

Clarification to Guidance – 223

Question: We have received questions about the use of estimated charges in PPS-2. The guidance to states in the January 12 CMS TA call indicated (on slide 6) that charges incorporated into the final version of the cost report may include anticipated visits and charges for CCBHC services not provided prior to DY1. It appears from line 2 of the cost PPS-2 cost report that estimated charges must be included as there will be no way of including actual charges for services not formerly offered. Yet, without a clear indication in the cost report that estimated charges may/must be included, organizations may be hesitant to sign off on a cost report that includes estimated charges. **Could you confirm whether estimated charges may be included in the cost report?**

Clarification: We confirm that estimated charges may be included in the cost report to the extent a clinic and/or state believes that actual charges are not representative of the charges that will occur during a demonstration year.

Question: We are concerned that CCBHCs will experience major challenges with implementing a cost-to-charge ratio in DY1 as a means of associating costs with special populations. In comparable instances where CMS has used a cost-to-charge ratio as a means of fine-tuning the PPS rate, such a ratio can be used only where there is the following paper trail: (1) a charge master that is in place for the cost report year, and (2) claims data containing detailed HCPCS/CPT coding for that year. For Medicare FQHC, Medicare began requiring the detailed coding in 2011, and the base years for the PPS rates were subsequent to 2011. We anticipate this type of detailed coding being extraordinarily difficult for behavioral health organizations to report in DY1. In addition to there being wide variation in whether behavioral health entities currently maintain schedules of charges, there is also presumably wide variation in the extent to which state Medicaid agencies currently require those providers to use detailed HCPCS/CPT coding. For that reason, a cost-to-charge ratio for the CCBHC base years doesn't yet exist – there simply isn't enough information – but perhaps it could exist for later years after the CCBHCs have been given time to develop their charge masters and ramp up their coding capabilities. **We suggest that CMS implement an alternative initial approach:** CMS could hold off on the idea of unique rates for patient populations for the first couple of years, or it could apply adjusters to the overall per UME rate based on national data about the cost of serving those categories of patients until individual provider data is available.

Clarification: We agree that during the cost report year a charge master encompassing all of the demonstration services may not be in place. Additionally, a clinic may not have complete data on service usage during the cost report year. To address the issue of incomplete data CMS: (1) permits clinics to estimate charges, costs and visits in a manner consistent with state policy, and (2) allows states to elect to rebase PPS in DY2 to reflect actual data from DY1. Additionally, the states may elect to use a different allocation methodology by developing their own cost report and using the CMS cost report crosswalk tool, or they may use the PPS-1 rate (statewide) to accommodate clinics who cannot develop the necessary data for PPS-2.

Question: CMS's instructions as to how it wants rows 4 and 5 completed appear to contradict the template. The cost report template, through how the fields are populated, suggests that CMS has in mind total costs (for all populations), as reflected on the trial balance; however, the instructions suggest that CMS has in mind the total cost associated with certain populations. **Which types of costs are to be entered on rows 4 and 5?**

Clarification: Lines 4 and 5 of the CCPPS-2 tab are *automatically* populated from the trial balance and indirect cost allocation tab and they are used to calculate total allowable costs. This total is divided by the total charges from line 3 to calculate the cost to charge ratio. The ratio is then multiplied by each populations charges to come up with the applicable costs. The directions for these two rows indicate that total direct and indirect costs are automatically populated on the form. The directions for the *columns* indicate that costs by certain populations will be entered. These costs are automatically generated by the cost to charge ratio. A user only needs to enter charges on the form.

