

Compliance Hotspots for CCBHCs: Establishing a Base Year Rate

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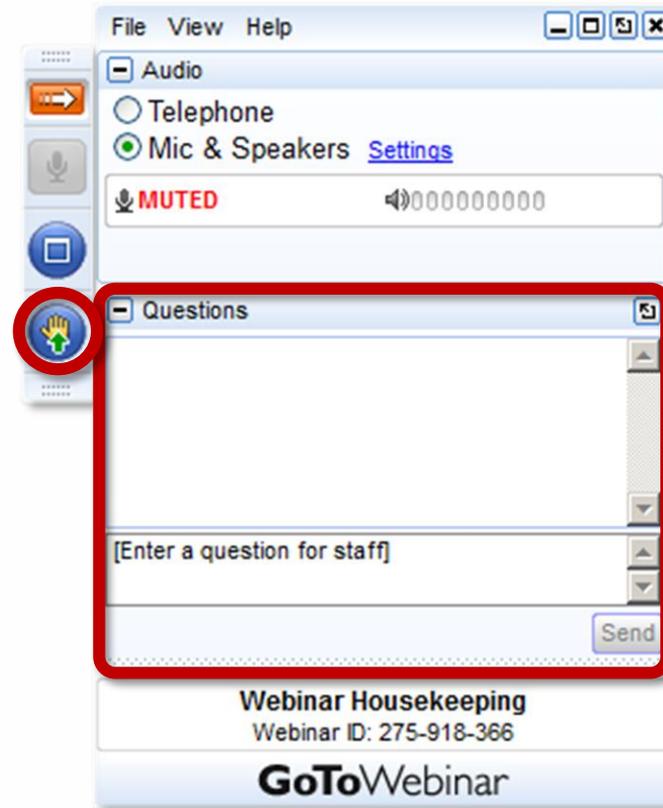
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Comments & Questions?



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Emerging Compliance Hotspots for CCBHCs: The Transition to a PPS Reimbursement Methodology



