DETERMINING FAIR MARKET VALUE FOR SERVICES RENDERED BY A DESIGNATED COLLABORATING ORGANIZATION

One of the most important features of any commercial contract is the type of "consideration"—the payment that is made by the purchasing party to the selling party—that it includes.

This is particularly true in the healthcare sphere, an industry that is highly regulated with numerous legal rules addressing the exchange of money or items of value between healthcare providers. When a certified community behavioral health clinic (CCBHC) furnishes services through a contract with a designated collaborating organization (DCO), it is critical for the CCBHC to document that the consideration paid to the DCO reflects fair market value (FMV). This documentation should be retained as part of the CCBHC's files.

The DCO Contract: A Procurement of Clinical Services

According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), when a CCBHC furnishes services under contract with a DCO, the CCBHC "is ultimately clinically responsible for all care provided."[99] In addition, guidance issued by the Centers for Medicare and Medicaid Services (CMS) makes clear that when a CCBHC provides a demonstration service to its consumer via a DCO, "the CCBHC must bill Medicaid for services."[100] CMS elaborated:

> "The cost of services provided on behalf of the CCBHC by DCOs will be reported in the CCBHC cost report used to determine the CCBHC prospective payment system (PPS) payment rate. The CCBHC will typically pay the DCO a contracted rate for a defined service."[101]

The relationship between the CCBHC and DCO is, therefore, contractual under which the CCBHC **procures services from the DCO** on behalf of CCBHC consumers. The CCBHC holds itself as the provider of the DCO-rendered services.

The Federal Rules and Limitations That Apply to DCO Contract Payments

Several sets of legal rules apply to the consideration paid in a CCBHC/DCO contracting relationship.

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[99] RFA for SAMHSA Planning Grants for CCBHC, Appendix II – Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (RFA, Appendix II), Criterion 4.a.1.

[100] CMS Q&A Set II 10/20/15, Question 6.

[101] CMS Q&A Set II 10/20/15, Question 5.

1. Principles of Reasonable Cost

The first set of legal rules is the **principles of reasonable cost** that apply to healthcare providers reimbursed on a cost-related basis. Under the CCBHC demonstration, states are required to reimburse CCBHCs under a prospective payment system (PPS). The PPS rate is a per-visit rate reflecting the total allowable per-visit costs of furnishing the entire bundle of CCBHC services in a base cost-reporting period.

According to a CCBHC cost report template issued by CMS, each CCBHC (or potential CCBHC seeking state certification) must include in its base period cost report as components of the "direct" costs of furnishing the entire bundle of CCBHC services, (1) the actual or anticipated costs to the CCBHC of procuring DCO services and (2) any other actual or anticipated direct costs specifically related to services performed by the DCO (for example, when a CCBHC contracts with a DCO to perform mobile crisis services, the DCO is compensated by the CCBHC for mileage associated with travel)).[102]

Therefore, the costs that a CCBHC incurs paying DCOs to render CCBHC services are subject to the same principles of reasonable costs as any other costs that the CCBHC documents on its cost report.

CMS explains that in reporting costs, states must require the providers to adhere to the principles of reasonable cost in both 45 C.F.R. Part 75 (Department of Health and Human Services (HHS) Uniform Administrative Requirements, Cost Principles and Audit Requirements for HHS Awards) (the HHS Uniform Guidance) and 42 C.F.R. Part 413 (the Medicare principles of reasonable cost).

- According to the **HHS Uniform Guidance**, where the costs of contracted services are claimed as allowable, the provider must document their reasonableness. A cost is reasonable if "in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost."[103] In determining whether costs are reasonable, consideration must be given to factors including "sound business practices," "arm's-length bargaining" and "market prices for comparable goods and services for the geographical area."[104]

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[102] Certified Community Behavioral Health Clinic (CCBHC) Cost Report, "Trial Balance" and "Anticipated Costs" tabs, Section 1-B); CCBHC Cost Report Instructions, OMB #0398-1148, CMS-10398 (#43) pp. 8-14.

[103] 45 C.F.R. § 75.404.

[104] 45 C.F.R. § 75.404 (b) and (c). The HHS Uniform Guidance also includes an extensive set of procurement standards relating to items purchased or services procured using federal grant funds or program income. *Id.* §§ 75.326-75.335. This summary assumes that the

- According to the **Medicare principles of reasonable cost,** providers of services are required to document on cost reports "the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider."[105] These costs are "appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity."[106]

Both sets of cost principles specifically designate certain types of "unallowable" costs, such as costs associated with entertainment and lobbying. In addition, both sets of cost principles place limitations on the allowability of other types of costs, such as costs incurred in contracting with a related organization (such as a subsidiary).