Question: **Either method of entering costs will be problematic for the cost-to-charge calculations.** If CMS intends for CCBHCs to enter the costs associated with specific populations in rows 4 and 5, that appears to be a circular calculation: it is impossible to specifically identify the service costs associated with a specific population; it's for that reason that CMS is suggesting an allocation mechanism. If CMS intends for CCBHCs to enter total costs associated with the whole population, then CMS is setting up a cost-to-charge ratio that is apples-to-oranges (overall costs for all populations compared to charges associated with a subpopulation). Importantly, a cost-to-charge ratio cannot be obtained by dividing total allowable costs by total charges on claims, because the total costs would include the costs of serving all patients, even the uninsured, whereas the charge/claims data would include only data from patients covered by that payor. **Can CMS provide any clarity on this point?**

Clarification: **As stated in the PPS TA webinar, clinics will need to have a charge master in order to implement the cost to charge ratio as demonstrated in the CMS cost report. The charges would be equal for all beneficiaries regardless of payer which enables a calculation of total allowable costs by total charges. During the webinar we covered how to fill out the PPS-2 rate tab; attached are the slides.**

Question: **Charge data for many types of patients is simply not available.** It is impossible to derive an accurate cost-to-charges ratio based on "total service costs (all populations)" because no provider will ever have total claims/charge data for all of the services it provides. Instead, typically providers have charge data only for a subset of their services: those services provided to individuals covered by a specific payor, reflected on claims to that payor containing CPT/HCPCS codes. To derive an accurate global cost-to-charge ratio of the type envisioned here, the provider would have to be able to amass charge data associated with all patients – including Medicare, Medicaid, uninsured, private pay. That task would probably exceed the ability of any health care provider, and it would certainly exceed the ability of CCBHCs which will be newly developing their schedules of charges. This is shown on paragraph 2 of tab 14 in the instructions, where CMS defines a cost-to-charge ratio as "total costs, including anticipated costs for all users ... divided by all charges for all users regardless of payor." That second component of the comparison is impossible to produce as a practical matter. CMS itself noted this in the background research supporting the FQHC Medicare PPS rate. A more feasible cost-to-charge ratio would be to compare "Medicaid costs (per UME or per encounter) to Medicaid charges." Practically speaking, for that reason, a cost-to-charge ratio can be applied only after a cost-based rate specific to one payor has been derived. **Can CMS provide any clarity on this point?**

Clarification: **Your question appears to assume that clinics participating in this demonstration have limited to no experience in billing for services. We are concerned that a clinic lacking experience in this basic business activity would not have the ability to meet the criteria for certification which include, among other activities, annual cost reporting. If a state finds that the proposed method is unworkable for their providers, they have the option to develop alternative methodologies or to utilize the PPS-1 rate.**

Question: Our interpretation of SAMHSA's guidance is that where CCBHC requires services are furnished via DCO, the CCBHC will be required (1) to procure DCO services contractually, at fair market value; and (2) to serve as the billing provider for the service rendered by the DCO. These requirements are more restrictive than the HRSA requirements governing community health centers, which contemplate that CHC required services may be provided on a referral basis. We believe the requirements will lead to numerous undesirable policy consequences as described in the attached memorandum. In addition, we do not believe that PAMA § 223 requires SAMHSA to impose such restrictive requirements in this regard.

Would SAMHSA consider modifying its guidance so as to permit CCBHCs to provide required services not only through the DCO mechanism, but also through formal referral relationships, where the referral provider (not the CCBHC) is clinically responsible for the care and serves as billing provider?

Clarification: **Thank you for helping us to clarify this; we understand how it might have been read that way. Here's further clarification: We do not anticipate modifying the guidance to permit PPS payments to CCBHCs for CCBHC services provided by organizations other than DCOs. No policy memorandum, referred to above, was attached.**

Question: Would a CCBHC still meet SAMHSA's requirement of being "clinically responsible" for provision of services rendered by DCOs if the CCBHC
a. contractually required the DCO to indemnify the CCBHC against malpractice liability for CCBHC services furnished by the DCO?

Clarification: **Yes. This would be permissible.**

Question:

b. contractually required the DCO to add the CCBHC as an insured on the DCO's medical malpractice insurance policy?

Clarification: **Yes. This would be permissible.**

Question: Would the CCBHC still meet SAMHSA's requirement of being "clinically responsible" for the provision of services rendered by the DCOs if the DCO's clinicians maintained charts in the DCO's own separate health record, and then shared information appropriately with the CCBHC? Or are the CCBHC and DCO required to maintain charts in the same health record?

