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.

See Attachment 2.1.a

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.

N/A

[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.

N/A

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.

N/A

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.

N/A

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.

N/A

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.

N/A

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.

N/A

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.

N/A

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.

N/A

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.

In Oregon, managed care plans are referred to as Coordinated Care Organizations (CCO). CCOs are required to cover, at a minimum, the services covered by the state on a fee-for-service basis. In developing the Oregon CCBHC Demonstration Service Crosswalk, Oregon utilized its existing Behavioral Health Fee Schedule to ensure that all services captured as a CCBHC service would also be covered for CCO enrolled members.

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.

N/A

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.

Oregon will use the wraparound process currently in operation for Federally Qualified Health Centers (FQHC) providing services for Medicaid members. CCOs will submit CCBHC encounter claims to the Oregon Medicaid Management Information System (MMIS). Encounters submitted directly to Oregon Medicaid from the CCBHC will be validated against paid encounters submitted by the CCO. A wraparound payment will be issued equal to the difference between managed care payments and the total PPS cost.

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

Wraparound payments are issued for one calendar quarter at a time, and generally occur within nine months of the close of the calendar quarter (to allow time for claims to register in the MMIS).

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.

N/A

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.

See Attachment 5.0.d

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.

Oregon intends to use the CCBHC encounter and modifier procedure codes for all billed CCBHC demonstration services, when they are released by CMS in late 2016. This will allow the Office of Financial Services (OFS) to easily claim the enhanced FMAP for CCBHC services by querying the MMIS data warehouse for all claims with the specified encounter code.

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.

Oregon has conducted a preliminary analysis of the impact of the CCBHC demonstration. The analysis appears to indicate that the savings in state general fund as a result of the enhanced match rate will be sufficient to fund the state portion of the PPS rate. If those projections are not realized Oregon will shift general funds from other program areas to fund the non-federal funding of the services

- 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 funding will come from appropriations from the legislature

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.).

Oregon is administering the PPS rate through a wrap payment methodology. Providers have contracts with the CCOs, Medicaid managed care organization. They will receive payments for CCBHC services from the CCO in accordance with their existing contracts. The Oregon Health Authority will then provide wrap payments to make-up the difference between the CCO payment and the PPS rate. There is no process which require the CCBHC to make any repayments.

Attachment 2.1.a

Each CCBHC in Oregon used the CMS Cost Report Template. Cost and visit data vary based on CCBHC size, location, economy, and scope of services offered. The majority of certified clinics utilized Dale Jarvis Consulting to establish CCBHC cost and visit data to be included in the cost report template. 16 of the 17 CCBHCs allocated indirect costs proportionally by the percentage of direct costs for CCBHC services. One CCBHC allocated indirect costs at 14% based on a cognizant agency (HUD). Oregon has contracted with actuarial firm *Optumas* to review cost report data for adherence 45 Code of Federal Regulations (CFR) §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for the U.S. Department of Health and Human Services (HHS) Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement. Optumas will engage with CCBHCs to finalize CC-PPS 1 rates.

Attachment 5.0.d

Each CCBHC will report on the 9 clinic-lead required measures and case load characteristics for each demonstration year of the CCBHC program. CCBHCs will each maintain an EHR that allows them to collect data and report each measure according to the specifications in the Metrics and Quality Measures for Behavioral Health Clinics: Technical Specifications and Resource Manual, allowing for specific modifications and guidance permitted by SAMHSA and the State of Oregon (at SAMHSA's approval), and will submit the data to the state 8 months after the end of each demonstration year using the Demonstration Data Reporting Template provided by SAMHSA. The state of Oregon will then examine the data prior to submitting the clinic-lead measures to SAMHSA 9 months after the end of each demonstration year. As part of the certification process, the State verified the ability of each CCBHC to report data and provide evidence of coordinating with their EHR vendor in meeting the reporting requirements. Each CCBHC was required to show evidence of care coordination agreements and MOUs that allow access to medical records for data reporting while protecting patient rights to privacy and confidentiality under HIPPA.

The State will collect the 13 state-lead required measures for each CCBHC according to the specifications in the Metrics and Quality Measures for Behavioral Health Clinics: Technical Specifications and Resource Manual. The states will submit this data to SAMHSA 12 months after the end of each demonstration year using the Demonstration Data Reporting Template provided by SAMHSA.

