

Wisconsin Department of Health Services



State of Wisconsin Department of Health Services

Comprehensive Community Services Program

Financial Updates for Statewide Expansion Planning

1

Wisconsin Department of Health Services



Comprehensive Community Services (CCS) Financial Process Updates

1. Regional Start Date Guidelines
2. Financial Process Updates
 - Interim Rates, Claiming and Documentation Requirements
 - Cost Categories, Reporting and Reconciliation
3. Regional Reconciliation Guidelines
4. Regional Service Scenarios
 - Shared Services Region
 - Multi-County Region
5. Questions

2



Start Date Guidelines

- The CCS Rollout Period will run from July 1, 2014 through December 31, 2015. This period includes special requirements for establishing and amending regional structures for statewide expansion purposes.
- Beginning January 1, 2016, counties may only be added or removed from an existing region (effective January 1).
- Non-regional CCS programs may continue after July 1, 2014 either indefinitely or until regionalization at the county's option.
- State funding will only be made available in place of county financial participation for dates of service after a region has completed the three-step certification process (Division of Mental Health and Substance Abuse Services approval, Division of Quality Assurance certification, and Medicaid provider enrollment).



Start Date Guidelines: CCS Expansion Rollout

- The initial formation of a region, where none of the participating counties are part of an existing region, may begin operation on the first of any month, beginning July 1, 2014.
- From July 1, 2014 through December 31, 2014, an established region may make one addition of a county or counties to the region.
- Regions may also add a county or counties at the beginning of calendar year 2015, effective January 1, 2015.
- During calendar year 2015, existing regions may add a county or counties one time in addition to the January 1 option.



Start Date Guidelines: Reconciliation Process

The current CCS reconciliation process will be used for January through June 2014 dates of service, while the new policies implemented July 1, 2014 will be used for the July through December 2014 dates of service.

Each time a county is added to a region a separate financial reconciliation period is required.



Example, if a region forms on July 1, 2014 and adds a county or counties on October 1, 2014, then separate reconciliations must be completed for July through September and October through December, 2014.

The reconciliation process will be discussed in more detail in later sections of the presentation.



CCS Financial Process Updates



CCS Financial Process

Under the current CCS reimbursement process, the Wisconsin Medicaid program reimburses providers the federal share of total allowable Medicaid program costs.

Reimbursement for the current CCS program consists of three primary processes:



1. County specific rate setting
2. Interim billing and CCS claims payments
3. Year-end cost reporting and financial reconciliation

7



Changes to CCS Rate Setting

- Effective July 1, 2014, the county specific rate setting process will be discontinued and county specific rates will be replaced with statewide interim rates.
- Providers will no longer need to annually complete the rate setting process prior to submitting interim claims for reimbursement.
- The full list of statewide interim rates by provider type will be published in an upcoming ForwardHealth Provider Update.

8



Changes to CCS Interim Billing

- Interim billing changes are effective for dates of service on or after July 1, 2014 for both regional and non-regional CCS providers.
- For dates of service on or after July 1, 2014, providers will use procedure code H2017 (Psychosocial Rehabilitation Service, per 15 minutes).
- These claims will use modifiers to indicate the professional type of the provider (MD, PhD, Masters, Bachelors, etc.).
- Modifiers must also be used to indicate whether the service was provided to an individual member or a group of members.
- The full list of modifiers will be published in an upcoming ForwardHealth Provider Update.

9



Changes to CCS Interim Billing Cont.

- For Procedure Code H2017, all claims must indicate the provider professional type as outlined below:

• MD	• Certified Peer Specialist
• PhD	• Rehabilitation Worker
• Bachelors Level	• Associate Degree
• Masters Level	• Qualified Treatment Trainee, Type I
• Advanced Practice Nurse Prescriber (APNP)	• Qualified Treatment Trainee, Type II
• Registered Nurse	• Other Provider Type (for approved Non-Traditional Services)
- All claims submitted under H2017 must also use a modifier to indicate whether the service was provided to an individual member or a group.

10



Changes to CCS Interim Billing: Services in a Residential Setting

- For Dates of Service on or after July 1, 2014, providers will no longer use procedure code H2018, Psychosocial Rehabilitation per diem.
- CCS will continue to pay for psychosocial rehabilitation services provided in residential settings; however, these services should now be billed using the H2017 procedure code with appropriate professional level modifier for the provider, the number of 15 minute increments provided, and whether the service was provided to an individual member or a group.
- The claim must also indicate the appropriate place of service.
- This is only a billing change and does not change the services that can be reimbursed under CCS.

