

Advocacy Issues for State Associations

SAMHSA and CMS will soon be announcing which states will receive planning grants to create Certified Community Behavioral Health Centers (CCBHCs) under the Excellence Act. There is much to do in the coming year, and this guide will help you understand important points of advocacy as you help your state and member agencies prepare to make the most out of the opportunities available in the Excellence Act demonstration.

Selecting a Prospective Payment System (PPS)

Under the CCBHC demo guidance, states have the option to choose between two prospective payment system options. One option is an all-inclusive PPS reimbursement rate similar to the Federally Qualified Health Center payment methodology (PPS-1). This system provides reimbursement of unduplicated encounters on a daily basis. This system allows, but does not require, states to also provide quality and incentive payments.

The second option uses a monthly payment system and includes varying rates depending on the services provided and also requires quality bonuses and metrics to be included in the rate setting. In theory, the reimbursement available under PPS-2 might be higher—with quality assurance payments built into the PPS-2 system; however, the reporting requirements for PPS-2 are more complicated, may have unintended consequences for rural providers that might not allow rural providers to reach the appropriate patient volume to attain the quality bonuses, and PPS-2 has yet to be implemented in practice.

State Associations should be aware of the benefits and drawbacks of each PPS system in order to advocate for a payment system that will ensure long-term sustainability of the CCBHC program.

Defining Practices and Procedures

Some of the services required for a CCBHC may not be included in the state Medicaid plan, or the CCBHC might offer a wider scope of services than is offered in the Medicaid state plan. Although the Excellence Act has not adopted the definition of “visit” from the Federally Qualified Health Center’s (FQHC) PPS definition, it will be important to receive guidance from CMS on how the visits for a CCBHC required service will interact with the state plan.

The denominator in both the all-inclusive rates under PPS-1 and the monthly rates under PPS-2 are set based upon how the state defines a “visit.” If CMS defines a “visit” based on the FQHC definition, then services that are not in the state plan, such as targeted case management, might not count as a visit for rate setting, but would still be an allowable cost. It is important to ask for a clear policy on how these interact.

Advocacy for Local Decision Making

The Substance Abuse and Mental Health Services Administration (SAMHSA) established broad regulations for CCBHC qualifications, but states have significant leeway in establishing in-state CCBHC guidelines. State associations should pay careful attention to further guidance from SAMHSA that may limit a state's ability to define services and procedures that are responsive to the local needs of a state in creating their CCBHCs.

DCO

CCBHCs will need to create formal relationships with designated collaborating organizations (DCOs) to create an effective network of providers. There are several important advocacy questions governing this relationship.

- The CCBHC must provide certain required services, but there is not guidance on whether a CCBHC can contract with a DCO to also provide a CCBHC required service.
- State associations need to ensure that the state provides clear guidance on documenting visits to the DCO for the sake of a PPS rate.
- State associations should also request clarification regarding the role of state supervision in the DCO process.

Quality Measures

The Excellence Act provides bonus payments based upon certain quality measures. There are several advocacy roles that a state association can play regarding quality measures.

- What's the role of the DCO in determining their quality metrics and how are these quality metrics reported to a CCBHC?
- Does the determination of the quality bonus extend to the services provided by the DCO? If so, how do we certify quality measures for the DCO that will be reported back to the CCBHC so that the CCBHC can keep track of the DCO's quality performance?
- If the DCO contributes to quality measurement payments, how do we ensure that a DCO receives some of the benefit of its quality performance?

Rate Setting

State Associations should play an active role in ensuring that rates are set at appropriate levels for services. This ties in with the above point regarding what constitutes a "visit." How a state defines a visit will have a direct consequence on how the rate is set for both PPS-1 and PPS-2.

FQHC Gap Fillers

States may be tempted to fill many of the gaps in the CCBHC guidance by carrying over FQHC regulations. State associations must ensure that problems with the FQHC system do not get imported into the CCBHC. For example, some FQHCs have caps on the administrative service costs. State associations should advocate to ensure that such a cap does not become a CCBHC fixture.

MCO Overlay and Reconciliation Issues

Just like FQHCs, states are responsible for ensuring that CCBHCs receive their full PPS rate. When states have managed care plans, this process can be handled in one of two ways:

- 1) The managed care plan pays the CCBHC an agreed upon rate and the State provides a wrap-around payment at some interval that pays the CCBHC the difference between the rate provided by the MCO and the PPS rate.
- 2) A second possibility is that the state provides the wrap around payment directly to the MCO in its capitated payment with the understanding that the MCO will pass the PPS payment on to the CCBHC.

Experience from the FQHC experience would suggest that this “up-front” wrap-around payment made directly to the MCO has been problematic in that the PPS rate is per-facility and therefore hard to predict at the beginning and therefore MCOs reduce referrals to FQHCs. State associations need to remain vigilant as to how payments will be remitted to CCBHCs.

Rebasing: To Do, or Not to Do?

The rates that will be received by a CCBHC will be determined by a rate established during the panning year based on a combination of actual and estimated costs. Ensuring accuracy in rate setting will be essential for CCBHC viability. States have the option of allowing rebasing between demonstration years 1 and 2 and this decision needs to be informed by the actual experience of the participating CCBHCs, ideally through a mid-year cost report analysis during demonstration year 1. It would be unfortunate and likely unwise to rebase to lower PPS rates.

Selection of CCBHCs within a State

In the planning grant application, States had to indicate how many CCBHCs they intended to certify and bring forward for participation in the demonstration application. We would recommend that State Associations work actively with their membership and state leadership to identify a process and total number of CCBHCs to make the demonstration attractive and viable.