reporting Provider Focus Group also provided feedback on developing exclusive cost reports for a few providers like Assisted Living Facilities (ALFs). Under this plan, while a vast majority of providers will submit only one cost report, a few providers will be required to submit 2-3 cost reports because of the wide array of services delivered.

1. **Assisted Living Facilities (ALFs):** This cost report will be exclusively for ALFs providers for the services listed below.

   Services:
   - Assisted Living Facilities and Adult Foster Care (SLTC)
   - Assisted Living (DD)
   - Assisted Living Facilities and Adult Foster Care (ABH)

   Report Details:

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- ALFs that receive reimbursement for other services in a waiver program including case management, meals, and respite services must include all associated costs within the ALF cost report and will not be required to submit other cost reports.
- This report should include revenue, expense, and wage components in Appendix B.

2. **Case Management:** This report will include Case Management services and programs across all populations. An exclusive report would allow providers that provide only Case Management or Targeted Case Management services to fill only the Case Management report instead of other broader reports that apply to waiver programs or state plan services. Additionally, capturing this information in a distinct report will be helpful for future analysis if DPHHS considers standardizing case management service delivery and potentially rates across programs.

   Services:
   - Targeted Case Management – Adult Behavioral Health
   - Targeted Case Management – Development Disability
   - Targeted Case Management – Youth Mental Health
   - Case Management (ABH)
   - Case Management (SLTC)

   Report Details:
   - The data in this report would include revenue, cost, and wage components similar to the data points captured in Appendix B.

3. **Nutrition (Meals):** This report will be applicable to Meal service providers across the SLTC and DD programs. Most meal providers for the programs in scope provide meal services exclusively. The cost reporting areas would be specific to meals and much simpler than other cost reports including cost of packing, operating, and providing meals services, staff salaries, and additional statistics on the number of meals provided.

   Services:
   - Nutrition – Meals (SLTC)
   - Nutrition – Meals (SLTC)
   - Meals (DD)

   Report Details:
   - Types of Costs: Personnel salaries, fringe benefits, bulk meal transportation costs, packaging costs, supplies, utilities, communications, building costs, building space, professional services, raw food caterer, equipment, insurance, mileage reimbursement, subcontracting expenses (e.g., caterer), volunteer programs

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- Number of Meals: Number of Medicaid home delivered meals, number of Medicaid congregate meals, and number of all other meals.

4. **Mental Health and Substance Use Disorder:** This cost report will cover all adult and children's mental health programs as well as substance use disorder treatment services.

   Services:
   - 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

   Report Details:
   - This report should include revenue and expense components capture in Appendix B.
   - Additional data for youth therapeutic group homes and adult group homes may be requested in this report since the nuances for these residential differ from the other services.

5. **Psychiatric Residential Treatment Facility (PRTF):** This report should capture costs and census data for PRTFs.

   Services:
   - In-State PRTF Service

   Report Details:
   - Revenue: Revenue components identified in Appendix B should be included in this report.
   - Costs: Expenses should include total Medicaid costs, costs attributable to the Department of Education, and other costs allowed under the PRTF State Plan Amendment.
   - Number of Beds: The total number of facility licensed beds, number of Medicaid-specific licensed beds and number of Medicaid occupied beds within the year.

6. **Waiver and Home Health Providers:** This report will include cost reporting for all waiver and home health provider services under the BigSky, SDMI, and DDP waivers as well as the CFC, PAS, and HHS programs. Providers that are ALFs or exclusively provide Meals and Case Management services under these programs are not required to submit this cost report in addition to reports 1, 2, or 3.

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Services:

- Big Sky Waiver: Supported Employment, In-Home and Personal Assistance Service, Private Duty Nursing, Respite
- Development Disability Waiver: Supported Employment, In-Home and Personal Assistance Services, Private Duty Nursing, Respite
- Severe Disabling Mental Illness Waiver: Supported Employment, In-Home and Personal Assistance Services, Private Duty Nursing, Respite
- Community First Choice: Personal Assistance, Nursing services
- Personal Attendant Services: Personal Assistance and Nursing services
- Home Health Services: Home Health Aide, Specially Trained Attendant

Report Details:

- This report should include revenue, expense, and wage components captured in Appendix B.
- ALFs, Meals, and Case Management service providers are excluded from this report.
- CFC and PAS services should be distinguished as agency-directed and self-directed services to allow providers to report costs between the two types of services.

