Kentucky Medicaid
CMHC FAQs
Revised: February 9, 2018

1. **Question:** What will the MCOs pay if the CMHC fee schedule is not going to be maintained?

   Response: The CMHC will need to negotiate the rate with the MCO.

2. **Question:** Define non-licensed staff as it pertains to regulation 907 KAR 1:045, which states that, "travel or related costs or expenses associated with non-licensed staff" are not allowable costs.

   Response: Non-licensed staff are those that do not require continuing education for a certification. Licensed staff could include, but are not limited to, physicians and other medical staff requiring continuing education to maintain a certification. To clarify, this policy is not intended to prohibit overhead costs associated with management carrying out duties that fulfill a business or Medicaid requirement (for example, costs associated with monthly provider association meetings, or the provider cost report training would be allowable for management to report).

3. **Question:** The current CMHC reimbursement manual is outdated. Will this be updated by the Department?

   Response: The reimbursement manual will be updated. Facilities will be made aware when the updated version is available.

4. **Question:** Please clarify Department policy regarding the $25,000 limit on automobiles as stated in 907 KAR 1:045?

   Response: The $25,000 limit will be applied to the value of the vehicle. In the case of a purchased vehicle, the purchase price will be considered during review of compliance with the policy. In the case of a leased vehicle, the retail value of the vehicle will be considered during review of compliance with the policy.

5. **Question:** Are benefits included in the MGMA salary limits?

   Response: Retirement benefits typically are not included in the MGMA salary limits.

6. **Question:** Are bonuses included in the MGMA salary limits?

   Response: Bonuses which are outlined in an employment agreement or earned as a result of meeting productivity goals are subject to MGMA salary limits, as these bonuses should mathematically result in a similar compensation per encounter amount.

However, bonuses which are paid to substantially all employees equally are not subject to MGMA salary limits.

7. **Question:** Do the MGMA surveys cover tele-health providers, specifically the encounters they are expected to perform?

   Response: Guidance from the MGMA to those who complete the survey defines an encounter as, "An encounter is an instance of direct provider to patient interaction, regardless of setting (including tele-visits and e-visits), between a patient and a healthcare provider who is vested with the primary responsibility of diagnosing, evaluating, and/or treating the patient's condition."

8. **Question:** Can additional lines be added to the cost report template?

   Response: Yes, lines can be added on a case by case basis. The template is password protected however, Myers and Stauffer can add lines to it upon request.

9. **Question:** How will interim rates work with the final cost settlement?

   Response: Interim rates for behavioral health services will be set from cost report data and are designed to pay the provider close to their Medicaid costs during the course of a cost report period. Primary care services will be reimbursed in the interim based on the Kentucky-specific Medicare physician fee schedule. Total interim payments during the fiscal year will be offset by total Medicaid allowable cost from the cost report in order to determine the final cost settlement. See 907 KAR 1:045, Section 3.

10. **Question:** How will interim rates be set, and paid for timed units of service?

    Response: All timed units of service should be rolled up into one service line on the cost report. Upon receipt of the 6/30/2017 cost reports the information will be reviewed to develop the interim rate methodology. Providers will receive a single interim rate (the exact calculation is still TBD) for all CMHC services which will be cost settled after the cost report is reviewed. Also, this will not affect your billing practices - they should go unchanged.

    For example, if the overall rate established is $100, then that would be paid on any service billed, in the interim. Once the cost report is reviewed, the interim payments received will be offset against actual costs.

11. **Question:** How fast will interim CMHC rates be communicated to providers?

    Response: This process is still in development, however, the Department will issue interim rates as soon as possible. It should be noted that interim rates for behavioral health services will be based on cost report information, which will not be submitted to the Department until January 2018. Please note that for primary care services, the Kentucky-specific Medicare physician fee schedule will continue to be used and no further communication of these reimbursement rates will be provided.

12. **Question:** When will paid claims listings (PCLs) be available?

    Response: The Department will develop a PCL and will be seeking provider input during this process. To allow for proper claims adjudication PCLs will be requested 14 months after the fiscal year end to be used in the final cost settlements. Typically, a PCL dated 3 months after a provider FYE can be requested to assist with cost report preparation.

