Certified Community Behavioral Health Clinics

Public Meeting

January 4, 2023

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Agenda

1. **Cost Report**
   - General instructions
   - Cost report overview, supplemental reporting, and review process
   - Q & A

2. **Certification Standards**
   - General overview
   - Tie-in to Cost Report

Current Working Timeline

PPS Implementation		Certification		MCO Contracting		Authority		Quality	
Dec 15	PPS guidance to support Cost Report submissions								
				Jan 30	DRAFT contract language to MCOs				
Feb 15	Cost Report due to State	Feb 1	Certification Application posted	Feb 15	MCOs review period ends	Feb 1	Draft SPA	Feb 1	DRAFT Measure Set and Incentive Program posted
Mar 15	Cost Report refinements and final submissions	Mar 15	CCBHC Certification Application due	Mar 1	Amendment issued				
Apr 30	State analysis & budget revision			Apr 15	MCO contract signed				
Apr 30	Finalize PPS rates based on Cost Reports			May 1	DRAFT Operational Manual to MCOs and CCBHCs			May 1	Draft Quality Incentive Program
Jul 1	State Budget Passes	Jul 1	CCBHCs Certified or Conditionally Certified	Jul 1	Final Operational Manual to MCOs and CCBHCs *(to be incorporated into MCO/CCBHC agreements)*	Jul 1	SPA submitted	Jul 1	Quality Measure set and Incentive Program

Cost Report

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General Cost Report Instructions & Submission

Cost reports must be submitted no later than February 15, 2023.

Submissions must:

- Follow CMS' CCBHC cost report instructions for **PPS-2** and supplemental EOHHS technical guidance
- Use SFY 2022 (July 1, 2021 – June 30, 2022) as the base year for cost report data
- Include supplemental reports in Appendix F
- Include one report per organization

Important Links & Updates

- Cost Report Technical Guidance: V2 of the Guidance being finalized with minor updates based on questions received to date.

- Supplemental Reporting Templates (Appendix F)

- **CMS CCBHC Cost Report Template** (macro-enabled workbook shared via Email on 1/3)
  - On page 3 of the technical guidance, EOHHS describes a cost report template error in the footnote. Since posting the supplemental guidance, CMS has provided RI EOHHS with an updated macro version of the CCBHC cost report workbook, which in addition to having the corrected formula in that cell, also contains macros that make it easier for providers to add additional information to certain areas of the cost report.

- CMS CCBHC Cost Report Instructions

Supplemental Technical Guidance

RI selected the PPS-2 rate-setting methodology given the structure to best meet the needs of both Medicaid members and providers.

The supplemental technical guidance includes:

- Attribution guidance: Members will qualify for the CCBHC program based on their need for CCBHC services as determined by the providers and verified by BHDDH.
- Population definitions and assignment information: The PPS-2 rate structure will include four population rate categories. 1) High Acuity Adult, 2) High Acuity Children and Youth; 3) High Acuity Substance Use Disorder, and 4) General Population.
- Service definitions: Required and allowable services (and evidence-based practices/programs), by population.
- Outlier payment parameters: The PPS-2 rate reimbursement methodology includes an outlier payment mechanism to reimburse clinics for costs above the state-defined threshold.
- Supplemental reports: To support EOHHS' evaluation of the CCBHC cost reports.

Attribution – Designation Process

Attribution & Program Assignment	Process

Initial	**Phase 1. Initial Cost Reporting**
	• BHDDH will send each provider a list of attributed members, using FY22 as the baseline, based on Behavioral Health On-Line Database (BHOLD) reporting.
	  ○ Providers will update the files and submit back to BHDDH.
	  ○ File will include: identifiers (e.g., RECNUM, SPID, SSN), PROGRAM, ADMITDATE, DISDATE, CCBHC Program Assignment (i.e., High Acuity Adult MH, High Acuity Children, High Acuity SUD, or the Standard Population).
	• For attribution lists, please email Jamieson.Goulet@bhddh.ri.gov with your agency's point of contact.
	
	Phase 2. Prior to go-live
	• Same process as Phase 1. The finalized lists will be submitted to Gainwell just before CCBHC go-live for program enrollment population in MMIS.