Sample Cost Report

CCBHC Cost Report				
MEDICAID ID:	500602527			
NPI:	123056017			
REPORTING PERIOD:	From:	7/1/2015	To:	6/30/2016
RATE PERIOD:	From:	7/1/2015	To:	6/30/2016
WORKSHEET:	Trial Balance			

PART 1 - DIRECT CCBHC EXPENSES

PART 1A - CCBHC STAFF COSTS

	Description	Compensation	Other	Total (Col. 1 + 2)	Reclassifications	Reclassified Trial Balance (Col. 3 + 4)	Adjustments Increases (Decreases)	Adjusted Amount (Col. 5 + 6)	Adjustments for Anticipated Cost Changes	Net Expenses (Col. 7 + 8)
		1	2	3	4	5	6	7	8	9
1.	Psychiatrist	$534,857	$111,544	$646,401		$646,401		$646,401	$512,115	$1,158,516
2.	Psychiatric nurse	$265,035	$151,234	$416,269		$416,269		$416,269	$256,331	$672,600
3.	Child psychiatrist	$56,073		$56,073		$56,073		$56,073	$256,057	$312,130
4.	Adolescent psychiatrist			$0		$0		$0		$0
5.	Substance abuse specialist	$867,899	$480,015	$1,347,914	-$24,012	$1,323,902		$1,323,902		$1,323,902
6.	Case manager	$703,247	$401,260	$1,104,507		$1,104,507		$1,104,507	$138,121	$1,242,628
7.	Recovery coach			$0		$0		$0		$0
8.	Peer specialist	$173,903	$99,226	$273,129		$273,129		$273,129	$117,299	$390,429
9.	Family support specialist			$0		$0		$0		$0
10.	Licensed clinical social worker	$814,392	$464,679	$1,279,071		$1,279,071		$1,279,071	$164,029	$1,443,099
11.	Licensed mental health counselor	$728,058	$415,418	$1,143,476	-$24,012	$1,119,464		$1,119,464		$1,119,464
12.	Mental health professional (trained and credentialed for psychological testing)	$1,818,852	$1,023,180	$2,842,032	-$157,782	$2,684,250		$2,684,250		$2,684,250
13.	Licensed marriage and family therapist	$183,039	$104,439	$287,478		$287,478		$287,478		$287,478
14.	Occupational therapist	$24,776	$14,137	$38,913		$38,913		$38,913		$38,913
15.	Interpreter or linguistic counselor			$0		$0		$0		$0
16.	General practice (performing CCBHC services)			$0		$0		$0		$0
17.	Other staff costs (specify details below)									
17a	Program Development Specialist	$67,487	$38,508	$105,995		$105,995		$105,995		$105,995
17b	Psychiatric Nurse Practitioner	$367,832	$123,575	$491,407		$491,407		$491,407		$491,407
17c	Behavioral Health Technician	$87,659	$50,020	$137,679	-$54,664	$83,015		$83,015		$83,015
17d				$0		$0		$0		$0
17e	Behavioral Health Deputy Director	$114,679	$65,438	$180,117	-$11,035	$169,082		$169,082		$169,082
17f	Health Services Program Supervisor	$88,334	$50,405	$138,739		$138,739		$138,739		$138,739
17g	Behavioral Health Program Manager	$401,068	$228,856	$629,924	-$40,965	$588,959		$588,959		$588,959
17h	Behavioral Health Specialist III	$811,147	$462,853	$1,274,000		$1,274,000		$1,274,000		$1,274,000
17i	Senior Secretary	$172,420	$98,385	$270,805		$270,805		$270,805	$362,357	$633,162
17j	Accountng Clerk II	$38,267	$21,836	$60,103		$60,103		$60,103		$60,103
17k				$0		$0		$0		$0
17l				$0		$0		$0		$0
17m				$0		$0		$0		$0
17n				$0		$0		$0		$0
17o				$0		$0		$0		$0
17p				$0		$0		$0		$0
17q				$0		$0		$0		$0

CCBHC Cost Report

MEDICAID ID:	500602527									
NPI:	123056017									
REPORTING PERIOD:	From:	7/1/2015	To:	6/30/2016						
17r				$0		$0		$0		$0
17s				$0		$0		$0		$0
17t				$0		$0		$0		$0
17u				$0		$0		$0		$0
17v				$0		$0		$0		$0
17w				$0		$0		$0		$0
17x				$0		$0		$0		$0
17y				$0		$0		$0		$0
17z				$0		$0		$0		$0
17aa				$0		$0		$0		$0
17ab				$0		$0		$0		$0
17ac				$0		$0		$0		$0
17ad				$0		$0		$0		$0
17ae				$0		$0		$0		$0
17af				$0		$0		$0		$0
17ag				$0		$0		$0		$0
17ah				$0		$0		$0		$0
17ai				$0		$0		$0		$0
18.	Subtotal staff costs (sum of lines 1-17)	$8,319,024	$4,405,008	$12,724,032	-$312,470	$12,411,562	$0	$12,411,562	$1,806,309	$14,217,870

