

Emerging Compliance Hotspots for CCBHCs: Billing Medicaid

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Presenters:

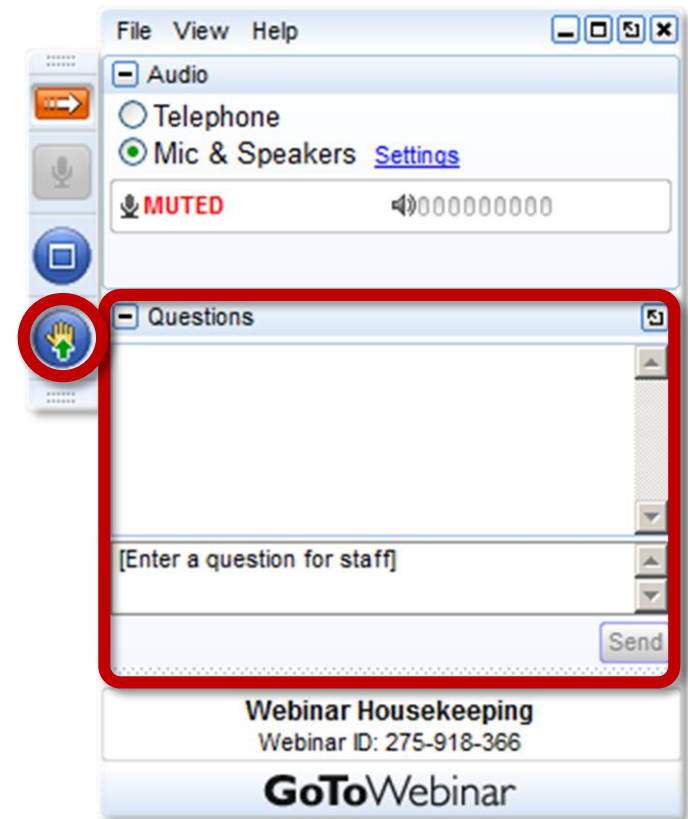
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Comments & Questions?



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EMERGING COMPLIANCE HOTSPOTS FOR CCBHC: BILLING MEDICAID FOR CCBHC SERVICES



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- Leads the firm's health care corporate compliance practice, helping clients avoid costly legal missteps that can jeopardize access to services within their communities
- Holds a masters' degree in public health and an adjunct faculty appointment at The George Washington University School of Public Health and Health Services



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- Partner at Feldesman Tucker Leifer Fidell, specializing in health care litigation and regulatory counseling, with a focus on Medicaid, Medicare, and coverage options under the Affordable Care Act
- Provides technical assistance to health care providers, state and local governments, and national provider associations on Medicaid and Medicare policy issues and administration
- Holds a J.D. from the University of Kentucky College of Law, M.I.A. from Columbia University School of International and Public Affairs and B.A. from Columbia University
- 2014 Washington, DC “Rising Star” in Health Care Law



AGENDA

- CCBHC certification
- Billing Medicaid under the CCBHC Prospective Payment System
- Compliance concerns with CCBHC PPS Billing
- Incorporating the CCBHC PPS into Medicaid Managed Care



CCBHC Certification

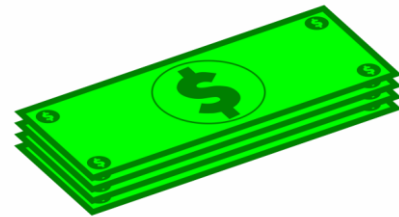
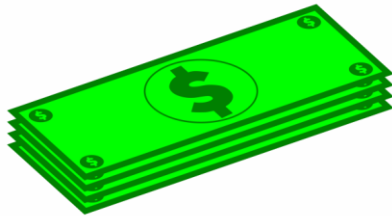


CCBHC CERTIFICATION

- The “hook” through which the SAMHSA CCBHC program requirements connect to PPS reimbursement
- CMS guidance requires that each planning grant State “certify” providers qualified to furnish CCBHC services by October 31, 2016, deadline for CCBHC demonstration
- Certification
 - Indicates CCBHC has substantially met SAMHSA program requirements
 - Is prerequisite for billing Medicaid for CCBHC services
- Each time a clinic bills Medicaid for CCBHC services, it impliedly certifies that it meets SAMHSA program requirements



Compliance Issues in CCBHC Fee-for-Service Billing



KEY FEATURES OF CCBHC PPS ENCOUNTER RATE

- Base year rate = **Total allowable costs / qualifying visits**
 - Same visit definition used for purposes of developing rate and for purposes of billing Medicaid
- PPS rate is unique to each CCBHC
- Rate based on allowable costs per unit of service (“basket” of CCBHC services)
- Same rate is paid for each qualifying unit of service, **regardless of the intensity of services provided**



