NATIONAL COUNCIL for Mental Wellbeing

HEALTHY MINDS STRONG COMMUNITIES

Prospective Payment System TA Series: Overview of PPS Rate-Setting and Cost Reporting

March 31, 2025

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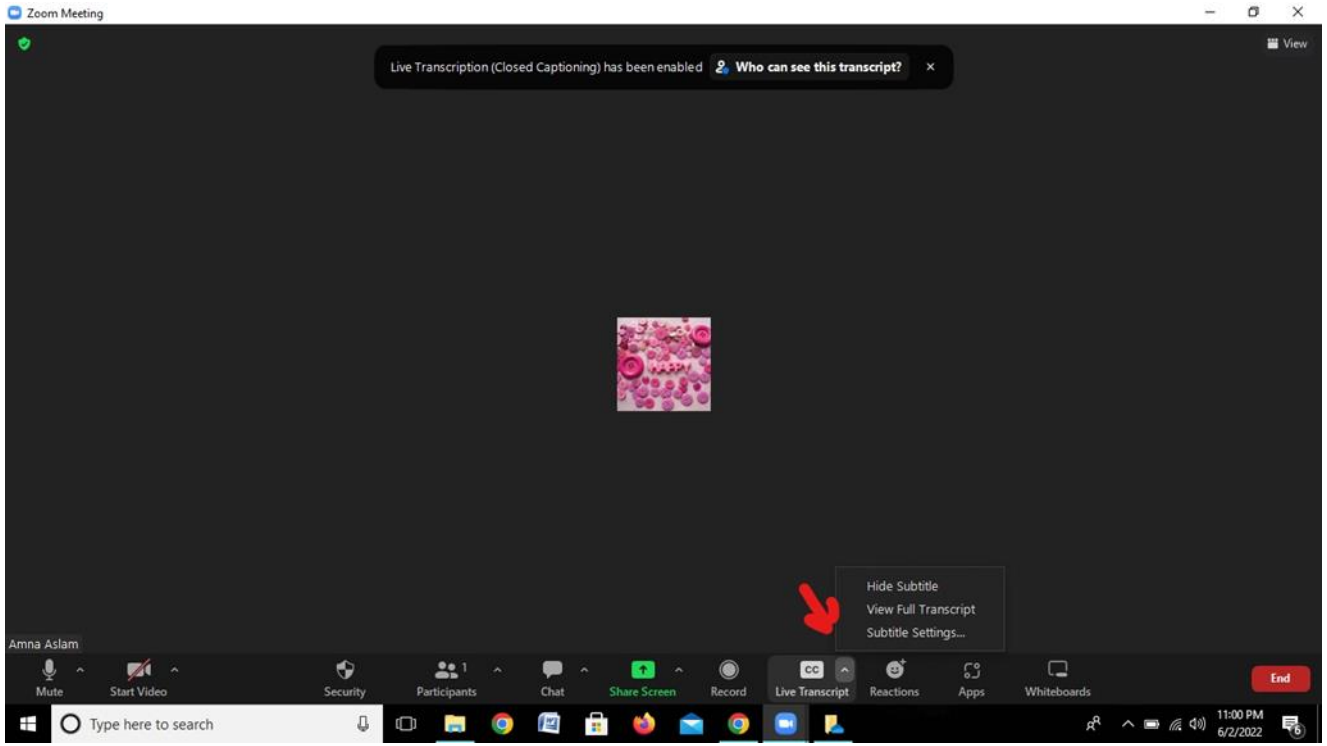

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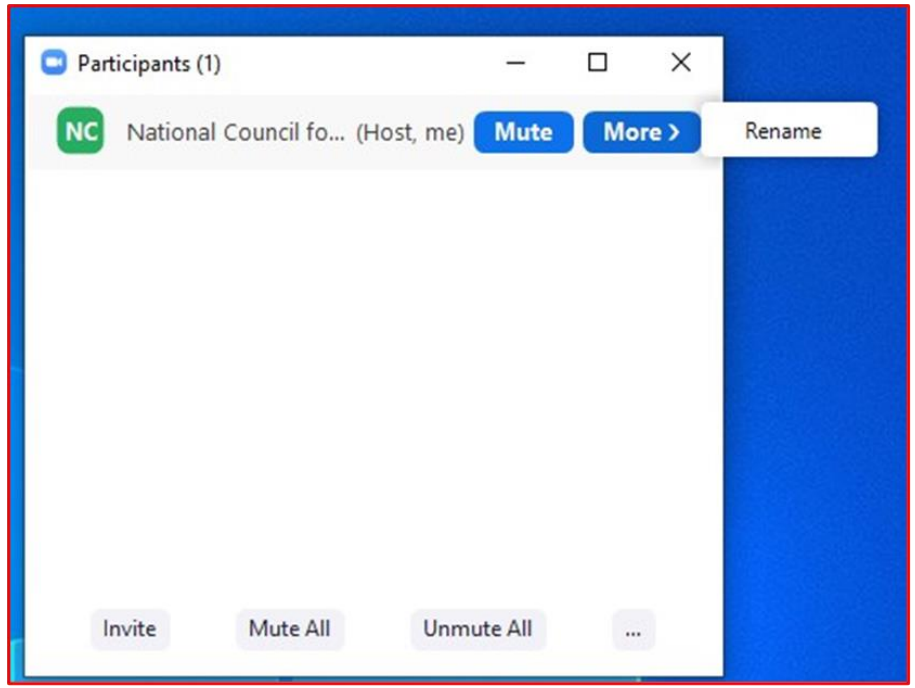