PART 1B - CCBHC COSTS UNDER AGREEMENT

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
19.	CCBHC costs from DCO			$0		$0		$0		$0
20.	Other CCBHC costs (specify details below)									
20a				$0		$0		$0		$0
21.	Subtotal costs under agreement (sum of lines 19-20)		$0	$0	$0	$0	$0	$0	$0	$0

CCBHC Cost Report

MEDICAID ID:	500602527			
NPI:	123056017			
REPORTING PERIOD:	From:	7/1/2015	To:	6/30/2016

PART 1C - OTHER DIRECT CCBHC COSTS

	Description	Compensation	Other	Total (Col. 1 + 2)	Reclassifications	Reclassified Trial Balance (Col. 3 + 4)	Adjustments Increases (Decreases)	Adjusted Amount (Col. 5 + 6)	Adjustments for Anticipated Cost Changes	Net Expenses (Col. 7 + 8)
		1	2	3	4	5	6	7	8	9
22.	Medical supplies		$4,694	$4,694		$4,694		$4,694	$469	$5,163
23.	Transportation (health care staff)		$209,610	$209,610		$209,610		$209,610	$20,961	$230,571
24.	Depreciation - medical equipment			$0		$0		$0		$0
25.	Professional liability insurance			$0		$0		$0		$0
26.	Telehealth			$0		$0		$0	$25,000	$25,000
27.	Other direct costs not already included (specify details below)									
27a	Alcohol Detox Program Treatment		$42,081	$42,081		$42,081		$42,081		$42,081
27b	Child & Family Contracts		$22,149	$22,149		$22,149		$22,149		$22,149
27c	Background Investigations		$452	$452		$452		$452		$452
27d	Contracts		$617,940	$617,940		$617,940		$617,940		$617,940
27e	Medical Lab		$8,451	$8,451		$8,451		$8,451	$845	$9,296
27f	Interpreter		$13,539	$13,539		$13,539		$13,539	$1,354	$14,893
27g	Testimony		$9,035	$9,035		$9,035		$9,035		$9,035
27h	Education Provider		$13,273	$13,273		$13,273		$13,273	$1,327	$14,600
27i	Client Stabilization		$1,560	$1,560		$1,560		$1,560	$156	$1,716
27j	Program Expenses		$1,991,523	$1,991,523		$1,991,523		$1,991,523	$199,152	$2,190,675
27k	OHP Flex Funds		$20,847	$20,847		$20,847		$20,847		$20,847
27l	MHC Flex Funds		$3,002	$3,002		$3,002		$3,002		$3,002
27m	Client Support Flex		$6,396	$6,396		$6,396		$6,396		$6,396
27n	Children's In-Home		$92,615	$92,615		$92,615		$92,615		$92,615
27o	Program Supplies		$19,946	$19,946		$19,946		$19,946	$1,995	$21,941
27p	Testing Supplies		$2,982	$2,982		$2,982		$2,982	$298	$3,280
27q	Licenses & Fees		$8,101	$8,101		$8,101		$8,101	$810	$8,911
27r	Membership/Dues		$18,688	$18,688		$18,688		$18,688	$1,869	$20,557
27s	Conf & Seminars		$16,135	$16,135		$16,135		$16,135	$1,613	$17,748
27t	Education/Training		$46,979	$46,979		$46,979		$46,979	$4,698	$51,677
27u	Grants		$39,007	$39,007		$39,007		$39,007		$39,007
27v	Interfund Contract		$257,387	$257,387		$257,387		$257,387		$257,387
27w				$0		$0		$0		$0
27x				$0		$0		$0		$0
28.	Subtotal other direct CCBHC costs (sum of lines 22-27)		$3,466,393	$3,466,393	$0	$3,466,393	$0	$3,466,393	$260,547	$3,726,940
29.	**Total cost of CCBHC services (other than overhead) (sum of lines 18, 21, and 28)**	**$8,319,024**	**$7,871,400**	**$16,190,424**	**-$312,470**	**$15,877,954**	**$0**	**$15,877,954**	**$2,066,856**	**$17,944,810**

