Section 223 Demonstration Programs to Improve Community Mental Health Services

Qs & As – Set III
06.01.16

Sustainability of Coverage and Payment through the Medicaid State Plan

Question 1: If a state has not been selected to participate in the demonstration, would it be able to pay community mental health clinics using the prospective payment system (PPS) rate originally determined for payment of demonstration services?

Answer 1: A state could elect to use the PPS methodology to pay community mental health clinics for behavioral health services that are covered through the state plan under a Medicaid recognized benefit category. The state has flexibility in establishing the state plan rate and in that instance would not be bound to all of the requirements for payment under Section 223 Criteria or the demonstration PPS guidance. For example, the state could establish a unitary PPS rate for all affected behavioral health providers instead of a rate that is clinic-specific. Additionally, the state could choose to pay for some services on a fee for service basis in addition to PPS. Of course, all payment methodologies must be consistent with efficiency, economy and quality of care, and must be sufficient to assure appropriate access to services. States not selected to participate in the demonstration cannot receive enhanced FMAP for behavioral health services.

Payment for Services Provided to Dually Eligible Medicare/Medicaid Beneficiaries

Question 2: How will certified clinics be paid for demonstration services provided to beneficiaries dually eligible for Medicare and Medicaid?

Answer 2: The Protecting Access to Medicare Act at section 223(d)(2)(B)(v) requires the state to pay up to the PPS rate for all demonstration services delivered to Medicaid beneficiaries. This payment requirement applies to services provided to dually eligible beneficiaries for whom the state must share in the cost of direct services, rather than just Medicare cost sharing.

There are two types of dually eligible beneficiaries--**Qualifying Individuals (QI), and Qualified Disabled and Working Individuals (QDWI)**--for whom Medicaid pays some or all of their Medicare premiums, but does not pay for services. Under a demonstration no Medicaid payment would be made for services furnished to such individuals by certified clinics.

For **Qualified Medicare Beneficiaries (QMBs)**, states must pay Medicare cost sharing, but may adopt a methodology that pays the lesser of Medicare cost sharing or the amount that would result in total payment equal to the PPS.

Specified Low-Income Medicare Beneficiaries (SLMB) are generally eligible only for payment of Medicare premiums, but there is a state option to pay Medicare Part B cost sharing. To the extent that the state elects that option, demonstration services for SLMBs would be treated the same way as services for QMBs (otherwise, no Medicaid payment would be due for

demonstration services). For full benefit dual eligible individuals, the statute requires payment up to PPS (after accounting for the Medicare payment).

PPS is not required to be paid for services provided to the following dually eligible Medicaid beneficiaries.

- Qualifying Individuals (QI);
- Qualified Disabled and Working Individuals (QDWI); and
- Specified Low-Income Medicare Beneficiaries (SLMB) Only

Payment in Addition to PPS

Question 3: Can a state make additional payment to a certified community behavioral health clinic (CCBHC) if, at the end of a demonstration year, actual costs are higher than the amount received through payment of the CC PPS-1 or CC PPS-2 rate?

Answer 3: No, the PPS is based on the expected cost of care and is not reconciled to actual costs. Making additional payments, or recouping payments, based on a reconciliation to actual cost would not be not consistent with the PPS.

A one-year planning phase-in of the PPS payment methodology is allowed to help states and potential certified clinics prepare to participate in this demonstration. We encourage states and clinics to work cooperatively during this period of time to develop payment rates that will reimburse the expected cost of care and note that states can use the extension of the demonstration start date from January 1, 2017 to not later than July 1, 2017 to further solidify rates.

Cost Reporting

Question 4: What time period(s) should be used for the cost reports and when are they due?

Answer 4: In section 2.1 of the PPS guidance, CMS specifies the use of one full year of cost and visit data from the planning phase to develop demonstration year one (DY1) PPS rates. In Section 5.a.5 of the Criteria, SAMHSA requires each CCBHC submit a cost report with supporting data within six months after the year of each demonstration year to the state. The state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each demonstration year to CMS.