Clarification: **The CCBHC and DCO are not required maintain charts in the same health record. CCBHCs are responsible for the treatment planning. CCBHC records must reflect that services are being rendered in compliance with the treatment plan. The CCBHC record must reflect a complete and accurate depiction of services for which the CCBHC is responsible for overseeing including services provided by a DCO.**

Question: Must a CCBHC have registered a patient, screened him/her for eligibility for the sliding fee discount schedule, and conducted the required CCBHC clinical screening, before the individual can access a service rendered in a DCO?

Clarification: **Yes. This is one of four core services that must be provided directly by the CCBHC. The CCBHC will provide this service, develop the treatment plan and refer the individual to needed services within the CCBHC and to any DCOs as warranted.**

Question: Would a CCBHC meet SAMHSA’s definition of being “financially responsible” for the provision of DCO services if the CCBHC contractually delegated to the DCO the following functions:

- a. verifying patient’s insurance status, collecting cost-sharing, and applying the sliding fee discount?

Clarification: **A state may choose to permit CCBHCs to delegate responsibility for the listed activities to DCOs.**

Question:

- b. filing claims with Medicaid and other payors on behalf of the CCBHC?

Clarification: **The CCBHC may not delegate this responsibility to the DCO. The CCBHC bills the state Medicaid office and reimburses the DCO for services rendered.**

Question: Some payors, including some Medicaid programs, require claims to include the NPI of a supervising clinician, who must be on site when the service is rendered. How will this be handled with respect to services rendered by DCOs?

Clarification: **States are responsible for setting policy on NPI reporting for services rendered by DCOs.**

Question: There may be complications in billing services rendered by DCOs to managed care plans (Medicaid and otherwise) if the CCBHC is in the plan’s network, but the DCO is not. How will this be handled?

Clarification: **States will work with their providers and MCOs to address this issue.**

Question: Federal law contains a safe harbor for purposes of the Anti-Kickback Statute (AKS) to permit federally-qualified health centers (FQHCs) to receive remuneration in the form of items, services, or donations that relate directly to services included in the health center’s scope of project, where the remuneration is not conditioned on the amount of Federal health care program business generated between the parties. See 42 U.S.C. § 1320a-7b(b)(3)(I); 42 C.F.R. § 1001.952(w). Congress’ main goal in enacting this safe harbor (and HHS’ main goal in promulgating regulations that clarify it) was to strengthen FQHCs’ capacity to care for underserved populations by allowing the health centers to enter arrangements with other types of health care providers, under which the other provider confers some type of benefit on the CHC that advances access to care in the community. The lack of a parallel “safe harbor” may impede effective care coordination for CCBHCs. Given that care coordination and person-centered care are the linchpins of the CCBHC program, as described by SAMHSA, would SAMHSA/CMS consider advocating for a parallel AKS safe harbor for CCBHCs?

Clarification: **We will take your recommendation under advisement. Thank you.**

Question: Can you please clarify who the populations of focus are for a CCBHC and are there 3 or 4 populations? It is clear that SED and SMI are two populations of focus, however, what is intended by additional language found in other places specific to SUD and then in another place we see “others” listed. (The PowerPoint lists three populations of focus but the RFA indicates 4):

a. How is “chronic SUD” as listed in the PowerPoint from the Introduction to CCBHC in June 2015 defined and how is “long term and serious substance use disorders” from the RFA, Part 1, page 4 defined?

Clarification: **Terminology describing duration and severity of substance disorders should be understood according to current criteria most widely used in the diagnosis and treatment of such disorders (i.e. – DSM V; ICD 10). Terms such as “chronic” and “long term and severe” SUD should be understood in that context as communicating the intent that CCBHCs shall manage and utilize the full scope of clinical resources needed to successfully treat those who are most severely impacted by substance use disorders. CCBHCs may provide a full array of SUD treatment either through direct provision of services or services provided through a DCO.**

b. Is “others with mental illness and substance use disorders” from the RFA, Part 1, page 4 a 4th population of focus and how is it defined?

