DEPARTMENT OF HUMAN SERVICES

Legislative Report

Preventing Duplication of Payment in Behavioral Health Integrated Treatment Models

Recommendations to the 2021 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 $11,500.

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I. Executive summary

Certified Community Behavioral Health Clinic (CCBHC) is an integrated clinic and service delivery model that uses a cost-based reimbursement structure. This service delivery model aims to integrate mental health and substance use disorder service provision, coordinate care across settings and providers to ensure seamless transitions for individuals across the full spectrum of health and social services, increase consistent use of evidence-based practices, and increase access to high-quality behavioral health care.

This report is submitted in response to 2019 legislation which directs the commissioner of human services to work with Certified Community Behavioral Health Clinic (CCBHC) providers and other stakeholders who also receive prospective payment system (PPS) rates—to study the various payment methodologies and ensure that payment is not duplicated across the continuum as Minnesota advances the integrated service model across health care sectors.

Prospective Payment System (PPS) is a method of reimbursement that falls in the category of alternative payment models (APM), also referred to as alternative payment methodologies. The Centers for Medicare and Medicaid Services (CMS) has supported states' use of alternative payment models because they reward providers for efficiency and incentivize outcomes. A PPS rate is bundled in nature. Under a bundled payment model, providers and/or healthcare facilities are paid a single payment for all the allowable services performed within a defined unit (e.g. daily or monthly).

With increased use of alternative payment methodologies, an important consideration is how the alternative payment model aligns with other payers and service models—for example, the payer must ensure that payments are not duplicated across multiple, integrated care service models. Ensuring that payment for behavioral health services and supports is not duplicated across Minnesota's service continuum is the focus of this report.

DHS identified the following integrated service models that receive an alternative payment model (APM) where behavioral health services are provided:

- Behavioral Health Homes (BHH)
- Certified Community Behavioral Health Centers (CCBHC)
- Federally Qualified Health Centers (FQHC)
- Integrated Health Partnerships (IHP)

Note – Indian Health Services (IHS)/Tribal 638 agencies receive the federally-negotiated encounter rate for an array of physical and behavioral health care services. Please see Section VI of this report for additional information.

An overview of each of the integrated service models and their respective payment is provided in Section IV. The payment methodologies were analyzed and conclusions follow.

DHS maintains an intentional effort to ensure that no duplication of payment occurs across the four service models.

- An IHP cannot receive a population-based payment (PBP) for an individual beneficiary attributed to them if any provider also received a BHH payment for that beneficiary during the same time period. Potential IHP shared savings payments or shared loss recoupments are only included in the Track 2 IHP model. These payments are not tied to specific services and are considered incentive payments to encourage the efficient delivery of overall health care to Medicaid and MinnesotaCare patients. Given the potential for shared losses, providers paid through an APM that includes a minimum daily encounter rate are unable to participate in Track 2 of the IHP program, such as FQHCs and RHCs. It appears that we would need to extend this prohibition to CCBHCs, allowing them to only potentially participate in a Track 1 IHP model. Any future considerations that might modify this prohibition would need to consider the impact on FQHCs, RHCs, and CCBHCs.

- DHS intentionally excludes all BHH costs from the cost base which was used to calculate each CCBHC's PPS rate.

- CCBHCs are certified by the State of Minnesota's Department of Human Services (DHS)—Minnesota state law and federal Medicaid (State Plan Amendment) rules determine the payment methodology.

- FQHCs are federally certified by the Health Resources and Services Administration (HRSA)—HRSA rules determine the payment. For this reason, the CCBHC and FQHC rates cannot be co-mingled.

- As the CCBHC model expands statewide, there is interest by providers in obtaining a dual certification (CCBHC-FQHC).
  - FQHCs provide a full array of health care services—they are able to offer behavioral health services that are included in the CCBHC model as long as the FQHC has the correct state certifications and licensures. If an FQHC wishes to also become certified by DHS as a CCBHC, the FQHC would incorporate all new costs into the existing FQHC encounter rate.
  - Conversely, if a CCBHC wants to become an FQHC in order to provide a fuller scope of services, they must work with HRSA to receive the certification, and then the FQHC rate would be paid by incorporating all new CCBHC costs into the existing FQHC encounter rate instead of the CCBHC rate.

