The Medicaid Certified Community Behavioral Health Clinic (CCBHC) Demonstration: New Opportunities, New Challenges

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The CCBHC Demonstration: What’s New?
CCBHC DEMONSTRATION TIMELINE

April 1, 2014

- Congress enacts the Protecting Access to Medicare Act
  
- PAMA § 223 establishes CCBHC Demonstration

October 19, 2015

- SAMHSA awards planning grants to 24 States

October 31, 2016

- States apply for CCBHC demonstration; CMS selects 8 States

2017

- Two-year Demonstration Project begins
In choosing demo States, CMS will give preference to States whose CCBHC demonstration program will:

| Provide the most complete scope of services | Improve availability of, access to, and participation in, services | Improve availability of, access to, and participation in assisted outpatient mental health treatment in the State | Demonstrate the potential to expand available mental health services in a demonstration area and increase the quality of such services without increasing net Federal spending |

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Demonstration
Tests effectiveness of the CCBHC model for Medicaid community-based behavioral health services

Providers
Become certified as CCBHCs and operate in accordance with State and Federal Rules

CMS
Issues guidance to States on the development of the CCBHC PPS and other reimbursement issues

States
Develop CCBHC PPS; certify at least two CCBHCs; implement demonstration

SAMHSA
Develops guidance for CCBHC requirements and criteria for CCBHC certification
CCBHC - WHAT’S NEW?
PAYMENT RELATES TO COST

• Reimbursement based on costs of serving CCBHC patients, not on fee schedule

• CCBHCs must:
  – Document base year costs;
  – Bill Medicaid on an encounter basis
  – Navigate requirements relating to PPS reimbursement for services provided under contract with a managed care entity (MCE)
PLATFORM - WHAT’S NEW?
PAYMENT PER VISIT, NOT PER SERVICE

- Payment triggered by visits to CCBHC, not by frequency or intensity of services provided in a visit
- States choose the unit for encounters
- State options:
  - Daily encounter (PPS-1); or
  - “Unique visit month” (PPS-2)
• Must provide broad array of services, *not* just current service offerings
• CCBHCs may provide required services directly or through formal relationships with other providers
CCBHC - WHAT’S NEW?
AVAILABILITY OF SERVICES

• Crisis management services must be available 24 hours a day;
• A sliding fee scale must be used to make services affordable for CCBHC patients;
• Patients cannot be rejected for services or limited in service utilization based on ability to pay or place of residence
  – This applies to all patients, not just Medicaid!
• Care must be coordinated across settings and providers, on full spectrum of health, including acute, chronic, and behavioral health needs
• Priority on partnerships with other community healthcare providers and with social service agencies
CURRENT BURNING QUESTIONS IN CCBHC IMPLEMENTATION

• How will CCBHCs be supported in carrying out SAMHSA program requirements?
  – Gathering of quality data
  – Making services available to all patients regardless of ability to pay

• What form will States’ CCBHC certification take? How will States ensure that providers billing as CCBHCs under Medicaid adhere to SAMHSA program requirements?

• How will designated collaborating organization (DCO) arrangements be structured so as to ensure effective delivery of services and minimize risk to CCBHCs?
CCBHC Collaborations

Care coordination agreements and Designated Collaborating Organizations
CCBHC Care Coordination Agreements with Other Community Providers and Agencies
OVERALL GOALS OF HEALTH CARE REFORM

Broader coverage (access)

More affordable (cost)

Better outcomes (quality)
• Health system transformation requires models of care:
  – Patient-centered
  – Team-based approach
  – Integrating behavioral and physical health services at one location
  – Attention to social determinants/correlates of health
  – Using Health IT to better manage care
WHY COLLABORATE?

• Per SAMHSA, care coordination is the linchpin of the CCBHC program.
  • Improve community mental health and substance use disorder services by providing integrated quality care
  • Ensure seamless transitions for patients across the full spectrum of health services (e.g. acute, chronic, and behavioral health), as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person
  • Offer care that is person- and family-centered
  • Improve population health management and data collection
CARE COORDINATION: EXAMPLE

• Licensed mental health and SUD provider coordinates care with other providers to reduce use of ER and inpatient facilities.
  – De-escalates client crises, transitions clients back to into the community, places clients into supportive housing
  – Psychiatric hospitalization rate among those served of less than 2.5% in 2014
  – Nearly 65% of clients diverted from ER

• Savings of successfully guiding just one high-resource-user to a model of customized community-based care is estimated to save $39,000 per year

• Both of these results align with cost savings, better health outcomes, and optimally tailored service to clients.
CLINICAL ADVANTAGES

- Maintain, expand, and enhance the amount, type, level and quality of services available in communities
- Enhance access to the full continuum of care and reduce service gaps
- Enhance and improve clinical, administrative and managerial capacities, resources, expertise and systems
- Improve recruitment / retention of clinical staff
- Increase integration within the medical community and provide opportunities to participate in programs that optimize clinical care
FINANCIAL ADVANTAGES

• Expand patient bases
• Enhance financial stability and strength of an agency/provider and its partner
• Reduce unnecessary duplication of services within the community thus maximizing resources
• Increase sources of, and access to, capital and financial support
“Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services including acute, chronic, and behavioral health needs.”

Protecting Access to Medicare Act of 2014 (PAMA) § 223(a)(2)(C)
• SAMHSA, “Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics”


• Favorite quote: “[T]he criteria set high expectations which are likely to require changes and adjustments to current service delivery systems.”
DEFINITION OF CARE COORDINATION

The CCBHC Criteria define “care coordination”:

- Using the Agency for Healthcare Research and Quality (AHRQ) definition of care coordination, which is:
  - “deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care.”
  - “This means the patient’s needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.”
DEFINITION OF CARE COORDINATION

The CCBHC Criteria further define “care coordination”:

- “As used here, the term applies to activities by CCBHCs that have the purpose of coordinating and managing the care and services furnished to each consumer as required by PAMA (including both behavioral and physical health care), regardless of whether the care and services are provided directly by the CCBHC or through referral or other affiliation with care providers and facilities outside the CCBHC.”

