Part 3: Prospective Payment System Methodology Description

Using the following format, describe the state's prospective payment system (PPS) methodology. This part of the Guidance will be scored up to a total of 20 points and your response may not exceed 30 pages. Each section of this part of the application corresponds to the same section of the CCBHC PPS Guidance. Sections 1-4 of this form pertain to fee for service prospective payment; managed care payment is addressed in section 5.

Section 1: Introduction

Section 223 of the Protecting Access to Medicare Act of 2014 (known as PAMA or "the statute"), requires payment using a prospective payment system (PPS) for Certified Community Behavioral Health Clinic (CCBHC) services provided by qualifying clinics and related satellite sites established prior to April 1, 2014. The Centers for Medicare & Medicaid Services (CMS) offers a state the option of using either the Certified Clinic (CC) PPS (CC PPS-1) or the CC PPS alternative (CC PPS-2) demonstration-wide for payments that are either fee for service (FFS) or made through managed care payment systems. The PPS guidance (Appendix III from the Planning Grant for CCBHCs) provides information about each of the allowed PPS payment methodologies.

Section 2: CCBHC PPS Rate-Setting Methodology Options

CMS offers a state the option of either the CC PPS-1 or CC PPS-2 for use demonstration-wide. The state chooses the following methodology (select one):

☐ Certified Clinic PPS (CC PPS-1) (Continue to Section 2.1)

☐ Certified Clinic PPS (CC PPS-2) (Continue to Section 2.2)

Section 2.1: Certified Clinic PPS (CC PPS-1)

The CC PPS-1 methodology is implemented as a fixed daily rate that reflects the expected cost of all CCBHC services provided on any given day to a Medicaid beneficiary. This is a cost based, per clinic rate that applies uniformly to all services rendered by a CCBHC and qualified satellite facilities established prior to April 1, 2014. The state has the option of offering Quality Bonus Payments (QBPs) that are to be paid in addition to the PPS rate to any certified clinic that achieves at least the six required measures as shown in Table 3 of the PPS guidance.

Section 2.1.a Components of the CC PPS-1 Rate Methodology

Demonstration Year One (DY1) Rate Data

In the box below explain the source(s) of cost and visit data used to determine the DY1 rate. Detail any estimates that the state used to determine allowable cost and the appropriate number of daily visits to include in the rate calculation. If more space is needed, please attach and identify the page that pertains to this section.

Cost and visit data used to determine DY1 rates came directly from data supplied in provider cost reports. The commonwealth used the cost report template provided by CMS. The cost reports were not audited, but the commonwealth performed a desk review of each cost report that involved checking data against audited financial reports. Providers were requested to provide supplemental data to the cost report outlining how daily visits were defined in order to avoid double-counting. Additional supplemental data was also requested for additional expense validation before inclusion in the final CC PPS-1 rate.

PPS-1 Rate Updates from DY1 to DY2

The DY1 CC PPS-1 rates will be updated for DY2 by (select one):

☐ The MEI

☐ Rebasing CC PPS-1 rate

If rebasing the DY2 rate to reflect DY1 cost experience, provide in the box below an explanation of the interim payment methodology[1]. Specify how the interim rate plus the DY2 rebased rate will cover the expected cost of care in DY2 and how long the interim payment will be in effect during DY2 If more space is needed, please attach and identify the page that pertains to this section.

The commonwealth plans to rebase the DY2 rate. Since DY1 cost experience will not be available in time to analyze at the beginning of DY2, the commonwealth plans to use updated cost reports to calculate DY2. The advantage of using updated cost reports is twofold: 1) more current expense information, and 2) as providers get closer to actual implementation, they can use more recent DY1 planning to inform Anticipated Cost projections. The cost reports would be validated through a desk review process similar to the DY1 rates (described above). This should lead to a more accurate DY2 rate. If there are delays in validating the updated cost reports, interim DY2 rates could be calculated using the DY1 rate and an MEI adjustment.

[1] An interim rate is requested because as it is likely that DY1 data will not be available to the state in time to analyze and rebase the rate for the DY2 payment.

Section 2.1.b CC PPS-1 Quality Bonus Payments (QBPs)

When using the CC PPS-1 method, a state may elect to offer a QBP to any CCBHC that has achieved all of the six required quality measures as shown in Table 3 of the PPS guidance in section 2.1. The state can make a QBP on the basis of additional measures provided in the PPS Guidance and may propose its own quality measures. Any additional state-defined measure must be approved by CMS. The state chooses to (select one):

☐ Not offer QBP(s) (Continue to Section 3)

☐ Offer QBP(s)

In the box below provide a list of the quality measures that will be used (in addition to the six required measures shown in Table 3 of the PPS guidance) for QBPs. Note any measure that is state-defined and provide a full description of the measure. If additional space is needed, please attach and identify the page that pertains to this section.

No additional measures will be utilized.

Description of Quality Bonus Payment Methodology

In the box below describe the CC PPS-1 QBP methodology, specifying (1) factors that trigger payment, (2) the methodology for making the payment, (3) the amount of the payment, and (4) how often the payment is made to CCBHCs. Also provide an annual estimate of the amount of QBP payment by demonstration year (DY) for all CCBHCs, including an estimate of the percentage of QBP payment to payment made through the PPS rate. If additional space is needed, please attach and identify the page that pertains to this section.

Details regarding the CC PPS-1 QBP methodology can be found in **Attachment Part 3 Additional Information, Pages 1-3.**
The maximum estimated percentage of the QBP payment is approximately 3% of the payments made through the PPS rate. This is based on a maximum payment of $300K per provider (10 providers) and utilizing the current cost report data. Note that a few cost reports are still in the final stages of review and the estimated impact may shift slightly above or below 3%.

If Section 2.1 is completed, skip Section 2.2 and continue to Section 3.