Ongoing	**Phase 3. Adjustments over time** • Will be each provider's responsibility in most cases*. We will utilize the Gainwell Eligibility Portal (same one that's used for IHH/ACT today). • Additional guidance to be released. **There will be an attribution assignment process for specified events listed in Appendix B of the Cost Report Technical Guidance.*

Milliman CCBHC Cost Reporting Overview

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Questions and Answers

Question	Response
PPS-1 vs. PPS-2: Why PPS-2?	The State selected the PPS-2 rate-setting methodology given the structure will allow us to best meet the needs of both Medicaid members and providers. Specifically, PPS-2: • allows for varying rates for special populations with specific needs; • is similar in structure to Rhode Island's Health Home Program bundles, IHH and ACT, and was initially proposed in RI's original CCBHC demonstration application, so there is some familiarity among both providers and the State; • and requires a quality component to incentivize value and pay providers beyond the PPS rate for high quality, aligning the model with value-based care initiatives occuring within RI Medicaid.
Managed Care Integration	The PPS-2 rate will be fully incorporated in the Managed Care capitation rates; each MCO will be responsible for paying the provider specific PPS-2 rate to each certified CCBHC according to program specifications.

Questions and Answers

Question	Response
Attribution: What is the process of changing attribution after go-live?	The State is developing further guidance which will be released ASAP.
Payment: What constitutes a monthly billable visit?	Page 4, Appendix B of the technical guidance discusses billable visits. The State is also releasing a more detailed visit definition document.
Should Healthy Transitions (HT) costs be included with High Acuity Adults or High Acuity Children population? Or split across the groups given HT serves individuals 16 to 25 years old?	Individuals receiving Healthy Transition services (and their associated costs) should be included in the high acuity adult group, regardless of age. This exception will be added to V2 of the technical guidance - reflected in the Technical Guidance Appendix C (Populations Definition) and Appendix D (Service Definitions), as well as in the CCBHC Standards.

Questions and Answers

Question	Response
What if all DCOs haven't been identified by the time of cost report submission? Is there an opportunity for more to be added later?	The State is developing further guidance which will be released ASAP.
What services specifically can the CCBHC have a DCO cover. It seems that the state requirements differ from the federal CCBHC model. Can you help clarify the rationale for difference.	The State is developing further guidance which will be released ASAP.
Can CCBHCs include the cost of services that are not required but allowed in the cost report, or would there need to be a discussion with BHDDH or DCYF ahead of time? If so, what would be the process?	Yes, CCBHCs can include these costs, however the State will make a determination as to which new costs will be approved in the final cost report.

Questions and Answers

Question	Response
General Population Services: • What services would be provided to adults with severe mental illness but who do not meet the high acuity category, as they can generally self manage their symptoms more adequately than most? • Can they be provided case management and care coordination services as part of the general population category if the CCBHC builds that into the staffing level in addition to ACT and ICCT team staffing?	The State is developing further guidance which will be released ASAP.
Please define Clubhouse services – will day program models other than true Clubhouse services be acceptable?	The State is developing further guidance which will be released ASAP.

Questions and Answers

Question	Response
For group home clients, will the existing daily MHPRR rate be billable in addition to the high acuity PPS-2 rate?	Yes, MHPRR services are not included in the PPS-2 rate.
EBP Training/ Coaching/ Fidelity What are the fidelity tools for the required evidence-based practices?	See Technical Guidance for additional clarification re: allowable EBP training costs. "CCBHCs may adopt additional EBPs beyond the minimum standard. Training and licensing costs for EBPs permitted by BHDDH according to established standards will qualify as an allowable CCBHC cost." Regarding fidelity tools, the State is developing further guidance which will be released ASAP.
Do staff need to be fully certified in best practice areas or will internal training and demonstration of fidelity suffice?	The State is developing further guidance which will be released ASAP.

Questions and Answers

Question	Response
What constitutes the Utilization of a Mobile Crisis Team where in that an unattributed member can get assigned by BHDDH to a CCBHC according to their geographic proximity?	The State is developing further guidance which will be released ASAP.
Can treatment teams blend IHH and ACT services or must teams be delineated based on level of care?	The State is developing further guidance which will be released ASAP.
Are there directions for providers who now operate one of the required CCBHC programs that is partially or fully grant funded, with that grant ending sometime in the future?	Page 18 of the CMS Cost Report Instructions, Allocation Descriptions Tab, notes that the CCBHC should offset salary costs by applicable revenues, such as grants received. As such, if a grant is expiring, and those revenues are not anticipated to be available in SFY 2024, the associated costs are allowable. If the grant revenues are expected for part of a year, the associated costs would also be allowable for the portion of the year when the grant funding is expired. Note, if applicable, these details should be included in the cost report comments tab, detailing the worksheets and lines in which the costs are included.