- “Care coordination is regarded as an activity rather than a service.”
STATUTORY REQUIREMENTS FOR CARE COORDINATION AGREEMENTS

Care coordination requirements shall include partnerships or formal contracts with the following:

1) Federally qualified health centers (and as applicable, rural health clinics)

2) Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs.

3) Other community or regional services, supports, and providers, including schools, child welfare agencies, and juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, State licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services.

4) Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the Department as defined in section 1801 of title 38, United States Code.

5) Inpatient acute care hospitals and hospital outpatient clinics.

Protecting Access to Medicare Act of 2014 (PAMA) § 223(a)(2)(C)
As used in the context of care coordination, an agreement is an arrangement between the CCBHC and external entities with which care is coordinated.

- Such an agreement is evidenced by a contract, Memorandum of Agreement (MOA), or Memorandum of Understanding (MOU) with the other entity, or by a letter of support, letter of agreement, or letter of commitment from the other entity.

- The agreement describes the parties’ mutual expectations and responsibilities related to care coordination.

Source: Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics
CRITERIA 3.C.1: CARE COORDINATION AGREEMENTS WITH FEDERALLY QUALIFIED HEALTH CENTERS & RURAL HEALTH CLINICS

With Whom?

Federally Qualified Health Centers (FQHCs) (and RHCs, if applicable) to provide health care services not provided directly by the CCBHC,

For consumers served by other primary care providers, the CCBHC has established protocols to ensure adequate care coordination.

• Notes:

  1. If the care coordination agreement cannot be established within the demonstration project, the CCBHC must provide justification to the certifying body and establish contingency plans with other providers of similar services.

  2. CCBHCs are expected to work toward formal contracts with entities with which they coordinate care if not established at the beginning of the demonstration project.

Source: SAMHSA, “Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics”
CRITERIA 3.C.2: CARE COORDINATION AGREEMENTS WITH IN-PATIENT PSYCH, DETOX, AND POST-DETOX PROGRAMS

**With Whom?** Programs that provide inpatient psychiatric treatment, with ambulatory and medical detoxification, post-detoxification step-down services, and residential programs to provide those services for CCBHC consumers.

- The CCHBC is able to track when consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity.
- The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric, detoxification, and residential settings to a safe community setting.
  - This includes transfer of medical records of services received (e.g., prescriptions), active follow-up after discharge and, as appropriate, a plan for suicide prevention and safety, and provision for peer services.
- Note: If the care coordination agreement cannot be established within the demonstration project, the CCBHC must provide justification to the certifying body and establish contingency plans, of which the State determines sufficiency.
**CRITERIA 3.C.3: CARE COORDINATION AGREEMENTS WITH COMMUNITY SERVICES, SUPPORTS & PROVIDERS**

**With Whom?** A variety of community or regional services, supports, and providers, including, as identified by statute:

1. Schools;
2. Child welfare agencies;
3. Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty courts);
4. Indian Health Service youth regional treatment centers;
5. State licensed and nationally accredited child placing agencies for therapeutic foster care service; and
6. Other social and human services.

- Note: If the care coordination agreements cannot be established within the demonstration project, the CCBHC must provide justification to the certifying body and establish contingency plans, of which the State determines sufficiency.
With Whom? To the extent necessary given the population served and the needs of individual consumers, such other community or regional services, supports, and providers as may be necessary, such as the following:

1. Specialty providers of medications for treatment of opioid and alcohol dependence;
2. Suicide/crisis hotlines and warmlines;
3. Indian Health Service or other tribal programs;
4. Homeless shelters;
5. Housing agencies;
6. Employment services systems;
7. Services for older adults, such as Aging and Disability Resource enters; and
8. Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs)
With Whom? The nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department.

- To the extent multiple Department facilities of different types are located nearby, the CCBHC should explore care coordination agreements with facilities of each type.

- Note: If the care coordination agreements cannot be established within the demonstration project, the CCBHC must provide justification to the certifying body and establish contingency plans, of which the State determines sufficiency.
CRITERIA 3.C.5: CARE COORDINATION AGREEMENTS WITH INPATIENT ACUTE CARE HOSPITALS & OUTPATIENT CLINICS

**With Whom?** Inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers, in the area served by the CCBHC.

- The agreement includes procedures and services, such as peer bridgers, to help transition individuals from the ED or hospital to CCBHC care and to shorten time lag between assessment and treatment.

- The agreement is such that the CCBHC can track when their consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to another entity.
• The CCBHC will make and document reasonable attempts to contact all CCBHC consumers who are discharged from these settings within 24 hours of discharge.

• For all CCBHC consumers being discharged from such facilities who presented to the facilities as a potential suicide risk, the care coordination agreement between these facilities and the CCBHC includes a requirement to coordinate consent and follow-up services with the consumer within 24 hours of discharge, and continues until the individual is linked to services or assessed to be no longer at risk.

• The agreement also provides for transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge.

• Note: If the care coordination agreements cannot be established within the demonstration project, the CCBHC must provide justification to the certifying body and establish contingency plans, of which the State determines sufficiency.
• **Mutual Expectations.** Care coordination agreements must address:
  
  – Transfer of medical records back to CCBHC, including prescriptions
  
  – Referral of consumer to external providers or resources, including obtaining an appointment to, and confirming the appointment was kept, if the consumer needs assistance.
  
  – Tracking of admission and discharge, if applicable
  
  – Appropriate follow-up care upon receipt of service or discharge from external provider or resources, as applicable
  
  – Coordination of specific services if the consumer presented as a potential suicide risk, discharge and, as appropriate, a plan for suicide prevention and safety, and provision for peer services
  
  – To the extent necessary, any other expectations necessary to carry out the other requirements related to care transitions
• **Privacy and confidentiality.** Care coordination agreements must contain privacy and confidentiality terms.
  
