

State of Wisconsin
Department of Health Services
Division of Mental Health & Substance Abuse Services
Bureau of Prevention, Treatment & Recovery

Community Recovery Services

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Background & Introduction

- Home and Community-Based Services (HCBS) 1915(i) state plan amendments allow states to expand eligibility for consumers with a history of psychiatric illness, risk factors indicating a need for continuing supports, and a need for one or more of the covered services as identified in a comprehensive service plan developed by an interdisciplinary team.
- DMHSAS plans to implement a comprehensive HCBS 1915(i) Psychosocial Rehabilitation State Plan Amendment (Community Recovery Services) that will address the support needs of consumers with mental illness. The state plan amendment will be focused on three core services for consumers:
 - **Community Living Supportive Services** – allows for consumers to live with maximum independence in community integrated housing;
 - **Supported Employment** – assists consumers with acquiring and maintaining competitive employment; and
 - **Peer Supports** – Provides payment for certified peer specialists to use their recovery based experiences to assist others to move toward recovery.

Background & Introduction (cont'd)

- DMHSAS has contracted with Public Consulting Group, Inc. (PCG) to assist with the following:
 - Obtaining approval from CMS
 - Implementing payment rates for providers and establishing billing policies and procedures
 - Training the provider community
 - Establishing a cost settlement and reconciliation process

CRS Cost Reporting

- Cost reporting for Community Recovery Services (CRS) will follow general accounting rules and closely resemble the reporting process for Wisconsin Medicaid Cost Reporting (WIMCR).
- WIMCR is a cost-based payment system for counties as Medicaid providers of community-based services.

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Medicaid Cost Reporting Cost Centers

- Cost reporting collects Direct Costs, Non-direct Service Costs, and Overhead Costs.
 - Direct Costs include payroll costs for staff (i.e., employees or contractors) delivering direct services, along with total paid hours and total paid hours delivering direct services.
 - Non-direct Service Costs include costs other than payroll costs for direct care staff, e.g., direct care staff non-payroll costs (e.g., travel and training costs), materials/supplies, supervisory costs, clerical costs, program administration costs, and program facility/operations costs.
 - Overhead Costs include agency general and administrative costs allocated to the program.

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Medicaid Cost Reporting Cost Allocation

- WIMCR cost reporting methodologies should be used by counties as a guide to what will be needed for cost reporting under CRS.
- WIMCR Cost Report calculates a cost per unit of service and compares that cost per unit of service with the county agency's payment per service.

Allowable Cost Allocation Methodologies

- Pro Rata Method: Allocation based on head count for the total group to arrive at the average expenditure cost per individual.
- Rate Application Method: Allocation as a percentage of salary for each participating individual.
- Many agencies allocate based on FTEs, which results in issues for allocating non-direct and overhead costs for contracted services.

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Recommended Cost Reporting Documentation

- Recommended documentation for counties contracting for some or all CRS services:
 - Payroll costs for each direct care staff, including employees and contractors
 - Total number of paid hours for each direct care staff (includes paid time off and time not with clients)
 - Total number of hours spent in delivering direct care services by type of service, Community Living Supportive Services, Supported Employment and Peer Support. Include start time, stop time, total time and participant name.
 - Allocation calculation documentation for non-direct services
 - Allocation calculation documentation for overhead services

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Common Cost Reporting Mistakes and Solutions

- **Common Mistake #1:**

- Reporting paid hours for direct staff only for Medicaid services and not for all direct services delivered, resulting in different calculated cost per unit than actual cost per unit.
- Reporting costs only for Medicaid services and not for all services delivered.

Solution: Always ensure full cost and volume statistics are utilized (i.e., cost and volume statistics must be “apples to apples”)

Common Cost Reporting Mistakes and Solutions (Cont'd)

- **Common Mistake #2:**

- Not allocating non-direct service and/or overhead costs for contracted services.

Solution: Ensure every overhead cost center has utilization statistics, including FTEs for contracted services.

- **Common Mistake #3:**

- Allocating direct service clinicians across various programs.

Solution: Maintain allocation statistics such as time studies or billing logs for cost allocation.

Interim Rates

- The interim rate is provisional payment pending the completion of cost reconciliation and a cost settlement for the cost report year.

- Service specific interim rates will be established for the following services:
 - **Community Living Supportive Services** – rates will be developed depending upon the individual’s residential setting.
 - **Supported Employment**
 - **Peer Supports**

- Interim rates will be based on a review of rate setting methods for similar services of selected states and a review of rates for similar services currently provided in Wisconsin.

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Cost Reconciliation Process

- Cost reports will cover services delivered in the prior calendar year.
 - Payments and cost reconciliation adjustments will occur after May 1st.

- Payments based on interim rates will be reconciled to the actual costs.

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Questions

- Questions and Comments