- As the CCBHC model expands statewide, CCBHCs may wish to offer a change in the type, intensity or duration of services.
  - In a previously-published legislative report (DHS-8032-ENG, *CCBHC Rate Methodology*)[1], a CCBHC change in scope process was explored, similar to what the FQHCs use. 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". The report recommended legislation that was eventually passed, allowing DHS to negotiate with CMS on a

[1] https://www.leg.mn.gov/docs/2020/mandated/200272.pdf

clinic-specific change in scope process for CCBHCs. These negotiations are currently underway as DHS seeks approval to include the CCBHC array of services, activities and cost into Minnesota's Medicaid state plan. The legislation can be found in Minnesota Laws 2020, 1st Special Session, Chapter 2, Article 2, Section 12[2] is found here.

- This same legislation also directs DHS to develop a Minnesota-specific quality incentive program for CCBHCs that achieve target performance on select quality measures. The CCBHC quality incentive program is under review by CMS as the state negotiates the terms of Minnesota's Medicaid state plan.
  - If an FQHC becomes certified as a CCBHC, DHS needs to explore any potential overlap in productivity adjustments and grants they receive before authorizing a CCBHC incentive payment to the FQHC.

The report recommends that as the CCBHC model evolves from the federal demonstration (Section 223 of the Protection Access to Medicare Act, PL 113-93) into a statewide Medicaid benefit under Minnesota's Medicaid state plan, CCBHCs should utilize the change in scope rate adjustment process to prevent duplication of payment.

[2] https://www.revisor.mn.gov/laws/2020/1/Session+Law/Chapter/2/

II. Legislation

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

(c) The commissioner shall consult with CCBHCs and other providers receiving a prospective payment system rate to study a rate methodology that eliminates potential duplication of payment for CCBHC providers who also receive a separate prospective payment system rate. By February 15, 2021, 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 findings and recommendations related to the rate methodology study under this paragraph, including any necessary statutory updates to implement recommendations.

The referenced legislation[3] is found here.

[3] https://www.revisor.mn.gov/laws/2020/1/Session+Law/Chapter/2/

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. It directs the commissioner of human services to work with CCBHC providers and other providers receiving a prospective payment system rate to study a rate methodology that eliminates potential duplication of payment for CCBHC providers who also receive a separate prospective payment system rate.

Background

The legislation requiring this report originated from the anticipated expansion of the Certified Community Behavioral Health Center (CCBHC) federal demonstration (Section 223 of the Protection Access to Medicare Act, PL 113-93) into a statewide Medicaid benefit under Minnesota's Medicaid state plan. This report explores payment across integrated treatment models where Behavioral Health services are provided as part of the service array.

How this report was prepared

A cross-divisional DHS workgroup was convened that included various divisions of the Community Supports Administration and the Health Care Administration. Staff and management from the Behavioral Health Division, Purchase of Service Delivery, Health Research and Quality, Federal Relations and Tribal Relations areas met during the fall and winter of 2020. The workgroup reviewed and discussed integrated service models where behavioral health services are provided, analyzed payment methodologies, identified key issues, weighed incentives/disincentives and formulated the recommended path forward that ensures continued non-duplication of payment across service models.

Certified Community Behavioral Health Centers (CCBHC) and Federally Qualified Health Centers (FQHC) were also engaged in November and December 2020. Information was shared through WebEx meetings and/or email, and their feedback was sought throughout that process.

This report is a summary of the workgroup's findings, conclusions and recommendation.

IV. Preventing Duplication of Payment across Integrated Service Models

Service Models that Receive an Alternative Payment Model (APM)

This report explores payment across integrated treatment models where Behavioral Health services are provided as part of the service array. DHS identified the following service models that receive an Alternative Payment Model (APM):

- Behavioral Health Homes (BHH)
- Certified Community Behavioral Health Centers (CCBHC)
- Federally Qualified Health Centers (FQHC)
- Integrated Health Partnerships (IHP)

Note – Indian Health Services (IHS)/Tribal 638 agencies receive the federally-negotiated encounter rate for an array of behavioral health and physical health services. Please see Section VI of this report for additional information.