  – Documentation of compliance with HIPAA and other federal and state patient privacy requirements
  
  – HIPAA Privacy Rule applies only to “protected health information”; routine communications between health care providers and a consumer’s family and friends are permissible so long as consumer does not object
  
  – 42 C.F.R. Part 2 contains additional protections on information about substance use disorder treatment
  
  – It is advisable (though not always legally required) to obtain patient consent for release of health information pursuant to care coordination relationships
KEY TERMS FOR CARE COORDINATION AGREEMENTS

• **Referrals.** Care coordination agreements should ensure that referrals between CCBHC and external provider describe:
  – How a referral will be made and managed
  – Patient tracking policies and procedures
  – Process for referring patient back to CCBHC for follow-up care
  – Whether services will be available and accessible equally to all referred patients regardless of ability to pay
  – How external provider will communicate whether it has capacity to accept additional patients
KEY TERMS FOR CARE COORDINATION AGREEMENTS

• **Independent Contractors.** Care coordination agreements should ensure that each provider is financially, clinically and legally responsible and is solely liable for claims related to services it directly provides
  – Patients are patients of the provider directly providing services
  – Each provider’s policies, procedures, standards govern its provision of services
  – Each provider bills and collects payment for the services it directly renders

• **Warranties and Representations.** Each provider should furnish assurances regarding professional qualifications of providers, eligibility to participate in federal/state health care programs, standards of care
CHECKLIST OF CONSIDERATIONS FOR CARE COORDINATION AGREEMENTS

Before entering into the care coordination agreement, have you:

- Evaluated whether the other party has sufficient personnel and facility space to see additional patients?
- Drafted an agreement that is written in clear and unambiguous language?
- Confirmed that the service or resource provided by the other party is equally available to all referred consumers?

Does the care coordination agreement:

Coordination of Services

- Specify how the referral, tracking of admission/discharge, and follow-up care will be made and managed (e.g., development of a referral protocol and procedures for tracking patients and ensuring appropriate follow-up care)?
- Describe the division of services (e.g., which entity will make initial appointments, etc.)?
- Describe the process by which the parties will share medical notes/records regarding diagnosis and treatment, including prescriptions?
- Describe the process by which the parties will coordinate specific services if the consumer presented as a suicide risk (e.g., discharge, plan for suicide prevention and safety, and provision for peer services)

Obligations of the “Referral Provider”

- Contain a provision stating that to the extent that referred patients receive services from Referral Provider, such individuals are considered patients of Referral Provider?
- Specify that the Referral Provider agrees to accept all patients referred to it by the CCBHC, subject to capacity limitations?
- Specify that the Referral Provider agrees to charge patients based on a patient’s ability to pay?
- Specify that the Referral Provider will be solely liable for all services provided by it and its health care professionals?
- Specify that the Referral Provider will be responsible for billing and collecting all payments from appropriate third party payors, funding sources, and, as applicable, patients, for its services?
CHECKLIST OF CONSIDERATIONS FOR CARE COORDINATION AGREEMENTS

Does the care coordination agreement:

Standards of Care

☐ Contain assurances that the Referral Provider and each of its professionals providing services pursuant to the referral agreement:
  ☐ Are appropriately licensed, certified and/or otherwise qualified to furnish the services, with appropriate training, education and experience in their particular field?
  ☐ Will furnish services consistent with the prevailing standards of care?
  ☐ Are not excluded from participating in Medicare, Medicaid and other federal health care programs?
  ☐ Will furnish services in accordance with applicable federal, state and local laws and published and final regulations?

Professional Judgment and Freedom of Choice

☐ Specify that nothing in the arrangement will, or is intended to, impair the exercise of professional judgment by any and all health care professionals employed by or contracted to either party when making referrals?

☐ Specify that nothing in the arrangement will, or is intended to, impair the exercise of freedom of choice of provider by any and all patients served by each party?

Insurance

☒ State that the Referral Provider will ensure that it and its employees providing services pursuant to the referral are covered by a professional liability insurance policy (malpractice, errors, and omissions) providing sufficient coverage against professional liabilities which may occur as a result of the services that the Referral Provider and its employees furnish to the referred patients?

Autonomy and Compliance with State and Federal Law

☐ Contain a provision stating that each party maintains the right to enter into arrangements with other providers, whether for the same or for similar services, if such party deems it necessary?

☒ Contain a provision stating each party agrees to comply with any federal or state law governing the privacy and confidentiality of the individually identifiable health information of patients originating with either party?
Providing Required Services Through Designated Collaborating Organizations (DCOs)
DESIGNATED COLLABORATING ORGANIZATIONS

- Per PAMA §223(a)(2)(D), CCBHC required services must be provided directly “or referred through formal relationships with other providers”
- Per SAMHSA and CMS guidance:
  - Payment for DCO services included within scope of CCBHC PPS rate (CMS guidance pages 7, 11)
  - CCBHC maintains clinical and financial responsibility for care provided by DCOs (SAMHSA guidance pages 6, 33)
  - CCBHC must be the Medicaid billing provider for DCO services (CMS 10/25/15 Qs and As, Questions 5 and 6)
  - Implication: Required services not provided directly must be provided via purchase of services agreement
CCBHC SERVICES THAT MAY BE PROVIDED BY DCO

• Per SAMHSA guidance, of the nine required CCBHC services, CCBHCs *may* contract with DCOs to provide:
  – Outpatient primary care screening and monitoring
  – Targeted case management
  – Psychiatric rehabilitation
  – Peer and family supports
  – Intensive community-based outpatient behavioral health care for members of the US Armed Forces and veterans.