Clarification: **No. “Others with mental illness and substance use disorders” communicates the intent that CCBHCs will serve all those with mental illness and/or substance use disorders who seek treatment, rather than limit treatment exclusively to individuals with SMI/SED /chronic SUD. Additional populations of focus may be identified according to state priorities, especially as derived from the Needs Assessment.**

Question: In looking at the CCBHC services criteria, does 4.h.1 imply states need to create a target population for case management, if it does not already exist, for “persons deemed at high risk for suicide, particularly during times of transitions such as from an ED or psychiatric hospitalization”?

Clarification: **Yes. Regardless of other diagnosis those deemed at high risk of suicide are specified to receive targeted case management (TCM). The duration of TCM for these individuals may be time limited, for example until no longer deemed at high risk. The CCBHC can establish appropriate utilization criteria to dictate length of service for TCM, but should ensure continuity of service during transitions in care. An important function of the Needs Assessment is identifying and clearly specifying other populations for TCM and the appropriate scope of their services. These may vary locally among different CCBHCs.**

CCBHC criteria - 4.h.1 The CCBHC is responsible for high quality targeted case management services that will assist individuals in sustaining recovery, and gaining access to needed medical, social, legal, educational, and other services and supports. Targeted case management should include supports for persons deemed at high risk of suicide, particularly during times of transitions such as from an ED or psychiatric hospitalization. Based upon the needs of the population served, states should specify the scope of other targeted case management services that will be required, and the specific populations for which they are intended.

Question: During the “Guidance to States to Apply for the Section 223 CCBHC Demonstration Program” webinar on February 3rd, a representative from Iowa inquired about integrating Health Homes into the CCBHC PPS Demonstration Project. Missouri is considering whether to integrate the cost of its CMHC Healthcare Homes into the proposed Prospective Payments to CCBHCs. If a state did integrate health home costs into the Prospective Payments to CCBHCs, we assume that the CCBHC would no longer receive a PMPM payment of health home services, that the costs associated with providing health home services would be included in calculating the PPS rate, that the CCBHC would continue to provide health home services (which may or not count as a visit), and that, under the CC PPS-1 Option, when an eligible individual received a CCBHC service provided by an eligible provider, constituting an eligible visit, the CCBHC would receive a PPS payment based on its daily visit rate which incorporated the cost of providing health home services. Is that correct? We see advantages and disadvantages to integrating health home costs into the PPS rate. Of course, health home services are an example, par excellence, of the CCBHC service “Outpatient clinic primary care screening and monitoring of key health indicators and health risk”. Incorporating the cost of health home services into the PPS rate has the advantage of capturing the enhanced Medicaid match for two years. But we want to be sure that converting this monthly model to the daily visit model embodied in the CC PPS-1 Option would not negatively impact the CCBHC reimbursement, especially in light of the fact that many of the most important functions of the health home staff are not likely to be considered to involve a “visit”, and that this is a “Medicaid only” service in terms of reimbursement.

Clarification: **CCBHCs 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 Health Home Services. 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.**

Question: Can a group of community mental health centers come together to form a CCBHC or would one need to be the lead and others be the DCOs?

Clarification: **This question relates to the prohibition against satellite facilities established after 4/1/2014. A group of existing community centers may come together to form a new CCBHC. Any subsequent proposal from the entity to create an additional CCBHC would be regarded as a satellite facility.**

Question: Can a for-profit serve as a DCO? I believe the answer is yes. A CCBHC has to be not-for-profit, but not the DCO.

Clarification: **Please see the SAMHSA website at <http://www.samhsa.gov/section-223/certification-resource-guides/ccbhc-eligibility>**

Question: Crisis Services and the requirement for level one withdrawal: PA has state sanctioned crisis services. We believe we can use those sanctioned services, as long as they provide the required level one withdrawal, and still meet the criteria. Is this accurate? Of course the crisis services would need to meet the other crisis requirements.