Section 2.2: CC PPS Alternative (CC PPS-2)

The CC PPS-2 methodology is implemented as a fixed monthly rate that reflects the expected cost of all CCBHC visits provided within any given month to a Medicaid beneficiary. This is a cost-based, per clinic rate that applies uniformly regardless of the number of services rendered within the month by a CCBHC and qualified satellite facilities established prior to April 1, 2014. Under this method, separate rates are developed for both the base population and clinic users with certain conditions. As part of the rate setting CC PPS-2 methodology, outlier payments paid for costs exceeding state-defined thresholds are considered. Finally, this methodology requires the state to select quality measure(s) and make bonus payments to incentivize improvements in quality of care.

DY1 Rate Data

In the box below explain the source(s) of cost and visit data used to determine the DY1 rate. Detail any estimates that the state used to determine allowable cost and the appropriate number of daily visits to include in the rate calculation. If more space is needed, please attach and identify the page that pertains to this section.

PPS-2 Rate Updates from DY1 to DY2

The DY1 CC PPS-2 rates will be updated in DY2 by (select one):

☐ The Medicare Economic Index (MEI)

☐ Rebasing CC PPS-2 rate

If rebasing the DY2 rate to reflect DY1 cost experience, provide in the box below an explanation of the interim payment methodology[2]. Specify how the interim rate plus the DY2 rebased rate will cover the expected cost of care in DY2 and how long the interim payment will be in effect during

[2] An interim rate is requested because as it is likely that DY1 data will not be available to the state in time to analyze and rebase the rate for the DY2 payment.

DY2. If more space is needed, please attach and identify the page that pertains to this section.

PPS-2 Identification of Populations with Certain Conditions

In the box below, identify populations with certain conditions for which separate PPS rates will be determined by the state and explain the criteria used to identify them. If more space is needed, please attach and identify the page that pertains to this section. Note: the populations listed below should match those shown on the sample cost report submitted by the state.

PPS-2 Outlier Payments

Outlier payments are reimbursements to clinics in addition to PPS rates for participant costs that exceed a state-defined threshold to ensure that clinics are able to meet the costs of serving their users.

In the box below provide a description of the outlier payment methodology including an explanation of the threshold for making payment and how much of total allowable cost is set aside for outlier payment; how often outlier payment is calculated; and, how often certified clinics receive outlier payment. If more space is needed, please attach and identify the page that pertains to this section.

Section 2.2.b CC PPS-2 Quality Bonus Payments

Under the CC PPS-2 method, a state *must* offer a QBP to any CCBHC that demonstrates it has achieved all of the six required quality measures as shown in Table 3 of the PPS guidance. The state can make a QBP on the basis of additional measures provided in Table 3 of the PPS guidance and may propose its own quality measures for CMS approval.

In the box below provide a list of the quality measures that will be used (in addition to the six required measures shown on Table 3 of the PPS guidance) and provide a full description of any state-defined measure. If more space is needed, please attach and identify the page that pertains to this section.

In the box below describe the CC PPS-2 QBP methodology, specifying (1) factors that trigger payment, (2) the methodology for making the payment, (3) the amount of the payment, and (4) how often the payment is made. Also provide an annual estimate of the amount of QBP payment by DY for all clinics expected to be certified, including an estimate of the percentage of QBP payment to payment made through the PPS rate. If more space is needed, please attach and identify the page that pertains to this section.

Section 3: Payment to CCBHCs that are FQHCs, Clinics, or Tribal Facilities

In some instances, a CCBHC already may participate in the Medicaid program as a Federally Qualified Health Center (FQHC), clinic services provider or Indian Health Service (IHS) facility that receives payment authorized through the Medicaid state plan. In these instances, the state should

refer to the guidance for how these Medicaid providers would be paid when a clinic user receives a service authorized under both the state plan and this demonstration.

☐ The state will require each certified clinic on its CCBHC cost report to report whether it is dually certified as a FQHC, clinic services provider or IHS facility.

Section 4: Cost Reporting and Documentation Requirements

In order to determine CCBHC PPS rates, states must identify allowable costs necessary to support the provision of services.

Section 4.1: Treatment of Select Costs

CMS provides additional guidance for the state regarding how to treat select costs, including uncompensated care, telehealth, and interpretation or translation service costs.

☐ The state excludes the cost of uncompensated care from its calculation of the CCBHC PPS.

Section 4.2: Cost Report Elements and Data Essentials

Cost Reporting

☐ The state will use the CMS CCBHC cost report and has attached a sample completed form plus an explanatory narrative that demonstrates the rate for DY1.

☐ The state will use its own cost report and has attached a sample completed form plus an explanatory narrative that demonstrates the rate for DY1.

The attached state-developed cost report template includes following key elements as specified in section 4.2 of the PPS guidance:

☐ Provider Information

☐ Direct and Indirect Cost-Identification

☐ Direct and Overhead Cost-Allocations

☐ Number of Visits

☐ Rate Calculations

Section 5: Managed Care Considerations

The statute requires payment of PPS and allows payment to be made FFS and through managed care systems for demonstration services. If the state chooses to include CCBHC service coverage in

their managed care agreements, CCBHCs must still receive the actual PPS rates, or their actuarial equivalent. The state has two options for incorporating the CCBHC rate into the managed care payment methodology: (1) fully incorporate the PPS payment into the managed care capitation rate and therefore require the managed care plan to pay the full PPS, or (2) have the managed care plans pay a rate that another provider would receive for a similar service and use a supplemental payment (wraparound) to ensure that total payment is equivalent to CCBHC PPS.

Section 5.0.a Managed Care Capitation CCBHC PPS Rate Method

☐ The PPS methodology selected in Section 2 will apply to services delivered in both managed care payment and FFS.

Section 5.0.b Building CCBHC PPS Rates into Managed Care Capitation

Explain how the state will ensure access to CCBHC services from Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), or Prepaid Ambulatory Health Plans (PAHP) through network adequacy requirements. If additional space is needed, please attach and identify the page that pertains to this section.