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    - **D'ara Lemon, National Council**
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Today's Learning Objectives

- Increase understanding of the CCBHC Prospective Payment System (PPS), including regulations, rate options, and reimbursement fundamentals.
- Improve knowledge of allowable CCBHC costs, including direct versus indirect costs and development of anticipated costs.
- Describe and clarify how clinical and operations staff work with finance staff to develop a CCBHC PPS rate.

Today's Presenters

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Poll #1

- What is your role at your agency?
  - Clinical/Program
  - Finance
  - Operations
  - Revenue Cycle/Data
  - Other

Poll #2

- Where is your state in participation in the CCBHC Medicaid Demonstration program?
  - State is participating in a CCBHC Medicaid program
  - State has been approved for participation in the CCBHC Medicaid Demonstration program and is implementing the program
  - State is considering participation in the CCBHC Medicaid program
  - State is currently not active in participation in the CCBHC Medicaid program

Overview

- CCBHC PPS Rate-setting
  - Underlying CCBHC Payment Guidance
  - Basic PPS Rate Construct and Fundamentals
  - Steps to Calculating Allowable Costs
  - Anticipated/Budgeted Services & Costs
  - Allowable Costs
  - Unallowable Costs & Services
  - Services Versus Visits
  - 3 Cost Report Workstreams
- Q&A

Underlying CCBHC Payment Guidance

- **H.R.4302 - Protecting Access to Medicare Act of 2014 (Federal Statute)**
  - Sec. 223. Demonstration programs to improve community mental health services
  - Federal statute provides flexibility to each state on how it implements Medicaid programs (e.g. CCBHC)
  - https://www.congress.gov/bill/113th-congress/house-bill/4302/text
- **Section 223 Certified Community Behavioral Health Clinic (CCBHC) Demonstration Prospective Payment System (PPS) Guidance - Updated February 2024**
  - https://www.medicaid.gov/medicaid/financial-management/downloads/section-223-ccbh-pps-prop-updates-022024.pdf
- **CCBHC Cost Report & Instructions**
  - https://www.medicaid.gov/medicaid/financial-management/section-223-demonstration-program-improve-community-mental-health-services/index.html
- ***State-Specific CCBHC Guidance !!!***
  - *CCBHC Covered Services AND Service Sites/Geography*
  - *PPS Rate "Triggering Events" – CPT codes/billable providers*
  - *PPS Rate-setting Approach*

CCBHC Rate Options and Elements

Rate Elements Base Rate	CC PPS-1 Daily	CC PPS-2 Monthly	CC PPS-3 Daily	CC PPS-4 Monthly
Special Crisis Services (SCS) PPS Rates – Payments for crisis services	N/A	N/A	Separate, daily PPS rate(s) for at least one of the following crisis services: • ARP 9813 CCBHC mobile crisis services • Other CCBHC mobile crisis services (not ARP 9813 mobile crisis services) • On-site CCBHC crisis stabilization services	Separate, monthly PPS rate(s) for at least one of the following crisis services: • ARP 9813 CCBHC mobile crisis services • Other CCBHC mobile crisis services (not ARP 9813 mobile crisis services) • On-site CCBHC crisis stabilization services
Special Populations (SP) Payment Rates – Payments for services provided to people with certain conditions	N/A	**Optional** – separate monthly SP PPS rate(s) to reimburse CCBHCs for the costs associated with providing all services necessary to meet the needs of higher need SPs	N/A	**Optional** – separate monthly SP PPS rate(s) to reimburse CCBHCs for the costs associated with providing all services necessary to meet the needs of higher need SPs
Outlier payments	N/A	Separate payment for a portion of Medicaid beneficiary costs in excess of threshold	N/A	Separate payment for a portion of Medicaid beneficiary costs in excess of threshold

