

MENTAL HEALTH FIRST AID
NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH
Healthy Minds. Strong Communities.



COMPLIANCE

WATCH



The following article is from the November/December 2015 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 1: Establishing a Base Year Rate

**By: Susannah Vance Gopalan, Esq., Feldesman Tucker Leifer
Fidell LLP**

On April 1, 2014, Congress enacted the Protecting Access to Medicare Act (PAMA) of 2014.¹ Section 223 of PAMA requires the U.S. Department of Health and Human Services (HHS) to establish a process for the certification of Certified Community Behavioral Health Centers (CCBHCs) under Medicaid. In October 2015, twenty-four states were awarded planning grants to design a CCBHC program. In 2016, CMS will select eight states to participate in a two-year (2017-2019) CCBHC demonstration.

States participating in the demonstration will be required to implement a “prospective payment system” (PPS) for the reimbursement of CCBHCs.² PAMA required the Centers for Medicare and Medicaid Services (CMS) to issue guidance to states on the development of the CCBHC PPS. In addition, the law set forth a long list of program requirements for CCBHCs relating to the availability and accessibility of services, care coordination, the scope and quality of services, and CCBHC governance. The Substance Abuse and Mental Health Services Administration (SAMHSA) issued guidance interpreting and implementing the statutory program requirements for CCBHCs.

The CCBHC demonstration program might appear to be of limited relevance to many behavioral health providers since only eight states will be selected to participate in the two-year Medicaid demonstration and states may choose to certify as few as two CCBHCs. However, behavioral health advocates hope that the demonstration will bear out the effectiveness of the CCBHC model and that the CCBHC model will become the prevalent model for the provision of community-based behavioral health services for Medicaid programs in other states.

¹ Protecting Access to Medicare Act, Pub. L. No. 113-93 (Apr. 1, 2014) § 223, 128 Stat. 1079.

² Each state participating in the demonstration is, per federal guidance, required to certify at least two providers to participate as CCBHCs.

The new PPS will be a positive development for community-based behavioral health providers participating in the demonstration because, for the first time, they will be entitled to reimbursement under Medicaid that tracks, at least to some extent, their costs of serving Medicaid beneficiaries.

The new reimbursement methodology will also impose new and complex requirements on CCBHCs that will create legal risks for non-compliance. This *Compliance Watch* article will review the payment methodology and the risks associated with the establishment of a base year rate. Upcoming articles in this series will focus on billing Medicaid for CCBHC services and for services provided under managed care, as well as “designated collaboration organization” arrangements.

What Is a “PPS” Methodology and How Will It Work for CCBHCs?

Under a “Prospective Payment System” methodology, as that term is used in the Medicaid and Medicare programs, payment is made according to a predetermined, fixed amount per unit of service. Under some PPS systems, the PPS rate is unique to each provider, because the rate is based on allowable costs per unit of service for that provider as reflected in its cost reports covering a base year or years. After the provider’s initial cost-based rate is established, the rate is trended forward annually by an inflation factor. Part of the rationale behind PPS methodologies is to reimburse providers commensurately with their costs, while at the same time motivating them to provide efficient care so that increases in their costs of care do not outpace inflation over time.

PPS methodology is sometimes referred to as “cost-related reimbursement.” The provider is not guaranteed to recover its costs under a PPS (in contrast to “cost-based reimbursement”), but the reimbursement bears a rational relationship to the provider’s costs as documented in a base year.

The basic PPS features described above will apply to the CCBHC PPS as detailed in CMS’ guidance on the demonstration.³

States participating in the CCBHC demonstration will have quite a bit of discretion in designing their PPS methodologies for CCBHCs. For example, states will be able to choose whether the unit of service for the PPS will be the daily encounter (PPS-1) or the “unduplicated monthly encounter” (PPS-2). If a state selects the PPS-2 methodology for CCBHCs, then it must also implement a separate PPS rate for specific high-needs populations (those populations can be identified by the state); implement a quality bonus payment system; and create a system for “outlier payments,” under which the costs associated with the costliest patients or encounters are excluded from the CCBHC’s cost report, and partial payment is later made for some of the outlier costs.

³ CMS’ guidance on the demonstration is available at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/223-demonstration-for-ccbhc.html>.

States will also have some discretion in choosing the method that will be used to update PPS rates from year to year. Finally, states will be able to choose the mechanism they use to ensure that CCBHCs receive their PPS rates for services provided under a contract with a Medicaid MCO.

Regardless of how each state designs its CCBHC PPS, the compliance challenges for behavioral health providers transitioning to CCBHC status will have some basic similarities from state to state.

Establishing a Base Year Rate

Each CCBHC will have a unique rate that is based on its allowable costs established in a base year. The rate is defined as follows:

Total annual allowable CCBHC costs

Total number of CCBHC daily visits per year (PPS-1) or CCBHC unduplicated monthly encounters per year (PPS-2)

While not specifically required in the federal guidance, we anticipate that states will require that the base year cost reports be subjected to audit. Auditors will examine whether the CCBHC prepared its cost report in compliance with applicable federal and state law. Some of the key compliance issues that arise when auditors review of the base year cost reports are the following.