The Primary Contractor and its BH-MCO (PIHPs) must maintain a provider network which is geographically accessible to Members. All levels of care must be accessible in a timely manner. The access standard for ambulatory services to which the member travels is at least two (2) Providers for each State Plan Service. The access standard for in plan crisis intervention services (telephone and mobile) is a minimum of one provider.

Specific contract language will be added to assure that the BH-MCO includes the CCBHC in the network for all of the required CCBHC services whether provided directly or through a DCO arrangement. The services provided by a CCBHC can be part of the BH-MCO plan to assure network adequacy in a particular geographic area.

CMS offers states the option of using either of the following methodologies for incorporating the CCBHC rate into the managed care payment methodology (select one):

☐ Fully incorporate the PPS payment into the managed care capitation rate and require the managed care plans to pay the full PPS or its actuarial equivalent.

Explain how the state will provide adequate oversight for CCBHCs that receive the actual PPS rates or their actuarial equivalent, including provisions for special populations and outlier payments. If

additional space is needed, please attach and identify the page that pertains to this section.

The state will require the managed care plans to pay the full PPS rates via contract language and will fund the PPS rates through the capitation rates. The state will be monitoring both claims and encounter data for compliance, as well as confirming the payment of the PPS rate through the CCBHC provider agreements between the CCBHC and the managed care plans. The PPS rate will be added to the State's medicaid claims payment system for CCBHCs for services provided to FFS individuals.

OR

☐ Require the managed care plans to pay a rate to the CCBHCs that other providers would receive for similar services then use a supplemental payment (wraparound) to ensure payment to CCBHCs is equal to the PPS.

Explain how the state will provide adequate oversight related to reconciling managed care payments with full PPS rates, including provisions for special populations and outlier payments. If additional space is needed, please attach and identify the page that pertains to this section.

Explain the frequency and timing of the wraparound payment used by the state:

Section 5.0.c PIHP and PAHP Coverage Areas in Managed Care States

☐ The state contracts with a PIHP or PAHP and intends to use these delivery systems as part of CCHBC service delivery.

Describe which managed care plans will be responsible for providing CCBHC services and what services provided in other managed care plans may duplicate the CCBHC services.

In PA, DHS contracts with a county / multi-county primary contractor with two exceptions where the contract is directly with the BH-MCO. In all cases, there is only one behavioral health managed care entity per county/multi-county region. Therefore, there would not be any duplication of CCBHC services by another managed care plan in each county/multi-county region. Each of the following BH-MCOs will be responsible for service provision within their discrete contracts: Community Care Behavioral Health Organization, Magellan Behavioral Health of PA, and Community Behavioral Health. Individuals from surrounding areas may be served by the CCBHC and those BH-MCO would be responsible for payment of the PPS rate and the same reporting requirements as the primary BH-MCOs for their enrolled individuals.

Explain the methodology for removing services that duplicate CCBHC demonstration services from the managed care plans not responsible for the CCBHC services, how managed care capitation rates will be changed, the timing/process for determining that the new managed care rates will be actuarially sound, and how the state will ensure no duplication of expenses. If additional space is needed, please attach and identify the page that pertains to this section.

N/A

If a state chooses not to include all demonstration services under one contractor, define the delineation of services between contractors. If this delineation will require a change to managed care capitation rates, explain how rates will be affected, the timing and process for determining that the new managed care rates will be actuarially sound, and how the state will ensure non-duplication of payments. If additional space is needed, please attach and identify the page that pertains to this section.

N/A

Section 5.0.d Data Reporting and Managed Care Contract Requirements

Describe the data reporting policies and processes, including specific data deliverables to be reported by each entity, collection of data, timing of reporting, and contract language for data reporting. If additional space is needed, please attach and identify the page that pertains to this section.

The Department of Human Services, HealthChoices Behavioral Health Program, Program Standards and Requirements (DHS-HCBH PS&R) guide the submission of data to the Department. A CCBHC specific Appendix will be added to the DHS-HCBH PS&R. Details regarding reporting can be found in **Attachment Part 3 Additional Information, Page 4.** In addition, the CCBHC will be expected to submit updated cost reports every six (6) months. The periodic cost reports will be utilized to monitor the accuracy of the PPS and to support the rebase of the PPS in year 2.

Section 5.0.e Identification of Expenditures Eligible for Enhanced Federal Matching Percentage (FMAP)

Describe the process whereby the state will ensure proper claiming of enhanced FMAP for CCBHC services by identifying the portion of the capitation payment(s) applicable to the new adult group rate cells and the existing managed care population associated with CCBHC services. If additional space is needed, please attach and identify the page that pertains to this section.

Utilizing unique provider identification fields, encounter data will be analyzed to calculate historical costs for CCBHC covered services for these providers. These historical costs will be removed from the managed care capitation rates. At the provider level, the CC PPS-1 rate from the cost reports will be combined with daily visit data from the historical encounter data to price out projected covered CCBHC costs. An adjustment to the capitation payment will be made to reflect paying the encounter claims for CCBHC providers at the CC PPS-1 rate. This adjustment will be documented on a PMPM basis by rate cell and is eligible for the enhanced FMAP.

Funding Questions: Section 223 Behavioral Health Demonstration

The questions below should be answered relative to all payments made to CCBHCs reimbursed pursuant to Section 223 of P.L. 113-93 Protecting Access to Medicare Act of 2014[3] and the methodology described in the state's application to participate in the demonstration program.

CMS requests the following information about the source(s) of the non-federal share of payment made for demonstration services.

[3] H.R. 4302, 113th Congress. Protecting Access to Medicare Act of 2014. PL No 113092; April 2, 2014. https://www.congress.gov/bill/113th-congress/house-bill/4302

1. Section 1902(a)(2) stipulates that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

- Describe how the non-federal share of each type of Medicaid payment (e.g., basic PPS rate, outlier payment and quality bonus payments) is funded.