Clarification: **Yes, you are correct.**

Question: If a CCBHC client chooses to receive a service outside of the CCBHC's direct or indirect services, will that client still be considered a CCBHC client and will the clinic be obligated to pay the outside provider for that service under the PPS rate? Follow-up comment about question: My recollection is they wanted to know if the person went to receive a required service from an entity the CCBHC had no existing relationship, would the clinic need to pay for the service and if so would it be with the PPS rate?

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

Question: Clinics here have raised questions about the licensure requirement. Are all clinicians required to have or be in pursuit of their license? With the BH provider shortage, can a clinic be licensed and individuals who are supervised by a licensed clinician count? PA currently accepts masters level clinicians.

Clarification: Please refer to the complete Criteria 1.b.2., Licensure and Credentialing of Providers, page 13 of the Criteria. It reads in part, "The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state, is informed by the state's initial needs assessment, and includes clinical and peer staff...The CCBHC must have staff, either employed or available through formal arrangements, who are credentialed substance abuse specialists...CCBHCs are not precluded by anything in this criterion from utilizing providers working towards licensure, provided they are working under the requisite supervision."

Question: For those states with pre-existing behavioral health home models what are the options for including or excluding the payment for those services in the PPS rate?

Clarification: **The statute does not require states to dismantle existing delivery systems, such as Health Home Services. 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.**

Question: The following excerpts from Appendix II – Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics contain many sections that indicate CCBHCs are required to provide primary care services. However, Section 223 (a) (2)(D)(V) of PAMA states that, “Outpatient clinic primary care screening and monitoring of key health indicators and health risk” is the minimum required CCBHC primary care service. Further, Criteria 4.g.1 states that, “Nothing in these criteria prevent a CCBHC from providing other primary care services.” However, Appendix III – Section 223 Demonstration Programs to Improve Community Mental Health Services Prospective Payment System (PPS) Guidance, Section 4.2.c states that, “States must identify and remove all non-CCBHC allowable costs in order to determine PPS. The statute implementing this demonstration prohibits payment for the following non-CCBHC services: inpatient care, residential treatment, room and board, or any other non-ambulatory expenses, as determined by the Secretary.” The section goes on to say, “Examples of additional types of costs incurred for non-CCBHC services include costs to support the provision of dental and optometry services.” Although it is clear that CCBHCs are required to provide primary health care services, either directly or through agreements with Designated Collaborating Organizations (DCOs), it is not clear which of the primary care services a state can consider to be “CCBHC services.” This distinction between “CCBHC services” and “non-CCBHC services” is important for purposes of identifying costs which can or cannot be included in the cost report as an allowable cost to calculate a PPS rate. Can states determine whether the following services can be considered “CCBHC” services for purposes of calculating the PPS?

- Tobacco screening for pregnant women
- Family Planning and counseling services
- Birth control pills
- Dental screening performed by a nurse practitioner
- Radiology services
- Drug testing and other laboratory services
- Pharmacy claims

Clarification: **As specified in the section 223(a)(2)(D)(v) of the PAMA* and detailed in section 4.G of the Criteria, CCBHCs are required to provide outpatient clinic primary care screening and monitoring. In interpreting this requirement to develop the PPS rate SAMHSA recommends that states adopt the Medicaid definition of screening services at 42 CFR 440.130 (b): “the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.” This definition will assist states in determining which services constitute primary care screening and monitoring for purposes of coverage and payment under this demonstration.**

***Protecting Access to Medicare Act**

Question: If the Needs Assessment for one CCBHC indicates a need for an additional service that is not indicated in the Needs Assessment for a different CCBHC, must the state require all CCBHCs be able to provide the additional service? Or can the state’s certification requirements differ by CCBHCs?