• CCBHCs *may not* contract with DCOs to provide:
  – Screening, assessment and diagnosis
  – Person-centered treatment planning
  – Outpatient mental health and substance use services

• CCBHC may contract with DCO to provide crisis behavioral health services under certain conditions set forth in SAMHSA guidance
INCLUSION OF DCO SERVICES IN CCBHC REIMBURSEMENT

• The CCBHC’s payment to the DCO for contracted services is included within the CCBHC PPS rate

• CCBHC must include on its cost report
  – Actual or anticipated costs to CCBHC of procuring DCO services (see Certified Community Behavioral Health Clinic (CCBHC) Cost Report, “Trial Balance” and “Anticipated Costs” tabs, Section 1-B)
  – Other costs specifically related to DCO (e.g., mileage associated with mobile crisis services billed separately)
SHOULD CCBHCs DIRECTLY PROVIDE SERVICE OR WORK WITH DCOs TO PROVIDE SERVICE?

1. Does the CCBHC have the ability to directly provide the services?
   – Both with regard to staffing and capacity
2. If not, does the demonstration allow the CCBHC to delegate the services?
3. If so,
   – Can the prospective DCO provide the services such that the services meet the same quality standards as those provided by the CCBHC?
   – Can the CCBHC adequately oversee care provided by DCO?
   – Does the CCBHC have the ability to control liability risks through contracting?

• NOTE: CMS expects DCO contracting arrangements to be in place by the time a State certifies an entity as a CCBHC
CCBHC OVERSIGHT OF SERVICES RENDERED BY DCOs

CCBHC is **clinically responsible** – CCBHC ensures that services rendered by DCOs

- Meet cultural competency requirement
- Are reflected in CCBHC Uniform Reporting System reporting
- Meet standards for accessibility (application of sliding fee scale; no denial of services based on ability to pay, regardless of insurance status; services rendered within specified time period after appointment request)
- Meet all relevant SAMHSA program requirements applicable to the service
- Are rendered in keeping with State law, *i.e.*, each clinician is acting within the scope of his/her license/certification

**Note:** CCBHC will be holding itself out as provider of the DCO-rendered service!
CCBHC is **financially responsible** – CCBHC

- Bears financial risk for collection of patient out-of-pocket liability
- Bears legal responsibility for effective coordination of benefits
- Is responsible for ensuring that DCO-related costs are included in CCBHC Medicaid cost report
- Is responsible for billing Medicaid for services furnished by DCOs

These risks/responsibilities apply to all consumers, not just Medicaid beneficiaries.

**Note: potentially more flexibility re: billing other payors**
CRITICAL PROTECTIONS FOR CCBHCs IN STRUCTURING DCO RELATIONSHIPS

• Credentialing
  – CCBHC should contractually require DCOs to attest periodically to compliance with federal, state and local laws re: license, certification, credentialing

• Exclusions List
  – CCBHC should contractually require DCOs to attest periodically that neither they nor their individual employees / management have been excluded from participation in federal health care programs

• Professional Liability Insurance
  – CCBHC may seek contractually
    • to require DCO indemnify CCBHC for malpractice liability associated with DCO-rendered services
    • to require DCO to add CCBHC as a named insured on its malpractice insurance policy
CRITICAL PROTECTIONS FOR CCBHCs IN STRUCTURING DCO RELATIONSHIPS

• Sharing of electronic health record (EHR)
  – CCBHC must work with DCO to ensure compliance with privacy and confidentiality requirements
    • Be aware of HIPAA, 42 C.F.R. Part 2, and state privacy laws!
  – CCBHC should consider modifying consumer consent to allow sharing of protected health information with DCO
  – CCBHC must develop a plan with DCOs for using health IT that includes information on how the CCBHC can support health IT exchange to improve care transitions
    • DCO share consumer information with CCBHC
    • CCHBC and DCO chart in same health record?
CRITICAL PROTECTIONS FOR CCBHCs IN STRUCTURING DCO RELATIONSHIPS

• Coordination of benefits and collection of cost-sharing – contract should address
  – Who will determine the consumer’s current forms of coverage and ensure that other payors are billed before Medicaid?
  – Who will collect patient fees?
  – Who will collect patient cost sharing?
  – Who will ensure that sliding fee discount schedule is applied?
• Consideration paid by CCBHC to DCO
  – Contract should provide for reimbursement at fair market value of services
  – Examples: DCO reimbursement based on
    • annual salary of clinicians who will furnish services plus overhead percentage;
    • Average historical annual costs of furnishing contracted service
  – Reimbursement should not be based on a percentage of the CCBHC PPS rate

Note: The CCBHC will be financially liable for services furnished by DCO to uninsured CCBHC patients
Does the DCO contract:

✓ Reimbursement
  ✓ Establish fair market value for clinical services and other services rendered by DCO?
  ✓ Cover the CCBHC’s costs associated with clinical oversight, financial oversight, and billing?

✓ Care coordination
  ✓ Require DCO to adhere to policies and protocols re: communication with CCBHC to improve patient care?

✓ Quality of Care
  ✓ Require the DCO to observe all substantive CCBHC requirements in delivering care?

✓ Indemnification
  ✓ Contain provisions for the DCO to indemnify the CCBHC for risks associated with the DCO relationship, including:
    ✓ Malpractice liability
    ✓ Government audits or penalties

✓ CCBHC-delegated duties
  ✓ List any obligations with respect to collection of cost-sharing, billing of payors, and/or collection and submission of data that the CCBHC is delegating to the DCO?
Does the DCO contract (cont.)

✓ Confidentiality (patient and business information)
  ✓ Contain provisions to ensure protection of patient privacy?
  ✓ Contain provisions requiring each party to appropriately guard the other’s sensitive business information?