An overview of each of the integrated service models and their respective payment methodologies follows.

Behavioral Health Homes (BHH)

BHH – Overview of Service Model

The Patient Protection and Affordable Care Act of 2010 (ACA) created an optional "health home" benefit so that states could better coordinate care for Medicaid enrollees with chronic conditions. Behavioral Health Home (BHH) services are Minnesota's version of the federal "health home" benefit for Medical Assistance (MA) enrollees. BHH services include the following:

- Comprehensive care management
- Care coordination
- Health promotion and wellness
- Comprehensive transitional care
- Patient and family support
- Referral to community and social support services

BHH – Overview of Payment Methodology

The rate for behavioral health home services is a per member per month payment. BHH services are covered only when provided by a certified BHH provider. Certified BHH service providers are required to carry out a service eligibility determination prior to billing for BHH services.

To receive payment for delivery of Behavioral Health Home services, certified providers must:

- Have personal contact with the person or the identified support at least once per month. Personal contact may include face-to-face, telephone contact or interactive video. An email, letter, voicemail or text alone does not meet the requirement for monthly personal contact.
- Conduct a face-to-face visit with the person at least every six months

Certified Community Behavioral Health Centers (CCBHC)

CCBHC – Overview of Service Model

Certified Community Behavioral Health Clinic (CCBHC) is an integrated clinic and service delivery model that uses a cost-based reimbursement structure. Originally a federal demonstration project from 2017-2019, this new service delivery model aims to integrate mental health and substance use disorder service provision, coordinate care across settings and providers to ensure seamless transitions for individuals across the full spectrum of health and social services, increase consistent use of evidence-based practices, and increase access to high-quality behavioral health care. The goal of CCBHC is to increase access to behavioral health services for underserved communities, particularly communities that are Black, Indigenous or People of Color or that speak languages other than English. CCBHCs are required to serve all ages, regardless of ability to pay or place of residence. CCBHCs are certified by the State of Minnesota utilizing the CCBHC federal criteria[4] defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as well as some state-specific requirements.

CCBHCs must offer care that is person-centered and family-centered, trauma-informed, recovery-oriented, and the integration of mental health and substance use disorder services in coordination with physical health care and social services must serve the "whole person" rather than disconnecting aspects of the individual. The CCBHC model embraces a recovery-oriented philosophy, supporting multiple pathways for individuals to recover from mental illness and substance use disorders including medication-assisted recovery—the use of medication, in combination with counseling and care coordination services, to provide effective support for recovery from addictive substances as well as mental illness. CCBHCs offer outpatient mental health and substance use disorder treatment services, mental health targeted case management, rehabilitative services, peer services,

[4] https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

diagnostic and treatment planning services, care coordination, primary care screenings and 24-hour mobile mental health crisis services in their defined service areas.

Six CCBHCs were certified by the State for the federal demonstration project and served approximately 20,000 people in those two years (approximately 15,000 were Medicaid enrollees). Four CCBHCs were later certified by SAMHSA and provided federal grant funds to operate in Minnesota. Two of those clinics have now been state-certified and are receiving the cost-based PPS rate contingent on CMS' approval of Minnesota's amendment to the Medicaid state plan to include CCBHC as a state-wide permanent benefit. It is projected that, once approved, four to six CCBHCs could be certified each year.

CCBHC – Overview of Payment Methodology

The CCBHC PPS rate is a bundled, per diem rate based on allowable costs of furnishing all CCBHC services, not on a fee schedule. The required services are operationalized in about 60 procedure codes in the CCBHC scope of services. It is an integrated payment for mental health and substance abuse disorder services. This payment model allows more people to be served, more people to be hired and increased capacity.

The PPS rate is a clinic-specific daily rate developed from audited cost data provided on CMS required cost reports and reported visits. Minnesota's certified clinics may eventually contract with designated collaborating organizations (DCOs)—however, there are no DCOs at the present time. The same rate is paid for each qualifying unit of service ("visit"), regardless of the intensity of services provided.

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.