Clarification: **The needs assessment is to be used to determine staffing, linguistic and cultural competence, and the evidence based practice needs of the community that the CCBHC serves. There is no requirement to develop additional services based on the needs assessment. The community needs assessment applies to CCBHC serving that community. The state must also develop a minimum set of evidence based practices that are required across the state and should be using the statewide stakeholder engagement process to develop the minimum set of practices. The state may also consider the local needs assessment for the statewide process, but it is not required. Please see <http://www.samhsa.gov/section-223/certification-resource-guides/conduct-needs-assessment>**

Question: Criteria 3.c.4 requires CCBHCs to have an agreement establishing care coordination expectations with the nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department. Because of Nevada's vast geographic area with low population density, the nearest VA facility for many parts of Nevada is located in a border state. How will this impact the state's demonstration grant application, and what should the state require from CCBHC's related to requirements to provide services to veterans?

Clarification: **Please refer to 4.K.1 describing the requirements of the CCBHC to deliver services to veterans. There is nothing in the criteria to prevent the CCBHC from referring consumers who are veterans to the closest VA facility if it is located in a different state.**

Question: What is the current standing of aligning CCBHC goals with that of Behavioral Health Homes?

Clarification: **CCBHCs 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 coordination of care provided via Health Home Services. 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.**

Question: Can clarity be provided with regards to specific services which can be provided in compliance with the "non-four walls" requirement of the CCBHC?

Clarification: **The state has the flexibility to determine which services can be provided outside the four walls and enumerated.**

Question: Can court-ordered SUD and SUD without counseling (State Plan currently requires counseling for SUD) be included as allowable costs?

Clarification: **These services would be allowable costs to the extent that they fall under one of the nine services required by the grant, excluding services provided in an institutional setting.**

Question: Managed Care- If CCBHC rates included B3 services currently provided under our BHO capitation, would the State retain its waiver authority to provide these services under a capitation as well?

Clarification: **The state would still maintain the (b)(3) authority to provide these services outside of the CCBHC and that would not be part of the PPS rate. 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.**

Question: Will services provided by DCO's also contribute to quality bonus payments?

Clarification: **Services that are used in the development of the PPS rate, provided by a CCBHC or DCO, will count toward meeting quality bonus measures. The DCO contracts with the CCBHC to provide demonstration services and as such does not submit a claim or receive payment from the State Medicaid Agency. However, a CCBHC may include a description of quality bonus measures and criteria for quality bonus payment within their contract with the DCO.**

Question: Are DCO's eligible to also receive a portion of the quality bonus payment?

Clarification: **Services that are used in the development of the PPS rate, provided by a CCBHC or DCO, will count toward meeting quality bonus measures. The DCO contracts with the CCBHC to provide demonstration services and as such does not submit a claim or receive payment from the State Medicaid Agency. However, a CCBHC may include a description of quality bonus measures and criteria for quality bonus payment within their contract with the DCO.**

Question: We are seeking additional clarification regarding potential CCBHC that operate from multiple sites. Does each clinic site have to offer all of the required services? What is the proximity requirement for sites? If we have a large program, under one management structure that offers SUD services in one location, mental health service in another, crisis services from another, is that permissible?

Clarification: **We anticipate the CCBHCs will be multiple site organizations in some communities. The purpose of the CCBHC is to improve quality and access and these are key determinants for consideration when states are selected for the demonstration program. All nine services must be available to everyone in the community served by the CCBHC. Please refer to the SAMHSA 223 website, Certification Resources and Guides.**

Question: Can you please provide some clarity regarding how states are able to comply with the Corporate Practice of Medicine rules as it relates to criteria 4.a.1 that states that "the CCBHC is ultimately clinically responsible for all care provided. The decision as to the scope of services to be provided directly by the CCBHC, as determined by the state and clinics as part of certification, reflects the CCBHC's responsibility and accountability for the clinical care of the consumers." There is some confusion regarding how are CCBHCs that do not provide primary care services, but rather contract with the DCO for the primary care services are able to be ultimately clinically responsible for all care provided, giving the limits set by the corporate practice of medicine rules.

Clarification: **CCBHCs are responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk as well as care coordination with primary care providers. They are not responsible for the provision of primary care.**

Question: Is there any additional guidance available about the recommended radius or region for the needs assessment?