✓ Records and reports
  ✓ Require the DCO to maintain and timely submit to the CCBHC all required data?
    ✓ Quality reporting
    ✓ Encounter data
    ✓ Other

✓ Other compliance issues
  ✓ Require the DCO to provide attestations:
    ✓ That its clinicians meet applicable licensure and supervision requirements?
    ✓ That neither it nor its clinicians or management have been excluded from participating in federal programs?

✓ Term, termination and remedies
  ✓ Contain appropriate recourse for the CCBHC if the DCO breaches the agreement?
ALTERNATIVE ARRANGEMENTS?

• Are there alternatives to the DCO model?
  – Full Integration for CCBHC Enterprise
    • Community behavioral health provider could partner with another provider to jointly create a CCBHC
      – Another community behavioral health provider
      – A primary care provider or clinic
  – Other referral arrangements that are “formal relationships”?
CARE COORDINATION OR DCO: WHAT TYPE OF ARRANGEMENT IS BEST?

### Care Coordination
- Entity is care coordination partner listed in law (PAMA § 223(a)(2)(C))
- Coordination would advance access to care for CCBHC patients

### DCO
- Potential partner provides a CCBHC required service
- CCBHC is unable to provide service directly
- Potential partner has clinical and operational ability to carry out DCO requirements
Strategies for Implementing Effective Compliance Programs
INTEGRATING ACCOUNTABILITY INTO YOUR COMPLIANCE PROGRAM

The Seven Elements

1. Designate a compliance officer
2. Develop written standards and policies to implement the compliance program and govern operations
3. Implement training and education programs
4. Establish effective, clear, open lines of communication (internal reporting)
5. Conduct internal monitoring and regular audits
6. Respond to detected issues
7. Publicize and enforce disciplinary standards
1. Designate a Compliance Officer

- Designate an employee with responsibility for the day-to-day operation of the compliance program
  - Employee’s duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out
    - Employee should not hold financial, billing/coding or legal/counsel responsibilities
  - Employee must report directly to the organization's chief executive, or senior administrator designated by the chief executive
Integrating Accountability: Compliance Officer

- Compliance Officer should be held accountable for:
  - Implementing a compliance program that meets OIG standards and, as applicable, legal requirements for compliance programs
  - Conducting compliance risk assessments
  - Development of annual compliance work plan
  - Preparing and revising compliance program policies and procedures
  - Periodic reporting to the Board of Directors

- Compliance Officer should not be held accountable for the organization’s compliance with all legal requirements.
2. Develop written standards

• Purpose: To establish and publicize standards for organization’s operations
  – Standards of Conduct / Conflicts of Interest
  – Compliance program
  – Clinical / Financial / Operational

• Caution: Do not adopt written standards that the organization cannot implement or with which the organization cannot comply

• Do tailor documents to your organization’s operations

• Must be accessible to those who are supposed to follow them
Standards of Conduct

- All organizations should formally adopt standards of conduct applicable to all Board members, employees and agents
- Content:
  - Organization’s mission
  - Commitment to compliance with law
  - Business conducted in accord with highest ethical standards
  - Procedures to avoid and address conflicts of interest, including disclosure requirements, recusal by conflicted persons from deliberation and/or votes, arm’s-length procurements, etc.
  - Emphasis on fraud abuse and prevention
- Required for grantees under federal procurement standards; Recommended by OIG
Integrating Accountability:

Written Policies

• Board of Directors should be held accountable for developing and approving written Standards of Conduct for the organization.

• CEO should hold each department accountable for development of policies and procedures to promote compliance as well as revising policies and procedures to comply with changes in legal requirements and best practices.

• Compliance Officer should be held responsible for developing compliance program policies and procedures consistent with applicable standards.
3. Training and education

• Need not be formal, classroom-style training
• Objective: Effective communication of organizational policies and procedures as well as applicable legal requirements
• Can offer:
  – In-person sessions
  – On-line courses
  – Newsletters
  – Office bulletin board/ Intraweb
INTEGRATING ACCOUNTABILITY INTO YOUR COMPLIANCE PROGRAM

General Compliance Training
• Operation and importance of program
• Benefits to organization, patients and community
• Role of each individual in compliance program operation
• Standards of conduct
• Consequences of violating standards and procedures, including potential civil and criminal liability to organization

Specialized Training
• Staff should receive training on risk areas specific to their job functions (claim development and submission, procurement, grant reporting, etc.)

Targeted Training
• Use training and education as corrective action to address specific problem areas or vulnerabilities identified by the organization
INTEGRATING ACCOUNTABILITY INTO YOUR COMPLIANCE PROGRAM

Integrating Accountability: Training and Education

• Should require each employee to obtain initial and annual General Compliance Training

• Should make completion of any required training a prerequisite for receiving a raise or performance bonus

• Should require departments to establish training and education goals for each employee.
4. Open Lines of Communication

• Internal Reporting

  – Require, as a condition of continued employment, the reporting of conduct that a reasonable person would, in good faith, believe to be non-compliant

  – Include provisions in written standards of conduct stating that failure to report potentially non-compliant conduct is a violation of compliance program policy

  – Develop procedure for individuals to seek clarification from compliance officer if questions arise
Internal Reporting

• Whistleblower protections
  – Ensure protection (non-retaliation) of those who report or assist in investigations (whistleblowers)
  – Prohibition on any form of retaliation for reporting in good faith
  – Individuals affiliated with organization will not be
    • Terminated
    • Suspended
    • Demoted
    • Subject to other adverse action
  – Any actual or threatened retaliation should be reported as non-compliant conduct
Integrating Accountability:
Open Communication

- Should require employee reporting of conduct that a reasonable person would, in good faith, believe to be non-compliant
  - Include flexibility of reporting to supervisor or Compliance Officer as well as anonymous reporting options
- Should require immediate reporting of loss of clinical licensure, or potential loss thereof.
5. Monitoring and Auditing