11



CCS Service Documentation

- The regional entity or county must maintain CCS documentation in accordance with State Medicaid Rules, Administrative Code Chapter DHS 36 and Chapter DHS 106. The regional entity or county must be able to produce documentation in accordance with these rules upon request from DHS, Single Audit firms, or federal auditors.
- Counties within the region must maintain appropriate documentation of all costs reported under CCS and the methodologies for cost allocations, and must provide that information to DHS for purposes of cost reconciliation upon request.

12



Important CCS Cost Category Concepts for Proper Interim Billing and Cost Reporting

Direct Costs: Reflect costs that support direct program operation. These costs represent program staffing for client services and program support. Also included are program non-personnel costs that directly contribute to program operation (e.g., program training and supplies).



Examples: Clinician service time, clinician program support time, supervisor support time, travel, training, or medical supply costs directly related to the program.

General Overhead Costs: Reflect central services related to overall agency operations that are allocable to all agency programs, including CCS.



Examples: Accounting and central financial services, human resources, information technology, legal services, and utilities.



Cost Reporting and Reconciliation

Terminology:

Cost Reporting represents the work conducted by each county or region to fulfill state and federal financial reporting requirements.

Cost Reconciliation represents activities completed by the Wisconsin Department of Health Services that results in either payment to, or recoupment from, the county or region to fulfill CCS cost-based reimbursement under the program.



CCS Cost Reporting for Direct Cost

See below for an example of the data elements needed for Cost Reporting for direct service staff. Information for both county staff and contracted staff will be required. **Note that the Wisconsin Medicaid Cost Reporting Program (WIMCR) will use a web tool, while CCS will continue to use a spreadsheet. Consistent methodologies will be used in both reports.**

			ANNUAL COST - MD STAFF			
Professional Type	First Name	Last Name	Salary	Benefits	Contract	Gross
MD	John	Smith	\$ 50,000.00	\$ 25,000.00		\$ 75,000.00
MD	Jane	Knight			\$ 80,000.00	\$ 80,000.00
MD	Michael	Jones	\$ 40,000.00	\$ 25,000.00		\$ 65,000.00
MD	Adam	Anderson	\$ 60,000.00	\$ 25,000.00		\$ 85,000.00
Total for MD Staff			\$ 150,000.00	\$ 75,000.00	\$ 80,000.00	\$ 305,000.00



CCS Cost Reporting for Direct Cost Cont.

See below an example of how Direct time will be included in both WIMCR and CCS Cost Reports. (Note that Direct vs. Direct Support concepts will be further clarified in the ForwardHealth Provider Update.)

			ANNUAL HOURS - MD STAFF		
Professional Type	First Name	Last Name	CCS Direct Hours	CCS Direct Support Hours	Other Non CCS Hours
MD	John	Smith	800	400	300
MD	Jane	Knight	1200	200	150
MD	Michael	Jones	1000	200	100
MD	Adam	Anderson	1200	300	100
Total for MD Staff			4200	1100	650



CCS Cost Reporting for General Overhead Cost

CCS cost reporting will calculate average overhead cost per Full Time Equivalent (FTE) employee, using a method consistent with WIMCR cost reporting changes also effective this year.

$$\text{Average Overhead per FTE} = \frac{\text{Total Dept. Overhead (\$)*}}{\text{Total Dept. FTEs**}}$$

*CCS will use WIMCR cost reporting methodology, which requires enumeration of agency overhead costs. The department overhead calculation and a central service allocation are combined to derive the "Total Department Overhead."

**Total Department FTEs reflects all department FTEs as well as total contracted FTEs to whom the department allocates overhead.

Note that the FTE method will be the default method; other methods may be approved by DHS.

17



CCS Cost Reporting for General Overhead Cost Cont.

Once the Average Overhead per FTE is calculated, the CCS portion of overhead costs will be calculated by the formula below.

$$\text{Total CCS Overhead Allocation} = \text{Number of CCS FTEs} * \text{Average Overhead per FTE}$$

Example:

20 CCS FTEs * Average Overhead per FTE of \$3,000



= \$60,000 CCS Overhead Allocation

18



CCS Cost Reporting and Reconciliation: General Guidelines

- Counties can only report General Overhead Costs if Direct Costs and billed service units are reported for that county. General Overhead Costs function as an add-on to the direct service unit cost; therefore these costs cannot be allocated unless Direct Costs and corresponding CCS billed service units are present.
- Financial reporting and cost settlement periods will represent the same dates of service and, under normal operation, will conform to the calendar year.
- Note that policy regarding what services should be billed on interim CCS claims will be clarified in the ForwardHealth Update.



