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DEPARTMENT OF HUMAN SERVICES

Legislative Report

CCBHC RATE METHODOLOGY

Recommendations to the 2020 Legislature

MN Department of Human Services

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $3,500.

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Contents

I. Executive summary

This report is submitted in response to 2019 legislation which directs the commissioner of human services to work with CCBHC providers and stakeholders to develop an ongoing rate methodology for Certified Community Behavioral Health Clinics (CCBHCs). Minnesota is one of eight states in a federal demonstration project to test a new model of community-based integrated mental health and substance use disorder care. The federal demonstration began July 1, 2017 and was expected to end June 30, 2019. Since that time, Congress has enacted many short-term extensions of the demonstration. The current ending date is May 22, 2020.

The 2019 legislation also directed the Minnesota Department of Human Services (DHS) to establish CCBHC as an ongoing benefit in Minnesota's Medical Assistance program, and to seek the necessary federal approvals. DHS received temporary federal approval with the condition that an ongoing Medicaid State Plan Amendment (SPA) be submitted by July 1, 2020. The recommendations in this report will inform the rates portion of the SPA, subject to CMS review and approval.

As required by the 2019 legislation, DHS developed this report in consultation with the CCBHC Rates Methodology workgroup which included all of Minnesota's current CCBHCs. The workgroup identified thirteen issues relating to CCBHC rates. This report provides background, discussion and recommendations regarding each issue. The following paragraphs summarize the most significant issues.

The authorizing legislation specifically directed DHS to develop a process to adjust rates to allow for **changes in each clinic's scope of services.** A proposed set of principles and a process for making rate changes based on a CCBHC's clinic-specific change in type, intensity or duration of services has been developed. The proposed process is consistent with current statutes—however, it does require a change in statute that directs DHS to seek federal approval to establish the basic authority to adjust the PPS rate for a clinic-specific change in the intensity, type or duration of services. DHS' recommended language is found in Section V of this report. Key aspects of the process will be included in the state's proposed SPA. The detailed process will be published in the state's Minnesota Health Care Programs (MHCP) provider manual or a future CCBHC rates manual.

Changes in the clinic-specific services will have to be evaluated within Minnesota's **statewide CCBHC scope of services.** The statewide definition of CCBHC services is currently defined in general categories in federal and state law, and operationalized by a table of procedure codes. CCBHC cost reports used for rate setting must be based on the allowable cost of providing CCBHC services that fall within the allowable statewide scope. CCBHCs are interested in expanding or at least clarifying the statewide scope of CCBHC services. DHS worked with the Rates Methodology Workgroup and drafted a process to mutually develop proposed changes in the statewide scope of CCBHC services. If these changes have a fiscal impact, they should be addressed in future legislation and biennial budgets.

Under federal rules, the CCBHC rate can include the cost of certain activities that are not billable services, but are necessary to provide billable CCBHC services according to federal CCBHC standards. This report documents discussions with the Rates Methodology Workgroup regarding the difference between **services versus activities**. The report recommends clarifications for inclusion in the cost report instructions for CCBHC costs and rates.

The authorizing legislation also directed DHS to develop a state-specific **Quality Incentive Program** intended to be implemented at the time the state plan is amended to include CCBHC as an ongoing benefit. In 2017, DHS implemented a Quality Bonus Program under the federal demonstration requirements. If Congress continues to extend the demonstration, Minnesota will have to continue the federal quality bonus program. This report acknowledges that possibility while also recommending evaluation measures that would be more relevant and consistent with Minnesota's other Medicaid quality programs. The primary recommendation is to implement an ongoing process for reviewing measures that are eligible for quality incentive payments. All of the proposed changes are consistent with current state law and do not require legislative action.

Finally, the report highlights an example where federal demonstration payment policy conflicts with established state payment policy for those who are dually eligible for Medicare and Medicaid. M.S. 256B.0625, subd. 5m (d) directed DHS to make certain changes in CCBHC payment, "unless otherwise indicated in applicable federal requirements." If Congress continues to extend the demonstration, the state's existing legislation related to payment for Medicare-Medicaid dual eligibles could conflict with federal demonstration policy. DHS staff expect that the demonstration is likely to apply only to the current six CCBHCs in Minnesota. The "unless" clause referenced above in the state legislation would allow DHS to continue to follow federal policy for the current CCBHCs but might not apply to new CCBHCs. DHS recommends legislation which would establish the state's preference for consistency in payment policy.

II. Legislation

Laws of 2019, First Special Session, CHAPTER 9, Article 6, Section 79. DIRECTION TO COMMISSIONER; CCBHC RATE METHODOLOGY.

(a) The commissioner of human services shall develop recommendations for a rate methodology that reflects each CCBHC's reasonable cost of providing the services described in Minnesota Statutes, section 245.735, subdivision 3, consistent with applicable federal requirements. In developing the rate methodology, the commissioner shall consider guidance issued by the Centers for Medicare and Medicaid Services for the Section 223 Demonstration Program for CCBHC and costs associated with the following:

(1) a new CCBHC service that is not incorporated in the baseline prospective payment system rate, or a deletion of a CCBHC service that is incorporated in the baseline rate;

(2) a change in service due to amended regulatory requirements or rules;

(3) a change in types of services due to a change in applicable technology and medical practice utilized by the clinic;

(4) a change in the scope of a project approved by the commissioner; and

(5) a Minnesota-specific quality incentive program for CCBHCs that achieve target performance on select quality measures. The commissioner shall develop the quality incentive program, in consultation with stakeholders, with the following requirements:

(i) the same terms of performance must apply to all CCBHCs;

(ii) quality payments must be in addition to the prospective payment rate and must not exceed an amount equal to five percent of total medical assistance payments for CCBHC services provided during the applicable time period; and

(iii) the quality measures must be consistent with measures used by the commissioner for other health care programs.

(b) By February 15, 2020, the commissioner of human services shall consult with CCBHC providers to develop the rate methodology under paragraph (a). The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health services and medical assistance on the recommendations to the CCBHC rate methodology including any necessary statutory updates required for federal approval.

III. Introduction

Purpose of report

This report is submitted to the Minnesota Legislature pursuant to Laws of 2019, First Special Session, Chapter 9, Article 6, Section 79. The legislation directs the commissioner of human services to work with CCBHC providers and stakeholders to develop an ongoing rate methodology, including a Minnesota-specific quality incentive program, for Certified Community Behavioral Health Clinics (CCBHCs).

Background

Minnesota is one of eight states that has been participating in a federal demonstration project to test a new model of community-based integrated mental health and substance use disorder care, known as Certified Community Behavioral Health Clinics (CCBHCs). This national demonstration was enacted under Section 223 of the Protecting Access to Medicare Act (PAMA) (PL 113-93) and is often referred to as the Section 223 Demonstration.

The federal legislation provides for a national evaluation of the demonstration, including annual updates to Congress. A final report with recommendations for continuation, expansion, modification, or termination of demonstration projects under Section 223 will be submitted to Congress no later than December 31, 2021.

Minnesota currently has six CCBHCs participating in a federal demonstration project and an additional two, separately funded, CCBHCs funded by grants from the federal Substance Abuse and Mental Health Services Administation (SAMHSA). CCBHCs provide a comprehensive set of mental health and substance use disorder services for both children and adults including screening, assessment and diagnosis, treatment planning, outpatient and rehabilitative services. As a part of this demonstration, Minnesota has used Medical Assistance (MA) with an enhanced federal match to fund six CCBHCs since July 1, 2017. This funding has been provided through a federally specified rate methodology.

The 2019 legislative requirement for a Minnesota-specific rate methodology was passed when the national demonstration was expected to end June 30, 2019. At that time, it was assumed that Minnesota's CCBHCs would continue to operate at current rates plus inflation until a new rate methodology was developed, recommended to the 2020 Legislature and approved by the federal Centers for Medicare & Medicaid Services (CMS). Since that time, Congress has approved five short-term extensions of the CCBHC demonstration. On December 21, 2019, the President signed the fifth short-term extension of the demonstration, this time through May 22, 2020. These extensions, including the enhanced federal match, only apply to the six CCBHCs that have been part of the demonstration since the beginning. Each of these extensions have been passed by Congress and signed by the President a few days before or after the expiration of each extension, thus making long-term planning difficult.