C.3.4. Supplemental Material and Support

In a recent training on Medicaid HCBS unallowable costs, CMS highlights unclear cost reporting guidance for providers as a frequent issue states face with including unallowable costs in the cost surveying and rate setting processes[13]. Developing robust cost reporting instructions is integral to assisting providers with cost reporting, especially since this will be a new initiative undertaken by DPHHS and its provider organizations. DPHHS can consider developing the following supplemental material to support providers during the cost reporting process.

1. **Checklist for Cost Reporting**: Several states develop checklists which include high-level topics and requirements that must be met my providers to consider a cost report complete. A checklist document can serve as check the box exercise for providers to ensure all requirements for cost reporting a met during the reporting and submission process.

2. **Instructions for Cost Reports**: An instruction manual would include detailed instructions on all cost reporting topics and data points providers can follow while populating a cost report. The State should specify which costs are unallowable and provide clear guidance as to how these costs should be reported. DPHHS should take precautionary measures to ensure there are not interpretive issues and providers do not

[13] Centers for Medicare and Medicaid Services, Preventing Unallowable Costs (December 2019) Available online: https://www.medicaid.gov/sites/default/files/2019-12/preventing-unallowable-costs.pdf

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unknowingly include unallowable costs. For example, room and board costs are excluded from most Medicaid HCBS waiver program reimbursement as mandated by the Federal government. Similarly, certain education costs and teachers' salaries for PRTFs may be incurred by the Department of Education and are not attributable to Medicaid programs. Instructions for cost reporting should clearly indicate how to capture and separate these unallowable costs. Additionally, the instructions should also include accounting requirements, uniform accounting rules, and other generally accepted principles to complete reports.

3. **Provider Training and Informational Sessions**: DPHHS may consider conducting cost reporting training for providers both initially while implementing a cost reporting program and on a recurring basis. Initial training would benefit all providers for first-time reporting. Recurring trainings would allow education for new providers as well as sharing of updates in policy or cost reporting guidelines with existing providers. DPHHS may also use training as an avenue to address questions from providers.

C.3.5. Administration and Operation Considerations

C.3.5.1. Frequency of Data Collection

Frequency of data collection defines how frequently data should be collected from provider organizations. A national scan of states' cost reporting programs revealed most states collect cost reporting data from Medicaid providers once a year. DPHHS should consider implementing an annual cost reporting process which would be beneficial for reviewing, rebasing, or rate setting purposes. An annual basis would also allow the flexibility in deriving the most recent snapshot of providers' costs for future analysis.

C.3.5.2. Time Period for Data Collection

Time period for data collection defines the period for which data should be collected and submitted. DPHHS should consider requiring providers to submit cost reporting data for their organization's 12-month fiscal year. Additionally, there would a lag of one year in the data to allow collection of audited financials after a provider's fiscal year ends. Most states operating similar programs collected data either based on the state's fiscal year or the provider organization's fiscal year. The Montana DPHHS Cost and Wage survey results revealed nearly 50 percent of participating providers across all programs follow the State's fiscal year cycle (July-June), nearly 40 percent of participating providers reported following the calendar year (January-December), and the remaining providers follow other time periods including the federal fiscal year cycle. Since organizations follow varying monitoring, auditing, and reporting periods, mandating the provider organization's fiscal year would allow providers the flexibility in completing and submitting cost reporting data. Varied reporting periods would also require the State to establish and prepare for appropriate administrative processes. This topic is discussed further in the subsequent sections.

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C.3.5.3. Base Year for Data Collection

A base year for data collection represents the first year for which cost reporting data will be submitted by providers to DPHHS. Since this is a new program to both the State and providers, DPHHS should consider conducting a pilot program for services that span multiple programs, before implementing cost reporting for all providers in scope. A pilot program has several benefits in allowing the State to implement cost reporting in a staggered cadence and allowing the opportunity to learn from the experience to scale it to the other programs after the first year. This would also give providers the opportunity to learn about cost reporting and prepare for the administrative efforts that would be involved in submitting required data to the State. For example, DPHHS may consider the Waiver Program and Home Health provider as well as the Case Management provider cost reports for the pilot implementation since these providers collectively span all programs and a wide range of common services.

