Section 223 Demonstration Programs to Improve Community Mental Health Services

Qs & As – Set II 10/20/15 (updated 5/26/16)

Question 1: Which Federal Medical Assistance Percentages (FMAP) apply to demonstration services provided by CCBHCs?

Answer 1: Under this demonstration a state may only claim expenditures for services provided to Medicaid beneficiaries. Consistent with section 223(d)(5) of the Protecting Access to Medicare Act (PAMA) of 2014, the matching rates for demonstration expenditures are as follows.

- For services provided to newly eligible Medicaid beneficiaries enrolled in the New Adult Eligibility Group as described in paragraph (2) of section 1905(y) of the Social Security Act (42 U.S.C. 1396(y), expenditures are matched at the newly eligible FMAP rate applicable under paragraph (1) of that section.

- For demonstration services provided by CCBHCs that are Indian Health Service or tribal facilities and furnished to American Indian and Alaskan Natives, the expenditures are matched at 100 percent.

- For services provided to targeted low income children in a Children's Health Insurance Program (CHIP) Medicaid expansion program, expenditures are matched at the enhanced FMAP at section 2105(b), including the 23 percentage point increase in effect October 1, 2015 – September 30, 2019 (please note that these expenditures are also applied against the state CHIP allotment), unless the state elects not to claim the 23 percentage point increase for that time period.

- For all other services, expenditures are matched at the CHIP enhanced FMAP at section 2105(b), without applying the 23 percentage point increase in effect October 1, 2015 – September 30, 2019.

Question 2: Can a state receive enhanced FMAP after the demonstration?

Answer 2: There is no authority for a state to receive enhanced FMAP when the demonstration ends. To the extent applicable, the newly eligible FMAP and the IHS/tribal FMAP would continue to apply.

Question 3: Can a state continue coverage and payment for the behavioral health services covered under this demonstration after the demonstration ends?

Answer 3: Yes. But, a state may receive federal matching funds for demonstration services after the end of the demonstration only to the extent that such services subsequently become authorized under the Medicaid state plan and are provided to Medicaid-individuals. CMS will provide technical assistance to a state, helping to evaluate options for continued coverage and payment of these behavioral health services.

Question 4: What is the treatment of third party liability (TPL) under this demonstration?

Answer 4: The legislation does not provide any waiver of general Coordination of Benefits (COB)/TPL requirements. States would follow their normal claims processing protocols for any beneficiary who has third party health insurance coverage for the services covered under the demonstration. Generally, under those protocols, states must require that providers bill third parties before billing the Medicaid program, and reduce the Medicaid claims by third party payments. The state should not pay the claim until the provider reports either a payment amount or a substantive denial of liability reason from the third party payer. These protocols apply whenever there is probable third party liability, except for prenatal care or preventive pediatric services or any Medicaid service when a child's third party coverage is under the authority of the state's Office of Child Support Enforcement (for these services, the Medicaid program pays and then pursues any third party liability). The required coordination of benefits is the same when the state uses managed care; however, there are several options available to the state for completing mandatory COB/TPL activities. A state may designate responsibility for some or all COB/TPL activities to the managed care organizations (MCO). The responsibility delegated to the MCOs should be clearly defined in the state's contract, and the state remains responsible to CMS for completion of all required COB/TPL activities.

Question 5: May the cost of services provided by Designated Collaborating Organizations (DCOs) be included in the CCBHC PPS?

Answer 5: Yes. 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. During the planning phase of the demonstration, the state and the CCBHC may rely on reasonable estimates of these costs in developing the PPS rate; during any subsequent filings or reviews, actual expenditure information would be used.

Question 6: When a DCO provides a demonstration service should the DCO or CCBHC bill Medicaid?

Answer 6: As the provider/clinic certified to participate in the demonstration the CCHBC must bill Medicaid for services.

Question 7: On page 11 of the RFA, it states that satellite facilities have to be established prior to April 1, 2014. Does this mean those satellite facilities had to be enrolled as a Medicaid provider or accepting Medicaid prior to April 1, 2014 or just that the satellite was open for business prior to then?