When the Minnesota Legislature passed the requirement for this report, it also:

- Established ongoing MA coverage for CCBHC services, including the current CCBHCs as well as additional CCBHCs
- Provided state MA funding for additional CCBHCs, assuming two additional CCBHCs would begin receiving MA funding October 2020 and three more January 2021
- Directed the commissioner of human services to seek federal approval for ongoing federal Medicaid matching funding

On June 30, 2019, the commissioner of human services received temporary federal authority to continue the CCBHC demonstration under an 1115 waiver. The waiver:

- Authorizes continuation of services and payment while the state develops a state plan amendment (SPA) for long-term federal authority
- Requires the state to submit a Medicaid State Plan Amendment (SPA) by June 30, 2020
- Continues while the SPA is going through the approval process
- Authorizes regular federal matching funds for the current six as well as additional CCBHCs

Since the current Congressional extension of the demonstration goes through May 2020 and additional CCBHCs are not expected to qualify until later in 2020, Minnesota is still operating solely under demonstration rules. If the demonstration is extended beyond 2020 and additional CCBHCs begin before the demonstration ends, the current CCBHCs will likely continue to operate under the demonstration while additional CCBHCs will operate under a waiver or SPA. In this report, this is referred to as the "dual track authority."

Congress also established a third track for CCBHC funding using temporary grants which are administered by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Minnesota has two CCBHCs which receive these grants directly from SAMHSA. These grants are scheduled to expire September 30, 2020. The state legislation and budget which were enacted in 2019 assumed that these two CCBHCs would transition to MA Prospective Payment System (PPS) reimbursement after their grants expired as long as they are certified as meeting the required federal criteria and state standards. Since that time, Congress has appropriated additional funding for these grants and there is a possibility that the grants may be extended.

How this report was prepared

While the 2019 Legislature was considering legislation that would require this report, DHS convened a CCBHC Rates Methodology workgroup consisting of CCBHCs, provider associations, and relevant areas of DHS including the Behavioral Health Division, Health Care Purchasing and Service Delivery - Rates and Analysis, Managed Care Contracting, and Federal Relations. The workgroup met in April, May and June 2019. The intent of the

workgroup was to gather input about the challenges, barriers and strengths of the Prospective Payment System (PPS) rate methodology that was piloted during the federal demonstration to inform future methodology to be implemented at the time CCBHC services become a state plan Medicaid service. Following these stakeholder meetings, DHS staff considered the issues raised and vetted options internally to determine feasibility.

Based on the input received from the workgroup in the spring of 2019 and the legislation that passed at the same time, DHS developed a draft report identifying key issues, with background, options and recommendations for each issue. The workgroup was reconvened in the fall and winter of 2019. The workgroup reviewed the draft report, identified additional key issues and options, and discussed how to resolve, implement and operationalize all identified issues. This report is a summary of the workgroup's discussions and recommendations.

IV. Rate methodology issues

The Rates Methodology Workgroup identified the following key issues:

1. Overall rate methodology
2. Targeted Case Management
3. Specificity vs flexibility
4. Reporting period and rate period
5. Rate adjustments due to clinic-specific changes in scope
6. State quality incentive program
7. Rates for new CCBHCs
8. Streamlining the CCBHC cost report
9. "Services" vs "Activities"
10. MCO directed payments
11. Potential differences between demonstration policy vs ongoing SPA policy
12. Funding for clients who are not MA-eligible
13. Process for changing the statewide scope of CCBHC services

The following is a summary of the workgroup's discussion regarding each issue and related recommendations.

1. Overall rate methodology

Background

Under the Section 223 Demonstration Program (July 1, 2017 – present) CCBHCs in Minnesota are paid using Prospective Payment System (PPS)-1, the Daily Visit Option. This was one of two methodologies allowed under the Demonstration—the other was a monthly option. PPS rates are clinic specific using each CCBHC's own costs and visits. The formula is:

CCBHC PPS rate = Total annual allowable CCBHC costs divided by total annual number of CCBHC daily visits

Total annual allowable CCBHC costs include direct costs for CCBHC services plus allocated indirect costs. The total annual number of CCBHC daily visits reflects a count of days for each patient in which any billable CCBHC service was provided by the CCBHC or designated collaborating organization (DCO). Visit enumeration is calculated using all payers – not just Medicaid. This is important to note because it signifies that CCBHC costs are spread across ALL visits. Using this denominator results in a rate that represents the "average" cost of a CCHBC visit – regardless of payer (MA, private pay, etc.). This methodology ensures that costs are appropriately allocated to each payer, and that MA does not pay any costs for other payers.

A qualifying encounter is the first billable unit for a CCBHC service on a given service date, for dates of service on or after July 1, 2017. Billable unit is defined by billing policies that apply to each procedure code.

Participating CCBHCs are enrolled Minnesota Health Care Program (MHCP) service providers for all CCBHC services and have been certified as meeting the required federal criteria and state standards as Certified Community Behavioral Health Clinics.

Allowable costs are determined using:

- Uniform Guidance (2 CFR 200 / 45 CFR 75)
- Principles of Reasonable Cost Reimbursement (42 CFR 413)

The reason for two 'Uniform Guidance' citations is that when they first released the Uniform Guidance several years ago to replace the former OMB Circulars, the new guidance was published by the Office of Management & Budget (OMB) and was intended to cover all federal agencies. They codified it in the federal regulation at 2 CFR 200. In 2016 the federal Department of Health and Human Services codified the new language into their own regulations (this was required of all federal agencies) at 45 CFR Part 75. When "Uniform Guidance" is referenced, it is sometimes referred to as 2 CFR 200, and other times as 45 CFR Part 75. This guidance is also referred to as the "Super Circular" because it combined regulations across a number of different OMB circulars.

The CCBHC PPS rate is a bundled, per diem rate based on allowable costs of furnishing all CCBHC services. The same rate is paid for each qualifying unit of service ("visit"), regardless of the intensity of services provided. PPS is not cost reimbursement. It bears a rational relationship to the provider's costs of providing a CCBHC basket of services. It likely will not result in reimbursement that precisely equals costs for a given year. (*National Council for Behavioral Health, 2016*).

Discussion—Overall rate methodology

The PPS-1 (daily option) is more transparent and significantly less complex to implement due to the PPS-2 (monthly) requirements of outlier payments, quality bonus payments and calculation by population groups. If a monthly rate methodology is used, there must be some way to differentiate between intensity of clients' needs. States that selected the monthly option use a 'tiered' system of rates to distinguish intensity level.

CMS has supported states' use of alternative payment methodologies. Cost-based rate setting may eventually be replaced with options like Value-based Payment (VBP) and Pay for Performance (P4P) methodologies/add-ons in the future. These methodologies reward providers for efficiency and incentivize outcomes. The CCBHC Quality Bonus Program is on the VBP/P4P spectrum as it incents providers who meet certain performance expectations. Providers assume a certain level of risk in PPS to maintain or minimize costs from year to year while sustaining or increasing quality levels. See Issue 6 – State Quality Incentive Program.

Since Minnesota's CCBHCs are still in a start-up demonstration period, it makes sense to continue the current rate methodology, but consider something like value-based payment or pay for performance methodologies in the future. The Quality Incentive Program is a good way to pilot these new methodologies. The national

evaluation report which is due to Congress by December 2021 may also provide guidance regarding long-term changes in the basic CCBHC rate methodology.

Recommendation—Overall rate methodology

For the immediate future (at least the coming 3-4 years), it would best serve CCBHCs in Minnesota to continue the PPS-1 daily option as opposed to the PPS-2 monthly option. The current CCBHCs, as well as new CCBHCs that are expected to be certified during the coming two years, need to have stable and predictable funding during this start-up period. No changes are recommended at this time in the basic structure of the CCBHC rate methodology.

For the long term, Minnesota should consider a value-based payment approach which would incentivize positive outcomes and improved access to, and engagement in, services for underserved populations. Some aspects of this approach are included in the recommendations relating to a new Quality Incentive Program. Experience gained through that program can provide a basis for long term future improvements in the basic CCBHC rate methodology.

This recommendation does not require legislation.