13. **Question:** What support is required for the cost report in order to support a federal indirect rate?

    Response: Where available, current federal indirect rates should be supported by the letter from the federal agency that communicated the rate. Additionally, documentation supporting the rate calculation should be submitted, such as an expense listing with mapping of direct versus indirect expense.

14. **Question:** How should providers which have an outdated federal indirect rate proceed?

    Response: If the federal indirect rate is outdated because the facility no longer receives grant funding from the grant agency, then the federal indirect rate does not have to be utilized for Medicaid reporting purposes. If the federal indirect rate is outdated because the facility has not revised the rate with the grant agency, then the current federal indirect rate on file should continue to be used for Medicaid reporting until an updated rate is approved.

15. **Question:** How will final cost settlements be communicated to providers?

    Response: After the cost report review is complete and a 14-month PCL is received (by October 1, if all information has been provided) Myers and Stauffer will issue draft adjustments for the cost report. The provider will have 30 days from the letter date to ask questions or make comments regarding these proposed adjustments. After

comments are considered, or if the provider agrees to the adjustments, the final cost settlement will be issued by the Department. Appeal rights for the final cost settlement will be provided in accordance with 907 KAR 1:671.

16. **Question:** Select CMHCs utilize related party companies to provide various services or personnel to the CMHC. These related parties do not manage, perform administrative, or human resource duties, they are simply contracted to provide the services or personnel for the associated CMHC. However, these would be considered subcontract agreements, which raises a concern for the CMHCs because subcontracts do not receive the step-down of administrative costs, as they are removed from total costs on Schedule B. All management, administrative, and human resource activities are performed in-house and therefore accrue administrative cost. The concern is that CMHCs would not be properly reimbursed for overhead costs associated with these expenses based on the current cost report design. How should CMHCs report these expenses?

    Response: For purposes of cost report classification, a subcontract agreement means the responsibility of an entire program or service area is delegated to a third party. Given this definition, if a CMHC contracts only to receive a service or personnel from a third party and maintains responsibility for the management, administrative, and human resource duties pertaining to these expenses, this would not be classified in the subcontracts section of the cost report. It is recommended that these subcontracting expenses be reported to salaries or other operating cost, which would allow the CMHCs to properly receive administrative cost allocations.

17. **Question:** Please clarify what type of transportation costs are allowable vs. non-allowable for services. As an example, peer support and ACT often requires patient transportation. Is this a covered expense?

    Response: Nonemergency medical transportation services for Medicaid recipients are covered under 907 KAR 3:066. As such, transportation of recipients will not be an allowable expense for CMHC cost settlement purposes.

18. **Question:** Please clarify what grants are to be included on Schedule G of the cost report. Is this schedule only to report grants that the facility applies for and receives directly or are providers to report all sources of grant income? This could include situations where another institution receives a grant and uses those funds to reimburse a facility.

    Response: All funds received from grants, both direct and from other agencies, should be reported.

Additional questions received after original 7/14/2017 version was published

19. **Question:** Are community wraparound services considered DMS Cost Settled Services?

    Response: Community wraparound is not a DMS cost settled service and should be grouped to a non-cost settled service line.

20. **Question:** Are providers still required to have an independent audit performed on the cost reports even though Myers and Stauffer will be reviewing them?

    Response: In accordance with 907 KAR 1: 045, Section 5, a CMHC cost report must be audited by an independent audit entity. Myers and Stauffer will be performing desk reviews on behalf of the Department. They will not be auditing the cost report or financial statements. The desk reviews will focus on reviewing the cost reports to ensure they are in conformance with state regulations as well as CMS cost reporting guidelines. Any additional information requested from providers will be used to support their cost report, check for reasonableness, as well as review for non-allowable expenses.

21. **Question:** Please provide a description of the units that are to be reported in the separate categories on Schedule D.

    Response: The grouping of units on Schedule D must be consistent with the grouping of costs on Schedule A of the cost report. The Department is working on a suggested grouping of service codes for the paid claims listing. However, if a facility's costs are grouped differently on their cost report, units should follow that grouping rather than the suggested grouping for proper cost determinations.