Additional Cost Report Questions?

Please submit Cost Report questions to OHHS.CCBHCReadiness@ohhs.ri.gov

Questions will be answered on a rolling basis.

Certification Standards

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Certification Standards Overview

Introduction

1. Overview of Certified Community Behavioral Health Clinics (CCBHC)
2. Purpose of CCBHC State Certification Guide
3. Eligibility to Apply to be Certified as a CCBHC
4. Catchment or Service Areas
5. How will CCBHCs be Certified for SFY 2024?
6. Interim Review Period for Certified Entities and Recertification

Requirements

Section 1 Staffing	Section 2 Availability & Accessibility of Services	Section 3 Care Coordination	Section 4 Scope of Services	Section 5 Quality & other reporting	Section 6 Organizational Authority Governance & Accreditation

Addenda

1. CCBHC CCBHC Medical Director - Specific Requirements and Duties
2. Accreditation Bodies and Standards, Relevant Endorsements and Certifications for Behavioral Healthcare Services
3. Requirements of Designated Collaborating Organizations (DCO)
4. Staffing Requirements
5. Populations of Focus – High Acuity Populations Diagnostic and Assessment Criteria
6. Required Evidence-Based Clinical Practices or Programs
7. Scope of Services
8. Additional Requirements for Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans

Certification Standards Overview

115 CCBHC Standards or Criteria Established by the Federal Government

- The Protecting Access to Medicare Act (PAMA) § 223 laid the groundwork for the establishment of Certified Community Behavioral Health Clinics (CCBHCs).
- The Substance Abuse and Mental Health Services Administration (SAMHSA) published Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (the Criteria) in 2015 as part of the Request for Applications (RFA) for Planning Grants in accordance with that legislation.
- SAMHSA recently published revised criteria or standards and has requested public comment on them. The revisions have not yet been formally adopted.
- The State Interagency Team is in the process of reviewing the revised criteria to determine if changes will be needed.

Certification Standards Overview

Six (6) Program Areas

CCBHCs are required to meet criteria/standards in six different program areas:

1. Staffing
2. Availability and accessibility of services
3. Care coordination
4. Scope of services
5. Quality and other reporting
6. Organizational authority, governance, and accreditation

Certification Standards Overview

Demonstration of Compliance with Criteria/Standards Across Nine (9) Services Required

CCBHCs are required to demonstrate compliance with criteria or standards that must be achieved across nine services:

1. Crisis Response
2. Screening, Evaluation and Diagnosis
3. Person-Centered and Family-Centered Treatment Planning
4. Outpatient Mental Health and Substance Use Disorder Services-- RI Specific requirement: Assertive Community Treatment for populations meeting specific diagnostic criteria
5. Primary Care Screening and Monitoring
6. Peer and Family Support
7. Psychiatric Rehabilitation
8. Targeted Case Management
9. Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans

Certification Standards Impacting Cost Reports

CCBHC Standards or Criteria Relevant to Completing PPS-2 Cost Report

DCO Arrangements

- Off hours mobile crisis partner
- Services provided by a CCBHC in another service area
- Specialty service and/or outreach and engagement efforts

Staffing

- Medical Director position
- Designated staff person to manage care coordination for veterans and Active-Duty Service Members and ensure that behavioral healthcare is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook.

Certification Standards Impacting Cost Reports

CCBHC Standards or Criteria Relevant to Completing PPS-2 Cost Report (cont'd)

Services

- Withdrawal Management services ASAM Level 1-WM and Level 2-WM
- Outreach and Engagement
- SMI/CSP services provided for non-High Acuity Adults
- EBP training, coaching and fidelity
- SAMHSA and RI priority populations: Adults with SPMI, children and youth with severe emotional disorders, individuals with SUD, Individuals with BH issues and IDD, LGBTQ+, culturally diverse groups, older adults, homeless, justice involved, transition age youth, and under- resourced communities.