The start of the State's fiscal year after the Cost Reporting Plan is approved can serve as the first year for implementation. For example, provider organization's FY2023 can be considered as the base year for data collection for the pilot program in July 2023, if the cost reporting plan is approved by the 2023 legislature. After the pilot is implemented in the first year, cost reporting can be extended to all providers and services in scope during the following year. For example, if the pilot program is completed for provider organization's FY2023, provider organization's FY2024 would be the base year for collecting data from all providers.

C.3.5.4. Cost Report Management and Staffing

A review of peer states' programs revealed cost reports are typically managed by state departments and staff responsible for auditing, budgeting, finance, and/or provider reimbursement. These staff manage the cost reporting program and serve as a liaison to providers. To initiate the process, DPHHS will benefit from identifying the appropriate staff to manage the program. The staff will benefit from establishing a formal communication plan for the state and providers during the cost reporting period. States typically communicate with providers to launch the process, request for clarification, and complete reporting. Providers may also need to communicate with the state to address questions during the cost reporting period. Additionally, as indicated by stakeholders, the Department may also consider establishing a process to report and track providers' administrative efforts involved in cost reporting.

Guidehouse estimated 4.25 FTEs as the number of employees that may be required to manage the six cost reporting programs outlined in Section C.3 of this report. The estimate assumes each type of cost report would require approximately 0.7 FTEs to review, audit, and manage the provider cost reports. For example, in one peer state that manages programs of similar magnitude and serving similar populations, 4.25 FTEs are required year round to manage six cost reporting programs. The team is comprised of 3 auditor FTEs, 1 supervisor FTE who provides subject matter expertise and oversees the work of the three auditors, and 0.25 SME supervisor FTE who serves as a liaison between the auditors and the State. Given the similarities in the programs, a similar staffing plan may work for DPHHS in Montana. This staffing proposal assumes there is no existing infrastructure for DPHHS to leverage for implementing and managing the proposed programs. For example, if DPHHS can leverage the

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0.25 FTE that already assists with nursing facility cost reporting, the staffing requirements for the new programs may be adjusted to account for existing staff.

C.3.5.5. Schedule for Cost Reporting and Monitoring

DPHHS should establish an annual schedule both for the State staff as well as provider organizations to streamline the cost reporting process and set expectations with all stakeholders involved in the process. DPHHS may put in place the following considerations:

- **Submission Period:** Providers may be required to submit cost reports within 4 months after the end of the provider organization's fiscal year. DPHHS may permit two cycles for submissions – one from January through May and the second from July through November – that would align with most provider organizations' fiscal year ending in December and June respectively to initiate and complete their cost reports. The sixth month of each half of the year could be used by the State to wrap up the auditing process for the respective cycles. For example, if a provider's fiscal year ends June 30th, the cost report and audit should be due December 1st. If the fiscal year ends December 31st, the cost report and audit should be due June 1st. In peer states, provider organizations typically initiate the process internally two months prior to the end of the fiscal year and submit their cost reports within six months after the reporting period ends.

  DPHHS should establish with providers that all incomplete or incorrect reports will be returned to the provider for corrections. Corrections and appeals to the cost report are to be made by the provider and resubmitted to the department within 30 calendar days of the initial inquiry from the State. Other states typically allow between 30 to 180 calendar days for the appeals process but given the flexibility in the time for submitting costs, the State should consider allowing no more than 30 days. Additionally, DPHHS should encourage providers to work closely with the State during the cost reporting period to address questions and receive guidance, and to avoid the appeals process altogether.

- **Auditing Schedule**: To continuously review and audit provider cost reports as and when they are submitted, DPHHS should conduct audits year around from January through December. As mentioned in the previous section, DPHHS could consider completing audits within a month after the last set of cost reports are submitted, i.e., June and December depending on the reporting cycle.

  The State may choose to audit a representative subset of all providers every year and target covering all providers within three years. Most states audit each provider's cost report once every 2-5 years. During the Cost Reporting Provider Focus Group meeting, one provider representative expressed that DPHHS may also consider following the State's legislature cycle of a biennium. Given this is a new cost reporting program, DPHHS should consider additional flexibility in targeting an audit schedule of once every three years for each provider. Therefore, DPHHS would audit approximately 100 providers' cost reports every year with the aim to complete the entire provider base over

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three years. Eventually, DPHHS may target a more rigorous review schedule based on initial experience to build additional efficiencies into the process if necessary.