CCBHC Rate Options and Elements

Rate Elements	CC PPS-1	CC PPS-2	CC PPS-3	CC PPS-4
Base Rate	**Daily**	**Monthly**	**Daily**	**Monthly**
Quality bonus payments (QBP)	**Optional** bonus payment for CCBHCs that meet quality measure thresholds	Bonus payment for CCBHCs that meet quality measure thresholds	**Optional** bonus payment for CCBHCs that meet quality measure thresholds	Bonus payment for CCBHCs that meet quality measure thresholds
Annual Updates to the PPS Rates	Medicare Economic Index (MEI) or rebasing using cost reports	Medicare Economic Index (MEI) or rebasing using cost reports	Medicare Economic Index (MEI) or rebasing using cost reports	Medicare Economic Index (MEI) or rebasing using cost reports
Required Rebasing of PPS Rates	States must rebase PPS rates for DY3 using DY2 cost report data and rebase PPS rates at least once every 3 years	States must rebase PPS rates for DY3 using DY2 cost report data and rebase PPS rates at least once every 3 years	States must rebase PPS rates for DY3 using DY2 cost report data and rebase PPS rates at least once every 3 years	States must rebase PPS rates for DY3 using DY2 cost report data and rebase PPS rates at least once every 3 years

Separate Rates for Crisis Services (PPS-3/4)

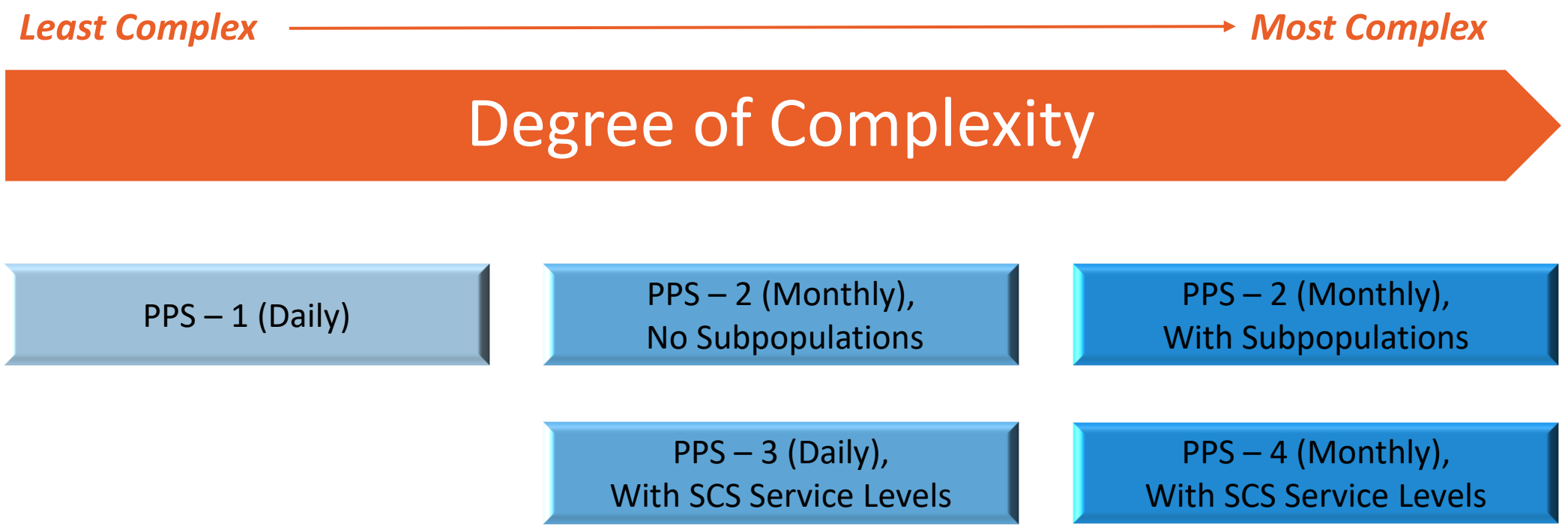
- If the state decides to establish separate PPS rates based on the type of Special Crisis Services (SCS) performed, CCBHCs will be required to allocate both costs and visits between the following 4 categories*
  - **Mobile Crisis 9813:** Intervention service provided to individuals experiencing a mental health or substance use disorder crisis outside of a hospital or other facility setting that meet the qualifying criteria specified in Section 9813 of the American Rescue Plan Act
  - **Mobile Crisis Non-9813**: Intervention service provided to individuals experiencing a mental health or substance use disorder crisis outside of a hospital or other facility setting
  - **Crisis Stabilization**: On-site services that are designed to help individuals who are experiencing a mental health or substance use crisis to de-escalate and return to a stable state
  - **Non-Crisis**: CCBHC services not satisfying the above 3 SCS levels

