Hot Topics in CCBHC Implementation: Cost Reporting, Clinic Licensure, State Financing and More

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ROAD MAP

I. Understanding the Prospective Payment System: Examining the service mix that is required to participate in the CCBHC program

II. Understanding Your Rate and the Relationship Between Licensure and Certification

III. Understanding Your Responsibility: How to pay for the state’s portion with money you may already have
I. UNDERSTANDING THE PROSPECTIVE PAYMENT SYSTEM

• What is PPS and How is it Calculated?
• Understanding the Issues Surrounding PPS Options
• Establishing a Cost Report
THE NINE REQUIRED CCBHC SERVICES

Four Required CCBHC Services

- Crisis behavioral health services.
- Person centered and family centered treatment planning.
- Screening, assessment and diagnosis.
- Outpatient mental health and substance use services.

Five Required CCBHC or DCO Services

- Peer Support
- Primary Care Screening and Monitoring
- Targeted Case Management
- Psychiatric Rehabilitation
- Armed Forces Veteran Services
WHAT IS A PROSPECTIVE PAYMENT SYSTEM (PPS)?
PAYMENT RELATES TO COST

- Reimbursement based on costs of serving consumers, **not** on fee schedule
- PPS rate is unique to each CCBHC
- Rate based on annual allowable costs in a base period for the “basket” of CCBHC services
WHAT IS A PROSPECTIVE PAYMENT SYSTEM (PPS)?
RATE BASED ON A BUNDLED PAYMENT PER UNIT OF SERVICE

• Rate based on average cost per unit of service (for CCBHCs, the “visit”)
• Same rate is paid for each qualifying unit of service, *regardless of the intensity of services provided*
WHAT IS A PROSPECTIVE PAYMENT SYSTEM (PPS)?
BASE YEAR RATE IS TRENDED FORWARD

- PPS rates are typically trended forward from year to year based on an inflation factor such as the Medicare Economic Index (MEI)
- Creates incentive to provider to provide care efficiently with goal that over time, PPS rate will keep pace with average costs per unit of service
PPS IS **NOT** COST REIMBURSEMENT

- Reimbursement under a PPS methodology
  - Bears a *rational relationship* to the provider’s costs
  - May not equal costs for a given year and is not subject to cost settlement
LEGAL FRAMEWORK FOR CCBHC PPS

- Protecting Access to Medicare Act (PAMA) § 223(b)(1)

Not later than September 1, 2015, the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, shall issue guidance for the establishment of a prospective payment system that shall only apply to medical assistance for mental health services furnished by a [CCBHC]

- Requirements:
  - No payment for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services
  - No payment to “satellite facilities of [CCBHCs] “if such facilities are established after the date of enactment of this Act”
  - CMS issued guidance on the PPS in 2015
  - Note: CMS, not Congress, chose “per visit” unit of payment
Implement PPS rate-setting methodology for payment made via fee for service or managed care systems.

Determine the clinic-specific PPS rate by collecting base year cost reports identifying all allowable costs and visit data relating to CCBHC services.

Develop actuarially sound rates for payments made through managed care systems (if applicable).

Prepare to collect CCBHC cost reports for Demonstration Years 1 and 2 with supporting data, as specified in the PPS guidance, no later than 9 months after the end of each demonstration year.

Design and implement billing procedures to support the collection of data necessary to help determine PPS and evaluate the overall demonstration.
A state must choose one methodology for use in determining the uniform per clinic rate it will use to pay for CCBHC services delivered by a clinic.

The rate methodology options include:

- Daily visit (CC PPS-1)
- Unique patient visit months (CC PPS-2)
CC PPS-1 is a per-clinic rate that applies uniformly to all CCBHC services rendered by a CCBHC

Base PPS rate =

Note: The rate is based on ALL allowable CCBHC costs divided by ALL daily visits; not just Medicaid costs and Medicaid visits
ESTABLISHING A BASE YEAR RATE: UNIQUE MONTHLY VISIT OPTION (CC PPS-2)

• CC PPS-2 is a per-clinic rate that applies uniformly to all CCBHC services rendered by a certified clinic.