Other

- Formation of Community and Consumer Advisory Councils
- Accreditation

Appendices

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CCBHC PPS Cost Reporting

Prospective Payment System (PPS)

- Organization-specific rates
- Organizations complete cost reports that, under the Demonstration, initially include anticipated costs
- State's review and approve cost reports thereby setting the final reimbursement rates
- The cost of DCO services is included in the CCBHC prospective payment rate, and DCO encounters are treated as CCBHC encounters for purposes of the prospective payment
- States have two options : **PPS-1 (daily) vs. PPS-2 (monthly)**

Visits Trigger Reimbursement

- Organizations receive payment for any qualifying visit
- A visit is a day or month in which there is at least one face-to-face encounter, or one eligible telehealth encounter, between a qualified practitioner and an eligible consumer involving the provision of a qualifying service
- No matter how many or how few services an individual receives in a given day/month, the organization receives the same reimbursement for that visit

PPS-2 (Monthly Encounter Payment)

- CCBHCs receive a fixed monthly reimbursement for every individual who has at least 1 visit in the month
- Payment is the same regardless of number of visits per month or intensity of services
- CCBHCs do NOT get paid in months when the patient does not receive any services
- Allows CCBHCs to establish separate reimbursement rates for distinct populations

PPS-2

- **Pros**
  - Includes a process to address outlier costs
  - Allows for more ability to match payment to patient condition
  - Requires quality bonus payments to CCBHCs
- **Cons**
  - Completion of cost report more complex
  - Data/system requirements are complex to produce required cost report elements by condition level
  - Difficult for State to review and validate payment rates
  - Administratively more complex for State to make payments to CCBHCs when factoring in condition level, outliers and quality bonus payments

Trial Balance Worksheet

- Part 1 Direct Costs for CCBHC Services
  A. Staff Costs
  B. Costs related to DCOs
  C. Other Direct Costs
- Part 2 Indirect Costs
  A. Site (Facility) Costs
  B. Administrative Costs
- Part 3 Direct Costs for Non-CCBHC Services & Non-reimbursable Costs
  A. Non-CCBHC Services
  B. Non-reimbursable Costs

Allocating Indirect Costs

- A percentage of all indirect costs are allocated to CCBHC services
  - Using the organization's approved Indirect Cost Rate

    or
  - Based on the percentage of the organizations total direct costs that is accounted for by the direct costs for CCBHC services

Allocating Indirect Costs

CCBHC Direct Costs + Non-CCBHC Direct Costs = Total Direct Costs

$13,969,581 + $4,584,520 = $18,554,101

CCBHC Direct Costs/Total Direct Costs = CCBHC % of Direct Costs

$13,969,581/$18,544,101 = 75.3%

CCBHC % of Direct Costs x Total Indirect Costs = Indirect CCBHC Costs

75.3% x $8,743,407 = $6,582,898

Visits Trigger Reimbursement

- Organizations receive payment for any qualifying visit
- A visit is a day or month in which there is at least one face-to-face encounter, or one eligible telehealth encounter, between a qualified practitioner and an eligible consumer involving the provision of a qualifying service
- No matter how many or how few services an individual receives in a given day/month, the organization receives the same reimbursement for that visit

Defining & Calculating Billable Visits

- States define what constitutes a billable visit
  - Some activities are included in the cost (e.g. care coordination) but do not count as visits, i.e. do not trigger a PPS payment
  - How broadly or narrowly the billable visit is defined can alter rates substantially: Telehealth? Mobile crisis teams? Other?
- Calculating the number of daily or monthly visits
  - Analyze prior years' service delivery to translate units of service into encounters, including services provided by DCOs
  - Estimate anticipated increase in volume of clients served including diagnostic profiles, including clients served by DCOs
- States review, assess for reasonableness, may work with clinics to adjust estimates

PPS-2 Populations

- The State establishes a “standard population” and one or more special populations “with certain conditions”
  - Special populations should be defined “at the participant level – not tied to services delivered.”
  - Populations must be defined so that they can be identified in CCBHC (and DCO) information systems, including being able to distinguish when an individual changes status during a year

PPS-2 Visits

- For the standard population and separately for each special population with certain conditions, CCBHCs total the number of months in which individuals in a given population received at least one CCBHC service, including services provided by DCOs, regardless of payer source

- For the standard population, and separately for each special population with certain conditions, CCBHCs total the number of additional unique patient visit/months the CCBHC and any DCOs expect to provide, regardless of payer source

Cost Reports

- Costs
  - Actual costs of providing CCBHC services as documented by the organizations most recent audit
  - Costs of providing CCBHC services that have been incurred since the audit
  - Projected costs of providing CCBHC services that have not yet been incurred
- Visits
  - Actual number of visits provided during the previous year
  - Projected number of additional visits projected to be provided
- Adjust annually using the Medicare Economic Index, periodically by rebasing