** States can elect to have less than the 3 Special Crisis Services (SCS) rates noted above.*

State-Specific CCBHC Payment Options

- States have the flexibility to tailor the CCBHC program to the needs of their individual state
- State-Specific CCBHC Guidance
  - CCBHC Certification Criteria
    - Needs assessment
    - Entity-wide certification versus site-specific/geographic boundaries
    - Covered services lists
    - Quality measures
    - Evidence-Based Practices
  - PPS Rate "Triggering Events" – CPT codes/billable providers
  - PPS Rate-setting Approach

Range of Complexity of PPS Rate Models



Basic PPS Rate Construct

- CCBHC Covered Services
- Anticipated "Budgeted" Costs
- Direct Costs & Allocated Overhead

Total "Allowable" CCBHC Costs *

Total CCBHC Visits *

= CCBHC PPS Rate

- Services Versus Billable Visits
- Daily vs. Monthly Visits
- Anticipated Visits

** For **ALL** clients!*

PPS Payment Model Fundamentals

All-Inclusive Rate (AIR) Equation

$$\frac{\text{Total "Allowable" CCBHC Costs}}{\text{Total CCBHC Visits}} = \text{CCBHC PPS Rate}$$

Description	Number of Visits Option A	Option B
Total Allowable Costs	$10,000,000	$10,000,000
Threshold visits	55,000	40,000
Projected CCBHC Medicaid Rate	**$181.82**	**$250.00**
Medicaid Payer Mix	90%	90%
Number of Medicaid Visits	49,500	36,000
Medicaid CCBHC Revenue	**$9,000,000**	**$9,000,000**
% of Allowable Costs Reimbursed	*90%*	*90%*

AIR Reimbursement Fundamentals

Impact of Payer Mix

The CCBHC Medicaid PPS Dilemma

- A basic premise of the CCBHC PPS payment methodology is that the same level of service (and cost) is provided to clients regardless of the underlying payer
- Medicaid will pay for their share of the cost of services provided to Medicaid patients
  - Will other payers increase payment rates consistent with the CCBHC Medicaid PPS rate?
  - Who will subsidize the gap in the CCBHC cost for non-Medicaid payers?

	Base Year			CCBHC Compliant		
	Medicaid	**Other**	**Total**	**Medicaid**	**Other**	**Total**
Visits	37,500	12,500	50,000	45,000	15,000	60,000
Payer Mix	*75%*	*25%*	*100%*	*75%*	*25%*	*100%*
Grants	750,000	750,000	1,500,000	0	1,500,000	1,500,000
Patient Revenue	5,625,000	937,500	6,562,500	11,250,000	1,125,000	12,375,000
Other	187,500	187,500	375,000	0	375,000	375,000
Total Revenue	6,562,500	1,875,000	8,437,500	11,250,000	3,000,000	14,250,000
Total Expenses	6,562,500	1,875,000	8,437,500	11,250,000	3,750,000	15,000,000
Surplus/(Loss)	0	0	0	0	(750,000)	(750,000)
"Per Visit" Metrics:						
Patient Revenue	$150.00	$75.00	$131.25	$250.00	$75.00	$206.25
Expenses	$175.00	$150.00	$168.75	$250.00	$250.00	$250.00

Poll #3

Hopefully, it is obvious that establishing/managing a CCBHC Medicaid PPS rate requires a multi-disciplinary team from the finance, clinical, program and operations functions. **Have you developed a multi-disciplinary team to implement/manage performance under the CCBHC Medicaid PPS rate model?**

- Yes
- No
- N/A

Why Cost Reports?

- Cost Reports capture the elements of the CCBHC PPS Rate Equation
  - Allowable CCBHC costs (base year plus anticipated costs) ÷
  - Allowable CCBHC visits (base year plus anticipated visits)
- Cost Reports vary in complexity based on year in the Demonstration program

Data Elements	Initial Cost Reports	Subsequent Cost Report
Allowable CCBHC Costs	Base Year Expenses	Actual Demonstration Year Expenses
	Anticipated Expenses	
Billable CCBHC Visits	Base Year Services/Visits	Actual Demonstration Year Visits
	Anticipated Services/Visits	

Steps to Calculating Allowable Costs

1st Understand CCBHC Covered Services*

- Review CCBHC core required services per the state's *CCBHC Scope of Services listing*

2nd Compare Existing Services Versus CCBHC Covered Services to Identify Gaps*

- How will gaps be covered – internal staff/resources versus an outside organization

3rd Calculate Direct CCBHC Service Costs

- Direct CCBHC service costs – personnel/other than personnel services
- CCBHC Program Administration
- "Anticipated Costs" (Year 1 budgeted costs to comply with CCBHC requirements and be successful)

4th Allocate Overhead Costs (Agency Wide)

- Overhead costs that benefit both CCBHC and non-CCBHC services which are allocated per the CCBHC cost report methodology