The non-federal (state) share of each type of Medicaid payment (PPS-1 rate and quality bonus payments) will be funded from an appropriation from the legislature to the PA Department of Human Services, the state Medicaid agency.

- Describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share.

The state share will be funded from appropriations from the General Assembly to the Medicaid agency (PA Department of Human Services) only. Funding will not be provided through IGTs, CPEs, provider taxes or any other mechanism.

Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

- If any of the non-federal share of payment is being provided using IGTs or CPEs, fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

N/A

- If certified public expenditures (CPEs) are used, describe the methodology used by the state to verify that the total expenditures being certified are eligible for federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or intergovernmental transfers (IGTs), please provide the following:
  I. A complete list of the names of entities transferring or certifying funds
  II. The operational nature of the entity (state, county, city, other)
  III. The total amounts transferred or certified by each entity
  IV. Whether the certifying or transferring entity has general taxing authority
  V. Whether the certifying or transferring entity received appropriations (identify level of appropriations)
  VI. A cost report for CMS approval for any CPE-funded payment(s)

N/A

2. Do CCBHC providers receive and retain the total Medicaid expenditures claimed by the state for demonstration services (includes basic PPS and enhanced payments) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization?

If providers are required to return any portion of payments, provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the state (e.g., general fund, medical services account, etc.).

CCBHC providers will retain the total Medicaid expenditures claimed by the state for demonstration services. No portion of the payments will be returned to the state, local governmental entity, or any other intermediary organization.

Section 2.1.b CC PPS-1 Quality Bonus Payments (QBPs)

OVERVIEW

As part of the CCBHC Demonstration Grant, the Department is implementing a Pay for Quality Bonus Payment (QBP) for enrolled Certified Community Health Clinics (CCBHC). This QBP is contingent on the grant award from SAMHSA, and the approval for the payment award in the state fiscal year (SFY) 18/19 Pennsylvania State Budget. The QBP will be paid directly to the CCBHC providers. This QBP is aligned with the Child & Adult Core Set measures as specified to the Center for Medicaid and CHIP Services (CMCS) and with the Department of Human Services initiatives relating to increased care coordination for individuals with a Mental Health (MH) diagnosis or a Co-occurring MH and Substance Use diagnosis (SUD).

Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS) have identified six (6) specific quality performance indicators designated for financial incentives based on measurability and reliable data. All six measures must be reported by the CCBHCs to receive a QBP during demonstration year (DY) 1 and DY2, and the submissions validated to the specifications by the external quality review organization (EQRO). In addition to the submission expectation by the CCBHCs, the QBP measure results to award the incentive awards during this grant period will be calculated by the EQRO for the individual CCBHCs. The two exceptions are the Child/Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C) and the Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A) measures. The CCBHC measurement results submitted by the CCBHCs in DY1 will be the baseline for the award in DY2.

The QBP specifications can be found at http://www.samhsa.gov/section-223/quality-measures in *Metrics and Quality Measures for Behavioral Health Clinics; Technical Specifications and Resource Manual, (Volume 1).*

The measurement periods will be in SFYs, commencing July 1, 2017 through June 30, 2018 for DY1 and from July1, 2018 through June 30, 2019 for DY2. Validation of supporting data will occur by the eighth month following the DY1 and DY2, with any eligible quality bonus payment made to the CCBHC in the fourth quarter of the year following DY1 and DY2.

PERFORMANCE INDICATORS

The following six (6) performance indicators are designated for financial incentive.

1) Follow-up after Hospitalization for Mental Illness, age 6 – 21 (FUH-BH-C)
2) Follow-up after Hospitalization for Mental Illness, ages 21+ (FUH-BH-A)
3) Adherence to Antipsychotics Medications for Individuals with Schizophrenia (SAA-BH)
4) Initiation and Engagement of Alcohol and Other drug Dependence Treatment (IET-BH)
5) Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)
6) Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)

The goal for B.1) – B.6) is to achieve a high level of follow-up, risk reduction and improve performance from the comparison year (s).

BASELINE YEARS

1) The SFY from July 1, 2016-June 30, 2017 will determine the performance payment for DY1, and DY1 will determine the performance payment for DY2 for the measures a. through d. below. The EQRO will determine the baseline year's result using the encounters submitted during the SFY. The CCBHC will submit the measurement results by in DY1 and the results are subject to the EQRO validation to determine the performance payment. In DY1, the individual CCBHC will submit their results by measures a. through d. below. The EQRO will validate the DY1 performance measure submissions to determine the performance payment. In DY2, the CCBHC will submit results by measure, and the Department will determine whether the validation is necessary based on the previous validation results.

a) FUH-BH-C has two reported rates; Follow-up after Hospitalization for Mental Illness in 7 Days and Follow-up after Hospitalization for Mental Illness in 30 Days
b) FUH-BH-A has two reported rates; Follow-up after Hospitalization for Mental Illness in 7 Days and Follow-up after Hospitalization for Mental Illness in 30 Days
c) IET-BH has two reported rates; the Initiation rate and the Engagement rate
d) SAA-BH has one reported rate for the measurement

2) The DY1 from January 1, 2017-June 30, 2017 is the baseline period for measures a. and b. below. The CCBHC will submit the measurement results by the baseline period and the results are subject to the EQRO validation to determine the baseline performance. In DY1, the CCBHC will submit the measurement results by measures a. and b. below. The EQRO will validate the DY1 performance measure submissions to determine the performance payment. In DY2, the CCBHC will submit results by measure, and the Department will determine whether the validation is necessary based on the previous validation results. These measurements are specified at the provider level, and are collected through the CCBHC electronic health record (EHR).

e) MDD/SRA-BH-C has one reported rate for this measurement.
f) MDD/SRA-BH-A has one reported rate for this measurement.