• Base PPS rate =

• If it chooses PPS-2, State must
  • implement a separate PPS rate for specific populations based on clinical condition
  • implement a quality bonus payment system
  • create a system for “outlier payments”
TRENDING THE CCBHC PPS RATE FORWARD

• DY1 rate reflects application of MEI to base period costs per visit

• To obtain DY2 rates, States may:
  – Apply MEI to DY1 PPS rate; OR
  – Conduct “rebase” (base rate on new cost report using DY1 costs)
    • Interim payment methodology may be used for portion of DY2, as DY1 data may not be available at start of DY2

• Even if MEI rather than rebase is used to adjust rate between DY1 and DY2, actual cost and visit data must be substituted for anticipated cost and visit data for purposes of calculating DY2 rates
QUALITY BONUS PAYMENTS

• Mandatory for CC PPS-2; optional for CC PPS-1
• Based on indicators set forth in CMS guidance
  – Follow-up after hospitalization
  – Adherence to antipsychotics for individuals with schizophrenia
  – Initiation and engagement of substance use disorder treatment
  – Suicide risk assessments
• Quality data to be reported to State
OUTLIER PAYMENTS – CC PPS-2

• Mandatory for CC PPS-2
• States establish threshold over which service costs excluded (e.g., $10,000 annually per patient; three standard deviations above average costs)
• “Outlier” costs segregated; states make payments equaling a portion of outlier costs
• Significant State discretion – watch for guidance
• See CMS cost report guidance for requirements re: cost allocation
PPS-1 VERSUS PPS-2: UNIT OF PAYMENT AFFECTS SERVICE DELIVERY INCENTIVES
PPS-1 VERSUS PPS-2: OVER TIME, DOES RATE TRACK INCREASES IN THE COSTS OF PROVIDING CARE?
“Direct costs” defined in Uniform Grants Principles as “those costs that can be identified specifically with a particular cost objective, such as a Federal award, or other internally or externally funded activity, or that can be directly assigned to such activities relatively easily with a high degree of accuracy.” 45 C.F.R. § 75.413(a)

- The dilemma: difficult to identify service costs associated with specific patient populations at the cost center level
- Example: salary costs
PPS-2: CHALLENGES RELATING TO IDENTIFYING OUTLIER COSTS

- CMS guidance and model cost report instructions would require
  - States to identify a level of costs associated with individual CCBHC consumers that would render the consumer an “outlier”
  - CCBHCs to identify in their cost reports service costs associated with individual outlier consumers
- Virtually impossible to identify costs associated with individual consumers at the cost center level
Cost reports are the documents used by CCBHCs for documenting (1) service costs and administrative costs associated with CCBHC services, and (2) qualifying visits.

States will use CCBHC base year cost reports, with an MEI adjustment, to calculate Demonstration Year 1 Prospective Payment System (PPS) rates.

States must supply CCBHCs with a cost report template and ensure that cost reporting adheres to:

- The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 CFR Part 75
- Medicare Principles of Reasonable Cost Reimbursement, 42 CFR Part 413

CMS has provided a cost report template (finalized January 6, 2016) – may be used at state option.

SAMHSA/CMS require annual submission of cost report by CCBHCs.
THE NUMERATOR: ALLOWABLE COSTS

• CCBHCs are required to report:
  o all allowable costs associated with provision of CCBHC required services
  o costs of providing “non-CCBHC services,” such as psychiatric residential treatment programs and habilitative services for developmentally disabled individuals
• Ensures that these costs are excluded from the rate
ALLOWABLE DIRECT CCBHC COSTS