CCBHC Cost Report

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PART 2 - INDIRECT COSTS

PART 2A - SITE COSTS

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
30.	Rent		$25,957	$25,957		$25,957		$25,957		$25,957
31.	Insurance		$128,370	$128,370		$128,370		$128,370	$12,837	$141,207
32.	Interest on mortgage or loans		$200,000	$200,000		$200,000		$200,000		$200,000
33.	Utilities		$98,444	$98,444		$98,444		$98,444	$9,844	$108,288
34.	Depreciation - buildings and fixtures			$0		$0		$0		$0
35.	Depreciation - equipment			$0		$0		$0		$0
36.	Housekeeping and maintenance	$420,257	$9,103	$429,360		$429,360		$429,360		$429,360
37.	Property tax			$0		$0		$0		$0
38.	Other site costs (specify details below)									
38a				$0		$0		$0		$0
39.	Subtotal site costs (sum of lines 30-38)	$420,257	$461,874	$882,131	$0	$882,131	$0	$882,131	$22,681	$904,812

PART 2B - ADMINISTRATIVE COSTS

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
40.	Office salaries			$0		$0		$0		$0
41.	Depreciation - office equipment			$0		$0		$0		$0
42.	Office supplies			$0		$0		$0		$0
43.	Legal	$106,969		$106,969		$106,969		$106,969	$10,697	$117,666
44.	Accounting	$151,753	$31,330	$183,083		$183,083		$183,083	$18,308	$201,391
45.	Insurance			$0		$0		$0		$0
46.	Telephone		$31,567	$31,567		$31,567		$31,567		$31,567
47.	Other administrative costs (specify details below)									
47a	Management Consultant		$74,663	$74,663		$74,663		$74,663	$7,466	$82,129
47b	Mail Service/Postage		$45,091	$45,091		$45,091		$45,091	$4,509	$49,600
47c	Archive Fees		$4,223	$4,223		$4,223		$4,223	$422	$4,645
47d	Internal Svc Chg - Admin	$149,579		$149,579		$149,579		$149,579	$14,958	$164,537
47e	Internal Svc Chg - Board of Comm	$51,752		$51,752		$51,752		$51,752	$5,175	$56,927
47f	Internal Service Charge - HR	$192,382		$192,382		$192,382		$192,382	$19,238	$211,620
47g	Internal Service Charge - IT	$399,980	$41,016	$440,996		$440,996		$440,996	$44,100	$485,096
47h	Computers and Software		$446,294	$446,294		$446,294		$446,294	$44,629	$490,923
47i	Equipment		$76,558	$76,558		$76,558		$76,558	$7,656	$84,214
47j	Office Supplies		$85,089	$85,089		$85,089		$85,089	$8,509	$93,598
47k	Furniture & Fixtures		$29,223	$29,223		$29,223		$29,223	$2,922	$32,145
47l	Advertising/Fair		$3,936	$3,936		$3,936		$3,936		$3,936
47m	Travel		$35,445	$35,445		$35,445		$35,445	$3,545	$38,990
47n	Refunds/Adjust		$53,083	$53,083		$53,083		$53,083		$53,083

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47o	Health Services Director	$89,246	$50,748	$139,994		$139,994		$139,994		$139,994
47p	Health Services Operations Manager	$61,655	$35,059	$96,714		$96,714		$96,714		$96,714
47q	Improvement	$159,289	$90,577	$249,866		$249,866		$249,866	$92,637	$342,503
47r	Systems Analyst	$62,403	$35,484	$97,887		$97,887		$97,887		$97,887
47s	Epidemiologist	$17,826	$10,137	$27,963		$27,963		$27,963		$27,963
47t	Specialist I	$48,967	$27,844	$76,811		$76,811		$76,811		$76,811
47u	Technician	$32,053	$18,227	$50,280		$50,280		$50,280		$50,280
47v	Technician	$58,345	$33,177	$91,522		$91,522		$91,522	$66,177	$157,699
47w	Analyst	$134,441	$76,448	$210,889		$210,889		$210,889	$185,273	$396,161
47x	ng Specialist	$40,232	$22,877	$63,109		$63,109		$63,109		$63,109
47y	Supervisor I	$191,196	$108,720	$299,916		$299,916		$299,916		$299,916
47z	Business Operations Manager	$70,048	$39,831	$109,879		$109,879		$109,879		$109,879
47aa	Registered Health Info Tech	$43,372	$24,662	$68,034		$68,034		$68,034		$68,034
47ab	Patient Account Specialist II	$83,889	$47,702	$131,591		$131,591		$131,591	$116,422	$248,014
47ac	Administrative Secretary	$14,742	$8,383	$23,125		$23,125		$23,125		$23,125
47ad	Medical Records Technician	$70,800	$40,259	$111,059		$111,059		$111,059		$111,059
47ae	HS Administrative Specialist II	$128,588	$73,119	$201,707		$201,707		$201,707	$53,715	$255,422
47af	HS Administrative Specialist I	$123,697	$70,338	$194,035		$194,035		$194,035	$49,511	$243,546
47ag	Temporary Help - Admin	$100,780		$100,780		$100,780		$100,780	$10,078	$110,858
47ah	Temporary Help - Labor	$7,307		$7,307		$7,307		$7,307	$731	$8,038
47ai				$0		$0		$0		$0
47aj				$0		$0		$0		$0
47ak				$0		$0		$0		$0
47al				$0		$0		$0		$0
47am				$0		$0		$0		$0
47an				$0		$0		$0		$0
47ao				$0		$0		$0		$0
48.	Subtotal administrative costs (sum of lines 40-47)	$2,591,291	$1,771,112	$4,362,403	$0	$4,362,403	$0	$4,362,403	$766,678	$5,129,082
49.	Total overhead (sum of lines 39 and 48)	$3,011,548	$2,232,986	$5,244,534	$0	$5,244,534	$0	$5,244,534	$789,359	$6,033,894

