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The following article is from the January/February 2016 issue of *Compliance Watch* and was written by Susannah Vance Gopalan, Esq., one of many attorneys from Feldesman Tucker Leifer Fidell LLP, who are the authors of the newsletter. *Compliance Watch* is a bimonthly newsletter, which keeps you up-to-date on regulatory changes and best practices in corporate compliance, giving you the information and guidance needed to reduce and manage risk. To subscribe, please [click here](#) and keep in mind that the National Council and *Compliance Watch* will continue to provide information and resources to help organizations navigate this and other payment reform initiatives.

## **Emerging Compliance Hotspots for CCBHCs; Part 2: Billing Medicaid**

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In the last issue of *Compliance Watch*, we began a three part series on compliance for Certified Community Behavioral Health Centers (CCBHCs) with an article reviewing the payment methodology and risks associated with the establishment of a base year rate. This new reimbursement methodology will impose a new and complex set of administrative requirements on community behavioral health providers. This article provides an in-depth look at compliance issues stemming from billing Medicaid for CCBHC services and for services provided under managed care.

### **Billing Medicaid for CCBHC Services**

Currently the most common reimbursement methodology for community-based behavioral health providers billing Medicaid is to bill under a fee schedule. The fee schedule lists fee amounts used to reimburse providers for each service provided.

Under a “Prospective Payment System” (PPS) methodology, as that term is used in the Medicaid and Medicare programs, payment to CCBHCs will be made according to a predetermined, fixed amount per visit.

As a CCBHC, a behavioral health provider billing Medicaid will face additional scrutiny from payors and government agencies which will, in many cases, be more than the provider is accustomed to as a provider of services under a fee schedule.

#### *Ensure that All Criteria for a Billable “Visit” Are Met*

Under Medicaid fee-for-service reimbursement, state Medicaid or federal agencies or payors conducting audits or claims reviews will typically examine whether the documentation in the medical record supports the HCPCS/CPT codes listed on the claims.

Under the CCBHC PPS, on the other hand, scrutiny by Medicaid agencies and MCOs may be more complex. The CCBHC will bill Medicaid for “visits” rather than for specific services rendered. The reimbursement for each visit encompasses the total average cost per visit. A clinical encounter is billable as a “visit” only if all the components of a “visit” are satisfied. For example:

- The encounter is with a clinician qualified to provide a “visit”;
- The encounter takes place in a recognized location (or via a recognized medium, in the case of telehealth visits); and
- A CCBHC service was provided in the encounter.

As of the date of this writing, it appears that states will have significant discretion in defining billable visits.

Experience with federally qualified health centers, which also bill under a PPS methodology, has shown that state Medicaid agencies do frequently scrutinize claims to determine whether the requirements for a billable visit were met. As one example, does the National Provider Identifier (NPI) that appears on the claim match the individual rendering service in the medical record, corresponding to a “billable provider” under the PPS definition?

#### *Adhere to Restrictions on Same-Day (or Same-Month) Billing*

In addition, not every clinical encounter that meets the definition of a CCBHC “visit” from the perspective of rendering clinician, location and type of service, *etc.*, will be billable, because the PPS-1 and PPS-2 methodologies both recognize only a limited number of billable visits per patient. Under PPS-1, only one visit per patient per day may be billed to Medicaid. For example, if a patient visits one site of the CCBHC in the morning to receive one CCBHC service and then visits a separate site in the afternoon to receive a different CCBHC service, the CCBHC may bill for only one visit that day.

Under PPS-2, only one visit per patient per *month* may be billed to Medicaid. Since it is a straightforward process to use the claims processing system to determine whether claims have been filed for the same individual on the same day or month, state Medicaid agencies will likely be vigilant in monitoring whether the CCBHC properly observes the limitations on same-day and same-month billing under the CCBHC PPS.

#### **Billing Medicaid for Services Provided Under Managed Care**

Managed care is an increasingly prevalent means of arranging Medicaid behavioral health services. The overlay of managed care on a PPS reimbursement methodology can be complex because, in many instances, managed care organizations (MCOs) and other types of Medicaid prepaid plans pay providers according to a fee schedule (rather than a bundled

visit rate). In addition, absent special reimbursement requirements imposed by the state, Medicaid MCOs' rates often fall short of providers' actual costs of providing services.

CMS, in its guidance on the CCBHC PPS, allows states to choose between two mechanisms to ensure that the PPS rate is meaningfully available. First, a state may choose to build the CCBHC PPS rate into the actuarially sound capitation payment that it makes to a Medicaid managed care plan. In this case, the state would be required to provide oversight to ensure that the plan is accurately using the supplemental amount incorporated into its capitation rate to pay each CCBHC its PPS rate for all CCBHC services.

Second, a state may choose to provide "wraparound" payments to CCBHCs to make up for any difference between the amount of reimbursement provided by the plan under its contract with the CCBHC and the amount the CCBHC would have been paid if the services had been directly reimbursed by the state agency under the PPS. Where the state chooses this method, CMS recommends that states make the wraparound payments no less frequently than every four months and conduct an annual reconciliation to ensure that the sum of the plan payments and wraparound payments over the course of the prior year is at least equal to payment under the PPS.

The compliance issues that CCBHCs will face in each scenario are different. Where the PPS is built into plans' capitation rates, plans will effectively stand in the shoes of the state in bearing the obligation to pay the PPS. Because the CCBHC will be entitled to special reimbursement, plans may have an incentive to apply their utilization review and service authorization protocols especially strictly to CCBHCs to avoid paying the special rates. In this situation, CCBHCs will need to be vigilant in monitoring claims payments to ensure that valid CCBHC visits are reimbursed by the plans. It will be important for the CCBHC to be familiar with the plan's policies for appealing claims denials and service authorization denials.

Where the state provides for "wraparound" payments for CCBHC services provided under managed care, the CCBHC will typically be required to file claims with the state listing all billable CCBHC encounters, as well as reimbursement from the plan for CCBHC services. The CCBHC's "wraparound" reimbursement from the state will equal the difference between the two (if managed care reimbursement falls short of PPS reimbursement). Here, CCBHCs will need to be vigilant in ensuring that only billable CCBHC encounters are claimed and that the CCBHC is fully disclosing all payment received from the plan for CCBHC services.

## **Conclusion**

CCBHCs will be required to bill Medicaid on an encounter basis for CCBHC services and to document payments received from MCOs. CCBHCs will benefit from having an active compliance program that can develop appropriate policies, procedures and trainings, as

well as conduct internal auditing and monitoring to assure the organization is in compliance with the requirements.

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