The main goal of the reasonable cost principles is to ensure that a provider includes costs on its cost report that are no higher than those necessary and appropriate to furnish care. Therefore, in including the payment made to a DCO on a cost report, it is important that a CCBHC or potential CCBHC ensure that the payment reflects no more than the FMV of this type of services in the community.

2. The Anti-Kickback Statute

A second applicable set of rules relating to exchange of money under a DCO contract is a federal law referred to as the Anti-Kickback Statute. This law prohibits any persons, including healthcare providers, from intentionally offering, paying, soliciting or receiving anything of value (remuneration) to induce or reward referrals involving "federal health care programs" or to generate federal healthcare program business.[107] One purpose behind this law is to ensure that providers do not have an incentive to make medically unnecessary referrals, which in turn could unnecessarily increase amounts billed to federal programs for healthcare services.

Uniform Guidance procurement standards do not control DCO contracting, because the CCBHC demonstration will not involve the receipt of federal grant funds by behavioral health providers.

[105] 42 C.F.R. § 413.9(c)(3).

[106] *Id.* § 413.9(b)(2).

[107] 42 U.S.C. §1320a-7b(b). The term "federal health care program" is defined to include both healthcare programs funded directly by the United States government (such as Medicare), and state healthcare programs, including the Medicaid and Children's Health Insurance Programs (CHIP). *Id.* §1320a-7b(f).

Remuneration exchanged between healthcare providers can include discounts, since a discount is an item of value to the recipient of the discount. In the context of CCBHC/DCO contracting, the Anti-Kickback Statute is relevant to the extent that if a CCBHC purchased services from a DCO at a rate that reflects a reduction from FMV, the discount could be interpreted as an inducement to the CCBHC to refer consumers to the DCO.[108]

Documenting FMV is important for purposes of the CCBHC's compliance with the Anti-Kickback Statute, chiefly from the perspective of ensuring that a CCBHC does not pay the DCO a rate below FMV.[109]

How Is "Fair Market Value" Established?

There is no one measure for fair market value. The core concept is that the consideration under the contract must correspond to the market prices in the area for the goods being purchased. The key step in determining and documenting FMV is to identify an objective indicator of the value of the services.

Quantifying FMV can be challenging when the CCBHC is contracting for a service that has not historically been covered by private insurers or under the Medicare or Medicaid programs. The task can be yet more challenging when the provider from which the services are purchased (the potential DCO) has typically furnished the services on an uncompensated basis in the past, using grant funds to support the uncompensated costs of care.

Below are several examples of acceptable measures of FMV:

- Average hourly or annual salary costs for clinicians furnishing service, based on published salary surveys applicable to the region.
    - Note: This measure would be most appropriate for services rendered by a single clinician.

[108] While the contracted service itself does not constitute a referral service, other services that a CCBHC consumer accesses at a DCO could be interpreted as referral services.

[109] The Anti-Kickback Statute includes numerous statutory and regulatory "safe harbors." *See* 42 U.S.C. § 1320a-b(b)(3); 42 C.F.R. § 1001.952. The safe harbors correspond to healthcare payment and business practices that, although they potentially implicate the federal anti-kickback statute, are not treated as offenses under the statute. If a provider in the community offers to contract with the CCBHC or potential CCBHC to furnish CCBHC services on a discounted basis, and the CCBHC is interested in entering such an arrangement, the CCBHC should seek legal counsel to determine whether the discounted arrangement would fall within a safe harbor.

- Fees per unit of service according to Medicare or Medicaid fee schedules, or a percentage of those fees.
    - Where FMV is based on the Medicare Part B Physician Fee Schedule, the Geographic Practice Cost Index (GPCI) applicable to the region should be taken into consideration.

Where no estimate of FMV for the services is available based on external data, such as average salaries or other payors' fees, information unique to the DCO could be taken into consideration, such as:

- The potential DCO's average charges for the type of services purchased (based on its schedule of charges).
    - Note: In general, the payment would be based on a percentage of charges, rather than the potential CCBHC's full charges, since few payors reimburse services as high as the provider's charges.
- The potential DCO's historical costs of furnishing the services to be purchased.

The CCBHC's basis for quantifying FMV (for example, salary surveys that the CCBHC located online and used in negotiating its contract rate for purchasing clinical services from the DCO) should be preserved in the CCBHC's procurement files.