Clarification: **The state prepared needs assessment will have a significant impact on many criteria, including staffing plans, EBPs, and cultural requirements. The needs assessment defines geographic service areas. CCBHCs or community behavioral health provider service areas conform to the needs assessment.**

Question: Our state currently pays its Medicaid Managed Care Organizations a set per-member-per-month (PMPM) capitation payment for services. We expect to incorporate the CCBHC PPS payment into the capitated rate. Since we expect to employ this approach, could we contract with the Medicaid MCOs to complete and audit the cost reports with the CCBHCs?

Clarification: **The criteria for a state to certify a clinic to participate in the demonstration require at 5.a.5 that “CCBHCs annually submit a cost report within six months after the end 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.” As such, a Medicaid MCO would be able to review a CCBHC’s cost report for completeness and submit the report and any additional clarifying information to CMS on behalf of the state so long as the state’s contract with the MCO specifies these activities. The cost of the MCO completing these activities on behalf of the state should not be considered CCBHC service costs when developing the capitation rates paid to the MCOs.**

Question: When developing services to be included in the CCBHC that are not already covered by the state plan, is it also allowable to look at alternative providers types that are not currently covered under the state plan? Example would be Community Health Workers. (Question in regards to which state providers can render demonstration services.)

Clarification: **The state may contract with providers not covered by the Medicaid State Plan in order to meet the requirements of the Criteria. The State should refer to the Criteria, section 1.b.2 on page 13, to ensure that providers meet the necessary requirements.**

Question: For CCBHCs in areas that border other states, does the CCBHC have to provide services for out of state clients? Just emergency services for out of state patients?

Clarification: **See Criteria 2.e.1 and 2.e.2 on page 22. CCBHCs have protocols addressing the needs of consumers who do not live close to a CCBHC or within the CCBHC catchment area as established by the state. CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence. The required protocols should address management of the individual’s on-going treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing CCBHCs to refer and track consumers seeking non-crisis services to the CCBHC or other clinic serving the consumer’s county of residence. For distant consumers within the CCBHC’s catchment area, CCBHCs should consider use of telehealth/telemedicine to the extent practicable. In no circumstances (and in accordance with PAMA § 223 (a)(2)(B)), may any consumer be refused services because of place of residence.**

Question: For a new assessment on a client at a CCBHC, is it allowable to both schedule clients and allow walk in availability for clients?

Clarification: **Yes, as long as services comply with the certification criteria. See Criteria 2.b. regarding timely access to services and initial and comprehensive evaluation.**

Question: When a site becomes a CCBHC, will it be a state or federal certification?

Clarification: **State**

Question: Once a person is enrolled or identified as a CCBHC member, will they be locked into the CCBHC site in which they are enrolled or can they go to a non-CCBHC site for services? How do we ensure the CCBHC PPS rate is paid for CCBHC members only (we discussed having CCBHC identifiers to denote individuals for whom a CCBHC PPS claim can be made)?

Clarification: **Medicaid beneficiaries are allowed free choice of providers as indicated in 1902(a)(23). As such, they are able to receive health services at their choice of CCBHC or non-CCBHC. To ensure the CCBHC PPS rate is paid only for the nine demonstration services when provided by a CCBHC, the Medicaid billing form will be adjusted to indicate a CCBHC encounter, likely through the addition of a new Place of Service Code. Although there is the concern of duplication of services, CCBHCs are required as a participant in the demonstration to provide are Care Coordination (PAMA §223 (a)(2)(C)) as a program requirement and TCM (PAMA §223 (a)(2)(D)(vi)) as one of the nine services. If done correctly, the use of TCM and care coordination should minimize duplicate care to beneficiaries.**

Question: How can we ensure non-CCBHCs aren't delivering duplicate care the CCBHCs are getting paid for under the PPS methodology? Would all non-CCBHC claims have to be denied for CCBHC members? Example: CCBHC member goes to CCBHC site A for care and is served under the CCBHC model and the site received the CCBHC PPS rate. Then the CCBHC member goes to a non-CCBHC site (not a DCO) and gets services covered under the PPS, but the non-CCBHC bills for the service through their normal reimbursement process. Not sure how to handle these types of scenarios.

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