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

State CCBHC Cost Report Crosswalk (updated 12.5.23)

The criteria below outlines the objectives of each section in the Certified Community Behavioral Health Clinic (CCBHC) Cost Report and should be followed to enable states using their own cost report to crosswalk a reviewer between the two reports in order to expedite analysis. According to the Paperwork Reduction Act of 1995, individuals are not required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148, and the CMS ID number is CMS-10398 (#43). The time required to complete this information collection is estimated to average 54 hours for PPS-1, 109 hours for PPS-2, 70 hours for PPS-3 and 129 hours for PPS-4 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Criteria
1. The cost report package includes: cost report template, instructions, explanation of data sources, narratives, and indirect cost rate approval letter (if applicable).
2. Provider Information includes: a. Selected PPS methodology (CC PPS-1, CC PPS-2, CC PPS-3 or CC PPS-4) b. Reporting period with start and end dates c. PPS rate period with start and end dates d. State-assigned Medicaid ID and National Provider Identifier (NPI) for the primary CCBHC e. CCBHC information • Official name and address • Organizational authority (Nonprofit, Local Government Behavioral Health Authority, Indian Health Service Organization, Indian Tribe or Tribal Organization, or Urban Indian Organization) • The CCBHC's headquarter location designation (Urban, Rural, or Unknown) • Whether the CCBHC is dually certified as a 1905(a)(9) clinic, FQHC, or other type • Whether the CCBHC provides non-CCBHC services • CCBHC operating days, operating times, and total hours (excluding hours for any 24-hour mobile crisis team) • Names and NPIs for individual practitioners/providers f. Whether the CCBHC is reporting as a consolidated entity, and if so, the above listed information for each satellite site g. Whether each satellite site established prior to April 1st, 2014 h. A list of any excluded satellite facilities and reasons for exclusion
3. Documentation reconciling cost report expenses to financial records and reasonable estimates of anticipated cost. *Note: The clinic should explain how it assessed reasonable, estimated costs including any accounting data and reconciliation calculations.*

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4. Direct costs are identified for:
   a. Direct staffing costs to provide CCBHC services
   b. Direct costs of designated collaborating organizations (DCO) under agreement are identified.
   c. Other direct costs to provide CCBHC services
   d. For CC PPS-2 and CC PPS-4 only: Direct staffing and other costs to provide CCBHC services are categorized by populations with certain conditions and as outliers
   e. Total direct costs of providing CCBHC services are identifiable and used to properly allocate indirect costs
   f. Direct costs to provide non-CCBHC services identified
   g. For CC PPS-3 and CC PPS-4 only: Direct staffing and other costs to provide special crisis services are distinguished from non-crisis services

5. Unallowable costs are removed from direct and indirect costs and identifiable on an adjustments section.
   a. Examples of common costs not allowed include, but are not limited to, vending, entertainment, accelerated depreciation expenses, etc.

6. Explanations are provided for:
   a. Reclassification of expenses between direct and indirect cost categories
   b. Expense adjustments
   c. Cost allocations

7. Cost report shows that indirect cost is allocated using one of the following 4 allowed methods[1]:
   a. Federally approved rate from a cognizant authority*
      - A copy of the agreement is included with the cost report
      - The correct rate being applied to the correct direct cost base, as dictated in by the rate agreement

These entities are required to obtain an indirect cost rate agreement:

- Non-profit organizations with direct federal funding (i.e. they are the grant recipient).
  - Pass through entities, such as state governments, are required to negotiate a rate with the non-profit sub recipient, or provide the minimum rate of 10% if the entity meets the requirements of its use.
- State or local governments with at least $35 million in direct Federal funding must obtain a federally approved cognizant agency rate.
  - State governments, local governments, or tribal agencies with less than $35 million in direct Federal funding are required to prepare an annual indirect cost rate proposal and keep it on file.

*Requirements for development and submission of indirect cost rate proposals for state and local governments, Indian Tribe, and nonprofit organizations are contained at 45 CFR §75 appendices IV and VII.

[1] Note that not all entities charge indirect cost rates and they are not required to establish such rates. Entities that are able to allocate and charge 100% of their costs directly are not required to obtain an indirect cost rate may utilize options 3 or 4 in the CMS CCBHC cost report.