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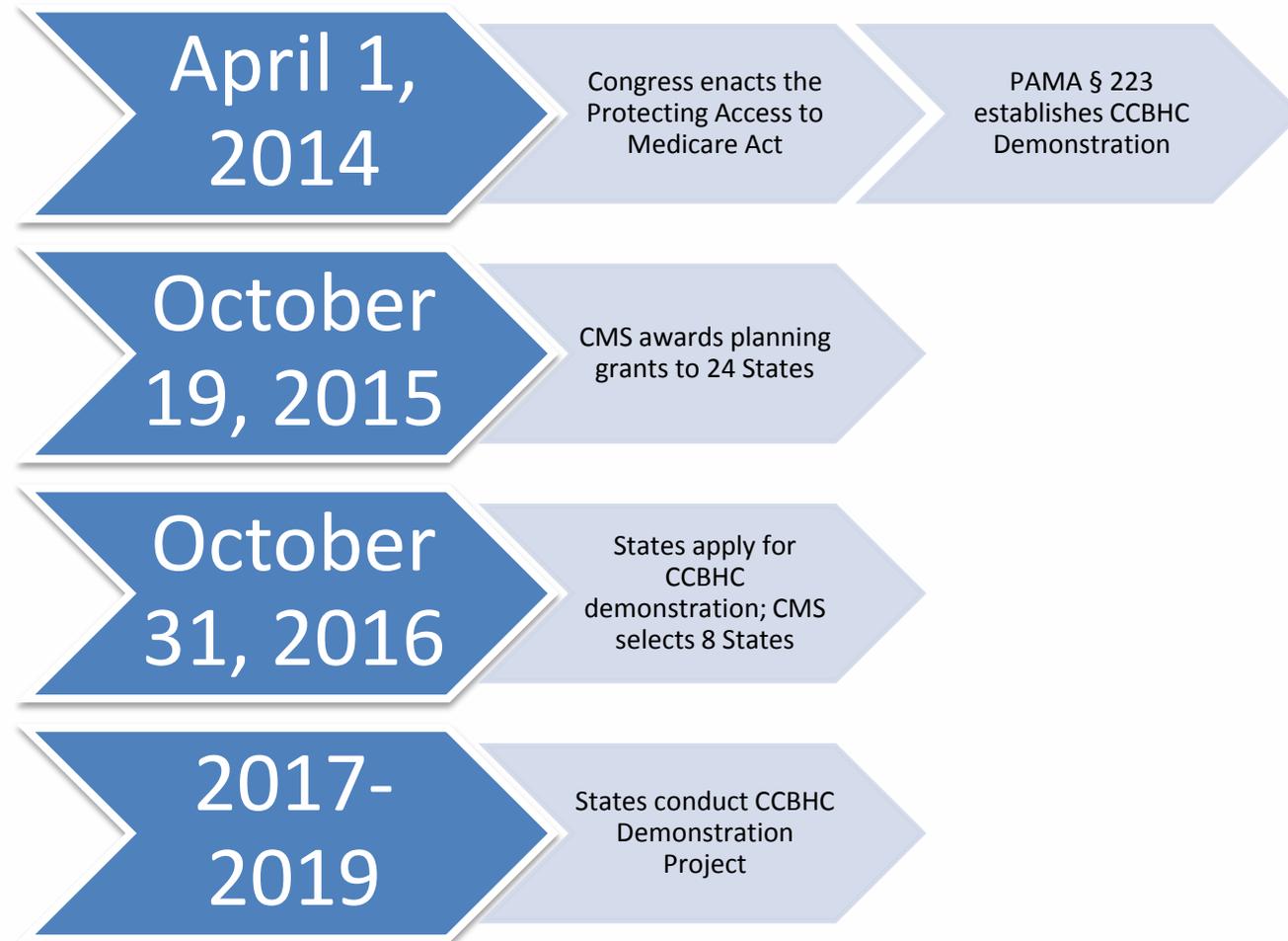
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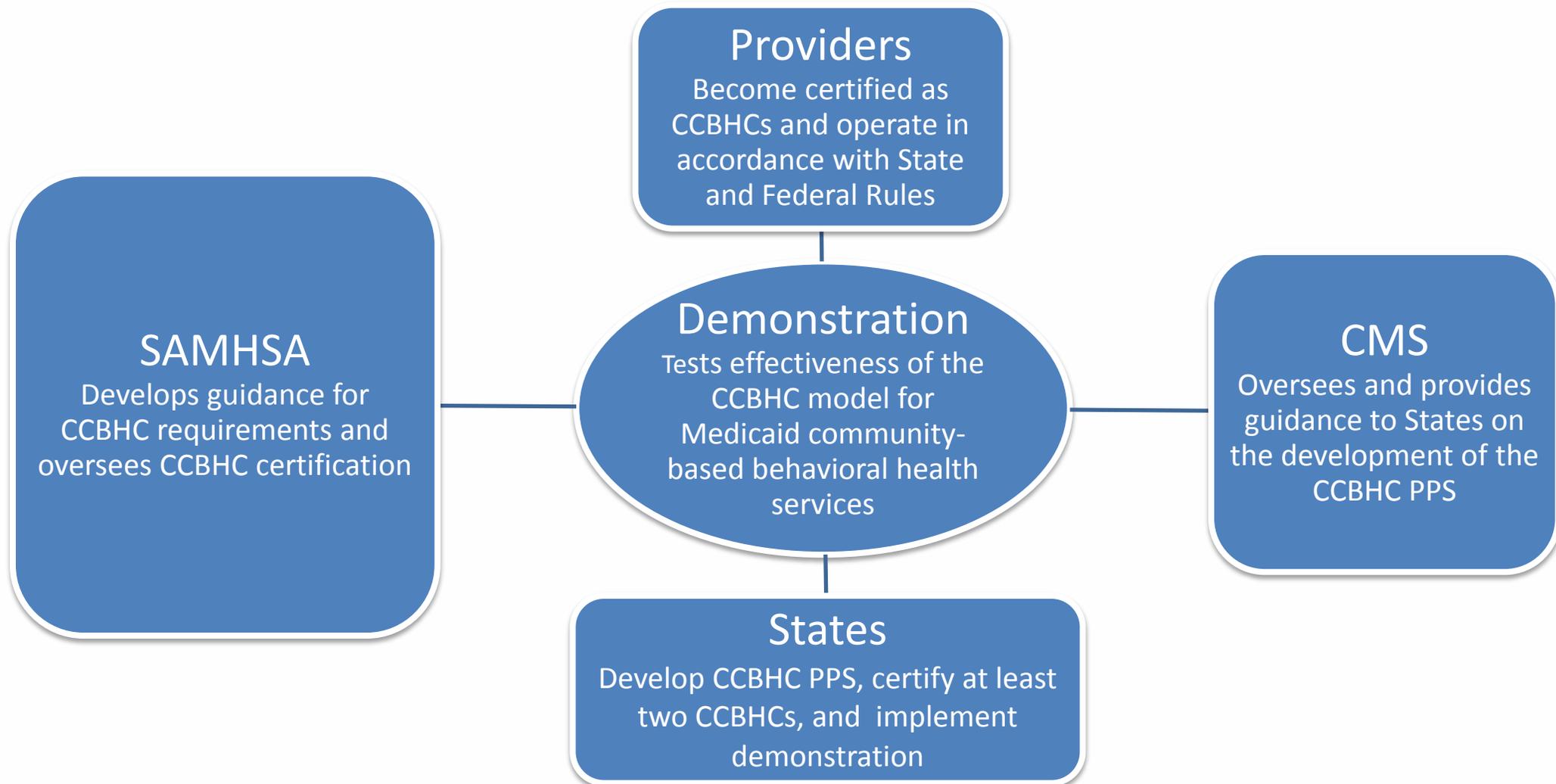
- Partner at Feldesman Tucker Leifer Fidell, specializing in health care litigation and regulatory counseling, with a focus on Medicaid, Medicare, and coverage options under the Affordable Care Act
- Provides technical assistance to health care providers, state and local governments, and national provider associations on Medicaid and Medicare policy issues and administration
- Holds a J.D. from the University of Kentucky College of Law, M.I.A. from Columbia University School of International and Public Affairs and B.A. from Columbia University
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CCBHC DEMONSTRATION TIMELINE