2. Targeted Case Management

Although Minnesota uses a daily PPS, only one encounter per month of mental health targeted case management (MH-TCM) is counted as a PPS encounter because that is Minnesota's current billing policy for MH-TCM. Consideration of a daily versus monthly TCM rate for CCBHCs was a significant issue that was discussed with the clinics three years ago when DHS designed the rate methodology for the demonstration. At that time, it looked like Minnesota might have to go to a daily TCM rate—but there were issues/complications with implementing this within existing IT billing systems. Clinics would have had to recalculate base period encounters, and both the state and the clinics would have had to implement a new daily procedure code for TCM. The consensus at that time was to leave the monthly rate as is and revisit in the future when the outcomes of the larger DHS case management redesign project are known, as they will likely have an impact on TCM rates.

If DHS converts TCM to daily for CCBHCs, the rate process would need to factor in additional visits, which means that the PPS rate would decrease. Since the PPS rate is an average across all services, it would result in the same outcome. However, changes in service mix are a different issue and might require a different solution.

No changes are recommended at this time regarding how targeted case management is accounted for in the PPS rate. This issue should be revisited after DHS completes the broader process of re-designing case management rates for all providers.

This issue does not require legislation.

3. Specificity vs flexibility

Wherever possible, it may be beneficial to propose a rate methodology that is not overly prescriptive—and instead broad enough to allow for minor adjustments – without having to amend the SPA every time minor adjustments are needed to the rate methodology.

Other states have been successful in obtaining approval from CMS using this type of broad language. See the following example – Missouri's SPA proposal was approved 7/1/19 with the following language: (note that CCBHC is called CCBHO in Missouri)

> The state agency will reimburse CCBHOs a clinic-specific fee schedule rate applicable to providers affiliated with the CCBHO. Payments will be limited to one payment per day per CCBHO regardless of the number of services provided by a given CCBHO within a single day by a clinic user accessing services from CCBHO practitioners. The clinic-specific CCBH Rehabilitative Services fee schedule rate will be published on the Department of Mental Health (DMH) website at: https://dmh.mo.gov/media/pdf/ccbhc-providers-rates-7012019 and is effective for CCBH rehabilitative services provided on or after July 1, 2019.

Rather than putting all details of the rate methodology in a SPA or in state law, there are other ways to document the rate methodology, e.g. via DHS Bulletin or DHS Rate Manual.

Recommendation—Specificity vs Flexibility

This was raised as a general issue in the workgroup. As a general rule, state statute and the Medicaid SPA should be limited to broad policy provisions, while operational issues are better addressed in the MHCP provider manual and CCBHC cost report instructions. However, each issue is different, and DHS will continue to work with CCBHCs to determine the level of specificity that makes the most sense for each issue, and where that specificity should be documented.

This recommendation does not require legislation.

4. Reporting period and rate period

Background

The federal demonstration period began July 1, 2017; therefore, the state was required to set fiscal-year (July - June) PPS rates. For the first year of the demonstration, CCBHCs were allowed to report their costs based on their own most recent audited year. Rates for the second year of the demonstration (July 2018 to June 2019) were based on the actual costs for the first demonstration year. Rates for both demonstration year 1 and 2 were based on the prior period actual costs adjusted by approved anticipated changes in costs and visits, and the appropriate application of MEI (Medicare Economic Index) to bridge the inflation gap between reported

costs and effective date of the rate. As DHS transitions CCBHC from the demonstration to a state plan benefit, this is an opportunity to examine the cost reporting and rate periods.

One significant factor is compliance with federal requirements for managed care organization (MCO) payments. To ensure that MCOs pay clinic-specific PPS rates, DHS implemented directed payments (see Issue 10). A post-demonstration rate setting process must transition to a timeline that aligns with the annual MCO contract period (calendar year) to the extent feasible. Annual PPS rates must be finalized by July 1st of each year due to the MCO contracting process. This necessitates use of a cost reporting period that allows for quarter-end fiscal closing processes, adequate time for report completion by providers and auditing/certifying completed cost reports used for rate setting by the state and its contractor.

At the same time, it appears that Congressional extensions of CCBHC demonstration status will require continuation of fiscal year cost reporting and fiscal year rates for current clinics. Under the demonstration, states have flexibility as to how often rates are rebased and which reporting period is used as the base for rebasing rates.

Discussion—Reporting period and rate period

The state's actuary needs estimated PPS rates by March of each year to begin contract negotiations with the MCOs in order to have rates ready to pay in January. With this in mind, the work group reviewed and discussed different options for a reporting period.

DHS believes that actuarially and audit-wise, it makes sense to use the clinic's fiscal period and audited financials as a cost report period for rate setting whenever possible—particularly because it is a clinic-specific PPS rate. CCBHCs support this option – it is less burdensome than reporting in an alternate period, than having to reconcile those figures back to audited financials from a previous reporting period. It also provides a cleaner audit trail when reports are reviewed, audited and certified by DHS. Note – some states have opted to use a partial reporting period (e.g. single quarter of data, etc.) to rebase rates; however, in Minnesota seasonality is a factor when people access services, simply due to weather. This seasonal variability affects both the number of visits, as well as the intensity of those visits. For this reason, it was determined that partial reporting periods are not a viable option.

At the present time, all current CCBHCs have a calendar year fiscal period except for one. The exception is a July – June fiscal period. An identified goal of stakeholders is to use the most recent year of actual data from the clinics for rate rebasing. With our MCO timeline, a calendar year reporting period results in the narrowest gap between reporting period and effective date of the rate. However, use of audited financials for a calendar-year reporting period would not produce final PPS rates by the required due date in March.

DHS determined that giving the MCOs estimates in March (using current PPS rates + appropriate application of MEI) then finalizing the PPS rates by July 1st, using audited financials reported by the clinics, would be acceptable and produce the desired outcome.

For CCCBHCs that use an alternate fiscal period (e.g. July – June), it is perfectly acceptable to use clinic-specific fiscal periods and resulting audited financials as the cost reporting period. DHS recognizes that in these cases, requiring the CCBHC to deviate from their own fiscal period for cost reporting purposes would ultimately require two rounds of cost reporting each year. For this reason, it is not DHS' intent to impose cost reporting periods for PPS rate setting. Using a calendar year reporting period for PPS rate setting was simply identified as the option that results in the minimum gap between reported costs and the effective date of the rebased PPS rate.

As a rule, PPS rates are generally two years behind. When using encounter data and a reporting period within two years, CCBHC is in line with hospital rate setting and other PPS-type rates.

State law requires rebasing of CCBHC PPS rates at least every three years. CCBHCs have the right to appeal a rebased CCBHC rate within 60 days of the initial communication of the PPS rate to the CCBHC. More details on the appeals process follow in the recommendation for Issue 7.

When the rate rebase cycle is finalized, CCBHCs are encouraged to conduct planning cycles that correspond to the rebasing timeline (e.g. strategic planning around new initiatives.) This report recommends a clinic-specific change in scope (CIS) process to accommodate requests for changes to services that arise in the "between" years when rates are trended forward using the MEI and not fully rebased (see Issue 5).

It was noted that Federally Qualified Health Centers (FQHCs) receive a productivity adjustment. CCBHCs do not currently have a productivity adjustment. In reviewing whether MEI is the best inflator to use, it was noted that CMS is continuously improving their inflators as they receive data from providers over time. They have developed several provider-specific inflators. DHS will monitor CMS' progress and instruction to states in this area.

Medicare Economic Index (MEI) in CCBHC PPS rate setting: Per CMS instruction on the CCBHC Cost Report, "the MEI should trend the costs from the midpoint of the cost period to the midpoint of the rate period." The MEI may be found here by downloading the "actual regulation market basket updates" file that provides applicable rates. The summary web table (not actual) for the 2006-based Medicare Economic Index is used. Federal CCBHC instructions do not include any productivity adjustments.

Recommendation—Reporting period and rate period

As long as the demonstration continues, it is necessary for CCBHCs to use CMS' fiscal year (7/1-6/30) for annual reporting. DHS will seek CMS approval to use clinic-specific reporting periods (audited financials) to set PPS rates after CMS' required fiscal-year Demonstration reporting is complete so that CCBHCs are not subject to double reporting requirements beyond the Demonstration. The majority of CCBHCs operate on a calendar year basis. In order for a calendar year reporting period to work for rate rebasing, given the MCO timeline, cost reports used for rate setting must be received by DHS no later than May 15th.