PERFORMANCE PAYMENTS

a. Performance Measure Weight
Each performance indicator listed in B.1-B.6 is weighted equally at 16.67%. When the performance indicator has two reported rates, the weight is divided equally (16.67%/2= 8.34%).

b. Performance Payment
The individual CCBHC may earn a performance payment based on their performance when compared to the previous year for B.1.-B.4 in DY1 and DY2. The CCBHC can earn an additional payment for B.5. and B.6. in DY2. The performance payment is a defined set of rates calculated from the encounters by the Pennsylvania contracted EQRO.

c. Performance Target

To be eligible to receive a performance payment for a measure, the CCBHC must:

- Submit all measures required, and
- Improve the yearly rate results by at least 1% from the previous year.

A rate below the previous comparison year's rate or an improvement less than 1% receives no performance payment for that measure

METHODOLOGY FOR IMPROVEMENT PAYMENTS

a. Improvement Payment

The performance payment by measure is determined by the CCBHC's actual performance in comparison to their previous year's rate result.

b. Improvement Targets

The improvement targets by measure are dependent on whether the measure is a one or two rate reported measure. Each performance incentive is calculated separately for each measure and totaled for the performance incentive paid to each individual CCBHC.

- Performance above previous year's measurement rate for a one rate measure
  - 1 percentage point improvement – 10% of incentive payment
  - 2 percentage point improvement – 20% of incentive payment
  - 3 percentage point improvement – 30% of incentive payment
  - 4 percentage point improvement – 40% of incentive payment
  - 5 percentage point improvement – 50% of incentive payment
  - 6 percentage point improvement – 60% of incentive payment
  - 7 percentage point improvement – 70% of incentive payment
  - 8 percentage point improvement – 80% of incentive payment
  - 9 percentage point improvement – 90% of incentive payment
  - 10 percentage point improvement –100% of incentive payment

- Performance above the previous year's measurement for each rate for a reported two rate measure
  - 1 percentage point improvement – 5% of incentive payment
  - 2 percentage point improvement – 10% of incentive payment
  - 3 percentage point improvement – 15% of incentive payment
  - 4 percentage point improvement – 20% of incentive payment
  - 5 percentage point improvement – 25% of incentive payment
  - 6 percentage point improvement – 30% of incentive payment
  - 7 percentage point improvement – 35% of incentive payment
  - 8 percentage point improvement – 40% of incentive payment
  - 9 percentage point improvement – 45% of incentive payment
  - 10 percentage point improvement –50% of incentive payment

Payment for Performance Incentives

The Department will inform the CCBHC of the incentive payment amount by the fourth quarter of the year following the Measurement Period.

Section 4.2: Cost Report Elements and Data Essentials

Attached please find 2 attachments: Attachment Part 3 Section 4.2 CCBHC Macro Cost Report, a completed cost report; and Attachment Part 3 Section 4.2 Cost Report Elements which includes 1) an explanatory narrative that demonstrates the PPS1 rate for DY1 for a provider; 2) documentation of the review of the cost report and supporting documents for reasonability and completeness; and 3) Memorandum of Acceptance of the Cost Report.

Section 5.0.d Data Reporting and Managed Care Contract Requirements

The Department of Human Services, HealthChoices Behavioral Health Program, Program Standards and Requirements (DHS-HCBH PS&R) has two appendices guiding the submission of data to the Department:

1) Appendix M, HealthChoices Behavioral Health Data Reporting Requirements (Non-Financial) describes the reporting requirements of the HC BH Primary Contractor for management reports; QM/UM data; monthly performance reports; person-level encounter; fiscal reports; aggregate encounter; Complaint and Grievance reporting by name, description, frequency data/file format and due date, and
2) Appendix K, BH-MCO Performance/Outcome Management System (POMS). The POMS consists of a database that is updated quarterly and serves as the basis for producing a set of performance measures/indicators

A CCBHC specific Appendix will be added to the DHS-HCBH PS&R. This Appendix will include the data deliverables that the BH-MCOs will be expected to provide in conjunction with each of the CCBHCs.

In addition to providing information already specified in the DHS-HCBH PS&R, the CCBHC will be expected to submit updated cost reports every six (6) months. The periodic cost reports will be utilized to monitor the accuracy of the PPS and to support the rebase of the PPS in year 2. The CCBHC will submit data through the dashboard to on a monthly basis to support the Pennsylvania specific evaluation describe in Part 2: Program Narrative.

MERCER
MAKE TOMORROW, TODAY

DESK REVIEW PROCEDURES FOR THE CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS DEMONSTRATION APPLICATION FOR OMHSAS

Medicaid Provider No #:	NPI #:
Cost Report Version (Original, Resubmission, Resubmission #2, etc.) Resubmission	
Provider Name:	
Prepared by: Joe Dobberke	Date: May 6, 2016
Shae Armstrong	8/11/2016
Reviewed by: Scott Banken	Date: August 18, 2016

General Instructions for Completing the Desk Review Tool

A Desk Review Tool needs to be completed for each cost report received. The Desk Review Tool is also the communication device to notify the provider that its cost report has been accepted as submitted or has been rejected and corrections are required.

For each item on the Review Tool enter an X in the appropriate column:
Yes – if the provider has completed the item correctly
NA – the item does not apply to this provider
Action Required – information is incorrect and the provider must correct or the provider must provide additional information/clarification

The **Comments Column** must be completed if you have placed an X in the Action Required Column. The comment that you enter should identify the error and how to correct it, or the additional information/clarification required.

If the cost report is acceptable, then the Memorandum – Acceptance should be completed and sent to the provider. Enter the provider's Medicaid Identification number, Cost Report Number and the email address to send results to, as recorded on the Certification Page, and the date the memorandum is completed. Only the Memorandum – Acceptance needs to be sent to the provider, not the entire Desk Review Tool.