22. **Question:** On Schedule A, can a given cost report line include both Facility Direct and Facility Allocated cost (columns 8 & 9)? This question applies to Travel & Transportation Direct and Travel & Transportation Allocated cost (columns 10 & 11) as well.

    Response: Yes, as long as the cost is not duplicative and any directly assigned costs are not subsequently included in the allocation calculation.

23. **Question:** How should the first cost report period, which is a short period spanning 11/1/2016 – 6/30/2017, be prepared?

    Response: Per 907 KAR 1:045 section 6, the first cost report period spans from November 1, 2016 to June 30, 2017 for Medicaid cost reporting purposes. The Department for Medicaid services will allow this cost report to be completed using actual cost and units of service data from the 8 relevant months **or** by prorating the full year of cost to include only 67% while still using actual units of service for the short period. This cost report must be audited by an independent auditor.

    However, the Department for Behavioral Health (DBHDID) still requires that each CMHC complete a full period cost report using actual costs and units of service for the full year spanning July 1, 2016 to June 30, 2017. If you only completed a short period cost report to submit to your auditors, DBHDID will accept the audit that is being performed on the short period cost report, rather than having two cost report audits performed, however, a full year report will still need to be filed with DBHDID. If you need additional time to file a full period report with DBHDID, they indicated extensions would be granted.

24. **Question:** Why do the Physical Therapy, Occupational Therapy, and Speech-Language Pathology/Speech Therapy cost centers appear as both cost settled and non-cost settled services on Schedule A of the cost report?

    Response: These services belong under DMS Cost Settled / Primary Care Services on lines 28-30 of the current cost report template. All PT/OT/ST should be reported on these lines and the units of service will apportion cost by payer. This will be revised on a later version of the cost report to eliminate the non-DMS cost settled service lines.

25. **Question:** Will functional updates be made to the cost report template for future periods, based on experiences from the first period?

    Response: Yes, along with the Department, Myers and Stauffer will track comments from providers regarding the cost report template. Updates will be made as needed before 6/30/2018. These changes will not affect the overall intent of the cost report, but will make the template more functional for future periods. Additionally, providers are encouraged to report all costs as whole numbers. Additional formatting updates have also been made to adjust the width of various columns which were not properly displaying the full values. If you would like your cost report in progress updated for formatting or formulas, please contact Myers and Stauffer and they will be able to assist you.

26. **Question:** What is the difference between DMS cost settled services and non-cost settled services?
    Response: DMS will only provide a cost settlement for the services listed in the cost settled section of the cost report. Services that are not cost settled will continue to receive payments as they do today, without a year-end cost settlement. All costs must still be reported to ensure a complete cost report, but the Department will not cost settle all services

27. **Question:** Are SCL-only or other waiver only providers required to fill out the CMHC cost settlement cost report?

    Response: No, only licensed Community Mental Health Centers are required to complete the cost report.

28. **Question:** Will both children and adult crisis services be cost settled?

    Response: Yes, both children and adult crisis services will be cost settled. However, these should be reported on separate cost report lines under the "DMS Cost Settled Services" section.

29. **Question:** Will you add a separate schedule to calculate the cost per unit for waiver services on Schedule E or Schedule F?

    Response: Yes, Myers and Stauffer will be developing a supplement schedule to show waiver costs similar to the manner in which Schedule E and F do for Medicaid and DBHDID costs, respectively.

30. **Question:** Will custom allocations of Clinical Support, which deviate from the cost report standard but are believed to be more accurate, be accepted?

    Response: This will be reviewed on a case-by-case basis. Providers will be required to submit their request to the Department in writing, which will be subject to review and approval.

31. **Question:** Should the DUI assessment line under non-cost settled services include all DUI services or just assessments?

    Response: Yes, all DUI services should be reported under non-cost settled services. The Department does not cost settle DUI services or assessments.

32. **Question:** What is included in "travel or related costs" for non-licensed staff attending a meeting or a conference?

    Response: In accordance with 907 KAR 1:045, travel or related costs or expenses associated with non-licensed staff attending a convention, a meeting, an assembly, or a conference are non-allowable for DMS cost settlement services. Related costs include, but are not limited to, registration fees, vehicle expenses, airfare, mileage, lodging, or meals.