• Derived from trial balance

• Three categories of direct CCBHC costs on CMS model cost report:
  1. Salary costs
     • Largest category of direct service costs for most community behavioral health providers. A cost allocation mechanism may be needed to identify the portion of a clinician’s salary attributable to CCBHC services
     • Anticipated costs may be used for services not provided in base period
  2. Costs of services provided under agreement
     • Includes contractual payment for services rendered by “designated collaborating organizations” and other costs under DCO agreement
  3. Other direct CCBHC costs (e.g., professional liability insurance, medical supplies)
ALLOWABLE DIRECT CCBHC COSTS: ANTICIPATED COSTS

• Additional costs for services needed to be a CCBHC
• Costs expected to increase as a result of offering CCBHC services
• Allowed only in year Demonstration Year 1
THE DENOMINATOR: QUALIFYING VISITS

• Same rules apply to counting of qualifying visits for purposes of (1) cost reports and (2) billing
• Anticipated visits may be used to reflect CCBHC services not yet provided in base period
• CCBHC counts all visits (with Medicaid and non-Medicaid patients) for purposes of cost report; but only visits with Medicaid patients may be billed to Medicaid
THE DENOMINATOR: QUALIFYING VISITS

• **Temporal limits** on qualifying visits
  – Daily encounter (CC PPS-1)
  – “unique patient visit months” (CC PPS-2)

• **Other limits** (significant State discretion)
  – Scope of service (qualifying visit only when CCBHC service provided)
  – Provider deemed qualified by State
  – Modality (State may choose to count telehealth visits)
  – Location (State may choose to count non “four walls” visit)
II. PUTTING IT TOGETHER: PPS RATES AND LICENSURE

• The PPS rate will incorporate many costs that may not be included inside your current licensure paradigm
Certification Versus Licensure

• Throw out the old rulebook
• Section 223 empowers states to certify clinics for Medicaid reimbursement unrelated to licensure
  – This is different from how we are used to thinking about a state licensing locations and services
  – These two processes do not necessarily overlap
Old Way of Thinking

State Licenses Location and Services

Medicaid Reimburses For Licensed Services Within Licensed Locations

CCBHC CCBHC Thinking

State Certifies For Services Unrelated To Licensing

Medicaid Reimburses For Certified Services Anywhere, Regardless Of Licensure
The State Medicaid Plan and CCBHCs

- Licensure was a precondition for service to be included in a state plan
- CCBHCs **must** provide certain services that may not be in the state plan
  - The costs of those services are included in the PPS rate, regardless of whether they are in the state plan
  - The state will need to decide whether these services will constitute an enumerated visit for purposes of drawing down the PPS rate, regardless of whether they are in the state plan or not
III. Paying for the State Share

• For the certification process, states must describe how they will pay for their share of participation in the program.

• This can take the form of a direct budget line, intergovernmental transfer, or certified public expenditures.
CERTIFIED PUBLIC EXPENDITURES: AN OVERVIEW

- The federal government reimburses states’ expenditures for Medicaid services at the relevant federal medical assistance percentage (FMAP).
- Remaining portion of medical assistance expenditures is covered by “nonfederal share”.
- On quarterly basis, states report actual Medicaid expenditures (“total computable”) and draw down federal share (42 C.F.R. § 430.40(d)).
- States must directly provide at least forty percent of the nonfederal share of Medicaid expenditures; the remainder may come from other sources, such as units of local government (Social Security Act § 1902(a)(2)).
CERTIFIED PUBLIC EXPENDITURES: AN OVERVIEW

• Local participation in the nonfederal share may be achieved through “intergovernmental transfers,” or when the local government “certifies” its own expenditures (CPE) as the nonfederal share (42 C.F.R. § 433.51)

• CPEs must, by regulation:
  • come from “public funds” that are not federal funds, or are federal funds authorized under federal law to be used to match other federal funds
  • be “certified by the contributing public agency as representing expenditures eligible for [federal financial participation]”

• Law does not set specific standards for localities to substantiate CPEs as actual expenditures or limit the definition of “public funds” beyond the above
Questions?

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