Regional Reconciliation Guidelines



Reimbursement for Non-Regional vs. Regional CCS Provider Structure

- **Non-regional CCS providers** will continue to receive only the federal share of reimbursement as part of the interim claiming and financial reconciliation process.
 - This means the local cost share requirement persists after July 1, 2014 for these providers.
 - Non-regional CCS providers should submit interim claims using the procedure codes, professional types, modifiers and time units described here.
- **Regional CCS providers** will realize enhanced CCS payments through a cost-based reimbursement method that does not require local cost share, beginning July 1, 2014. Interim claim submissions by regions will depend on the regional model.

21



Cost Alignment with Units of Service

Direct Costs must be reported with corresponding CCS service units rendered and billed (per county) within a cost report.

Simplified Direct Cost Example:

County A submits interim claims to Medicaid as the billing/rendering provider for direct service units provided by an MD.

\$30 per unit * 2,000 units = \$60,000 interim payments from Medicaid

The Cost Reporting and Reconciliation process shows that County A's actual cost is \$32 per unit of service for the 2,000 units provided by the MD.

\$32 per unit * 2,000 units = \$64,000 total cost

The settlement payment is the additional \$4,000 in costs for the MD.

Note: the interim rate above is not an official rate.

22



Regional Billing Structures

- **Billing Provider:** the billing entity that submits the claim.
- **Rendering Provider:** the entity that rendered the service.
- Rendering Provider can also be thought of as "**rendering via contract**".

In this case, the Rendering Provider would reflect the county that has paid for the contracted service (either contract with another county's staff person or a contract with a vendor).

- The billing and rendering provider numbers will be used to assign interim claims to counties for cost reporting and reconciliation purposes.

23



Regional Billing Structures Cont.

For regional CCS providers, interim billing providers will depend on which regional model the provider is using:

- **Population Based Model:** The county will be both billing and rendering provider.
- **Shared Services Model:** Each county in the region will be both a billing and rendering provider. A county's rendering provider number should only be submitted on claims for which direct costs were incurred by the county.
- **Multi-County Model:** The region's lead county should be listed as billing provider on all interim claims, while the rendering provider number on the claim should indicate the rendering county that incurred the cost.
- **51.42 Model:** The 51.42 legal entity should be listed as the billing and rendering provider on all claims.

24



Regional Billing Structures Cont.

- If a county plans to report costs associated with direct service interim claims, then that county must be the Rendering Provider on the interim claims.



In other words, the “rendering via contract” concept can be used to assign the interim claim units to the county that has incurred costs associated with those interim claim units.

- Note: If one county in a Shared Services region intends to complete all billing on behalf of counties in the region, then that county should act as a “third party biller” and use the billing and rendering provider numbers for the county that incurred the cost.



Contractual Arrangements

- Counties have the flexibility to enter into contractual arrangements for service provision either among regional county entities or with non-county contractors.
- Additionally, a region may contract with a county outside of the region for services. This outside county would be treated as a subcontractor and would not have a county section on the cost report.



Contractual Arrangements Cont.

- If there is a financial contract between counties in a region, then the interim claims should use the rendering provider number to attribute those interim claims to the county that incurred costs associated with those contracted units.
- If there is no financial contract between counties in a region, then the costs should stay with the county that performs the service and incurs the cost.
- Counties in the region should serve members of all regional counties; a member's residence county should not affect the county that the claim is attributed to.

27



51.42 Regional Cost Reporting

- Regional entities operating under Wisconsin ss. 51.42 statutory authority are required to both bill 100% of service units and report 100% of costs. Costs should be self-contained in the 51.42 entity.
- DHS will work with 51.42 regions individually to develop the details for cost reporting.

28



Shared Services Regional Scenario

Sharing County Staff Direct Costs:

A contract for CCS program services exists between **County A** and **County B**:

- As a Shared Services region, both **County A** and **County B** are expected to individually bill Medicaid for interim claims.
- A clinician (MD) employed by **County A** is contracted to **County B**:
 - Given this financial contract, **County B** should report the MD's contract costs. **County B** should bill for the units provided by the MD under the contract so that reported costs and billed units are aligned on the cost report.
 - **County A** is required to reflect contractual revenues from **County B** as an offset to its provider costs.
 - **Note:** If there was no contract (e.g. a "pro bono" relationship) between **County A** and **County B**, then **County A** would report all costs associated with the MD as well as all units billed for the MD.