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**



REIMBURSEMENT IMPLEMENTATION

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

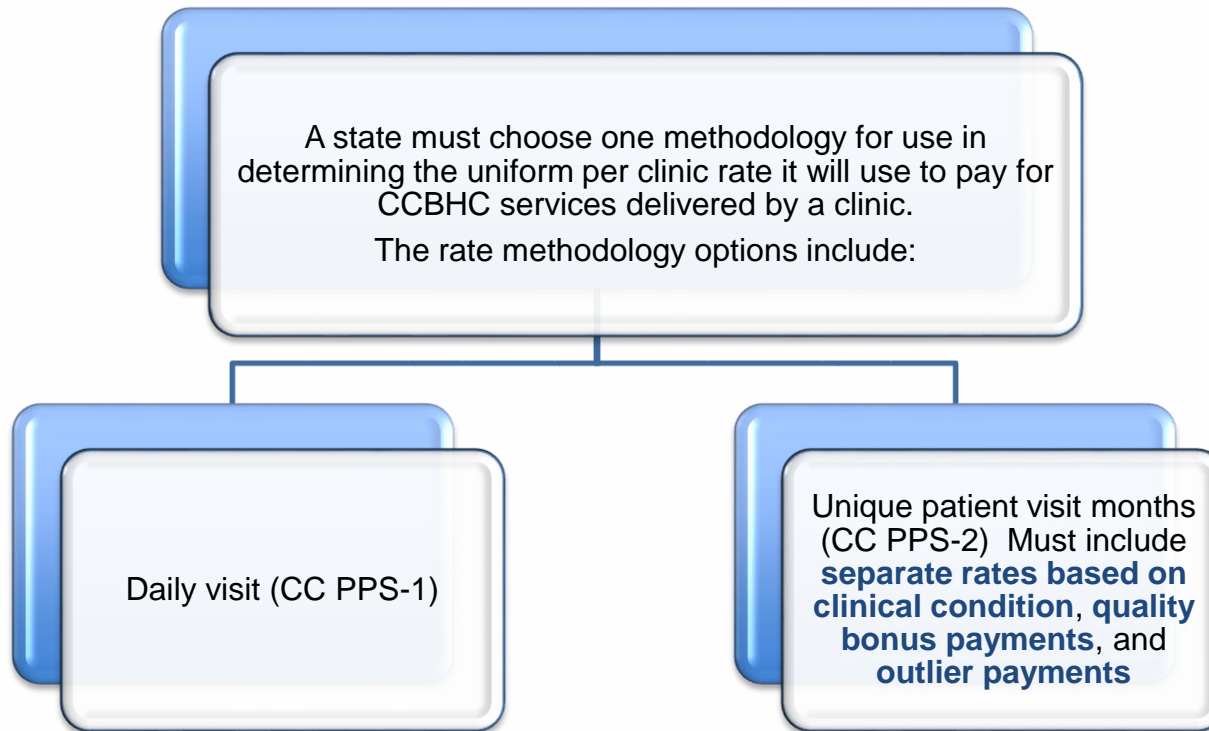
Develop actuarially sound rates for payments made through managed care systems (if applicable)

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 for reimbursement under CCBHC PPS (including quality bonus payments and outlier payments, if applicable)



RATE-SETTING METHODOLOGY OPTIONS



CC PPS-1: THE “UNIQUE DAILY VISIT”

- “Cost-based, per clinic [daily] rate that applies uniformly to all CCBHC services rendered by a certified clinic, including those delivered by satellite facilities established prior to April 1, 2014”
- For a multi-site CCBHC, only one visit per day can be counted for the entire CCBHC
- If clinic is dually certified as CCBHC and federally qualified health center (FQHC), CCBHC visit may be recorded (and billed) in same day as FQHC visit
- Examples:
 - Consumer visits CCBHC site 1 for a counseling session and its DCO for a peer support session in the same day. **One CCBHC visit is billed to Medicaid for that day.**
 - Consumer visits dually certified CCBHC/FQHC and receives one behavioral health counseling session and one primary care services. **One CCBHC visit is billed to Medicaid for that day.**



CC PPS-2: THE “UNIQUE PATIENT VISIT MONTH”

- “Cost-based, per clinic monthly rate that applies uniformly to all CCBHC services rendered by a certified clinic, including those delivered by satellite facilities established prior to April 1, 2014”
- For a multi-site CCBHC, only one visit per month can be counted for the entire CCBHC
- Example:
 - Consumer experiencing crisis situation accesses 12 CCBHC services in January of DY1, 12 CCBHC services in February, and no services for the remainder of the year. **Two CCBHC unique patient visit months are billed to Medicaid for that consumer.**
 - Consumer visits CCBHC once per month in each month of DY1. **Twelve CCBHC unique visit months are billed to Medicaid for the consumer.**



VISIT CRITERIA (PER CMS INFORMAL GUIDANCE)

- There is no uniform federal “visit” definition; States have significant discretion
- Criteria
 - Scope of services
 - During the visit, consumer must have received one of nine required CCBHC services
 - Care management is a required CCBHC activity but does not trigger a visit
 - Provider / clinician
 - States will determine which providers are deemed qualified to furnish a visit
 - **Note:** not the same issue as whether those providers are qualified to render a CCBHC service!