Answer 7: The Protecting Access to Medicare Act at section 223(b)(B) specifies that no payment shall be made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act. The statute does not require that a clinic be enrolled in Medicaid prior to April 1, 2014 to qualify for participation in the demonstration.

Question 8: Is the time spent by all CCBHC facility staff to coordinate the care of an individual reimbursable through the PPS?

Answer 8: A state may potentially include in the determination of the PPS calculation cost associated with the time spent by CCBHC staff on care coordination; however, in order to definitively answer this question CMS would need more detailed information about the methodology for allocating cost. During the planning phase of this demonstration CMS is available to work with a state to identify allocation of cost associated with care coordination by CCBHC and DCO staff.

Question 9: Is a state required to settle annually to actual cost for CCBHC PPS payment made fee for service (FFS)? What, if any, action should a state take if a certified clinic's actual cost is higher or lower than the PPS rate?

Answer 9: Annual settlement to actual cost is not required under the CCBHC prospective payment system, which reimburses a provider the expected cost of care. The PPS guidance permits states to develop a prospective payment rate that is based on a combination of historical cost experience and anticipated cost.

If a state pays a CCBHC more than its actual cost of care through the DY1 rate it cannot:

- require the certified clinic to return any portion of the demonstration payment;
- retrospectively adjust the CCBHC PPS; or,
- recoup such payment through adjustment to the following year's rate.

The state may rebase the DY2 rate to better reflect the expected cost of care, incorporating cost experience gained during DY1.

CMS encourages states to work closely with clinics during the planning phase to help assure the rate determined for demonstration services appropriately reimburses a provider's expected cost of care.

Managed Care Payment

Question 10: Is a managed care entity in a demonstration state required to include at least one certified community behavioral health clinics (CCBHC) in its network?

Answer 10: There is no requirement that a managed care entity include at least one certified clinic in its network although a state participating in the demonstration must certify a minimum of two CCBHCs, one urban and one rural.

Question 11: If a managed care entity in a demonstration program state has a CCBHC within its provider network, must it pay PPS for demonstration services?

Answer 11: No. The CCBHC must receive the PPS but the state can choose to have the MCO pay the certified clinic at least PPS for services covered under the demonstration or the managed care entity may pay the CCBHC a different rate with the state paying a supplemental (wraparound) or reconciliation payment to assure the CCBHC receives not less than PPS.

Question 12: Is a state required to reconcile annually to the CCBHC PPS payment made through managed care?

Answer 12: No. If a state requires the managed care entity to pay at least PPS to the CCBHC for demonstration services then the state is not bound to make a supplemental payment. In this instance CMS expects the state to exercise adequate oversight to ensure providers receive the full PPS payment. When a state elects to ensure full payment of PPS through supplemental payment there must be periodic reconciliation of the managed care payment to PPS. CMS does not prescribe a specific timeframe for reconciliation but suggests that it occur not less than annually.

Question 13: If the CCBHC receives payment through a managed care entity, how must the state develop payment to the managed care entity?

Answer 13: The state must develop payment to the managed care entity using an actuarially sound methodology. Moreover, in a separate section of the actuarial certification, the state must include payment to CCBHCs for demonstration services and describe how this payment to the managed care entity was developed.

Question 14: With respect to behavioral health services provided through the demonstration can a managed care plan continue to require preauthorization and impose utilization management guidelines on clinics even if such policies result in non-payment to the CCBHC?

Answer 14: Managed care plans are permitted to use medical management strategies as long as they are in compliance with mental health parity and in alignment with the state's clinic certification criteria. If there are not similar strategies placed on medical/surgical benefits then the plan should not be placing those limits on the CCBHC services. Likewise, there should not be a management strategy that disallows or restricts a service required under the certification criteria.

Question 15: Can a state implement payment for CCBHC services solely through managed care even if some Medicaid beneficiaries require behavioral health services and are covered under fee for service plans?

Answer 15: If a state chooses to implement the CCBHC demonstration, they must make available coverage for CCBHC services for all individuals enrolled in the Medicaid program in

the geographic service area. If the beneficiary is not enrolled in managed care then the state must make the CCBHC services available through its FFS program.