DHS will provide for a 60-day appeals process as follows: the CCBHC must notify DHS of the appeal in writing by sending a letter to the Director of the Behavioral Health Division. The appeal must include relevant supporting documentation that clearly lays out their case and includes details of any special circumstances.

Within the workgroup, DHS drafted an annual cycle/timeline for CCBHC rate changes that addresses these issues, as well as other goals identified in the stakeholder work. The annual cycle/timeline was reviewed with stakeholders. DHS intends to address the broader requirements related to rate methodology with CMS in the State Plan Amendment (e.g. PPS-1 methodology, intent to rebase at least every three years, etc.), however we intend to allow for flexibility when it comes to the finer details that are left to the state's discretion. That flexibility will allow us to continue refining the draft annual cycle/timeline while working within the requirements of the SPA. DHS will work together with the CCBHCs to look ahead and build the annual cycle/ timeline out into the future, then publish it so CCBHCs can plan and budget accordingly for rate rebase years.

This recommendation does not require legislation.

5. Rate adjustments due to clinic-specific changes in scope

Background

For the first two years of the CCBHC demonstration, CMS allowed an exception for the anticipated cost of changes that were necessary to implement the new CCBHC criteria. DHS does not expect that CMS will allow such a broad inclusion of anticipated costs in future rates. DHS recommends seeking approval of a change in scope process similar to what has been used for FQHCs. This means that changes beyond historical cost plus inflation must be justified by a change in the type, intensity or duration of services to be provided.

Discussion—Rate adjustments due to clinic-specific changes in scope

CMS based many aspects of the CCBHC payment methodology on the FQHC payment model. In developing a CCBHC change in scope process, DHS and providers are fortunate to have the FQHC clinic-specific change in scope rate adjustment process for guidance and precedent. CMS defines the term "change in the scope of services" as a mechanism for adjusting the reimbursement rate of an FQHC due to "a change in the type, intensity or duration of services". DHS will adhere to this definition for CCBHCs.

In Minnesota, FQHC change in scope policy requires a 2.5% threshold – the proposed change must result in at least a 2.5% change in the rate in order to qualify for a rate adjustment. If below that threshold, the rate will not be adjusted. DHS will adhere to this practice for CCBHCs. The change must be prospective (e.g. have not occurred in the past) for something specific, and must be a new service that has not been offered before nor provided by someone with a different specialty. Changes in the intensity or duration of services provided are also considered. Providers must contact DHS ahead of time – they are not able to contact DHS after the change in scope has already been implemented. DHS is unable to approve "retroactive" clinic-specific change in scope rate adjustments. This is especially important when considering the MCO timeline and our need to finalize rates with the health plans well in advance of the effective date. For this reason, rate adjustments must also be limited to the annual rate change timeline.

During the stakeholder work, it was necessary to develop a framework to be used as a tool for reviewing the criteria for a clinic-specific change in scope, and demonstrate the process for determining whether costs of

activities can be included in the PPS rate. DHS is recommending use of this framework to make those determinations. Eventually, this work will also inform the cost report instructions for future clarity, specifically the ability to easily discern whether costs can be treated as direct versus indirect—an identified goal of the work group.

The clinic-specific change in scope is a two-part process: Step 1 is determining whether the service change that the clinic is proposing aligns with CCBHC statewide goals and legal requirements; Step 2 is calculating the change in rate.

Since the clinic-specific change in scope must be a future endeavor (in order to qualify for a rate adjustment) reasonable use of estimated costs will be allowed, subject to CMS approval, legislative authority and DHS review and approval. After the demonstration period, oversight and monitoring is required when estimated costs are used to set a PPS rate (assuming CMS approves the use of estimated costs). DHS recommends use of the CCBHC Key Indicators Report (a tool developed during the demonstration) as a means to compare estimated costs to actual after the rate has been adjusted. DHS recommends doing this at the six-month mark to determine whether the variance is within acceptable margin.

CCBHCs will be advised that use of estimated costs (to adjust the PPS rate) outside the demonstration period requires that they are subject to recoupment of federal Medicaid payments in the unlikely event that significant overpayments result from the clinic-specific change in scope rate adjustment. How unforeseen circumstances played a role in a significant overpayment situation (e.g. workforce shortages, natural disasters, etc.) will be reviewed at the time, on a case by case basis.

At the point in the future when MCOs are making the full PPS payment, DHS will submit clinic-specific change in scope rate adjustments to MCOs at the annual rate change time.

Recommendation—Rate adjustments due to clinic-specific changes in scope

DHS recommends proposing to CMS in the State Plan Amendment a clinic-specific change in scope process that is modeled after FQHCs, as described in the discussion section of this issue. DHS recommends seeking approval of the use of estimated costs in a clinic-specific change in scope rate adjustment process since CCBHCs are relatively new and continuing to ramp up. This volatility will eventually decrease over time.

This recommendation requires legislation proposed in the report under "Implementation language" – see (9)

6. State quality incentive program

Background

2019 legislation directs DHS to develop a Minnesota-specific quality incentive program for CCBHCs that achieve target performance on select quality measures, with the following requirements:

(i) the same terms of performance must apply to all CCBHCs;

(ii) quality payments must be in addition to the prospective payment rate and must not exceed an amount equal to five percent of total medical assistance payments for CCBHC services provided during the applicable time period; and

(iii) the quality measures must be consistent with measures used by the commissioner for other health care programs.

Discussion—State quality incentive program

During the summer and fall of 2019, DHS convened a workgroup which included members of the CCBHC Rates Methodology Workgroup as well as DHS quality staff and CCBHC evaluation staff. Additional background and discussion is provided in the Appendix - State quality incentive program.

Recommendation—State quality incentive program

Seven detailed recommendations are provided in the Appendix - State quality incentive program. A primary recommendation is to implement an ongoing process for reviewing measures that are eligible for quality incentive payments. None of the recommendations require a legislative change. DHS will seek federal approval to implement the recommendations.

This recommendation does not require legislation.

7. Rates for new CCBHCs

Background

2019 legislation [256B.0625, subd. 5m (d)(6)] requires initial rates for clinics certified after July 1, 2019 to be based on a comparable clinic's rate. If there is no comparable clinic, DHS sets a CCBHC-specific rate based on the CCBHC's audited costs adjusted for changes in the scope of services.

For reference, DHS considers the following to determine "comparability" for new FQHCs:

- Caseload – procedures provided, volume of claims, categories of service
- Demographic: Rural – 60 mile radius, Urban – 30 mile radius

Government versus non-government is not considered; nor are costs used to determine comparability.

There have been several instances where an FQHC argued that the rate was not at all comparable (with their costs). In these cases, they were given their own cost-based rate. With so few CCBHC providers in existence in Minnesota, locating a comparable clinic is unlikely at the present time.

Discussion—Rates for new CCBHCs

What is the definition of "comparability"? The dimensions of "comparability" that DHS proposes to assess are limited to caseload and demographics. Will these be sufficient to determine comparability in the specialty behavioral health sector? For example, should DHS look at demographic and clinical profile of the patient population, use of technologies to support care delivery, or other dimensions?

- What is the process for a CCBHC to appeal the decision of scope?
- What would the process for appeals be if a new CCBHC did not feel it was truly comparable to a clinic deemed comparable by DHS?
- What would be the process whereby a CCBHC could receive their own cost-based rate? How is the decision made and by whom?
- If a CCBHC won the appeal, would anticipated costs be kept in the rate?
- If a new CCBHC is granted the option to have their own cost-based rate calculated, is DHS making sure that it will include anticipated costs?

In reviewing the Intensive Mental Health Service Providers' rate methodology (cost-based daily rate), these providers receive the benefit of a new/startup rate and the CMS-approved methodology allows use of estimated actual costs to establish an initial rate.