Federally Qualified Health Centers (FQHC)

FQHC – Overview of Service Model

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) are community based clinics that provide services to underserved communities. FQHC's are required to provide preventive and primary care services. FQHCs may also offer other ambulatory care services such as dental, vision and behavioral health services. FQHCs are required to treat all patients regardless of the ability to pay and may only charge nominal fees to patients with incomes below the federal poverty level. Given these requirements, an FQHC's Medicaid patient base is often the main revenue generating population. FQHCs must be certified by the Health Resources

and Services Administration (HRSA) and are eligible for federal grant funds from that agency. The grant funds help offset the costs of providing services to low income and uninsured patients.

Medicaid programs are required to include FQHC services and to include FQHC clinics in their provider networks. Medicaid programs have also historically been required to reimburse FQHCs at cost. This ensured that federal grant dollars were used to offset the cost of treating uninsured patients instead of subsidizing Medicaid costs.

FQHC – Overview of Payment Methodology

In 2000, Congress established a new prospective payment system (PPS) for FQHCs and RHCs as part of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (PL 106-554). This was in response to the expansion of managed care plans in Medicaid. The new PPS payment methodology required that FQHCs and RHCs be paid, at a minimum, their baseline (1999-2000) costs and ensured that the payments would be indexed to medical inflation each year. The law also required states to compute and reimburse the clinics for any shortfall between the clinic's costs and the payments they received from Medicaid managed care plans for treating Medicaid patients. States are free to set payment rates that are higher than the PPS rate but cannot pay a rate that would be lower than the PPS rate.

In accordance with the 2000 law change, Medicaid agencies are required to calculate and pay FQHCs and RHCs an encounter payment. Encounter payments are once daily payments that are triggered on any day in which a licensed professional provides a billable service to a Medicaid client. All services provided on that day are included in the encounter payment. Encounter payments are calculated such that all of a clinic's allowable costs are covered by the encounter payment. Specifically, encounter rates are computed by summing the clinic's total annual allowable costs, and dividing the total costs by the unduplicated number of visits, or encounters, with a medical or behavioral health provider that is eligible to bill DHS independently. In this way, all the clinic's costs are accounted for in the rate even if not every service is billed.

Integrated Health Partnerships (IHP)

IHP – Overview of Service Model

In 2008, Minnesota passed health care legislation to improve affordability of health care, expand coverage and improve the overall health of Minnesotans. In addition, the 2010 Legislature mandated that the Minnesota Department of Human Services (DHS) develop and implement a demonstration testing alternative health care delivery systems, which includes accountable care organizations (ACOs). This led to the development of IHP, formerly called the Health Care Delivery Systems (HCDS) demonstration, which strives to deliver higher quality and lower cost health care through innovative approaches to care and payment. The first IHPs launched in 2013.

With this program, Minnesota is one of a growing number of states to implement an ACO model in its Medical Assistance (Medicaid) program, with the goal of improving the health of the population and of individual members.

IHP Request for Proposal (RFP) Process | Core System Requirements

- Ability to provide or coordinate full scope of health care services
- Innovative care delivery model able to lower total cost of care, enhance quality of care delivered, focus on population health
- Care model includes partnerships with community-based organizations, social service agencies, counties, and public health resources
- Meaningful engagement with patients and families as partners in care delivery, quality improvement
- Ability to take on level of financial risk/loss commensurate with potential gains
- Minnesota Health Care Program (MHCP) enrolled providers able to receive and engage with health data from DHS

IHP – Overview of Payment Methodology

There is a core set of services that providers are accountable for regardless of whether they deliver the care. An IHP may elect to include additional services. Fee-for-service payments to providers continue with a settlement for gain or loss sharing payments made annually based on performance on cost and quality.

There are two separate tracks for payment as outlined below:

1) Track 1 – IHP entity receives a risk-adjusted quarterly population-based payment (PBP) tied to clinical, utilization and social determinant metrics

2) Track 2 – IHP entity receives a risk-adjusted quarterly PBP *and* enters into a two-way risk model for shared savings/losses tied to clinical, patient experience, social determinants, and Health Information Exchange (HIE) infrastructure metrics

Within the two-way risk model, a total cost of care (TCOC) financial target is measured against actual enrollee medical expenses to determine shared savings or loss if providers go above or below their target.