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REPORTING PERIOD:	From:	7/1/2015	To:	6/30/2016

PART 3 - DIRECT COSTS FOR NON-CCBHC SERVICES

PART 3A - DIRECT COSTS FOR SERVICES OTHER THAN CCHBC SERVICES

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
50.	Direct costs for non-CCBHC services covered by Medicaid (specify details below)									
50a	Mental Health Professional			$0	$157,782	$157,782		$157,782		$157,782
50b	Behavioral Health Deputy Director			$0	$11,035	$11,035		$11,035		$11,035
50c	Behavioral Health Program Manager			$0	$40,965	$40,965		$40,965		$40,965
50d	Developmental Disabilities Spec III	$149,578	$85,055	$234,633		$234,633		$234,633		$234,633
50e	Developmental Disabilities Spec II	$88,091	$50,091	$138,182		$138,182		$138,182		$138,182
50f	Developmental Disabilities Spec I	$633,420	$360,183	$993,603		$993,603		$993,603		$993,603
50g	DD Family Grant		$3,013	$3,013		$3,013		$3,013		$3,013
50h	Local Match TCM-MAC		$93,766	$93,766		$93,766		$93,766		$93,766
50i	Other Counties		$268,783	$268,783		$268,783		$268,783		$268,783
50j	Program Development Assistant	$22,768	$12,947	$35,715		$35,715		$35,715		$35,715
50k	Behavioral Health Technician			$0	$54,664	$54,664		$54,664		$54,664
50l	Secretary	$69,616	$39,586	$109,202		$109,202		$109,202		$109,202
50m	Admininstrative Supervisor I			$0		$0		$0		$0
50n	Health Services Director			$0		$0		$0		$0
50o	Health Services Operations Manager			$0		$0		$0		$0
50p	Epidemiologist			$0		$0		$0		$0
50q	Senior Accounting Technician			$0		$0		$0		$0
50r	Accounting Technician			$0		$0		$0		$0
50s	Contract/Credentialing Specialist			$0		$0		$0		$0
50t	Business Operations Manager			$0		$0		$0		$0
50u	Administrative Secretary			$0		$0		$0		$0
50v	Substance Abuse Specialist			$0	$24,012	$24,012		$24,012		$24,012
50w	Licensed Mental Health Counselor			$0	$24,012	$24,012		$24,012		$24,012

PART 3B - NON-REIMBURSABLE COSTS

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
51.	Direct costs for non-CCBHC services *not* covered by Medicaid (specify details below)									
51a				$0		$0		$0		$0
51b				$0		$0		$0		$0
51c				$0		$0		$0		$0
51d				$0		$0		$0		$0
51e				$0		$0		$0		$0
51f				$0		$0		$0		$0
51g				$0		$0		$0		$0
51h				$0		$0		$0		$0

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51i				$0		$0		$0		$0
51j				$0		$0		$0		$0
51k				$0		$0		$0		$0
51l				$0		$0		$0		$0
51m				$0		$0		$0		$0
51n				$0		$0		$0		$0
51o				$0		$0		$0		$0
51p				$0		$0		$0		$0
51q				$0		$0		$0		$0
51r				$0		$0		$0		$0
51s				$0		$0		$0		$0
51t				$0		$0		$0		$0
51g				$0		$0		$0		$0
52.	Total costs for non-CCBHC services (sum of lines 50-51)	$963,473	$913,424	$1,876,897	$312,470	$2,189,367	$0	$2,189,367	$0	$2,189,367
53.	**Total costs (sum of lines 29, 49, and 52)**	$12,294,045	$11,017,811	$23,311,856	$0	$23,311,856	$0	$23,311,856	$2,856,215	$26,168,070