Calculating Total CCBHC Costs

CCBHC Direct Costs + Non-CCBHC Direct Costs = Total Direct Costs

$13,969,581 + $4,584,520 = $18,554,101

CCBHC Direct Costs/Total Direct Costs = CCBHC % of Direct Costs

$13,969,581/ $18,554,101 = 75.3%

CCBHC % of Direct Costs x Total Indirect Costs = Indirect CCBHC Costs

75.3% x $8,743,407 = $6,582,898

CCBHC Direct Costs + Indirect CCBHC Costs = Total CCBHC Costs

$13,969,581 + $6,582,898 = $20,552,479

PPS-2

State Target Populations

- Populations must be defined so that they can be identified in CCBHC (and DCO) information systems
- Examples
  - Standard population
  - Adults with serious mental illness
  - Children and adolescents with serious emotional disorders
  - Individuals with substance use disorders
  - Adults with PTSD

Establishing Costs for each PPS-2 Population

- Total organizational costs need to be allocated to each population
- The CMS cost report uses the organization's charges to allocate costs to distinct populations
  - Organizations typically have a "Charge Master" that lists the amount the organization will charge individuals or third-party payers for providing each service
  - Organizations don't always receive the amount they charge
- Total charges are calculated for each population in the previous year and for the organization as a whole.
- Each populations percentage of the total organizational charges are used to allocate the organizations costs to that population.

PPS-2 Rates

Total Costs = $13,642,815 Total Charges = $11,198,287

Total Costs/Total Charges = Cost to Charge Ratio

$13,642,815/$11,198,287 = 122%

- Standard Population
  - Charges = $1,755,053
  - Costs = $1,755,053 x 122% = $2,138,172
  - Unadjusted Rate = $2,138,172/8,941 = $239
- SMI
  - Charges = $6,338,482
  - Costs = $6,338,482 x 122% = $7,772,148
  - Unadjusted Rate = $7,772,148/16,443 = $470

PPS-2

"Outliers"

- Outliers: Individuals in a given population whose costs significantly exceed the average cost of serving individuals in that population
    - The state has flexibility in establishing the threshold above which costs are considered "outliers".
    - The threshold can be expressed as an absolute dollar amount (e.g. $10,000) or as a function of the organization's distribution of costs (e.g. three standard deviations above the mean organizational costs).

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PPS-2
"Outliers"

- Charges associated with outliers are separated from the charges associated with non-outliers in each population
- Costs are associated with the outliers in each population by multiplying the cost-to-charge ratio times the total charges for the outliers in each population
- The total costs associated with outliers are combined to establish an "outlier pool" that is used to make an additional annual payment to CCBHCs to address the costs that they have incurred in serving outliers

State Review and Approval of Rates

- CMS Cost Report “anticipated costs” include both costs the organization has incurred since their most recent audit as well as proposed new costs

- States should ask organizations to separate “anticipated costs” that involved proposed new costs from “anticipated costs” that the organization has already incurred

- State should review and approve proposed new costs to assure they are consistent with the CCBHC certification criteria and state expectations regarding CCBHC implementation

Certification Standards – Add. Details

Section 1 Staffing	Section 2 Availability & Accessibility of Services	Section 3 Care Coordination	Section 4 Scope of Services	Section 5 Quality & other reporting	Section 6 Authority Governance & Accreditation
• General Staffing Requirements • Licensure & credentialing of Providers • Cultural Competence & other training • Linguistic Competence & confidentiality of Consumer Information	• General requirements of Access & Availability • Requirements for Timely Access to Services and Comprehensive Evaluation for New Consumers • Access to Crisis Management Services • No refusal of Services Due to Inability to Pay • Provision of Services Regardless of Residence	• General Requirements of Care Coordination • Care Coordination and Other Health Information Systems • Treatment team, treatment planning and Care Coordination Activities	• General Service Provisions • Person Centered & Family Centered Care • Crisis BH Services • Screening, Assessment & Diagnosis • Person Centered & Family Centered Treatment Planning • OP MH & Substance Use Services • OP clinic primary care screening & monitoring • Targeted Case Mgmt Services • Psychiatric Rehabilitation Services • Peer Supports, Peer Counseling & Family Caregiver Supports • Intensive Community Based MH Care for Members of the Armed forces & Veterans	• Data Collection, Reporting and Tracking • Continuous Quality Improvement	• General Requirements of Organizational Authority and Finance • Governance • Accreditation