29



Multi-County Regional Scenario

Sharing County Staff Direct Costs:

A contract for CCS program services exists between **County A** and **County B**:

- As a Multi-County region, **County A** is the lead county and is expected to bill Medicaid for interim claims as the billing provider.
- A clinician (MD) employed by **County A** is contracted to **County B**:
 - Given this financial contract, **County B** should report the MD's contract costs. **County B** should also be the rendering provider on the units billed for that MD under the contract so that reported costs and billed units are aligned on the cost report.
 - **County A** is required to reflect contractual revenues from **County B** as an offset to its provider costs.
 - **Note:** If there was no contract (e.g. a "pro bono" relationship) between **County A** and **County B**, then **County A** would report all costs associated with the MD as well as all units billed for the MD.

30



Shared Services Regional Scenario

Sharing Contract for Vendor (non-county staff):

County A and **County B** share a contract with the same vendor (non-county direct service staff).

- As a Shared Services region, both **County A** and **County B** are expected to individually bill Medicaid for interim claims.
- A vendor clinician (MD) is contracted to both **County A** and **County B** and invoices each county in the region for interim claims.
 - Given this contracting relationship, **County A** should report all contracted costs they are invoiced for and should complete interim billing for all units the vendor provides under the contract with **County A**.
 - **County B** should report all contracted costs they are invoiced for and should complete interim billing for all units the vendor provides under the contract with **County B**.

31



Multi-County Regional Scenario

Sharing Contract for Vendor (non-county staff):

The region that includes **County A** and **County B** has a contract with a vendor.

- As a Multi-County region, **County A** is the lead county and is expected to bill Medicaid for interim claims as the billing provider.
- A vendor clinician (MD) is contracted to the region and invoices **County A** for regional costs.
 - Given this contracting relationship, **County A** should report all contracted costs the region is invoiced for and should complete interim billing for all units the vendor provides for the region under the contract.
 - In this scenario, **County A** is credited with all costs for the contractor, while **County B** shows no contractor costs for this MD in the **County B** section of the regional cost report.
 - Alternatively, **County A** charges **County B** a portion of the contractual costs allowing **County B** to report contract costs along with corresponding billed units.

32



Sharing General Overhead Costs

- General overhead costs function as an **“add on”** to direct costs per unit on a cost report.
- A county may only report general overhead costs if the county also reports direct costs.
- As noted previously, general overhead costs reflect central services related to overall agency operations that are allocable to all agency programs, including CCS.

33



Cost Reporting and Reconciliation Regional Guidelines

- Regions may only operate under one regional model during each financial reporting and cost settlement period.
 - For example, a single region may not employ a Multi-County model that uses a lead biller to submit certain CCS program claims, while at the same time employing a Shared Services model to submit other CCS program claims.
 - The regional model must cover all CCS service areas and contracts for billing purposes.
- Counties may not be engaged in multiple regions simultaneously for CCS program participation.

34



Regional Cost Reporting Guidelines

The cost reporting structure for CCS regions represents the summation of county specific costs for participating counties.

- This means that each county participating in a CCS regional service model must fulfill county-based cost reporting requirements, for each corresponding fiscal period, in a way that clearly represents the disaggregation of regional CCS costs at the individual county level.
- As an example, if a county participating in a CCS region wishes to claim direct or general overhead costs for reconciliation purposes, then these costs must appear in that county's cost report, or county-specific section of the regional cost report.

35



Regional Cost Reporting Guidelines Cont.

- In a Multi-County region, each county will be provided a section on the cost report in order to report their individual county costs.
- In a Shared Services region, each county will submit their own cost report.
- For Population-based and 51.42 regions, one cost report will be submitted.
- Counties are required to clearly state their individual cost structure within the region according to direct cost and general overhead cost as it relates to each county's claims for billed CCS services.

36



Shared Services vs. Multi-County Models

Shared Services Model

- Each county in the region is Division of Quality Assurance (DQA) certified and enrolled as a Medicaid provider (enrolled as both billing and rendering provider).
- Each county bills Medicaid and receives payment for interim claims.

Multi-County Model

- Region is DQA certified with a designated lead county. Non-lead county providers are Medicaid enrolled as rendering, lead county Medicaid enrolled as billing and rendering provider.
- Lead county bills Medicaid and receives payment for interim claims. Payments from lead to non-lead counties may be necessary, according to county economic preference.

37



Questions

Please send additional CCS Financial Questions to the DHS central CCS email address:

DHSDMHSASCCS@wisconsin.gov

38