If the Cost Report is not acceptable, then the Memorandum – Resubmission should be completed and sent to the provider along with a list of identified errors that need to be corrected and/or follow-up items. Enter the provider's Medicaid Identification number, Cost Report Number and the email address to send results to, as recorded on the Certification Page, and the date the memorandum is completed. Enter the Review Tool Reference Number of all items that need to be

corrected. The Memorandum – Resubmission and the summary, if issues, needs to be sent to the provider.

The total hours to complete the desk review are estimated to take 30 hours.

Schedules Needed From CCBHC

- Completed cost report template in Microsoft Excel
- Copy of the signed Certification Statement
- Audited Financial Statements from the most recent period, corresponding to the reporting period included in the cost report
- Working Trial Balance for the same time period as the Audited Financial Statements
- Crosswalk of the Working Trial Balance to the Audited Financial Statements
- Crosswalk of Working Trial Balance accounts to line items in the Trial Balance tab of the cost report
- Visit data, by patient identifier (HIPAA compliant), by day, by service provided
- List of services identified as CCBHC services
- Any allocation agreement with a cognizant authority used to allocate indirect costs

General Procedures

#		Yes	NA	Action Required	Comments
1	Confirm correct version of cost report has been identified for review. The cost report must meet this requirement prior to continuing the review.	X			
2	Confirm calculations are correct and template is functioning correctly. Verify the totals are accurate for the Trial Balance for each column for all three parts. Verify the amounts in the CC PPS-1 Rate tab in lines 1, 2 and 5 are linked correctly and the source data for each cell is working properly. The cost report must meet this requirement prior to continuing the review.	X			
3	Confirm certification requirements have been met. The name of a specific individual should be provided as the responsible party. Confirm individual is indicated as an officer or administrator. The cost report must meet this requirement prior to continuing the review.	X			
4	Does it appear that all tabs have been completed and all appropriate fields completed?	X			
5	Are there any provider comments or data included in the cost report "Comment" tab? Review any documents/notes prior to starting the desk review procedures.	X			
6	Has the CCBHC provided detail identifying how costs were allocated	X			

#		Yes	NA	Action Required	Comments
	or identified based on the service definitions assigned to the 9 general services defined in statute 223.				

Provider Information, Certification

#		Yes	NA	Action Required	Comments
7	Are all appropriate fields completed?	X			
8	Does the cost report cover the same fiscal year period as the submitted and audited financial statements and trial balance? The cost report must meet this requirement prior to continuing the review.	X			
9	Do the various clinics listed on the Provider Information tab reconcile to the provider numbers listed on Services Provided tab?	X			
10	Were all satellite facilities listed in Part 2 established prior to April 1, 2014?		X		

Trial Balance tab

#		Yes	NA	Action Required	Comments
11	The "total costs" in column 3 line 53 must tie to total expenses from the working trial balance. If this value does not tie, the CCBHC is required to submit a reconciliation of the trial balance total expenses to the cost report total costs. If the values are not equal and the CCBHC does not submit a required reconciliation, the cost report will be returned to the CCBHC for correction.	X			
12	The values from the Trial Balance Reclassification tab do NOT automatically populate the Trial Balance tab. Verify that all	X			

#		Yes	NA	Action Required	Comments
	transactions in the Trial Balance Reclassifications tab are accounted for in column 4 of the Trial Balance tab. If not, the cost report will be returned to the CCBHC for correction.				
13.	Verify column 5, line 53 is equal to column 3, line 53. If the totals do not equal prior to submission of the cost report, the cost report will be returned to the CCBHC for correction.	X			
14	The values from the Trial Balance Adjustments tab do NOT automatically populate the Trial Balance tab. Verify that all transactions in the Trial Balance Adjustments tab are accounted for in column 6 of the Trial Balance tab. If not, the cost report will be returned to the CCBHC for correction.	X			
15	The values from the Anticipated Costs tab do NOT automatically populate the Trial Balance tab. Verify that all transactions in the Anticipated Costs tab are accounted for in column 8 of the Trial Balance tab. If not, the cost report will be returned to the CCBHC for correction.	X			

Trial Balance Reclassifications tab

#		Yes	NA	Action Required	Comments
16	Does the total (line 36) of column 3 and column 6 equal zero? Is the schedule in balance and free of errors?	X			
17	Are the descriptions included with each reclassification complete, appropriate and sufficiently explanatory?	X			

18	Have all reclassifications been categorized with the proper expense category reference in columns 1, 2, 4 and 5?	X			
19	Review all reclassifications for reasonableness. If the basis for any allocation is unclear or questionable, request additional support and documentation from the provider.	X			

Trial Balance Adjustments tab

#		Yes	NA	Action Required	Comments
20	Have all adjustments been categorized with the proper expense category reference in columns 3 and 4?	X			
21	Are the descriptions included with each adjustment complete, appropriate and sufficiently explanatory?	X			
22	Do all adjustments comply Medicare cost principles as outlined in 45 CFR §75 and Cost Report Instructions?	X			
23	Using the WTB, have all adjustments for revenue offsets and unallowable costs been adjusted?	X			
24	If any adjustment warrants additional explanation, request supporting schedules from the provider. Is the documentation sufficient, and does the methodology of the adjustment comply with appropriate State and federal regulations?	X			
25	Note any adjustments that warrant special attention by Mercer and OMHSAS, even if such adjustments do not require correction.	X			

Anticipated Costs

#		Yes	NA	Action Required	Comments
26	Has the CCBHC submitted supporting schedules and a narrative to substantiate amounts and staffing levels included in the Anticipated Costs tab?			X	- **Review salaries and benefits for lines 1-4 and 17f** - **Ask about indirect costs in line 27h and lines 47a-47d** - **Anticipated costs seem to be more aggressive than anticipated visits**
27	Review all anticipated costs for reasonableness. If the basis for any estimate is unclear or questionable, request additional support and documentation from the provider.			X	**See questions in question 26**
28	Are the anticipated visits added in the Daily Visits tabs reasonable for the anticipated costs listed?			X	**Need more clarity as the visits seem low and create a very high rate for all anticipated costs**
29	Prepare a schedule comparing anticipated costs divided by anticipated visits. Compare to the PPS rate calculated. Determine what portion of the overall rate is attributed to anticipated costs.	X			