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b. Use of the federal minimum rate (10%) (45 CFR §75.414(f))

Any non-Federal entity that has never received a negotiated indirect cost rate, except for state and local governments that receive more than $35M in direct federal funding, may elect to charge a rate of 10% of modified total direct costs (MTDC)[2] which may be used indefinitely.

- Organizations that qualify for the 10% minimum rate include:
  - Non-profits with no direct federal funding who have never negotiated an indirect cost rate.
  - Non-profits with Federal funding who have never negotiated an indirect cost rate with a Federal agency, or

c. Allocation of indirect costs by the percentage of direct costs for CCBHC services versus total allowable costs less indirect costs

d. Other indirect allocation method – explain in Notes column

- The indirect allocation method is thoroughly documented and adheres to Medicare and Medicaid cost principles identified in 45 CFR §75.

8. Visit enumeration clearly identifies daily or monthly visits provided directly by the CCBHC, additional visits from DCOs and anticipated visits, when applicable. For PPS-3 and PPS-4, visits should differentiate between special crisis services visits and non-crisis visits.

9. Rate calculations include:
   a. Indirect cost allocated to direct CCBHC costs
   b. For CC PPS-1:
      - Total allowable cost divided by total annual daily visits for the standard daily base PPS-1 rate
      - DY1 preliminary rates are based on expected plus actual cost, visits and charges
   c. For CC PPS-2:
      - Total allowable cost excluding costs for services provided to persons with certain conditions and outlier payments divided by total annual monthly visits for the standard monthly base PPS-2 rate
      - Total annual allowable CCBHC costs including only services provided to persons with certain conditions excluding outlier payments divided by total annual monthly visits for the special population rate(s)
      - The cost report separately shows actual and expected charges by population for DY1 rate setting purposes
   d. For CC PPS-3:
      - Total annual allowable CCBHC costs excluding costs for crisis services included under SCS services divided by the total number of CCBHC daily visits per year excluding crisis services visits included under SCS services for the standard daily base PPS-3 rate
      - Total annual allowable CCBHC costs including only those for one of the three categories of SCS services divided by the total number of CCBHC daily visits per year including only those for same category of SCS services for each SCS rate
      - DY1 preliminary rates are based on expected plus actual cost, visits and charges

[2] MTDC is defined at 45 CFR §75.2 as all direct salaries and wages, applicable fringe benefits, materials and supplies, services, travel, and up to the first $25,000 of each subaward (regardless of the period of performance of the subawards under the award). MTDC excludes equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs and the portion of each subaward in excess of $25,000. Other items may only be excluded when necessary to avoid a serious inequity in the distribution of indirect costs, and with the approval of the cognizant agency for indirect costs.

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e. For CC PPS-4
- Total annual allowable CCBHC costs excluding the costs for services provided to persons with certain conditions, costs for crisis services included under SCS services, and outlier payments divided by the total number of CCBHC unduplicated monthly visits per year excluding visits for persons with certain conditions and crisis services visits included under SCS services for the standard monthly base PPS-4 rate
- Total annual allowable CCBHC costs including only those costs associated with one of the three categories of SCS services and excluding the costs for services provided to the standard population, persons with certain conditions, costs for crisis services included under the other two SCS services categories divided by the total number of CCBHC unduplicated monthly visits per year including only visits for the same category of SCS services used in the numerator and excluding the visits for the standard population, persons with certain conditions, and visits for crisis services included under the other two SCS services categories for each SCS rate
- Total annual allowable CCBHC costs including only the costs for services to persons with certain conditions and excluding costs for the standard population, crisis services included under SCS services and outlier payments divided by the total number of CCBHC unduplicated monthly visits per year including only the visits for services to persons with certain conditions and excluding visits for the standard population and crisis services included under SCS services for the special population rate(s).
- The cost report separately shows actual and expected charges for each special crisis rate and by population for DY1 rate setting purposes

f. Inflation adjustment using the Medicare Economic Index (MEI) for DY2 rates

g. If other metric used, then explain in Notes column

*If using the MEI or other inflation adjustment metric, it must be applied using the approved OACT MEI tool for the CCBHC demonstration.

10. The cost report was certified by the clinic's chief executive officer, chief financial officer, or a direct delegate to ensure completeness and accuracy.

11. As shown in the CMS cost report template, staff FTEs, direct costs and services are identifiable by occupational grouping. Services may be duplicative to properly represent each group.