VISIT CRITERIA (PER CMS INFORMAL GUIDANCE)

- Criteria, cont.
 - Modality
 - Billable visit may, at State option, include telehealth visits or online modular treatments
 - Location
 - States may elect to count in-home visits and other “non-four walls” visits
 - Presumably visits rendered in DCO will be counted
 - Documentation
 - All activities that trigger a billable visit must be documented in consumer’s medical record



COMMON AREAS OF AUDIT FOCUS FOR PROVIDERS BILLING UNDER A PPS

Did the clinic...

- Bill Medicaid for more than one CCBHC encounter per consumer per day (for PPS-1) or for more than one per consumer per month (for PPS-2)?
- Bill Medicaid for encounters where no CCBHC required service was rendered?
 - Procedure codes
- Bill Medicaid for activities of clinicians who do not meet State's standards for furnishing a billable visit?
 - NPI
- Bill Medicaid for activities furnished through modalities or in locations that do not meet billable "visit" definition?
 - Procedure codes
 - Place of service code on claim forms
- State agencies will likely continue to require detailed procedure coding in addition to a visit code
- **Note importance of consistent "visit" logic between base period cost report and billing Medicaid**



WHAT IS DCOs' ROLE IN CCBHC PPS BILLING?

- If a CCBHC unable to provide a service directly, service must be provided through “designated collaborating organization” (DCO)
- CCBHC is **legally and financially responsible** for services furnished by the DCO
- Consequences of this arrangement:
 - The CCBHC **serves as billing provider** (for Medicaid) for service furnished by DCO
 - It is expected that the CCBHC will **contract with the DCO to pay fair market value** for delegated CCBHC services
 - Costs (actual or anticipated) associated with DCO contract are included as CCBHC service costs in CCBHC cost report
 - While DCO service may trigger billable CCBHC visit, PPS payment is made by State Medicaid agency to CCBHC, not to DCO
 - Note: DCO’s contracted rate should not reflect “splitting” of PPS



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

- 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



OTHER COMPLIANCE HOT SPOTS

- Coordination of benefits
 - Provider must bill other payors before Medicaid
- Billing other payors for CCBHC services furnished to non-Medicaid individuals
 - CCBHC services must be provided to all consumers but new reimbursement methodology applies only to Medicaid
 - The present billing, coding requirements will continue to apply with other payors



OTHER COMPLIANCE HOT SPOTS, CONT.

- The federal **Civil Monetary Penalties Law** (42 U.S.C. § 1320a-7a) authorizes penalties against health care providers that offer or give remuneration to any Medicare or Medicaid beneficiary likely to induce the receipt of items or services reimbursable under those programs
- Collection of cost-sharing
 - Must collect Medicaid cost-sharing if consumer able to pay
 - Note re: reduction of cost-sharing by application of sliding fee scale



OTHER COMPLIANCE HOT SPOTS, CONT.

- The federal **False Claims Act** (31 U.S.C. § 3729) makes it unlawful for any person or entity to “knowingly present[], or cause[] to be presented, a false or fraudulent claim” for government reimbursement
- “Factually” false claims are those that request reimbursement for products or services that the entity or individual did not provide (e.g., submitting claim for service not rendered)
- “Legally” false claims can occur when provider violates a condition of payment imposed by law or contract
- *Examples:*
 - Claim for CCBHC PPS reimbursement for clinical activities that the provider knew did not meet “visit” definition
 - Claim for CCBHC PPS reimbursement based on cost report encounter rate that reflected intentional overstatement of service costs or understatement of qualifying visits
 - Claim for quality bonus payment that relied on misstatement of quality data
- Most states have equivalent state laws



Compliance Issues in Managed Care



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MANAGED CARE CONSIDERATIONS

Which PPS methodology will the state use in its managed care delivery system?