Recommendation—Rates for new CCBHCs

DHS recommends developing rates for new CCBHCs in a manner consistent with the process for FQHCs. Until more CCBHCs are certified, making it feasible to identify comparable CCBHCs, rates for new CCBHCs will need to be set using the same process used to develop start-up rates for our current CCBHCs. This process used historical cost adjusted for inflation and anticipated changes as required to implement federal CCBHC criteria. M.S. 256B.0625, subd. 5m (d) authorizes DHS to seek approval from CMS on the use of anticipated or estimated costs in developing startup rates for a new CCBHCs. The specific clause is referenced below:

> *(6) initial prospective payment rates for CCBHCs certified after July 1, 2019, shall be based on rates for comparable CCBHCs. If no comparable provider exists, the commissioner shall compute a CCBHC-specific rate based upon the CCBHC's audited costs adjusted for changes in the scope of services;*

As required by M.S. 256B.0625, subd. 5m (d), DHS is developing a 60-day appeals process which would allow a CCBHC to appeal their rate, especially relating to rates for new CCBHCs. CCBHCs have the right to appeal a rebased CCBHC rate within 60 days of the initial communication of the PPS rate to the CCBHC. DHS will provide for a 60-day appeals process as follows: the CCBHC must notify DHS of the appeal in writing by sending a letter to the Director of the Behavioral Health Division. The appeal must include relevant supporting documentation that clearly lays out the case and includes details of any special circumstances.

This recommendation does not require legislation.

8. Streamlining the CCBHC cost report

Background

Under the federal demonstration, states were given the option of using a federally defined cost report or creating their own, subject to federal review and approval for any changes. Minnesota chose to use the federal cost report. The report is in an Excel spreadsheet format with 14 inter-related sheets and 33 pages of instructions.

Discussion—Streamlining the CCBHC cost report

CCBHCs have expressed concern about the overall complexity of the CCBHC Demonstration Cost Report. Specifically, it is time-intensive and requires extraneous information and details that are specific only to the federal demonstration program. DHS staff agree with these concerns and are willing to work with the clinics to develop a streamlined report, simplified instructions and the ability to easily discern whether costs can be treated as direct versus indirect.

Recommendation—Streamlining the CCBHC Cost Report

DHS will work with CMS and the CCBHCs to develop a streamlined cost report that will eliminate any information that is not essential to the rate-setting process. This will include better definition of areas which have been unclear, such as allowable costs and activities (see next issue).

This recommendation does not require legislation.

9. "Services" vs "Activities"

Background

Federal CCBHC statute and criteria distinguish between billable CCBHC services versus activities that are not billable in their own right, but are necessary to support the billable services. The PPS rate is based on the cost of the billable CCBHC services as well as the activities that support those services.

Discussion—"Services" vs "Activities"

CCBHCs are interested in expanding the scope of billable services and activities, particularly to improve integration of behavioral health services with primary care and other health services. Minnesota has had a list of billable CCBHC procedure codes from the beginning of the project. Neither CMS nor DHS has had a clear list of activities that are allowed to be included in the PPS rate. SAMHSA Section 223 guidance, which has been available since 2016 and is published on SAMHSA's web site, outlines the 'scope' of the CCBHC demonstration. This scope provides a comprehensive detailed list of requirements which may be reviewed for applicable cost implications. For example, if CCBHCs are required to have a medical director, then it follows that there may be a

cost for that requirement. These requirements are used to certify clinics and may be used to monitor adherence to the CCBHC model. Minnesota needs a clear public process for making changes related to the definitions of both CCBHC services and activities.

Recommendation—"Services" vs "Activities"

DHS will clarify "Services" versus "Activities" in the CCBHC cost report instructions. A process will be developed for changing the statewide scope of CCBHC services (see Issue 13). The cost report instructions will include greater specificity regarding inclusion of costs for allowable activities. This will include principles for inclusion of allowable activities, both direct and indirect, as well as examples of specific allowable and non-allowable activities. The list of allowable activities will allow for inclusion of additional creative activities that support the basic principles and service criteria.

This recommendation does not require legislation.

10. MCO directed payments

Background

Under the federal demonstration, states were given two options for PPS payments for recipients in managed care:

- Fully incorporate the PPS payment into the managed care capitation rate and require the managed care plans to pay the full PPS or its actuarial equivalent, or
- Require the managed care plans to pay a rate to the CCBHCs that other providers would receive for similar services, then use a supplemental payment (wraparound) to ensure payment to CCBHCs is equal to the PPS.

Minnesota chose the second option, with the state making a monthly wrap payment based on the difference between the usual MCO payment and the PPS rate.

Federal statute gave CMS authority to waive certain Medicaid rules so they could implement the 223 CCBHC Demonstration. Under regular Medicaid rules, states are not permitted to directly pay providers for services covered by an MCO. As the Demonstration was nearing completion, and there uncertainty at that time as to whether Congress would extend it, the only solution to bring CCBHCs up to the PPS rate was to direct MCO expenditures.

DHS sought approval from CMS for what is referred to as an "MCO directed payment" and worked with Minnesota's contracted Medicaid MCOs to have the MCOs make the PPS wrap payment based on the state-approved PPS rates. The actuarial work was done to incorporate the cost of these payments into MCO capitations and contracts were revised. At the same time, Congress passed two short-term extensions of the demonstration. DHS was able to delay implementation of the MCO directed payments to September 1, 2019.

At that time, the demonstration had only been extended to September 13, 2019 and no further congressional action was expected until late September 2019. DHS decided to proceed with MCO directed payments to ensure that it would have a legal method to pay for services after September 13, 2019 if Congress did not enact another extension. This continues to be true due to the unpredictable and temporary nature of the Congressional extensions which have been approved so far.

Discussion—MCO directed payments

In the stakeholder process, CCBHCs expressed concerns about receiving correct and timely payments from the managed care plans, specifically:

- What level of oversight will there be to ensure that the PPS is being paid in full and that MCOs are not engaging in strategies to restrict enrollees' access to CCBHCs? What oversight does the state/ DHS have to ensure and enforce MCOs compliance?
- How are MCOs prevented from shifting incentives to favor other providers?
- How will MCOs negotiate access across disparate CCBHCs?
- What if MCOs do not pay full PPS rates?
- What are the rights of the CCBHCs in MCO conversations?
- Which division of DHS (Purchasing Services or Behavioral Health) enforces rules for compliance?
- Which division of DHS should clinics refer to when compliance issues arise?

DHS managed care staff met with the CCBHCs to discuss the above concerns. Current DHS contracts with the MCOs require the MCOs to make the state-specified PPS wrap payment within 30 days after the Behavioral Health Division notifies the MCO of the amount due for the preceding month. If any concerns do arise, the CCBHCs have been provided with contact information at the MCOs and at DHS, and instructions as to which concerns should be directed where. DHS is committed to developing a payment rate methodology that facilitates a robust and constructive relationship between CCBHCs and the health plans.

Given the background on this issue, no changes will be made regarding MCO directed payments. DHS will continue to work with the MCOs and the CCBHCs to monitor and address any issues that may arise, especially any issues regarding access to appropriate services as needed by each recipient.

This issue requires legislation proposed in the report—see (10) under "Implementation language"

11. Potential differences between demonstration policy vs ongoing SPA policy

Background

Since the current Congressional extension of the demonstration goes through May 2020 and additional CCBHCs are not expected to qualify until later in 2020, Minnesota is still operating solely under demonstration rules. If

the demonstration is extended beyond 2020 and additional CCBHCs begin before the demonstration ends, the current CCBHCs will likely continue to operate under the demonstration rules while additional CCBHCs will operate under a waiver or SPA. In this report, this is referred to as the "dual track authority."

M.S. 256B.0625, subd. 5m (d) directs the commissioner to include the following provisions in Minnesota's PPS, unless otherwise indicated in applicable federal requirements:

(1) the commissioner shall rebase CCBHC rates at least every three years;

(2) the commissioner shall provide for a 60-day appeals process of the rebasing;

(3) the prohibition against inclusion of new facilities in the demonstration does not apply after the demonstration ends;

(4) the prospective payment rate under this section does not apply to services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. An entity that receives a prospective payment system rate that overlaps with the CCBHC rate is not eligible for the CCBHC rate;

(5) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments;

(6) initial prospective payment rates for CCBHCs certified after July 1, 2019, shall be based on rates for comparable CCBHCs. If no comparable provider exists, the commissioner shall compute a CCBHC-specific rate based upon the CCBHC's audited costs adjusted for changes in the scope of services; and

(7) the prospective payment rate for each CCBHC shall be adjusted annually by the Medicare Economic Index as defined for the federal section 223 CCBHC demonstration.