- Loss - Delivery system pays back a pre-negotiated share of spending above the minimum threshold
- Gain - Savings achieved beyond the minimum threshold are shared with the delivery system at pre-negotiated levels, contingent on quality measurement performance

Analysis of Service Model Payment

Behavioral Health Homes (BHH)

Before the CCBHC Demonstration began, DHS established BHH coverage policy in a manner that would prevent payment for potentially duplicative services. Under BHH policy, a person is not able to receive BHH services and any of the following services in the same calendar month:

- Mental health targeted case management (MH-TCM)
- Assertive Community Treatment (ACT) or Youth Assertive Community Treatment (Youth ACT)
- Relocation service coordination targeted case management (RSC-TCM)
- Vulnerable adult/developmental disability targeted case management (VA/DD-TCM)
- Health care homes (HCH) care coordination

A person who meets the eligibility criteria for one or more of these covered services must choose which service best meets his or her needs. MH-TCM is the primary CCBHC service that could overlap with BHH. The above policy addressed most of the potential overlap between CCBHC and BHH payment.

When CCBHC rates were established in 2017 and rebased in 2018, DHS took the additional step of excluding all BHH costs from the cost base which was used to calculate each CCBHC's PPS rate.

The above steps have ensured that that there is no overlap between BHH payment and the CCBHC rate. These steps have worked well and should be continued. No additional changes are necessary to prevent duplication of payment between BHH and CCBHCs.

Integrated Health Partnerships (IHP)

Based on authorizing state plan language and contract terms between DHS and participating IHP providers, an IHP cannot receive a population-based payment (PBP) for an individual beneficiary attributed to them if any provider also received a BHH payment for that beneficiary during the same time period. To implement this requirement, DHS conducts an annual reconciliation process in the quarter following the close of a given IHP performance period. Within this process, DHS identifies any beneficiaries for which a BHH payment was made during that performance period that was also attributed to an IHP, and recovers a dollar amount equivalent to the average individual PBP payment for each identified beneficiary.

Potential shared savings payments or shared loss recoupments are only included in the Track 2 IHP model. Generally, Track 2 is available only to those IHPs that have a sufficient number of attributed Medicaid or MinnesotaCare beneficiaries and are able to accommodate a recoupment if a shared loss occurs. For these Track 2 IHPs, a shared savings payment occurs when their actual, overall total cost of care for a given performance period is at least 2% lower than an established target. IHP shared savings payments are not tied to any specific services and are not considered a reimbursement or encounter rate payment. They are an incentive payment to encourage the efficient delivery of overall health care to Medicaid and MinnesotaCare patients. Therefore, they are not considered duplicative or redundant with any service or encounter rate payments in place to support care coordination or care management.

One potential future consideration within the IHP program is whether a provider system that receives reimbursement through an APM that includes a minimum encounter rate, such as with FQHCs and RHCs, would be eligible to participate in a model with shared loss potential. DHS's current understanding of these payment models suggests that they would *not* be able to. During previous discussions, CMS suggested that we consider allowing only the population-based payment to be at risk in these cases. At this point, we have no IHPs that contain an FQHC, RHC, or a CCBHC provider participating in a Track 2 model.

CCBHC, FQHC – An In-depth Look

CCBHCs are state certified by DHS—the federal Section 223 demonstration rules, Minnesota state law and pending Medicaid State Plan amendment (SPA) determine the rate methodology. FQHCs are federally certified by the Health Resources and Services Administration (HRSA)—HRSA rules determine the payment. For this reason, the two rates cannot be co-mingled.

As the CCBHC model expands statewide, there is interest in a dual certification (CCBHC-FQHC). FQHCs provide a full array of services—they are able to offer behavioral health services with the correct licensures. If an FQHC wishes to also become certified by DHS to be recognized as providing the CCBHC model of integrated care, the FQHC would incorporate all new costs into the existing FQHC encounter rate. Conversely, if a CCBHC wants to become an FQHC in order to provide a fuller scope of services, they must work with HRSA to receive the certification and submit an FQHC cost report to DHS. Subsequently the FQHC rate would be paid instead of the CCBHC rate.