• Monitoring v. Auditing
  – An audit is an organization’s retroactive assessment of compliance with applicable legal requirements
    • An internal audit or self-audit is an organization’s objective assessment, performed by internal staff or at their direction, with results not reported outside the organization
  – Monitoring is a “real-time” assessment of whether on-going activities or operations are in compliance with applicable legal requirements
Conduct Audits that are Appropriate for Your Organization

Recommendations:

– Conduct comprehensive baseline self-audit of coding and billing practices
– Claims submission practices should be audited at least once per year
– Audit other functions as appropriate, considering historic high risk areas for your organization
– Conduct an “audit” of your written policies and procedures
– Conduct an “audit” of your compliance program
– Implement follow-up audits and monitoring
– Promptly communicate results to Compliance Officer, as applicable
Integrating Accountability: Auditing and Monitoring

- Should integrate compliance monitoring activities into day-to-day policies and procedures
- Should expect departments to audit compliance with legal requirements and policies/procedures
- Should establish performance goals for compliance in key risk areas
6. Responding to Detected Issues

- Organization must promptly respond to suspected non-compliance
- Response often includes an investigation to determine facts
- Engage legal counsel, outside auditors or health care experts to assist, as appropriate
- Report results and take corrective action
Integrating Accountability: Responding to Detected Issues

- Compliance Officer should maintain a confidential log of compliance issues.
- Department manager should be responsible for:
  - Conducting root cause analysis to determine cause of non-compliance.
  - Implementing or revising procedures to reduce potential risk of recurrence.
  - Auditing issue in 60 or 90 days to determine if changes fully addressed issue.
- Compliance Officer should report outcome of compliance investigation and response to CEO.
- CEO should hold department manager accountable for resolving compliance matters.
7. Disciplinary Standards

- Establish procedures for disciplining individuals who violate law/applicable standards
- Set forth standards of conduct in governing board policies, personnel policies and contracts, including disciplinary actions that may be imposed as a result of illegal/unethical conduct
- Address guidelines in in-house training
- Necessary to add credibility and integrity to your compliance program
Integrating Accountability: Disciplinary Standards

• All employees should be held accountable for complying with applicable policies and procedures:
  – Condition of employment or contracting
  – Incorporate “compliance” in performance reviews

• Make failure to report potentially non-compliant conduct a violation of organization’s compliance program

• Make failure to report loss, or potential loss, of license a violation of organization’s compliance program
Knowledge is at the core of a high-performing compliance program.

– Educating boards and staff on their legal requirements and obligations.
– Experience of a seasoned Compliance Officer.
– Information gathered from reports of potential non-compliance.
– Learning of non-compliance from audits and monitoring.
– Analyzing the reasons that led to non-compliance.
– Solving the business challenge of “operationalizing” compliance requirements.
RE-FOCUS YOUR COMPLIANCE PROGRAM

Focus on “big-ticket” compliance matters that will offer the best return on investment.

• Conduct an objective compliance risk assessment to identify the organization’s highest risks.

• Develop a compliance program work plan based on the results of the compliance risk assessment.

• Monitor (and report) progress of completing activities on the compliance program work plan.
Address risk areas by developing a work plan

• A work plan is a list of projects or actions that are conducted in response to a risk area

• Potential work plan “actions”:
  – Training and education
  – Review and development of policies and procedures
  – Audits / assessments
  – Monitoring

• Disperse responsibility for work plan activities among senior management.
• Don’t sweat the small stuff. Focus on “big-ticket” compliance matters that will offer the best return on investment.

• Support is a two-way street. Build support for compliance by supporting others to fulfill their compliance obligations.

• Promote accountability for compliance. Activate the compliance program by making it matter.
Financial and Billing Risk Areas for CCBHCs
PPS IS **NOT** COST REIMBURSEMENT

• Reimbursement under a PPS methodology
  – Bears a *rational relationship* to the provider’s costs
  – Does not necessarily *equal* costs for any given year and is not subject to cost settlement
CCBHC REIMBURSEMENT IMPLEMENTATION – STATES MUST:

**Implement PPS rate-setting methodology** for payment made via fee for service or managed care systems.

Collect base year cost reports to support Demonstration Year 1 PPS rates

**Develop actuarially sound rates** for CCBHC payments made through managed care systems, OR develop logistical capability for supplemental payments

**Collect CCBHC cost reports** on an ongoing basis no later than **9 months** after the end of each demonstration year.

**Design procedures** to allow CCBHCs to bill the PPS rate and to support the collection of CCBHC data necessary to determine Quality Bonus Payments and Outlier Payments (if applicable).
A state must choose one methodology for use in determining the uniform per clinic rate it will use to pay for CCBHC services delivered by a clinic.

The rate methodology options include:

- Daily encounter (CC PPS-1)
- Unique patient visit months (CC PPS-2)
ESTABLISHING A BASE YEAR RATE: DAILY ENCOUNTER OPTION (CC PPS-1)

- The daily encounter option is a cost-based, per clinic rate that applies uniformly to all CCBHC services rendered by a certified clinic.

- CMS requires the use of one full year of cost data and visit data, unless a state can justify the use of a shorter period of time.

- Base PPS rate = \[
\frac{\text{Total annual allowable CCBHC costs}}{\text{Total number of CCBHC daily visits per year}}\]

- Base year cost per visit is trended forward by the Medicare Economic Index to yield demonstration year 1 (DY1) PPS rate.
ESTABLISHING A BASE YEAR RATE: MONTHLY ENCOUNTER OPTION (CC PPS-2)

• The monthly encounter option (CC PPS-2) is a cost-based, per clinic rate that applies uniformly to all CCBHC services rendered by a certified clinic

• Base PPS rate =

  \[
  \text{Base PPS rate} = \frac{\text{Total annual allowable CCBHC costs excluding costs for services to clinic users with certain conditions and outlier payments}}{\text{Total number of CCBHC unduplicated monthly visits per year excluding clinic users with certain conditions}}
  \]

• If it chooses PPS-2, state must implement a separate PPS rate for specific high-needs populations; implement a quality bonus payment system; and create a system for “outlier payments”

• Base year cost per visit is trended forward by the Medicare Economic Index to yield demonstration year 1 (DY1) PPS rate
WHAT IS A COST REPORT?