** These steps must be performed through a multi-disciplinary effort of the clinical, operational and financial teams!*

Anticipated/Budgeted Services & Costs

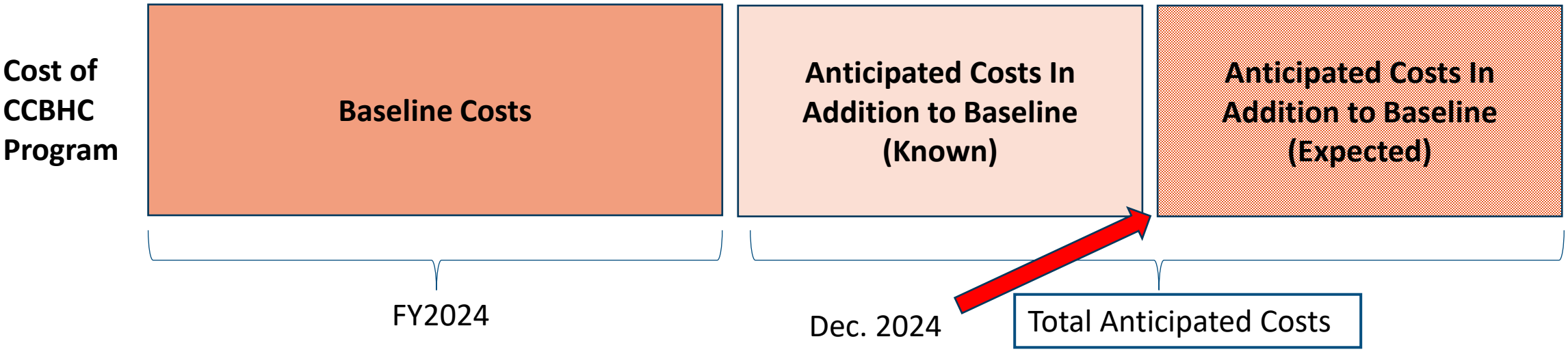
- ***Project/Manage Year 1 budgeted costs to comply with CCBHC requirements AND BE SUCCESSFUL versus existing baseline services!***
- Review the 9 core CCBHC services with operations, clinical and financial personnel to determine:
  - Which services are currently provided to confirm whether any gaps exist?
  - For those services that are identified gaps, determine whether the CCBHC will expand services to provide them directly or whether they will be performed through an agreement with a Designated Collaborating Organization (DCO)

Service Requirement	Services Currently Provided	Services Not Currently Provided	Gap to be Covered Internally	Gap to be Covered Thru DCO

- Review additional services outside of the 9 core CCBHC services that the CCBHC provides to determine whether additional services are needed to be both "compliant and successful" as a CCBHC (e.g., care coordination; quality reporting)

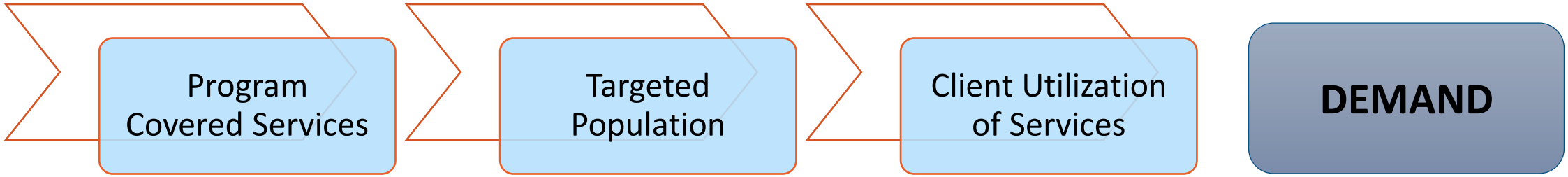
Anticipated/Budgeted CCBHC Costs

- Development of anticipated costs includes costs that have been, or will be incurred after the base year that are additive to baseline costs
- **Example: if Fiscal Year 2024 is used as the Base Year for assessing baseline costs, anticipated costs would include incremental actual costs through present and projected through CCBHC implementation/compliance**



Anticipated/Budgeted Services & Costs

Process for defining demand for services identified by Needs Assessment:



What are the types of services covered by the CCBHC program that your agency needs to add access to?

What populations are you targeting with the CCBHC services to be added?

How often do you anticipate a client in the target population would need to access services, by type?