CCBHCs have also expressed interest in expanding their services. In a previously-published legislative report (DHS-8032-ENG, CCBHC Rate Methodology)[5], a CCBHC change in scope process was explored, similar to what the FQHCs use. 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". The report recommended legislation that was eventually passed, allowing DHS to negotiate with CMS on a clinic-specific change in scope process for CCBHCs. These negotiations are currently underway as we seek approval of an amendment to Minnesota's Medicaid State Plan to add the CCBHC service and payment model as a statewide Medicaid benefit. The legislation (Minnesota Session Laws – 2020, 1st Special Session, chapter 2, article 2, sec. 12)[6] is found here.

This same legislation also directs DHS to develop a Minnesota-specific quality incentive program for CCBHCs that achieve target performance on select quality measures. The CCBHC quality incentive program is under review by CMS as the state negotiates the terms of Minnesota's Medicaid state plan. In the future, if an FQHC becomes certified as a CCBHC, DHS needs to explore any potential overlap with productivity adjustments and grants they receive in order to fully understand whether or how a CCBHC incentive payment to the FQHC would work. There are other considerations that need to be weighed—e.g. federal authority, state budget authority and data reporting/evaluation measurement issues to work through.

[5] https://www.leg.mn.gov/docs/2020/mandated/200272.pdf

[6] https://www.revisor.mn.gov/laws/2020/1/Session+Law/Chapter/2/

V. Recommendation

As CCBHC evolves from the federal demonstration (Section 223 of the Protection Access to Medicare Act, PL 113-93) into a statewide Medicaid benefit under Minnesota's Medicaid state plan, the recommendation in this report is to utilize the change in scope rate adjustment process to prevent duplication of payment.

This recommendation is supported by the following considerations:

- While FQHCs can also become certified as CCBHCs, we would not want to see them drop their FQHC status. By virtue of being an FQHC, they receive technical assistance funding from HRSA and have community boards and incentives, which are an important piece of the model.

- As part of the overall analysis, important goals surfaced:
  - Maintain the integrity of the FQHC's payment and not disrupt the one-rate model
  - Avoid creating any disincentives for one service model versus another

- Recognition that there is not anything in the CCBHC scope of services that does not currently align with the FQHC service model.
  - CCBHC PPS is limited to the costs of behavioral health services/activities in the CCBHC scope of services
  - FQHC PPS includes the cost of all primary care and behavioral health services/activities

- Cost reporting rules and formats are different for FQHCs and CCBHCs; integrating all costs into one FQHC cost report is simpler, more efficient and less prone to error.

- Billing and claims processing rules are also different for FQHCs and CCBHCs; a single, all-inclusive encounter rate is more efficient and less expensive to administer.

- Since the FQHC rate and the CCBHC rate are both cost-based rates, there is no financial advantage to the provider to have two rates instead of one.

- An integrated FQHC cost report and rate supports better integration of primary and behavioral health care.

- Separating behavioral health costs into a CCBHC cost report could raise questions regarding use of FQHC grants for behavioral health costs of uninsured patients.

The recommendation in this report does not require legislation as current processes exist.

VI. Indian Health Services (IHS)

This report explores payment across integrated treatment models where Behavioral Health services are provided as part of the service array.

An important distinction here is that CCBHCs and FQHCs receive only one PPS payment per day for providing behavioral health services, regardless of the number of services provided to an eligible recipient on that date of service. This differs from the Indian Health Services (IHS) Encounter Rate—which is billed more than once per day. This nuance creates a financial disincentive for the tribes if they are interested in becoming certified as a CCBHC or FQHC.

DHS is interested in working with our tribal partners to operationalize the construct for a culturally-appropriate model that integrates primary care, behavioral health (including historical trauma), substance use disorder (SUD) treatment, medication-assisted treatment (MAT) – while maintaining the financial incentive of tribal encounter rate billing for multiple services.

While DHS recognizes there is no duplication of payment between CCBHCs, FQHCs and IHS, the interest in a tribal integrated model of care requires further study, which is outside the scope of this report. DHS looks forward to continued work with the tribal behavioral health providers to further explore a culturally-relevant integrated model of care.