- **Maintaining Records:** Most states require providers maintain on their premises the required service records and financial information sufficient to provide for a proper audit or review, including documentation to support the rationale for allocation of costs. Sufficient data must be available as of the audit date to fully support any item being claimed on the cost report. For example, some states require providers and the state's responsible department to maintain records supporting cost reporting for up to 6-10 years following the submission of the cost reports. Records are typically made available upon reasonable request to representatives within the state.

  DPHHS should consider implementing similar recordkeeping requirements consistent with requirements under the Montana Public Records Act[14]. The Montana Public Records Act states that citizens are entitled to public records and documents in the State. However, the Montana Supreme Court has recognized an entity's property right is confidential or proprietary information such that the information should be shielded from public disclosure. Therefore, if the cost report data is disclosed by the Department, the Department must consider de-identifying provider information before it is made public.

C.4. Cost Reporting Recommendations

The recommendations below are related to the Cost Reporting Plan outlined in Section C.1-C.3.

C.4.1. Conduct a pilot cost reporting program that prioritizes services and programs that span all programs.

Since cost reporting is new to both DPHHS and DPHHS's providers, Guidehouse acknowledges implementing multiple types of cost reports and requiring all providers to engage all at once at the beginning would involve significant administrative, programmatic, and logistical challenges. Although we consider the entirety of the Cost Reporting Plan important to implement, some of the details reflect fewer implementation challenges and greater potential value in learning relative to others.

During the first year of implementation, DPHHS may consider conducting a pilot cost reporting program that would include a subset of all proposed cost reports in the plan. Programs that span services across all populations and include high volume services identified in Section C.3.2 could be prioritized for initial implementation.

[14] Montana Public Records Act. Available online: https://leg.mt.gov/bills/mca/title_0020/chapter_0060/part_0100/sections_index.html

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C.4.2. Engage with providers during implementation of the cost reporting plan.

DPHHS should consider engaging with provider stakeholders to design and implement cost reporting template and instructions. If DPHHS considers implementing the Cost Reporting Plan, additional work will be required to design customized templates to completion and develop supporting material to ensure providers are equipped to complete the cost reports. The Cost Reporting Provider Focus Group provided valuable feedback on the types of revenue and costs that would be relevant to provider organizations, as captured in Appendix B. Similar focus group working sessions with provider representatives during the implementation phase may assist with developing holistic cost reporting material and ease the implementation process for both DPHHS and the providers. DPHHS may also leverage existing stakeholder forums as an avenue to discuss cost reporting implementation updates.

C.4.3. Consider developing a comprehensive web-based portal for cost reporting.

The Department may consider developing a one-stop-shop web portal for providers to submit cost reporting data. A few states have implemented similar solutions for their cost reporting programs, and there are benefits of the web-based method:

- Reduced administrative burden for both DPHHS and the providers: Providers would be able to populate, save, and submit all information through the web portal instead of an Excel spreadsheet. This may reduce the level of effort required by the Department to quality check and standardize the information received from providers.
- Increased accuracy and efficiency in data reporting: The web-based tool reduces human processing errors and rework and increases standardization. This method would also enable fast data reporting processes.

The Department may develop a cost reporting web-based application by using Software as a Service (SaaS) tools. A SaaS platform or application is a way to provide services on the internet through a cloud infrastructure. Once the cost reporting data is finalized, the Department may customize cost reporting forms for providers to access on a SaaS-based platform. This would allow users (e.g., providers, state staff) to access the cost reporting application without having any software installed on their computer. Additionally, the Department may put in place appropriate security protocols and implement multi-factor authentication for restricted access.

Guidehouse also recognizes that DPHHS should consider the initial financial outlay to develop and deploy such a solution. Alternatively, DPHHS could design cost reporting templates on MS Excel which is a common practice in many states.

C.4.5. 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. However, to protect a provider’s identity if the information is ever disclosed, the Department should consider

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implementing protocols to de-identify provider identification details before transmitting the information. Moreover, based on the Department's feedback, Guidehouse notes the Montana Supreme Court has recognized that an entity's property right in confidential or proprietary information should be shielded from public disclosure. Therefore, if the information is ever transmitted to the Department, there is legal authority to shield it from public disclosure where an entity has asserted a property right.

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