Discussion—Potential differences between demonstration policy vs ongoing SPA policy

CMS approval appears to be feasible for a SPA that includes all of the provisions listed above except for (4) relating to payment for dual eligibles. Under the CCBHC demonstration, CMS has required full payment of the PPS for all Medicaid enrollees, including dual eligibles. If current CCBHCs continue under demonstration authority while new CCBHCs come under a waiver or SPA, it will be difficult for the state, the MCOs and the CCBHCs to administer different payment policies for current versus new CCBHCs. How the rules under a continued Demonstration extension line up with established DHS dual eligible payment policy must be considered carefully as DHS works through the finer points of the State Plan Amendment.

Recommendation—Potential differences between demonstration policy vs ongoing SPA policy

DHS recommends legislation which would establish the state's preference for consistency in payment policy if certain CCBHCs will be under demonstration authority and others under SPA or waiver authority. This may

require an amendment clarifying M.S. 256B.0625, subd. 5m (d) which directs the commissioner to make certain changes to current CCBHC demonstration policy.

This recommendation requires legislation proposed in the report—see (8) under "Implementation language"

12. Funding for clients who are not MA-eligible

Background

Under the federal demonstration, PPS payments are limited to CCBHC services only for Medicaid recipients. The PPS rate is based on the total cost of CCBHC services divided by the total number of encounters. This means that the PPS rate represents the "average" cost of a CCHBC visit – regardless of payer (MA, private pay, etc.). MA only pays for MA visits. This methodology ensures that costs are appropriately allocated to each payer, and that MA does not pay any costs for other payers.

Federal CCBHC criteria require CCBHCs to provide CCBHC services to everyone in their service area, regardless of insurance coverage or ability to pay. This requirement results in CCBHCs providing needed services to people who are underinsured and uninsured at little to no reimbursement. FQHCs have had similar requirements for a much longer period. For FQHCs, this issue has been addressed via a system of state and federal grants which are used for recipients and costs that are not eligible for PPS reimbursement.

Under Minnesota law, counties are responsible for mental health services which are mandated in the state's Adult and Children's Mental Health Acts, to the extent that these are not covered by the individual's health care coverage. Counties have worked with CCBHCs and other providers to implement sliding fee scales for individuals who are not on MA or who are uninsured or underinsured. The portion of the cost which is not covered by client fees or non-MA health insurance can be covered by counties. However, counties can limit their funding to the amount available, as defined in the state Mental Health Acts.

Discussion—Funding for clients who are not MA-eligible

DHS has been working with CCBHCs to focus their existing state and county grants on non-MA eligibles, thus maximizing the PPS for MA-eligibles. Two years ago, Congress enacted temporary CCBHC grants which are administered by SAMHSA primarily for new CCBHCs that are not currently funded by PPS. FQHCs receive federal funding (section 330) to serve people who are uninsured.

Recommendation—Funding for clients who are not MA-eligible

CCBHCs only receive the PPS rate for recipients who are enrolled in Medicaid. Theoretically, this issue falls outside the scope of the PPS rate methodology. However, both FQHCs and CCBHCs are required to provide services to everyone who comes through their doors. A key difference is that FQHCs receive additional funds to supplement the costs related to the requirement of serving clients who are not MA eligible. FQHCs receive state

and local funding streams—e.g. MN Department of Health, Health Care Access Fund. DHS may need to look at something similar so that CCBHCs can sustain the model.

DHS acknowledges this issue and will continue to work with CCBHCs to focus available grants and other non-MA funding on services for clients who are not MA eligible.

This recommendation does not require legislation.

13. Process for changing the statewide scope of CCBHC services

During the stakeholder workgroup process, questions arose about how to change the set of services that are considered CCBHC services. The CCBHC scope of billable services is a list of procedure codes that defines which billable services are considered to be CCBHC services—also referred to as encounters. Minnesota's scope of CCBHC services was derived from the nine federal categories of services, and are further defined by Minnesota state statute [section 235.735, subd. 3, paragraph (a)]. These questions prompted in-depth discussion on how the set of services identified as CCBHC services could be modified. DHS staff developed draft principles and processes for CCBHC scope of services changes—one related to clinic-specific changes and another to address changes to the statewide scope. A process for determining changes (such as adding services) to the statewide scope of services will be finalized as part of ongoing work.

During the coming years, DHS will apply the finalized principles and process to proposed new CCBHC services. If these changes have a fiscal impact, DHS will consider this in the development of the biennial budget.

Recommendation—Process for changing the statewide scope of CCBHC services

DHS will continue to work with CCBHCs to develop a uniform process and principles for changing the statewide scope of CCBHC services. During the coming years, DHS will apply this process to proposed new CCBHC services. If these changes have a fiscal impact, DHS will consider this in the development of the biennial budget.

This recommendation does not require legislation.

V. Implementation language

DHS recommends the following amendment in M.S. 256B.0625, subd. 5m (d):

M.S. 256B.0625, subd. 5m (d) is amended to read:

Subd. 5m.Certified community behavioral health clinic services.

(a) Medical assistance covers certified community behavioral health clinic (CCBHC) services that meet the requirements of section 245.735, subdivision 3.

(b) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for services delivered by a CCBHC, in accordance with guidance issued by the Centers for Medicare and Medicaid Services. The commissioner shall include a quality bonus payment in the prospective payment system based on federal criteria.

(c) To the extent allowed by federal law, the commissioner may limit the number of CCBHCs for the prospective payment system in paragraph (b) to ensure that the projected claims do not exceed the money appropriated for this purpose. The commissioner shall apply the following priorities, in the order listed, to give preference to clinics that:

(1) provide a comprehensive range of services and evidence-based practices for all age groups, with services being fully coordinated and integrated;

(2) are certified as CCBHCs during the federal section 223 CCBHC demonstration period;

(3) receive CCBHC grants from the United States Department of Health and Human Services; or

(4) focus on serving individuals in tribal areas and other underserved communities.

(d) Unless otherwise indicated in applicable federal requirements, the prospective payment system must continue to be based on the federal instructions issued for the federal section 223 CCBHC demonstration, except:

(1) the commissioner shall rebase CCBHC rates at least every three years;

(2) the commissioner shall provide for a 60-day appeals process of the rebasing;

(3) the prohibition against inclusion of new facilities in the demonstration does not apply after the demonstration ends;

(4) the prospective payment rate under this section does not apply to services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. An entity that receives a prospective payment system rate that overlaps with the CCBHC rate is not eligible for the CCBHC rate;

(5) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments;

(6) initial prospective payment rates for CCBHCs certified after July 1, 2019, shall be based on rates for comparable CCBHCs. If no comparable provider exists, the commissioner shall compute a CCBHC-specific rate based upon the CCBHC's audited costs adjusted for changes in the scope of services; and

(7) the prospective payment rate for each CCBHC shall be adjusted annually by the Medicare Economic Index as defined for the federal section 223 CCBHC demonstration.

(8) If different federal requirements apply to payment for Section 223 demonstration CCBHCs versus those CCBHCs operating under another federal authority, the commissioner shall seek federal approval for a CCBHC payment policy that maximizes uniformity.

(9) The commissioner shall seek federal approval for a CCBHC rate methodology which will allow for changes in rates based on clinic-specific changes in the type, intensity or duration of services. Upon federal approval, CCBHCs may submit change of scope requests to the commissioner if the change of scope would result in an increase or decrease of 2.5 percent or higher in the PPS rate currently received by the CCBHC. CCBHC rate change requests must be according to a format and timeline to be determined by the commissioner, in consultation with the CCBHCs.

(10) Managed care plans and county-based purchasing plans must reimburse CCBHC providers the prospective payment rate under this section. The commissioner shall monitor the effect of this requirement on the rate of access to the services delivered by CCBHC providers. If, for any contract year, federal approval is not received due to the provisions of this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. If federal approval is not received at any time due to the provisions of this paragraph, this paragraph will expire.