Anticipated/Budgeted Services & Costs

Process for defining supply (capacity) needed to deliver services:

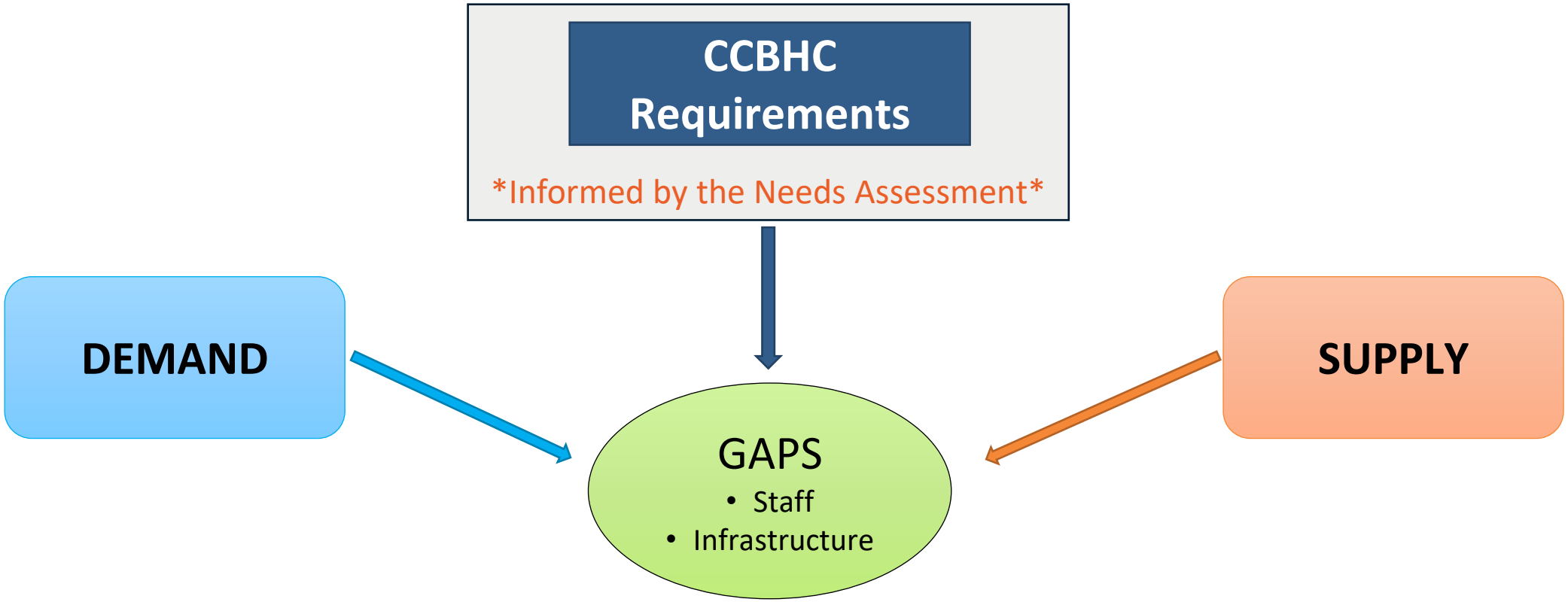
What is the current profile of staff, by position?

Factoring in non-client, indirect time, what is the capacity of existing staff to provide required services?

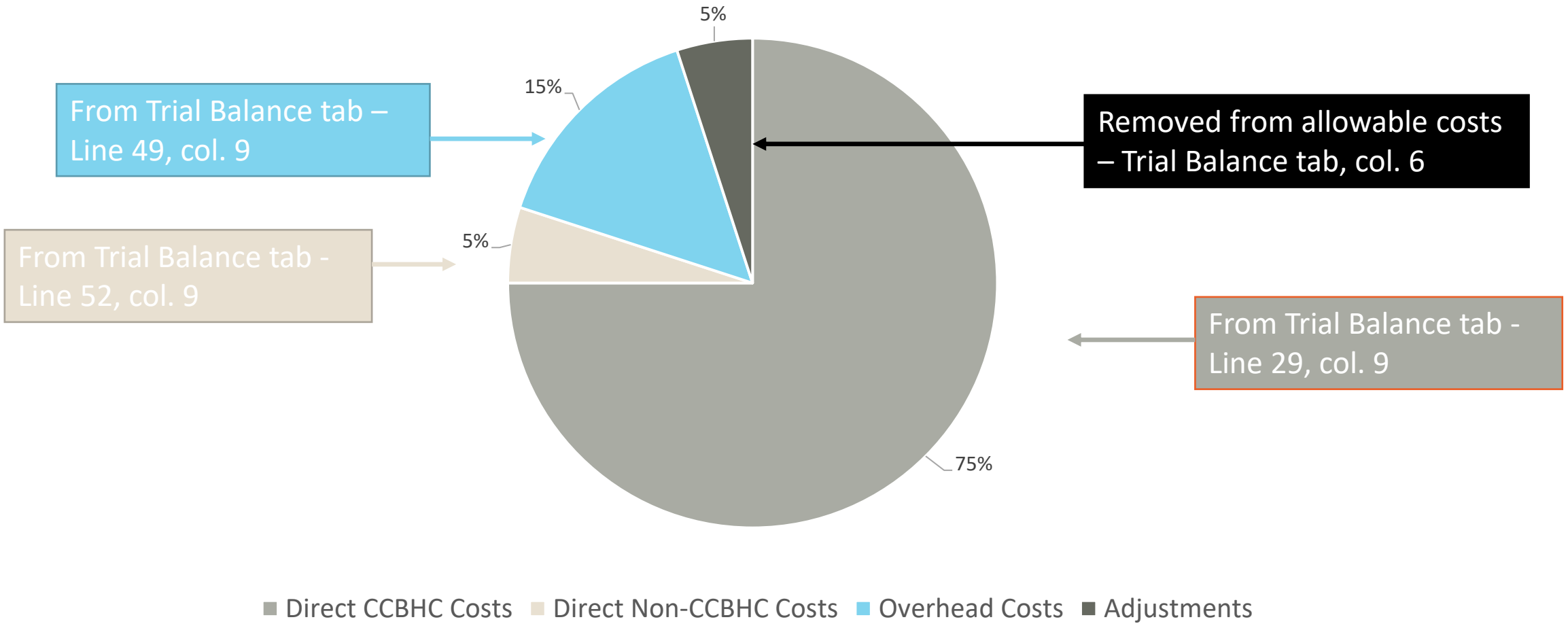
What is the clinic's infrastructure available to support existing service delivery?