Indirect Cost Allocation

#		Yes	NA	Action Required	Comments
30	If the answer to line 1 is "yes," then review the rate agreement from the cognizant agency. If not, go to question 31. Do the amounts in lines 4 through 6 follow the terms of the rate agreement? Does line 16 equal line 6? Skip to question 34.		X		

#		Yes	NA	Action Required	Comments
31	If the answer to line 7 is "yes," then review the federal revenue supplied to the CCBHC. If not, go to question 32. Does the federal revenue exceed $35 million? Does line 16 equal line 10? Skip to question 34.		X		
32	If the answer to line 11 is "yes," then review the rate listed in line 12. If not, go to question 33. Does line 16 equal line 14? Skip to question 34	X			
33	If lines 1, 7 and 11 are all "no," is there a description of the indirect allocation method explained in the Allocation Descriptions tab or supporting schedules? Does line 15 equal line 16?		X		
34	Does the amount in line 16 equal the amount in line 2 of the CC PPS-1 Rate tab?	X			

Allocation Descriptions

#		Yes	NA	Action Required	Comments
35	Do the allocation methods appear reasonable? Are direct costs for CCBHC services, direct costs for non-CCBHC services, indirect costs and unallowable costs appropriately classified? If the basis for any estimate is unclear or questionable, request additional support and documentation from the provider.	X			
36	Note any details that require special attention by Mercer and the State, even if the allocation methods do not require correction.		X		

Daily Visits

#		Yes	NA	Action Required	Comments
37	Review the data supporting the number of visits. Were visits identified by the services characterized as CCHBC services? Were visits identified by member by day?	X			

PPS Rates

#		Yes	NA	Action Required	Comments
38	Is the MEI listed for the correct time period?			X	MEI corrected

Errors

#		Yes	NA	Action Required	Comments
39	Are there any errors or miscalculations identified in the cost report?	X			No errors

Comments

#		Yes	NA	Action Required	Comments
40	Have any comments been noted that warrant requesting additional information?	X			No additional info on comments
41	Has the CCBHC not made any required adjustments and described within the Comments? If necessary, request the provider to correct through a resubmission even if the provider disagrees and continues to include the comment.		X		
42	If a comment explains why an otherwise required adjustment was not made and the provider is within its authority to not make the adjustment		X		

#		Yes	NA	Action Required	Comments
	or refuses to make the adjustment, notify the State of the issue, the amount associated with such an adjustment if it were to be made and the impact on the cost per encounter.				

Finalization

#		Yes	NA	Action Required	Comments
43	Have desk review peer reviewed.	X			
44	Schedule an exit conference with the CCBHC and State to discuss the desk review findings.				
45	Participate in the exit conference and note significant comments and next steps.				
46	If cost report requires no correction, forward a copy of the cost report, memorandum of acceptance and desk review checklist to the State.				
47	If the cost report requires correcting, copy the State on the notification of corrections sent to the CCBHC.	X			
48	Upon receipt of the revised cost report, confirm that only the requested corrections have been made.	X			
49	Review the corrections for compliance with requested changes. Confirm the impact of such changes to all aspects of the cost report.	X			
50	If the revised cost report is acceptable, send the CCBHC a memorandum of acceptance.				Pending state review.
51	Forward a copy of the revised cost report, memorandum of acceptance for the revised version, and desk review checklist to the State.				