Question 5: Should a clinic certified to participate in the demonstration use a cost report template supplied by the state?

Answer 5: Yes, the clinic must use the state's CMS-approved cost report template. A clinic is not permitted to modify the state's CMS-approved cost report absent approval from the state.

Question 6: When should a state submit its modified cost report template to CMS for approval?

Answer 6: CMS requests states to submit their modified cost report templates to CMS for approval by no later than **Monday August 1, 2016**. In planning the demonstration timeline, the state should consider that providers will need sufficient time to complete their cost reports. Additionally, the state will need time to review the completed CCBHC cost reports for the purpose of PPS rate determinations.

Question 7: When applying to participate in this demonstration is the state required to submit finalized cost reports for each certified clinic that show finalized rates?

Answer 7: Every planning grant state is required to submit at least one completed cost report for a single clinic as part of its application to participate in the demonstration. States should submit finalized DY1 CCBHC PPS rates with their applications, but this is not a requirement.

Question 8: Is a state allowed to modify the staffing categories shown on the CMS CCBHC cost report template?

Answer 8: Yes, the state can modify the practitioner list in Lines 1-16 under Part 1A of the Trial Balance tab consistent with section 1.b.2 of the Criteria which requires that "states specify which staff disciplines they will require as part of the certification." The options for modifying the CMS CCBHC cost report template include the following:

Adding additional lines for other staff costs

To add another category under Part 1A of the Trial Balance tab of the CMS CCBHC cost report, the state could add Center staffing/titles/categories by clicking the button "Insert additional lines for other staff costs" located under line 17a. Reporting costs separately for each type of staff position enhances the clarity of cost reported for demonstration services.

Creating a completely new Cost Report (requires CMS approval)

If the state would like to create a new cost report template then it must obtain CMS approval prior to distribution to CCBHCs. A clinic is not permitted to modify its cost report absent approval from the state.

Question 9: Can a state add a line to report electronic health record (EHR) costs?

Answer 9: Yes, CMS confirms this addition to the Trial Balance Tab is allowable and that the state also may add a line to the Anticipated Cost Tabs to reflect EHR-related costs. We note that EHR incentive payments are not reimbursement of costs and, therefore, should not be treated as

a cost offset. Additionally, EHR costs should be amortized over the useful life of the software and equipment. When modifying the CMS CCBHC Cost Report and instructions to add EHR costs the state does not need to submit this change to CMS for approval.

Managed Care Payment

Question 10: Will a state's 1915(b) cost-effectiveness demonstration for b(3) services provided under the Behavioral Health Organization's (BHO) capitation program need to be modified to exclude b(3) services provided through the CCBHC program?

Answer 10: Certified clinics are required to provide the nine demonstration services as indicated by Section 223 of the Protecting Access to Medicare Act, (b)(2)(C). The statute does not require states to dismantle existing delivery systems, such as the State's 1915(b) cost-effectiveness demonstration for b(3) services provided under the BHO. In the instance that the state provides (b)(3) services through a CCBHC, the service would need to be provided in the context of one of the nine demonstration services and be paid through the PPS rate. As participants in this demonstration, states have flexibility in planning their demonstrations and their applications should include details about key components of their CCBHC proposal such as non-duplication of payment and the incorporation of the expected costs of the nine demonstration services into the PPS rate.

Services Received Outside of a CCBHC or Designated Collaborating Organization (DCO)

Question 11: If a CCBHC client chooses to receive a required service from an entity with which the CCBHC has no existing relationship, will that client still be considered a CCBHC client and is the CCBHC obligated to pay the outside provider at the PPS rate?

Answer 11: PPS rates are paid to CCBHCs for services that they or DCOs provide. The CCBHC is not obligated to pay for services that it has not delivered directly or through a formal arrangement with a DCO.