Anticipated/Budgeted Services & Costs

Difference between Demand and Supply (informed by the Needs Assessment) = Resources Required to Implement CCBHC -



Example - CCBHC Cost Report Expense Allocation



Allowable Costs

- **CMS Provider Reimbursement Manual 15-1**
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929
- **45 CFR 75 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards**
  - https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75
- **42 CFR 413 – Principles of Reasonable Cost Reimbursement; Payment for End-Stage Renal Disease Services; Prospectively Determined Payment Rates for Skilled Nursing Facilities; Payment for Acute Kidney Injury Dialysis**
  - https://www.ecfr.gov/cgi-bin/text-idx?SID=7d844a74313fb4e209aa3b4e1eb230c0&mc=true&node=pt42.2.413&rgn=div5

Unallowable Services & Costs

- Non-CCBHC Costs (Per CCBHC guidance)
  - Inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services
  - Non-CCBHC sites/programs
  - State-specific program exclusions
  - Dental (App III)
  - Optometry (App III)
- Non-reimbursable Expenses (PRM 15-1, Chapter 21)
  - Bad debt expense
  - Entertainment
  - Fines or penalties
  - Gifts or donations
  - Lobbying
  - Related party transactions (in excess of cost to related party)

Overview – Accounting Records

- When filing the CCBHC cost report, a crosswalk between the trial balance and the cost report must be submitted to the State for desk audit purposes
- There is no specific format of the trial balance; what is important is that the trial balance accounts can be grouped and traced to the cost report lines
- In general, when developing a crosswalk from the trial balance to the cost report, the CCBHCs existing subaccount coding structure should be assigned to the following 3 cost categories:
  - CCBHC Direct Costs
  - Non-CCBHC Direct Costs
  - Organization-wide Overhead
- What is important to note is once the crosswalk is created, there will be limited if any adjustments required to the chart of accounts subaccount coding structure in the general ledger

Steps to Review Current Subaccount Coding Structure

- Create a table to crosswalk the current subaccount codes to the 3 cost report categories (e.g., CCBHC Direct Costs, Non-CCBHC Direct Costs, Organization-wide Overhead)

Program Number	Program Description	CCBHC Direct	Non-CCBHC Direct	Overhead
Program A	Outpatient Clinic	XXX		
Program B	Care Management	XXX		
Program C	Residential Inpatient		XXX	
Department 1	Administrative	XXX		XXX

Steps to Review Current Subaccount Coding Structure

- If a subaccount contains cost items in more than one category, the CCBHC has 2 options
  1. The CCBHC Cost Report includes a tab to allow for the Allocation of expenses between 2 cost categories. In this case, the subaccount structure does not need to be revised; the cost allocation can be done in the cost report itself.
  2. Separate the current subaccount category into 2 or more new subaccounts
- Most CCBHCS opt for option 1.
- Special Note on Salary Cost: We recommend that a detailed salary list by individual name, job title, salary paid, FTE and services provided, if any, be prepared to support the salary cost, FTEs and services provided in the CCBHC Cost Report
  - With this approach, the total salary of the supporting worksheet must agree to total salaries in the trial balance. This approach is acceptable in all cost reporting venues including CCBHC.