VI. Appendix – State quality incentive program

Recommendations for the CCBHC Quality Incentive Program

Background Information about the CCBHC Program

The six Certified Community Behavioral Health Clinics (CCBHCs) and the Minnesota Department of Human Services (DHS) are required to collect and report on quality, client perception of care, and impact data as a condition of participation in the CCBHC Section 223 federal demonstration program. The data reporting requirements are designed to evaluate whether the priorities of the CCBHC program are met: to improve access to care and high-quality services.

Currently, CCBHC federal reporting requirements include 22 quality measures: nine measures calculated by CCBHCs from clinical data collected in their electronic health records; ten measures calculated by DHS from claims data; one measure calculated based on client level data from the CCBHCs; and two client experience of care surveys (one for adults and one for families and children). This appendix includes a list of the current quality measures. Beyond the 22 federally required quality measures, the CCBHC program is also evaluated on eight Minnesota impact measures.

Under the current CCBHC Section 223 federal demonstration payment policy, six of the federally required measures – Suicide Risk Assessment for adults and children, Adherence to Antipsychotics for Individuals with Schizophrenia, Follow up after Hospitalization for Mental Illness for adults and children, and the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – are tied to financial incentives. Specifically, a quality bonus payment (QBP) is paid annually as a lump sum in addition to the basic prospective payment system (PPS) rate to any CCBHC that meets the minimum performance targets set forth for all six measures. Beginning in demonstration year two (DY2) a portion of the QBP is available to CCBHCs who meet two additional optional measures – Plan All Cause Readmission and Screening for Clinical Depression and Follow-up Plan.

Recently, the MN State legislature has required the DHS Commissioner to develop recommendations for a Minnesota-specific quality incentive program for CCBHC. Recommendations will be included in a legislative report on CCBHC rate methodology to be considered for the state plan amendment (SPA) submission. The quality incentive program recommendations are to be developed in consultation with DHS quality staff and stakeholders and must be consistent with measures used for other health care programs. The legislative direction states, “quality payments must be in addition to the prospective payment rate and must not exceed an amount equal to five percent of total medical assistance payment for CCBHC services provided during the applicable time period and the same terms of performance” and must apply to all CCBHCs. (Minnesota Session Laws – 2019, 1st Special Session, Chapter 9--S.F. No. 12, Article 6, Sec.79).

DHS acknowledges the possibility of a congressional extension of the CCBHC Section 223 federal demonstration for additional years. In the event that the federal demonstration is extended, DHS and CCBHC providers are

obligated to follow the reporting requirements and quality bonus program defined by the Centers for Medicare and Medicaid (CMS) for the Section 223 program. An extension would impact the current six CCBHCs certified under the federal demonstration. However, this contingency may not impact new CCBHC programs operating under an 1115 waiver or a state plan amendment (SPA). DHS intends to align data reporting requirements and quality bonus program expectations.

DHS Medicaid Program Priorities

DHS aims to ensure access to quality health care for all people. DHS works with stakeholders to improve access, quality and continuity of care. DHS has continuously engaged in various quality improvement initiatives for its Medicaid program. The CCBHC model aligns with the priorities of the state Medicaid program by improving quality of care, increasing access to services, creating a comprehensive continuum of care that provides coordinated care, and reducing disparities for American Indians, communities of color, veterans, and other cultural groups.

These priorities and goals guided the recommendation to incentivize performance improvement on certain measures. Quality measures recommended for the quality incentive program are consistent with measures used for other health care programs such as Integrated Health Partnership (IHP) and Behavioral Health Homes (BHH). The recommendations presented below by DHS align with the priorities and goals of Minnesota's Medicaid program and the CCBHC model.

Evolution of Quality Measures

DHS acknowledges that Quality Measurement is a dynamic field and change is continuous. Quality measures, value sets, clinical guidelines and priorities may change year to year. The initial goal is to define the priorities of the CCBHC program and the quality measures that will assess and support those priorities. As change occurs, the assessment measures will evolve. DHS recommends implementing an annual review of the quality program and the specific measures to ensure the measures meet the needs of the beneficiaries, providers and the state. See recommendation six below.

Summary of Recommendations

Recommendations were informed by the quality staff across the Department's Healthcare Research and Quality (HRQ) and Behavioral Health Divisions and the CCBHC providers. The DHS quality staff are experienced with quality measures for CCBHC, IHP, and BHH programs. The DHS quality staff recommend that the CCBHC quality incentive program build on measures currently tied to the CCBHC Section 223 quality bonus program, as well as expand the current scope to include new outcome and process measures related to primary care and social determinants of health. The expansion of the scope of measurement to include primary care and social determinants of care emphasizes the role of CCBHCs in coordinating high quality whole person care to Medicaid enrollees. DHS acknowledges that it would be helpful for providers to gain access to care management reports

and other data. The CCBHC providers recommend having access to reports such as those currently available in the BHH Partners Portal to help with performance, quality improvement and care coordination. See recommendation seven below.

Recommendations for the Quality Incentive Program

Recommendation 1a: DHS quality staff recommend grandfathering in the following behavioral health measures:

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)
- Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (FUH-BH-A)
- Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (FUH-BH-C)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)

Reasoning: CCBHCs have committed resources to improve on these measures but have not been able to meet the targets yet. Also, these behavioral health measures are consistent with measures used for other health care programs such as BHH, IHP, and the Medicaid Adult and Child Core Set. In 2024, these behavioral health measures will become mandatory for federal reporting. These measures are calculated from DHS claims and would not require providers to submit additional data to DHS.

The CCBHC providers recommend DHS quality staff explore the possibility of adding additional services to the value sets for these measures, such as peer services, targeted case management (TCM), children's therapeutic services and supports (CTSS) to better align the measures with the CCBHC model. These are typical follow-up services after an individual is hospitalized. DHS quality staff will analyze the data to assess if adding these additional services to the value sets will result in significant changes in the rates for these measures. The CCBHC providers and DHS quality staff acknowledge that non-billable activities will not appear in the claims data and therefore, will not be included in the measure calculations.

Recommendation 1b: DHS quality staff recommend grandfathering in the following clinic-reported quality measures:

- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)
- Major Depressive Disorder: Suicide Risk Assessment (SRA-A)

Reasoning: While DHS acknowledges that the two suicide risk assessment measures have been identified as problematic, the CCBHCs will be responsible for collecting and reporting on these measures to DHS as a requirement of Minnesota's continued participation in the Section 223 federal demonstration should Congress decide to extend the demonstration for one full year (July 2019-June 2020). DHS considered the following options:

1) Do not recommend the SRA measures to be grandfathered into the new Minnesota-specific Quality Incentive Program because of the feedback gathered from CCBHCs providers. However, to align reporting requirements for all CCBHCs (Section 23 demonstration and all others) we recommend continuation of these measures at this time. In particular, the requirements for these measures are that

a person is assessed for suicide risk at every visit. Although this is a relevant requirement for primary care settings or clients seen infrequently in a behavioral health setting; the providers reported that it is not clinically sound to assess for suicide risk on a daily basis when a person is in day treatment, for example. The CCBHC providers and DHS quality staff acknowledge that these measures may result in perverse incentives for the provider, but may not be in the best interest of the person being served. Perhaps a lower rate of suicide risk assessment may be an indicator of a more person-centered approach.

2) Due to the above concerns DHS will work with evaluation staff from the states participating in the Section 223 demonstration to formulate joint recommendations regarding this measure and seek approval by CMS/SAMHSA/ASPE to remove or modify the SRA measures from the quality bonus program.

Recommendations 2 and 3: The following recommendations relate to the expectations of CCBHCs to coordinate care with the primary care providers of the people they serve within their behavioral health clinic. One of the primary goals of CCBHC is to integrate mental health and substance use disorder services as well as coordinate with primary care. Although CCBHCs would not administer some of the primary care screenings and preventive services below, we recommend incentivizing performance to assist the people they serve with scheduling and completing these screenings in order to reach the goal of improving a person's overall health.