CCBHC DEMONSTRATION STAKEHOLDERS



WHAT'S NEW ABOUT THE CCBHC PPS?

PAYMENT RELATES TO COST

- Reimbursement based on costs of serving Medicaid beneficiaries, not on fee schedule
- PPS rate is unique to each CCBHC
- Rate based on allowable costs per unit of service ("basket" of CCBHC services)
- Same rate is paid for each qualifying unit of service, regardless of the intensity of services provided
- Rate trended forward annually by inflation factor (States have option to use rebase)

PPS IS NOT COST REIMBURSEMENT

- Reimbursement under a PPS methodology
 - Bears a *rational relationship* to the provider's costs
 - May not equal costs for a given year and is not subject to cost settlement



REIMBURSEMENT IMPLEMENTATION

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

Determine the clinic-specific PPS rate by collective **base year** cost reports **identifying all allowable costs and visit data** relating to CCBHC services

Develop actuarially sound rates for payments made through managed care systems (if applicable)

Prepare to collect CCBHC cost reports for Demonstration Years 1 and 2 with supporting data, as specified in the PPS guidance, **no later than 9 months** after the end of each demonstration year.

Design and implement billing procedures to support the collection of data necessary to help determine PPS and evaluate the overall demonstration.

RATE-SETTING METHODOLOGY OPTIONS

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 visit (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 =
$$\frac{\text{Total annual allowable CCBHC costs}^*}{\text{Total number of CCBHC daily visits per year}}$$
- PPS rate for demonstration year 1 (DY1) is trended forward by the MEI to reflect changes due to inflation, and DY1 rate will be updated for DY2 by the MEI or by rebasing of the 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 =
$$\frac{\text{Total annual allowable CCBHC costs*}}{\text{Total number of CCBHC unduplicated monthly visits per year}} \text{ excluding costs for services to clinic users with certain conditions and outlier payments}$$

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”
- Update factor for demonstration year 2 calculated by MEI or rebasing