Services Vs. Visits

- Services are NOT the same as daily "triggering" visits or monthly visits
  - Daily "triggering" visits are a subset of Services that are determined to be billable based Billable Visit Criteria established in the state's listing of CCBHC "Triggering Events"
- Billable Visit Criteria per CMS webcast (Dec. 2015)
  - CCBHC Scope of service
  - Eligible (qualified) provider
  - Service modality (e.g., telehealth?)
  - Approved Location
  - Documentation
- *Ensure that all services provided are coded and documented!*

PART 1A - CCBHC STAFF SERVICES

	Description	Number of Full-Time Equivalent (FTE) Staff 1	Total Number of Services Provided for CCBHC Services 2	Direct Cost (from Trial Balance, Col. 9) 3	Average Cost per Service by Position (Col. 3 divided by Col. 2) 4
1.	Psychiatrist			$ -	$ -
2.	Psychiatric nurse			$ -	$ -
3.	Child psychiatrist			$ -	$ -
4.	Adolescent psychiatrist			$ -	$ -
5.	Substance abuse specialist			$ -	$ -
6.	Case manager			$ -	$ -
7.	Recovery coach			$ -	$ -
8.	Peer specialist			$ -	$ -
9.	Family support specialist			$ -	$ -
10.	Licensed clinical social worker			$ -	$ -
11.	Licensed mental health counselor			$ -	$ -
12.	Mental health professional (trained and credentialed for psychological testing)			$ -	$ -
13.	Licensed marriage and family therapist			$ -	$ -
14.	Occupational therapist			$ -	$ -
15.	Interpreters or linguistic counselor			$ -	$ -
16.	General practice (performing CCBHC services)			$ -	$ -
17.	Subtotal other staff services (specify details in Comments tab)			$ -	$ -
18.	Subtotal staff services (sum of lines 1-17)	0	0	$ -	$ -

Calculation of CCBHC Visits

1st - Start with all services (contacts/touches) between CCBHC staff and clients

2nd - Remove all non-billable ("non-triggering") services

- Non-CCBHC services
- No-shows and void claims
- Non-billable CCBHC providers
- Non-billable CCBHC procedures (CPT codes)

3rd - Daily "Triggering" Visits

- Remove duplicate billable services per client per day to arrive at one "Daily Visit" per client

4th - Monthly "Triggering" Visits, if applicable

- Remove duplicate daily billable services per client per month to arrive at one "Monthly Visit" per client

CCBHC Services Versus Visits

Example – Differentiation Between Services and Visits (Daily/Monthly):

	Number of Services			Number of Daily "Triggering" Visits		Number of Monthly Visits	
Provider Type	**# of Services**	**Less: Services by Non-billable Providers**	**Billable Services**	**Less: Duplicate Same-Day Visits**	**Number of Daily (PPS Trigger) Visits**	**Less: Duplicate Monthly Visits**	**Number of Monthly Visits**
Billable providers -							
Psychiatrists	15,000		15,000		15,000	(7,500)	7,500
Licensed Social Workers	40,000		40,000	(15,000)	25,000	(12,500)	12,500
Subtotal	55,000	0	55,000	(15,000)	40,000	(20,000)	20,000
Non-billable providers -							
Unlicensed Mental Health Worker (undupervised)	15,000	(15,000)	0		0		0
TOTAL	**70,000**	**(15,000)**	**55,000**	**(15,000)**	**40,000**	**(20,000)**	**20,000**

CCBHC Services Versus Visits

Example – Impact of Incorrect Visit Count on CCBHC Rate and Total Reimbursement:

	Scenario A (Bad Student)		Scenario B (Good Student)
Rate Calculation (Per Cost Report):			
Total Allowable Costs	$10,000,000		$10,000,000
Total "Reported" Visits	40,000		20,000
Cost Per Visit (PPS Rate)	**$250.00**		**$500.00**
Actual Billing/Reimbursement Activity:			
Total "Actual" Billable Visits	20,000		20,000
Medicaid Payer Mix	90%		90%
Number of "Actual" Billable Visits	18,000		18,000
PPS Rate	$250.00		$500.00
Medicaid CCBHC Revenue	$4,500,000		$9,000,000
% of Allowable Costs Reimbursed	*45%*		*90%*

Duplicate visits not removed from visits reported on cost report

3 Cost Report Workstreams

- The multi-disciplinary crosswalk of the 3 cost report workstreams:

Finance	Program/Operations
1. Establishment of Base Year Costs	
Identification of CCBHC program expenses and staff costs in the accounting records	Review and identification of programs and staff that are included in the CCBHC program
2. Development of Anticipated Costs	
Projection of new personnel costs and other anticipated expenses (e.g., infrastructure)	Identification of gaps; development of anticipated staffing profile (e.g., FTEs)
3. Development of Base Year and Anticipated Services/Visits	
Identification of CCBHC clinicians and services in the billing system; conversion of services to CCBHC visits	Development of service/visit projections

Questions & Discussion

Thank You!

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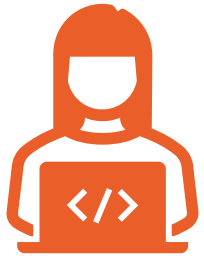

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