The “Numerator”: Allowable Costs

The first area relates to the numerator shown above. The CCBHC PPS rate is based only on the provision of CCBHC services. Auditors will scrutinize whether the CCBHC has adequately narrowed the scope of service costs that it identifies as CCBHC costs. Those services, as defined in the federal statute, include crisis mental health services; screening, assessment, and diagnosis; patient-centered treatment planning; outpatient mental health and substance use services; primary care screening; targeted case management; psychiatric rehabilitation services; peer support and counselor services; and certain specialized services for members of the armed forces and veterans.⁴

A CCBHC will be required to report all of its allowable costs associated with provision of the CCBHC required services, *regardless of the recipient of the services*. For example, all service costs relating to crisis mental health services, whether performed on behalf of

⁴ PAMA §223(a)(2)(D).

Medicaid beneficiaries, uninsured individuals, or patients with other forms of coverage, should be included on the cost report as CCBHC allowable costs.

The CCBHC will also be required to identify the costs of providing “non-CCBHC services,” so that those costs can be excluded from the rate. Examples of “non-CCBHC” services that a community behavioral health provider might provide include psychiatric residential treatment programs and habilitative services for developmentally disabled individuals. Auditors will scrutinize whether the provider has inappropriately classified any costs associated with non-CCBHC services as CCBHC service costs.

For a behavioral health provider, the largest single budget item associated with services will typically be clinician salaries. For clinicians who provide both CCBHC and non-CCBHC services, the provider will need to use an allocation to assign portions of the individual’s salary costs to CCBHC services and to non-CCBHC services.

Another risk area in the establishment of the initial CCBHC rate relates to overhead allocation. As noted above, the CCBHC will be required to identify in the cost report its costs associated with “CCBHC services” and with “non-CCBHC services.” Overhead (facility and administrative expenses that cannot be directly assigned to a cost center) will be allocated to CCBHC services based on the percentage of total service costs attributable to CCBHC services. For example, if CCBHC service costs account for 70% of total service costs, then 70% of total overhead will be allocated to CCBHC for purposes of the CCBHC rate. Only facility and administrative costs attributable to CCBHC services will be included in the numerator. Because there can be an incentive to under-report non-CCBHC service costs, the auditor will scrutinize the cost report to determine whether the provider has fully disclosed the extent of its non-CCBHC service costs.

The Denominator: Daily or Monthly Visits

The second area relates to the denominator in the CCBHC rate: visits. To develop its base year rate, the CCBHC will be required to report all of its allowable “visits,” *including visits with both Medicaid and non-Medicaid patients*. Depending on the methodology that each state selects for its PPS rate, the unit of payment will be either the “daily encounter” (PPS-1) or the “unduplicated monthly encounter” (PPS-2). It bears noting that while higher costs (numerator) lead to a higher rate, a *lower* number of visits produces a higher encounter rate.

Auditors will test the visit count to determine whether the encounter count that the CCBHC reported for the base period reflects all clinical “touches” that meet the definition of a CCBHC billable “visit.”⁵

The auditor will likely look for the following potential flaws in the visit count:

⁵ CMS/HHS has conveyed informally to the National Council that CMS intends to establish a uniform federal definition of a billable CCBHC “visit.” CMS has not yet issued the definition, so we cannot provide guidance on the particulars of this issue.

- Did the provider properly exclude same-day encounters for a single patient (for PPS-1) or multiple encounters within the month for a single patient (for PPS-2)? Did the provider properly exclude contacts with clinicians who do not meet the standard for a billable clinician under the “visit” definition?
- Did the provider properly exclude contacts that occur in locations or through means that do not qualify as billable under the “visit” definition?
- Did the provider properly *include* in the encounter count any patient contact that meets the definition of “visit,” regardless of the patient’s form of coverage (or uninsured status)?

Why Is an Accurate Base Rate So Important?

Ensuring that the CCBHC’s initial cost-based rate is accurate in the ways described above will be critical for several reasons.

First, in general under a PPS methodology, due to timing issues, initial encounter rates are based on unaudited cost reports. A settlement process occurs after the audit is complete, often a year or two after reimbursement under the PPS begins, and reimbursement is typically retrospectively adjusted at that time -- often, to the detriment of the provider. Preparing the cost reports properly at the outset will allow the provider to avoid a significant recoupment when the audit is completed.

Conversely, an even more prevalent problem that providers reimbursed under a PPS methodology encounter in preparing base year cost reports is that, through inattention, they “give away” costs that are in fact allowable. It is difficult to overstate the importance of the base year cost report, because the initial cost report establishes the fixed baseline for the encounter rate. In designing their CCBHC programs, states will have the discretion to agree to a “rebase” – *i.e.*, the resetting of rates based on updated cost reports – for CCBHCs’ rates in future years, but the use of a rebase is not mandatory.

Experience in representing health care providers reimbursed under PPS methodologies, such as federally-qualified health centers (FQHCs), has shown that there are just as many providers that *under* report allowable service costs, resulting in a depressed PPS rate over time, as there are providers that over report allowable service costs and end up owing funds when the cost report settlement process is completed. Behavioral health providers should work closely with cost reporting experts to ensure that their cost reports capture all allowable costs as reflected in the guidance.

Conclusion

CMS’ CCBHC PPS provides community behavioral health organizations with important reimbursement opportunities along with significant compliance requirements. The

National Council and *Compliance Watch* will continue to provide information and resources to help organizations navigate this and other payment reform initiatives.

Susannah Vance Gopalan is a partner and member of the health law and federal grants practices at Feldesman Tucker Leifer Fidell LLP in Washington, DC. Her e-mail address is SGopalan@FTLF.com.