• Cost reports are the documents used by CCBHCs for documenting (1) service costs and administrative costs associated with CCBHC services, and (2) qualifying CCBHC visits

• States will use CCBHC base year cost reports, with an MEI adjustment, to calculate Demonstration Year 1 Prospective Payment System (PPS) rates

• CCBHCs with multiple sites may choose to file consolidated cost report
WHAT IS A COST REPORT?

• States must supply CCBHCs with a cost report template and ensure that cost reporting adheres to
  – The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 CFR Part 75
  – Medicare Principles of Reasonable Cost Reimbursement, 42 CFR Part 413

• CMS has provided a cost report template (finalized January 6, 2016) – may be used at state option

• SAMHSA/CMS require annual submission of cost report by CCBHCs
THE NUMERATOR: ALLOWABLE COSTS

• CCBHCs are required to report:
  – all allowable costs associated with provision of CCBHC required services
  – costs of providing “non-CCBHC services,” such as psychiatric residential treatment programs and habilitative services for developmentally disabled individuals
  • Ensures that these costs are excluded from the rate
ALLOWABLE DIRECT CCBHC COSTS

• Three categories of direct CCBHC costs on CMS model cost report (Trial Balance tab):
  1. Salary costs
     • Largest category of direct service costs for most community behavioral health providers. A cost allocation mechanism may be needed to identify the portion of a clinician’s salary attributable to CCBHC services
     • Anticipated costs may be used for services not provided in base period
  2. Costs of services provided under agreement
     • Includes contractual payment for services rendered by “designated collaborating organizations” and other costs under DCO agreement
  3. Other direct CCBHC costs (e.g., professional liability insurance, medical supplies)

Note: assumption that all items in trial balance are based on audited financial statements
ALLOWABLE DIRECT CCBHC COSTS

- Includes the costs associated with rendering CCBHC services to **all** CCBHC patients (Medicaid and non-Medicaid)

[Diagram of allowable direct CCBHC costs]

Total Allowable Service Costs

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ALLOWABLE INDIRECT CCBHC COSTS

• Identify allocable indirect costs using
  – An indirect cost rate approved by cognizant federal agency;
  – A minimum 10% rate;
  – Calculated indirect cost allocable to CCBHC services; or
  – Other method

• See CMS model cost report instructions p. 15
THE DENOMINATOR: QUALIFYING VISITS

• Same rules apply to counting of qualifying visits for purposes of (1) cost reports and (2) billing
• In base year cost report, CCBHC may use “anticipated visits” to reflect CCBHC services not yet provided
• CCBHC counts *all visits* (with Medicaid and non-Medicaid patients) for purposes of cost report; but only visits with Medicaid patients may be billed to Medicaid
• [CMS model cost report instructions](#) p. 19
THE DENOMINATOR: QUALIFYING VISITS

• **Temporal limits** on qualifying visits
  – Daily encounter (CC PPS-1)
  – “unique patient visit months” (CC PPS-2)

• **Other limits** (significant State discretion – CMS issued informal guidance in December 2015)
  – Scope of service (qualifying visit only when CCBHC service provided)
    • Note re: CCBHC care coordination
  – Provider deemed qualified by State?
  – Modality (e.g., State may choose to count telehealth visits, online modular treatments)
  – Location (State may choose to count non-“four walls” visit, e.g., home visit)
• **Note** distinction between allowable service costs and qualifying visits!
  – Example: care management activities
• Modifications to EHR, practice management and billing systems required
• Base year cost reports may “give away” or under-report costs that are allowable – may result in a depressed PPS rate over time

• Conversely, if service costs overstated (or encounters understated), CCBHC may face recoupment due to cost report audit
TRENDING THE PPS RATE FORWARD

• DY1 rate reflects application of MEI to base year costs per visit
• To obtain DY2 rates, States may
  – Apply MEI
  – Conduct “rebase” (new cost report using DY1 costs)
• Even if MEI is used to adjust rate, actual cost and visit data must be substituted for anticipated cost and visit data for purposes of calculating DY2 rates
• Interim payment methodology may be used for portion of DY2, as DY1 data may not be available at start of DY2
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?

- While DCO service may trigger billable CCBHC visit, PPS payment is made by State Medicaid agency to CCBHC, not to DCO
- DCO is reimbursed through private contractual relationship with CCBHC
- 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
Healthcare 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 PPS reimbursement methodology applies only to Medicaid
• The present billing, coding requirements will continue to apply with other payors
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**
  - CCBHC must collect Medicaid cost-sharing if consumer able to pay
  - Note re: reduction of cost-sharing by application of sliding fee scale
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.
Exclusion and Debarment: CCBHCs should refer to exclusion databases to ensure that they are not working with entities or persons that have been excluded from participating in federal grant programs

- HHS Office of Inspector General
  - exclusions.oig.hhs.gov
- System for Award Management
  - SAM.gov
• The **Anti-Kickback Statute** prohibits persons and entities from intentionally offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate federal health care program business

• Particularly relevant in structuring care coordination agreements and DCO relationships

• **Bottom line:** Can’t purchase referrals
CCBHC COMPLIANCE “MOMENTS”

- Audit of CCBHC base year cost report
- CCBHC certification process
- Audit of CCBHC DY1 and DY2 cost reports
  - Note: will involve review of DCO arrangements
- State review of CCBHC quality reporting
- Medicaid audits of CCBHC claims
- HHS OIG audit
- Potential SAMHSA audits or site visits
Integrating the CCBHC PPS into Managed Care
SELECT AN OPTION FOR INCORPORATING THE CCBHC RATE INTO THE MANAGED CARE PAYMENT METHODOLOGY.