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

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

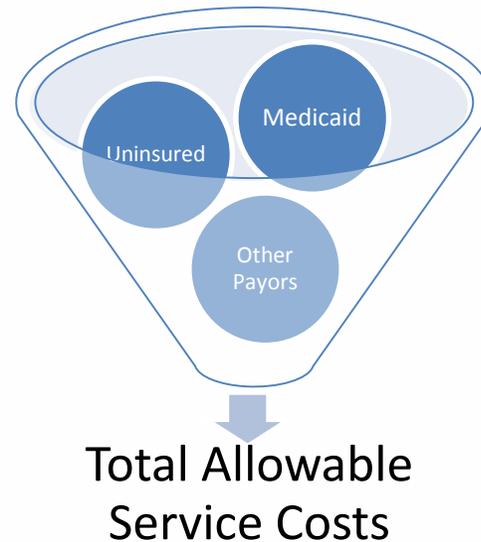
2. Costs of services provided under agreement

- 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)

ALLOWABLE DIRECT CCBHC COSTS

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



ALLOWABLE DIRECT CCBHC COSTS - CC PPS-2

- Calls for different rates for different populations based on clinical conditions
- Impracticable for health care providers to “identify specifically” service costs associated with patient populations
- In final cost report guidance, CMS required use of cost-to-charge ratio to allocate costs to populations

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



THE DENOMINATOR: QUALIFYING VISITS

- Same rules apply to counting of qualifying visits for purposes of (1) cost reports and (2) billing
- Anticipated visits may be used to reflect CCBHC services not yet provided in base period
- 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

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)
 - Scope of service (qualifying visit only when CCBHC service provided)
 - Provider deemed qualified by State
 - Modality (State may choose to count telehealth visits)
 - Location (State may choose to count non “four walls” visit)

THE DENOMINATOR: QUALIFYING VISITS

- **Note** distinction between allowable service costs and qualifying visits!
- Modifications to EHR, practice management and billing systems required



THE DENOMINATOR: QUALIFYING VISITS

CCBHC
required to
report all of its
allowable
visits,
including visits
with both
Medicaid and
non-Medicaid
patients.

Auditors will check to see if:

- The provider properly excluded same-day encounters for a single patient (for PPS-1) or multiple encounters within the month for a single patient (for PPS-2)?
- The provider properly excluded contacts with clinicians who do not meet the standard for billable clinician under the “visit” definition?
- The provider properly excluded contacts that occur in locations or through means that do not qualify as billable under the “visit” definition?
- The provider properly **included** in the encounter count any patient contact that meets the definition of “visit,” regardless of the patient’s form of coverage (or uninsured status)?



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 - CC PPS-2

- 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

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

Healthcare Compliance Concerns



IMPORTANCE OF ACCURATE CCBHC COST REPORTS

- Base year cost reports may “give away” or under-report costs that are allowable
 - may result in a too-low PPS rate over time
- Conversely, if service costs overstated (or encounters understated), CCBHC may face recoupment due to cost report audit

CCBHC COMPLIANCE “MOMENTS”

- Audit of CCBHC base year cost report
- Audit of subsequent years' CCBHC cost reports
- CCBHC certification process
- CCBHC quality reporting



"I'VE BEEN HERE SO LONG I
DON'T REMEMBER WHAT I DID,
BUT IT HAD SOMETHING TO
DO WITH NON-COMPLIANCE."



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EXCLUSIONS AND DEBARMENT

To avoid civil monetary penalties, CCBHCs should refer to exclusion databases to ensure that they are not working with entities or persons who 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 AND BENEFICIARY INDUCEMENT

- 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.
- *Criminal* fines up to \$25,000 per violation and up to a 5 year prison term per violation.
- *Civil* penalties include false claims act liability, civil monetary penalties (CMP) and program exclusion, potential \$50,000 CMP per violation, civil assessment of up to three times amount of kickback
- Bottom line:
 - Can't purchase referrals
 - Can't vary a provider's compensation to induce referring patients

THE FALSE CLAIMS ACT

- The False Claims Act 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
 - *Example:* claim for reimbursement for an encounter rate based on cost report that reflected overstatement of service costs or understatement of qualifying visits
- Most states have equivalent state laws

QUESTIONS?



Next webinar of the CCBHC compliance series:

Billing Medicaid

Wed, Feb 10 at 2PM EST

Please fill out a brief post webinar survey.

If you have questions, feel free to contact me at

adrianob@thenationalcouncil.org