States have two options for incorporating the PPS rates into Medicaid managed care programs:

Incorporate cost of the PPS rates into the managed care capitation rates and require managed care entities (MCEs) to pay PPS rates to CCBHCs

Pay supplemental (“wraparound”) payments to what CCBHCs receive from MCEs so that combined payments equal PPS rates



OPTION 1: MCEs PAY CCBHCs FULL PPS RATES

- State bumps up capitation payments to managed care entities to account for additional costs related to PPS rates and anticipated utilization
- State contracts with MCEs must:
 - require MCEs to pay CCBHCs the full PPS rates, or their actuarial equivalents
 - require the MCEs to ensure access to CCBHC services for their enrollees
- MCEs must in turn modify contracts with CCBHCs to reflect CCBHC scope of services and substitute PPS rates in place of existing compensation levels
- In addition, CCBHCs will likely need modifications to standard managed care contract provisions to permit subcontracting arrangements with DCOs and credentialing of DCO entities and/or practitioners

OPTION 1 : MCEs PAY CCBHCs FULL PPS RATES

- The problem:
 - If CCBHCs now cost MCEs more than other providers of similar services, an unintended consequence of this methodology is that MCEs will have a financial disincentive to contract with CCBHCs
 - If MCEs receive capitation rate bump but then exclude CCBHCs in provider networks, MCEs will enjoy a financial windfall (*i.e.*, MCE pockets the difference between new and old capitation rates)
- Potential solution:
 - State requires MCEs to contract with **all** CCBHCs in their service areas.



OPTION 2: SUPPLEMENTAL (“WRAPAROUND”) PAYMENTS

- State contracts with managed care entities require MCEs to pay rates to the CCBHC at least equal to what other providers would receive for similar services
- The State:
 - Makes periodic supplemental payments (CMS recommends that payments be made at least once per four months) to equal the difference between payments received from MCE and payments that would have been received under CCBHC PPS
 - Conducts an annual reconciliation to ensure that total payments to CCBHCs (MCE payments plus supplemental payments) are equal to reimbursement under the CCBHC PPS
- States may delegate supplemental payment function to MCEs as pass-through for the State
- CCBHCs will likely need modifications to standard managed care contract provisions to permit subcontracting arrangements with DCOs and credentialing of DCO entities and/or practitioners

OPTION 2: SUPPLEMENTAL (“WRAPAROUND”) PAYMENTS

- The problem: State **undercounts** the number of visits that qualify to receive a supplemental payment, resulting in loss of revenue.
 - For example, State refuses to pay wraparound on a claim unless the MCE pays the claim first (often referred to as a “paid claim” policy)
 - If MCE fails to pay a *bona fide* claim, state should make wraparound payment equal to full PPS rate
- Potential solutions:
 - (Best) State does not establish a “paid claims” policy on supplemental payments
 - (Better than nothing) State establishes a special appeal process in the event that MCE rejects CCBHC’s underlying claim for services



OPTION 2: WRAP-AROUND PAYMENTS

- The problem: State **overstates** amount of MCE payments to the CCBHC, offsetting potential revenue. For example:
 - State includes non-CCBHC revenue such as payments received by CCBHC for behavioral health home or residential services
 - State includes non-Medicaid revenue such as payments received for other lines of business (e.g., Medicare/commercial)
 - State includes MCE incentive payments (e.g., shared savings payments, risk pool payments)
- Potential solution: State establishes an appeal process in the event of disagreement with total amount of MCE payments to CCBHC
 - CCBHCs should carefully document compliance with state policies and procedures
 - CCBHCs should establish accounting systems to distinguish different lines of revenue received from MCEs



OPTION 2: WRAP-AROUND PAYMENTS

- The problem: State fails to ensure that CCBHCs receive fully compensatory supplemental payments due to timing issues:
 - State fails to pay supplemental payments at least every four months
 - State fails to conduct a timely annual reconciliation at end of year
- Potential solution:
 - State establishes remedies in the event of untimely payments or reconciliation, such as:
 - Interest automatically accrues on late payments
 - administrative appeals similar to denial of FFS payments
 - CCBHCs should carefully document compliance with state policies and procedures related to supplemental payments and reconciliation



ADDITIONAL MANAGED CARE CONSIDERATIONS

- CMS recommends that states consider assigning all CCBHCs to one managed care entity that is capable of collecting all data pertinent to demonstration payment
- If state chooses not to include all demonstration services in contract with one managed care entity, or if contracted MCO delegates some responsibility to other prepaid plans (e.g., PIHP/PAHP), then State must ensure that:
 - Responsibilities of each contractor will be delineated
 - No duplication of services or payments will occur



DATA REPORTING AND MANAGED CARE CONTRACT REQUIREMENTS

- State's contract with managed care entity must contain requirements for CCBHC quality reporting and encounter data
- States should include the following items in their MCE contracts:
 - Data to be reported
 - The period during which data must be collected
 - The method to meet reporting requirements
 - The entity responsible for data collection

QUESTIONS?

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Last webinar of the CCBHCs compliance series
*Care Coordination and Arrangements with Designated
Collaborating Organizations*
Mon, Feb 29 at 2PM EST

Please fill out a brief post webinar survey.

If you have questions, feel free to contact me at
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