ID	Category	Document	Location	Observation	Action Required
01	Medicaid Economic Index	SAMPLE_CCBHC Macro Cost Report REVISED 7.28.xlsm	CC PPS-1 Rate worksheet Item 7	The MEI factor entered on the CC PPS-1 Rate tab is not consistent with the MEI equation. The MEI percentage should be 7.0085%, which is 1.252 (rate period) divided by 1.170 (midpoint of the reporting period).	Please update the cost report with the appropriate MEI.
02.	Anticipated Costs	SAMPLE_CCBHC Macro Cost Report REVISED 7.28.xlsm	Exhibit 2 - Row 2	Anticipated Costs account for 69.1% of net expenses; however, anticipated visits account for 24.8% of total visits. These ratios generate an anticipated rate orders of magnitude higher than current operations.	Please explain what is driving the difference between the anticipated cost per visit and adjusted audited financials cost per visit. Revisiting the anticipated visits may be required to ensure anticipated productivity is in approximate alignment with current productivity.
03.	Direct Cost - Salaries	SAMPLE_CCBHC Macro Cost Report REVISED 7.28.xlsm	Trial Balance - Line 1	Psychiatrist salary and benefits (line 1) appear inflated. When dividing total costs from column 9 in the trial balance by the FTEs in the Services Provided tab salaries show abnormally high. Psychiatrist cost of $416K for 1.3 FTE (translates to $320K for 1FTE). BLS.gov shows psychiatrist salary, plus 15% of salary for benefits, around $196K.	Please review the FTE totals from the Services Provided tabs and salary costs for lines 1-4 and 17f in the Trial Balance.
04.	Direct Cost - Salaries	SAMPLE_CCBHC Macro Cost Report REVISED 7.28.xlsm	Trial Balance - Line 2	Psychiatric Nurse salary and benefits (line 2) appear inflated. When dividing total costs from column 9 in the trial balance by the FTEs in the Services Provided tab salaries show abnormally high. Psychiatric Nurse cost of $130K for 1 FTE. BLS.gov shows register nurse high end salary, plus $15K in benefits, around $105K.	Please review the FTE totals from the Services Provided tabs and salary costs for lines 1-4 and 17f in the Trial Balance.
05.	Direct Cost - Salaries	SAMPLE_CCBHC Macro Cost Report REVISED 7.28.xlsm	Trial Balance - Line 3	Child Psychiatrist salary and benefits (line 3) appear inflated. When dividing total costs from column 9 in the trial balance by the FTEs in the Services Provided tab salaries show abnormally high. Child Psychiatrist cost of $56K for 0.2 FTE (translates to $279K for 1FTE). BLS.gov shows psychiatrist salary, plus 15% of salary for benefits, around $196K.	Please review the FTE totals from the Services Provided tabs and salary costs for lines 1-4 and 17f in the Trial Balance.
06.	Direct Cost - Salaries	SAMPLE_CCBHC Macro Cost Report REVISED 7.28.xlsm	Trial Balance - Line 4	Adolescent Psychiatrist salary and benefits (line 4) appear inflated. When dividing total costs from column 9 in the trial balance by the FTEs in the Services Provided tab salaries show abnormally high. Adolescent Psychiatrist cost of $59K for 0.2 FTE (translates to $296K for 1FTE). BLS.gov shows psychiatrist salary, plus 15% of salary for benefits, around $196K.	Please review the FTE totals from the Services Provided tabs and salary costs for lines 1-4 and 17f in the Trial Balance.
07.	Direct Cost - Salaries	SAMPLE_CCBHC Macro Cost Report REVISED 7.28.xlsm	Trial Balance - Line 17f	Medical Director salary and benefits (line 17f) appear inflated. When dividing total costs from column 9 in the trial balance by the FTEs in the Services Provided tab salaries show abnormally high. Medical Director cost of $172K for 0.5 FTE (translates to $343K for 1FTE). BLS.gov shows physician and surgeon salary, plus 15% of salary for benefits, around $175K.	Please review the FTE totals from the Services Provided tabs and salary costs for lines 1-4 and 17f in the Trial Balance.
08.	Indirect Cost	SAMPLE_CCBHC Macro Cost Report REVISED 7.28.xlsm	Trial Balance - Line 27h	Need to understand if the $120K investment in software will be used solely for CCBHC services or a comination of CCBHC and other services.	Please detail how this technology will be used and if it is not solely for CCBHC services please remove the amount that will be used for non-CCBHC services
09.	Indirect Cost	SAMPLE_CCBHC Macro Cost Report REVISED 7.28.xlsm	Trial Balance - Lines 47a-47d	Anticpated Cost (column 8) lines 47a-47d are double the audited financial costs (column 7). Home office expense, line 47d, especially stands out with its significant increase.	Please review the increase in Home Office Expense and verify that these expenses can be classified as CCBHC approved.

MERCER
MAKE TOMORROW, TODAY

Memorandum – Acceptance

Office of Mental Health and Substance Abuse Services
Commonwealth of Pennsylvania
CCBHC Cost Report Desk Review
Status: Additional Action Not Required

RE: Provider: SAMPLE CCBHC
Medicaid #:
Cost reporting period: 07/01/2014 through 06/30/2015
Memorandum completion date: 09/22/2016
CC: Kimberly Butsch

Dear Provider,

Thank you for your submission of the CCBHC Cost Report. The document referenced above has been received and reviewed. It has been accepted based upon the initial desk review procedures.

Thank you for your timely and complete submission. If you have any questions, please send an email to Kimberly Butsch at RA-PWCCBHC@pa.gov and we will respond as quickly as possible.

CCBHC Cost Report

MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:	7/1/2014	To:	6/30/2015
RATE PERIOD:	From:	7/1/2017	To:	6/30/2018
WORKSHEET:	Trial Balance Adjustments			

PART 1 COMMON ADJUSTMENTS

	Description	Basis for Adjustment* 1	Amount** 2	Expense Classification*** 3	Line Number 4
1.	Investment income on commingled restricted and unrestricted funds				
2.	Trade, quantity, and time discounts on purchases				
3.	Rebates and refunds of expenses				
4.	Rental of building or office space to others				
5.	Home office costs	A	already in Trial Bal	Home office expense	47d
6.	Adjustment resulting from transactions with related organizations				
7.	Vending machines				
8.	Practitioner assigned by National Health Service Corps				
9.	Depreciation - buildings and fixtures				
10.	Depreciation - equipment				
11.	Other common adjustments (specify details below)				
11a					
12.	Subtotal of common adjustments (sum of lines 1-11)		$0		

PART 2 COSTS NOT ALLOWED (Must be removed from allowable costs)

	Description	Basis for Adjustment* 1	Amount** 2	Expense Classification*** 3	Line Number 4
13.	Bad debts	A			
14.	Charitable contributions	A			
15.	Entertainment costs, including costs of alcoholic beverages	A			
16.	Federal, state, or local sanctions or fines	A			
17.	Fund-raising costs	A			
18.	Goodwill, organization costs, or other amortization	A			
19.	Legal fees related to criminal investigations	A			
20.	Lobbying costs	A			
21.	Selling and marketing costs	A			
22.	Subtotal of other costs not allowed (specify details below)				
22a	Fines and missing funds	A	-$465	Other operating	47a
22b	Fines and missing funds - related overhead	A	-$65	Home office expense	47d
22c		A			
23.	Subtotal of costs not allowed (sum of lines 13-22)	A	-$530		
24.	Total Adjustments (sum of lines 12 and 23)		-$530		

*Basis for adjustment
A. Costs - if cost (including applicable overhead) can be determined
B. Amount received - if cost cannot be determined

** Transfer to Trial Balance worksheet, column 6 as appropriate

*** Expense classification on Trial Balance worksheet from which amount is to be deducted or to which the amount is to be added

OMB #0398-1148 CMS-10398 (#43)

End of Worksheet

There are 9 total charts.
For a copy of the other 8, email: RA-PWCCBHC@pa.gov