STATES HAVE TWO OPTIONS:

- Fully incorporate the PPS payment into the managed care capitation rate
- Supplemental OR “Wraparound” payment to ensure that total payment is equivalent to CCBHC PPS
OPTION 1: BUILDING CCBHC PPS RATES INTO MANAGED CARE CAPITATION

- State must provide **adequate oversight** to ensure that CCBHCs receive the actual PPS rates or their actuarial equivalent for services provided under managed care, including provisions for special populations and outlier payments.

- State capitation payments to managed care entities must take into account specific PPS rates of each network CCBHC and anticipated utilization.

- State contracts with MCEs must
  - require the plan to pay CCBHC the full PPS or its actuarial equivalent
  - require the plan to ensure access to CCBHC services for its enrollees
  - may need to include requirements re: out-of-network access to CCBHCs
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 (at least once every four months, per CMS recommendation) 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
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 are 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
SAMHSA CCBHC Program Requirement Risk Areas
STATE CERTIFICATION PROCESS

Create and finalize application processes and review procedures for clinics to be certified as CCBHCs

Certify at least two community behavioral health clinics that represent diverse geographic areas, including rural and underserved areas

Assist clinics with meeting certification standards by facilitating access to training and technical assistance

Training and TA for clinics to include: Assessing staffing gaps; building partnerships and formal relationships; implementing evidence-based practices; care coordination; performance measurement and reporting; continuous quality improvement processes; and optimizing health IT
STAFFING

• Must meet all State licensure and accreditation standards
• Must have adequate training in person-centered, family-centered, trauma-informed, culturally-competent, and recovery-oriented care
• Medical director should be psychiatrist unless documented behavioral health professional shortage
• Unlike FQHCs, CCBHC does not need to independently credential staff
AVAILABILITY AND ACCESSIBILITY OF SERVICES

• States have flexibility in defining required hours
• Preliminary screening and risk assessment may be telephonic

• To the extent possible:
  • transportation or transportation vouchers
  • mobile in-home, telehealth/telemedicine, and online treatment services

• Cannot deny services because of inability to pay
  • Must reduce fees or payments to enable access
  • Must have published sliding fee discount schedule
  • Must have written policies and procedures describing eligibility

• Cannot deny services based on residence

• Requirements apply to all patients, not just Medicaid patients!!
SCREENING, ASSESSMENT & DIAGNOSIS

• CCBHC directly must conduct screening, assessment, and diagnosis, including risk assessment
• Must complete comprehensive evaluation within 60 days
• Screening may occur at initial CCBHC patient intake/registration or later
• Other care may be provided by CCBHC in 60-day period even if screening has not yet been completed
• Screening may be billable “visit” depending on State “visit” definition
CCBHCs must **directly** provide:

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
- Screening, assessment, and diagnosis, including risk assessment.
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
- Outpatient mental health and substance use services.
SCOPE OF SERVICES

CCBHCs must provide (either directly or indirectly by DCO):

• Outpatient clinic primary care screening and monitoring of key health indicators and health risk (See Appendix A)
• Targeted case management
• Psychiatric rehabilitation services
• Peer support and counselor services and family supports
• Intensive, community-based mental health care for members of the armed forces and veterans
  - Care must be consistent with the Veterans Health Administration including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration
QUALITY AND OTHER REPORTING

- Uniform Reporting System
  - State must obtain and link consumer level information to claim

- Reporting is annual and data must be reported for all consumers

- CCBHC must develop and implement a Continuous Quality Improvement plan
QUALITY AND OTHER REPORTING

Additional Issues:

- **Staffing**: heavy lift but no grants for additional personnel

- **Indirect services**: how will CCBHCs gather qualify information from DCOs?
• CCBHC must be non-profit, part of local government, or operated under Indian Health Service or tribal organization
  • Cannot be for-profit clinic, though it may be a DCO
• Requirements for board composition similar to FQHCs:
  • As a group, must be representative of the individuals served by the CCBHC in terms of demographic factors:
    • Geography
    • Race
    • Ethnicity
    • Sex
    • Gender Identity
    • Disability
    • Age
    • Sexual Orientation
    • Types of Disorders
Consumers (or their family members) must comprise 51 percent of Board.

No more than half of the governing board may derive more than 10 percent of their annual income from the health care industry.

The following entities can use an advisory board to satisfy governing board requirements:

- Governmental or tribal organization
- Subsidiary or part of larger corporate organization
- Any organization that cannot meet board governance requirements (if alternative is acceptable by the state)
Closing Thoughts
The base period cost report is the foundation of your rate going forward. Prepare carefully and with proper assistance.
LEARNING FROM EXPERIENCE OF FQHCs

Ensures that a consistent standard for “qualifying visits” is used for purposes of:

- Cost report preparation and
- Billing Medicaid
LEARNING FROM EXPERIENCE OF FQHCs

- Accurate annual updating of rates by the State is critical to PPS as viable reimbursement methodology over time.
- Particularly important for providers to monitor rate update process if changes in law or policy allow CCBHC services to continue beyond two-year demonstration period.
LEARNING FROM EXPERIENCE OF FQHCs

Given rise of managed care, effectiveness of CCBHC PPS will largely hinge on whether rate is meaningfully available for services provided to managed care enrollees. CCBHCs should

- Educate managed care entities
- Advocate with State agency for more clarity and greater oversight
Costs relating to designated collaborating organizations (DCOs) will be included in the CCBHC’s base period cost report.

Auditors may scrutinize reimbursement provisions in DCO contracts.

Clinics should structure relationships with DCOs carefully with input of counsel where needed.
Cost-related reimbursement is consistent with CCBHCs’ participation in payment reform activities such as ACOs, health homes, and value-based payment!
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