Recommendation 2: DHS quality staff recommend including primary care access and preventive health measures, such as:

- Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)
- Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)
- Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)

Reasoning: These measures will set forth incentives for CCBHC providers to coordinate healthcare services with primary care providers to achieve a whole person care approach. A better provision of primary care services may lead to lower costs by helping patients receive appropriate services at appropriate healthcare settings. CCBHCs have already committed resources to collect and report data on these measures around screening for body mass index, tobacco use, and unhealthy alcohol use.

DHS quality staff recommend phasing in additional preventive health measures such as Adolescent Well-Child Visits and Dental Visits for Adults and Children. However, DHS quality staff and the CCBHC providers recommend analyzing historical data for claim-based primary care and preventive health measures before the final measures are selected for the CCBHC quality incentive program. These preventive and access measures are consistent with measures used for other health care programs such as BHH, IHP, and the Medicaid Adult and Child Core Set. In 2024, the child core set measures will become mandatory for federal reporting. These measures are calculated from DHS claims and would not require providers to submit additional data to DHS. The CCBHC providers recommend that DHS research additional preventive care measures around diabetes and cardiovascular screening for potential inclusion in the quality program.

Recommendation 3: DHS quality staff recommend incentivizing providers to focus on process outcomes related to coordination of care with primary care as well as community organizations to address social determinants of health. The following measures are being recommended:

- The number of enrollees with an identified primary care provided on file.
- Referrals to primary care provider: make an appointment, and close the loop by following up with the provider and the patient.
- Referrals to community-based organization: make an appointment, and close the loop by following up with the community-based organization and the patient for services like legal services, housing and food insecurity.

Reasoning: Improvements in health outcomes are often not possible when clients are struggling with basic human needs like access to food or stable housing. Likewise, coordination with primary care services is not possible without establishing a relationship with a primary care provider. Including these measures will create incentives for CCBHCs to support whole person care; referring clients for medical and social needs and closing the loop after the referral. Also, these types of measures concerned with equity are consistent with incentives used in other health care programs such as BHH and IHP. These measures would require a direct data collection from CCBHCs, similar to the data collected from EHRs currently used by CCBHCs to report on the clinic-led measures. CCBHC providers recommend identifying clinic specific measures based on the needs of the communities served by the clinic.

Recommendations 4 and 5: The following recommendations relate to the payment process of the CCBHC quality incentive program and establishing minimum performance thresholds. Quality bonus payments are in addition to the basic PPS rate and will be made to the CCBHCs annually if they meet minimum performance thresholds.

Recommendation 4: DHS quality staff recommend that the performance on the measures listed above be tied to payment in a similar way to how it is done under the current CCBHC Section 223 quality bonus program. Currently, a lump sum is paid to any CCBHC that meets the minimum thresholds for all six quality measures. An additional payment can be made to those CCBHCs who meet the thresholds for all six quality measures and also meet thresholds for two additional optional measures. In the second demonstration year, the payments are made to CCBHCs who exceed their performance on quality measures by fixed percentage points.

CCBHC Demonstration – Quality Bonus Program Payment Formula

The overall bonus pool is equal to 5% of the total PPS payments (not just the wrap portion) – for the year being measured.

- 25% of the overall bonus pool is allocated equally across all Demonstration clinics
- 75% of the overall bonus pool is allocated in proportion to the clinics' number of overall visits

Only the clinics that meet the criteria are awarded their allocation of the overall bonus pool.

Source – Section 223 Demonstration - CCBHC Application Part 3: Prospective Payment System Methodology Description - Minnesota

Reasoning: DHS and CCBHC providers are familiar with the current payment methodology that allocates five percent of the total CCBHC payments to support the quality bonus payments for each demonstration year. Consistent with the current payment methodology, the 2019 MN State legislature required that payments from the new quality incentive program be made in addition to the PPS rate and that they do not exceed the five percent to the total CCBHC payment amount for one demonstration year.

Recommendation 5: The minimum performance thresholds should be established before the new quality incentive program is implemented. DHS quality staff will use a systematic process which will include engaging stakeholders. DHS quality staff will use standard practices when establishing minimum performance thresholds. For example:

- A minimum of 30 clients/visits (i.e., denominator size) for each CCBHC must be present in order for DHS to calculate any given measure. For measures with multiple reported rates, the minimum denominator size will need to be met for all rates calculated under the measure (e.g., 7 day and 30 day follow up measures).
- DHS quality staff will review historical data and will analyze trends to inform benchmarks.
- DHS quality staff will also consider regional and national benchmarks as well as MN statewide averages and performance of comparable non-CCBHC providers.
- DHS quality staff may consider establishing benchmarks that are clinic-specific. DHS quality staff acknowledge that each CCBHC has a different level of experience with quality measures and data collection. In addition, the measures are not risk-adjusted to account for the differences in the client population at each CCBHC.
- DHS quality staff will work with each CCBHC to establish minimum performance thresholds that are reasonably achievable but represent opportunities to incrementally improve performance compared to historical performance.

Recommendations 6 and 7: The following recommendations relate to the measure review process of the CCBHC quality incentive program and access to data. Data is a critical component of the measure review process and performance. DHS also acknowledges that it would be helpful for providers to gain access to care management reports and other data to help with performance on the measures.

Recommendation 6: DHS quality staff recommend establishing a process for periodically reviewing and revisiting the CCBHC quality incentive program. DHS is aware that quality measures can evolve over time and that quality measure criteria, value sets, clinical guidelines and priorities may change from year to year. The CCBHC quality incentive program will progress with the needs and priorities of CCBHC. It is recommended that the process for reviewing, revisiting and finalizing the measures to include in the CCBHC quality incentive program begin in Spring 2020. DHS quality staff will use a systematic process in reviewing measures. For example:

- DHS quality staff will engage stakeholders in its measure review process. This will allow stakeholders to participate, engage, and influence decisions made around quality incentive program measures. This will also allow for transparency around the measure review process.
- DHS quality staff and stakeholders will review the quality incentive program measures on an annual basis for the coming year to:
    - Make note of any changes to the measurement specifications that may occur in the coming year.
    - Ensure that the measures continue to align with other DHS health programs, the state Medicaid program, and goals and priorities of the CCBHC model.
    - Review performance on the measures and take into consideration if a measure should be continued or removed from the CCBHC quality incentive program.
    - Review performance to address topped out measures.
    - Consider additional measures to the CCBHC quality incentive program.
- DHS quality staff will document all measure review processes and decisions made around quality incentive program measures.
- DHS quality staff and stakeholders will complete measure review before performance thresholds are established for the coming year. For example, measures will be reviewed in November and thresholds will be established in December for a performance period beginning January 1.

Recommendation 7: CCBHC providers recommend having access to reports such as those currently available in the BHH Partners Portal to help with performance, quality improvement and care coordination.

Reasoning: The CCBHC providers acknowledge that they have an indirect impact on some of the quality measures, especially the measures being calculated based on DHS Medicaid claims data. The providers would like access to timely data (such as on a quarterly basis) to help the providers with performance as well as quality improvement. The CCBHC providers will also be able to use the data to better meet expectations for care coordination.

Clinic-Led Measures (Data source: CCBHC)

Measure Name	Measure Steward
Time to Initial Evaluation (I-EVAL)	SAMHSA
Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	CMS
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-BH)	NCQA
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	AMA-PCPI
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	AMA-PCPI
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	AMA-PCPI
Major Depressive Disorder: Suicide Risk Assessment (SRA-A)	AMA-PCPI
Screening for Clinical Depression and Follow-Up Plan (CDF-BH)	CMS
Depression Remission at Twelve Months (DEP-REM-12)	MNCM

State-Led Measures (Data source: DHS MMIS)

Measure Name	Measure Steward
Housing Status (HOU)*	SAMHSA
Patient Experience of Care Survey (PEC)^	SAMHSA
Youth/Family Experience of Care Survey (Y/FEC)^	SAMHSA
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	NCQA
Plan All-Cause Readmission Rate (PCR-BH)	NCQA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD)	NCQA
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)	CMS
Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (FUH-BH-A)	NCQA

Measure Name	Measure Steward
Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (FUH-BH-C)	NCQA
Follow-up care for children prescribed ADHD medication (ADD-BH)	NCQA
Antidepressant Medication Management (AMM-BH)	NCQA
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)	NCQA

*Calculated from client level data provided by CCBHCs