VII. Stakeholder feedback

In the development of this report DHS consulted with CCBHCs and other providers receiving a prospective payment system rate to study a rate methodology that eliminates potential duplication of payment for CCBHC providers who also receive a separate prospective payment system rate. Following consultation written responses were received from the Minnesota Association of Community Health Centers (MNACHC) and the Minnesota Association of Community Mental Health Programs (MACMHP). The two letters are attached as appendices to this report.

MNACHC expressed their overall support for the report. They agree with utilizing the state's existing "change of scope" process to allow additional costs to be added to the FQHC's Medical Assistance Alternative Payment Model 4 rate if an FQHC becomes certified as a CCBHC. They support the use of a single cost report, based on the Medicare Cost Report that is currently used, and they agree with the need to evaluate whether any overlap exists between FQHC productivity adjustments / grants and potential future CCBHC incentive payments. MNACHC agrees that while FQHCs can also become certified as CCBHCs, they would not want to lose their FQHC status and pointed to several important reasons. They too want to maintain the integrity of the FQHC's payment, not disrupt the one-rate model and avoid creating any disincentives for one service model versus another.

MACMHP also supports the use of a single, all-inclusive encounter rate for dually-certified FQHCs and CCBHCs. They agree that integrating all costs into a single cost report improves efficiency and removes the potential for error. They support the use of a cost reporting tool that is established and recognized by both the state of Minnesota and federal government. MACMHP believes that an integrated process, cost report and rate supports integration of primary and behavioral health and crossover needs of both models.

MNACHC and MACMHP encouraged DHS to ensure that the costs related to addressing social determinants of health and providing targeted case management services are included as part of an integrated PPS model, not only from a reimbursement perspective but also to address social factors that create health care disparities. DHS is commited to addressing disparities as main priority of the Governor and Administration.

DHS thanks everyone who participated in the stakeholder engagement process, appreciates the partnership and collaboration in preparing this report and looks forward to continuing our work together.

VIII. Implementation language

No statutory updates are needed to implement recommendations.

IX. Appendix

Minnesota Association of Community Mental Health Programs

TO: Minnesota Department of Human Services
FROM: Minnesota Association of Community Mental Health Programs
DATE: January 11, 2021
RE: Comments to Preventing Duplication of Payment in Behavioral Health Integrated Treatment Models DRAFT Legislative Report

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On behalf of the Minnesota Association of Community Mental Health Programs (MACMHP), I am submitting these comments regarding the draft Legislative Report - *Preventing Duplication of Payment in Behavioral Health Integrated Treatment Models*.

Minnesota Community Mental Health Programs' Perspective
The Minnesota Association of Community Mental Health Programs (MACMHP) is the state's leading association for Community Mental Health Programs, representing 32 community-based mental health providers and agencies across the state. Collectively, we serve over 200,000 Minnesota families, children and adults. Our mission is to serve all who come to us seeking mental and chemical health services, regardless of their insurance status, ability to pay or where they live. All eight of the current certified community behavioral health clinics (CCBHCs) are member agencies of the association and represented by MACMHP.

Overall, MACMHP supports the recommendations – using the change in scope process to prevent duplicated payments – and analyses in this report. MACMHP understands the Department is continuing the development of a CCBHC change in scope rate adjustment process. We encourage the Department to keep this recommendation in consideration as it continues this work. We also appreciate continued partnership and participation in the development of this process.

In addition to our overall support, I included comments to specific recommendations and rationale:

V. Recommendation

- Recognition that there is not anything in the CCBHC scope of services that does not currently align with the FQHC service model.
    - CCBHC PPS is limited to the costs of behavioral health services/activities in the CCBHC scope of services
    - FQHC PPS includes the cost of all primary care and behavioral health services/activities

      MACMHP: Both entities also provide numerous services addressing clients/ patients' social determinants of health. We encourage the Department to continue to ensure FQHCs and CCBHCs can provide these critical services and be paid accordingly for them - i.e. housing, transportation, language interpretation, food access, care coordination, occupational therapy and preventive care. We encourage the Department to incorporate the costs of services addressing social determinants of health into allowable costs of an integrated PPS model. As equity is a main priority of the Governor and Administration, we believe this will aligns well with that commitment.

