Section 223 Demonstration Programs to Improve Community Mental Health Services

Qs & As – Set IV 09/28/16

Sustainability of Coverage and Payment through the Medicaid State Plan

Question 1: Can a state not selected to participate in the demonstration submit a Medicaid state plan amendment (SPA) to add certified behavioral health clinic (CCBHC) as a clinic type under the clinic services benefit?

Answer 1: Yes, a state not selected to participate in the demonstration may add a CCBHC as a clinic type under the clinic services benefit in the state plan when the SPA meets state plan standards. Some services offered by a CCBHC may not be allowed under state plan authority. For example, clinic services authorized through the state plan must be provided under the direction of a physician and within the facility, with the exception of services provided offsite to homeless individuals. In contrast, CCBHC demonstration services may be provided outside the four walls of the clinic, and can include services furnished by designated collaborating organizations (DCOs). For more information on the clinic services benefit please refer to: 42 CFR 440.90, section 4320 of the state Medicaid manual and Q#3 of Set II Qs and As. See: Set IV Qs & As https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/223-demonstration-for-ccbhc.htmlS

Treatment of Costs Included in the CCBHC PPS Rate

Question 2: May a clinic or the state include the value of an intergovernmental transfer (IGT)--a transfer of funding from a local governmental entity to the state--as an allowable cost reimbursed through the CCBHC PPS rate?

Answer 2: No, an IGT cannot be included in the CCBHC cost report or PPS rate as an allowable cost because it is not part of the cost of patient care, it is a means to fund the non-federal share of the expenditures.

Question 3: May costs for non-emergency medical transportation (NEMT) be included in the CCBHC PPS rate?

Answer 3: No, NEMT costs may not be included in the CCBHC PPS rate because NEMT is not one of the services covered under this demonstration. The Medicaid agency still must adhere to Assurance of transportation, 42 CFR 431.53, which requires that the Medicaid agency will ensure necessary transportation for beneficiaries to and from providers. A state may provide NEMT as an administrative activity or by electing a transportation service benefit under its state plan consistent with 42 CFR 440.170(a).

Depending on the state's election, federal financial participation (FFP) for NEMT can be claimed as either an optional medical service or as an administrative expense. Claiming of expenditures

for NEMT provided for access to Demonstration services must follow the NEMT program and claiming described in the state plan.

Transportation cost noted in section 4.2c Direct Costs – Other of the PPS guidance and on line 23 Transportation (health care staff) on the Trial Balance worksheet of the CMS CCBHC cost report refers to transportation cost incurred for the administration/provision of services, not NEMT provided to clinic users.

Rate Updates from Demonstration Year 1 to Demonstration Year 2

Question 4: Is a state locked into the update methodology used to set the DY2 rate that was shown in the demonstration application?

Answer 4: No, a state may choose to modify how it will update the rate for DY2 in one of two ways, either by rebasing or by trending the DY1 rate by the Medicare Economic Index (MEI), but must notify CMS of the change. We expect the state to notify CCBHCs as soon as possible of any change that deviates from the methodology documented in the demonstration application.

Question 5: Will a CCBHC need to submit a cost report to the state showing DY1 costs if the state opts to determine the DY2 rate based on the DY1 rate trended by the MEI?

Answer 5: Yes, the program criteria at section 5.a.5 indicates that CCBHCs are required to submit a cost report with supporting data to the state within six months after the end of each demonstration year. The state then must review the CCBHC cost reports for completeness and submit them and any additional clarifying information to CMS within nine months after the end of each demonstration year.

Payment to DCOs and CCBHCs

Question 6: Will CCBHCs and DCOs receive PPS payment from the demonstration state for demonstration services provided to clients of the CCBHC who are enrolled in another state's Medicaid program?

Answer 6: No, a state participating in the demonstration is not required to pay a certified clinic or DCO the CCBHC PPS rate for demonstration services furnished to any client who is not enrolled in that state's Medicaid program. Thus, no payment would be required for individuals enrolled in an out of state Medicaid program (or for demonstration services furnished to clients who are not enrolled in any Medicaid program). A CCBHC must be paid the PPS rate when a Medicaid beneficiary in the state accesses demonstration services from a DCO within its catchment area.

In section 2.E of the Criteria, SAMHSA specifies that CCBHCs have protocols addressing the needs of consumers who do not live close to a CCBHC or within the CCBHC's catchment area

as established by the state. Specifically, the certified clinic is responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence. In no circumstance (and in accordance with the Protecting Access to Medicare Act §223 (a)(2)(B)), may any consumer be refused services because of place of residence. States participating in the demonstration must pay PPS for demonstration services provided to their own beneficiaries.

Funding

Question 7: Is additional grant funding available to states beyond what was received through the planning grants?

Answer 7: No, the statute does not authorize additional funding beyond the planning grants and provided through the enhanced match rate for demonstration services.

State Sanctioned Crisis Services

Question 8: Our state has a state sanctioned crisis service that we'd like to continue using for the demonstration. Could you please clarify how this should be handled with respect to the guidance that crisis services are one of the services CCBHCs must directly provide and that the costs of all nine categories of demonstration services must be factored into the PPS rate?

Answer 8: SAMHSA indicates in Program Requirement 4: Scope of Services (see 223 - RFA) that crisis services are among the four services that a CCBHC must provide directly, unless there is an existing state-sanctioned, certified, or licensed system or network for the provision of these services. The certified clinic must receive the entire PPS payment, even when the CCBHC contracts with the state as a DCO for crisis management services. The state is not permitted to retain a portion of the Medicaid payment in consideration for providing crisis services through the DCO arrangement.

State Sanctioned Crisis Services Provided through Managed Care and Fee for Service

Question 9: What are the options for paying for state sanctioned crisis services through managed care?

Response 9: In section five of the PPS guidance CMS indicates that managed care payment may be made by: (1) fully incorporating the PPS payment into the managed care capitation rate, or (2) using a reconciliation process to make a wraparound supplemental payment to ensure that the total payment is equivalent to the CCBHC PPS. The first option—incorporation of the PPS payment into the managed care capitation rate—gives the state greater predictability for CCBHC expenditures at the beginning of the demonstration. The second option—a wraparound reconciliation process—will require oversight related to reconciling managed care payments with full PPS rates.

When crisis services are provided by the certified clinic through a state sanctioned system, the CCBHC PPS rates finalized by the state must incorporate the cost to the certified clinics of providing services. The costs to the certified clinic of providing these services would be

equivalent to the contractually agreed upon amount for the state, when acting as a DCO, to provide these services on behalf of the CCBHC.

Question 10: Is the state required to include a cost for state sanctioned crisis services in the CCBHC PPS rate when there will be no contractual cost incurred by the CCBHC to provide this service?

Answer 10: No,there is no requirement to include a dollar amount in the CCBHC PPS rate for state sanctioned crisis services. The PPS rate should only include cost incurred by the CCBHC.

DCOs and Enrollment in Medicaid

Question 11: Must a DCO and/or any of the DCO's practitioners be enrolled in Medicaid as a provider?

Answer 11: No, for the duration of the demonstration, the state is not required to enroll a DCO or DCO practitioners as Medicaid providers. But a state may elect to do so if it chooses. The CCBHC is responsible, however, for determining that services are furnished by qualified providers and practitioners, including ensuring that no services are furnished by providers or practitioners who have been debarred or excluded from participation in Medicaid or other health care programs.

When the demonstration ends the CCBHCs and DCOs must adhere to all provider enrollment requirements that apply to state plan services. For information about these requirements see: https://www.medicaid.gov/affordablecareact/provisions/downloads/mpec-032116.pdf