      Additionally, MACMHP represents some Metro-based FQHCs in our association. We encourage the Department to implement a payment process that ensures FQHCs' PPS reimbursement incorporates targeted case management and other critical behavioral health services they provide to patients.

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- *Cost reporting rules and formats are different for FQHCs and CCBHCs; integrating all costs into one FQHC cost report is simpler, more efficient and less prone to error.*

  MACMHP: MACMHP supports integrating all costs into one consistent cost report for efficiency and removing potentials for error. MACMHP also supports using a cost reporting tool that is established and recognized by both the state of Minnesota and Federal government public benefit programs. We would want to ensure the cost report incorporates/ accommodates Minnesota Medicaid-covered services required by either model, which may not be covered by Medicare or other public benefits.

- *Billing and claims processing rules are also different for FQHCs and CCBHCs; a single, all-inclusive encounter rate is more efficient and less expensive to administer.*

  MACMHP: MACMHP supports a single, all-inclusive encounter rate and payment process as opposed to separate different billing and claims processing rules. As appropriate, MACMHP requests to partner and participate in the development of this process.

- *An integrated FQHC cost report and rate supports better integration of primary and behavioral health care.*

  MACMHP: MACMHP supports the recommendation of an integrated process, cost report and rate for better integration of primary and behavioral health care. We believe this will support crossover needs of both models – FQHCs expanding behavioral health care access and CCBHCs expanding access to primary care. As appropriate, MACMHP requests to partner and participate in the development of this process.

Thank you for the opportunity to participate in this process and provide feedback to the report. Please do not hesitate to reach out with questions to our comments.

Thank you for your leadership in addressing this issue.

Sincerely,

Jin Lee Palen,
Executive Director
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651-571-0515

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January 8, 2021

Kristy Graume
Director of Legislative and External Affairs | Community Supports
Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55155-0967

Sent electronically

Dear Ms. Graume:

The Minnesota Association of Community Health Centers (MNACHC) appreciates the opportunity to comment as a stakeholder on the Department of Human Services' (DHS) report, "Preventing Duplication of Payment in Behavioral Health Integrated Treatment Models." MNACHC represents the interests of Minnesota's 17 federally qualified health centers (FQHCs) commonly referred to as Community Health Centers (CHCs). Collectively, FQHCs serve nearly 200,000 low-income Minnesotans.

We also appreciate DHS' outreach to our membership through a webinar in December of 2020 to solicit Community Health Center feedback.

Overall, MNACHC supports the recommendations outlined in the report. All CHCs have expressed interest in expanding and deepening behavioral health services to our patients. There are a variety of pathways to achieve this goal ranging from expanding services under the FQHC designation, exploring CCBHC designation and understanding the state's substance use disorder (SUD) reforms per the "245G" program.

The following lists MNACHC's feedback to specific portions of the draft report:

15	"If an FQHC wishes to also become certified by DHS to be recognized as providing the CCBHC model of integrated care, the FQHC would incorporate all new costs into the existing FQHC encounter rate"	MNACHC agrees that for any FQHC that secures CCBHC designation, the additional allowable costs that result from the modification of the delivery model should be included in the FQHC's Medical Assistance PPS/APM4 rate. This will be formally requested and evaluated through the state's "change of scope" process[1].

[1] Minn. Stat. 256B.0625, subd. 30, para (l), section (9)

15	In the future, if an FQHC becomes certified as a CCBHC, DHS needs to explore any potential overlap with productivity adjustments and grants they receive in order to fully understand whether or how a CCBHC incentive payment to the FQHC would work. There are other considerations that need to be weighed—e.g. federal authority, state budget authority and data reporting/evaluation measurement issues to work through.	MNACHC agrees that an evaluation of potential overlap productivity adjustments and grants is necessary to understand potential incentive payments. To clarify, FQHCs are eligible currently for incentive payments that do not affect each FQHC's Medical Assistance PPS/APM rate.
Report Recommendations (page 16)		
1	While FQHCs can also become certified as CCBHCs, we would not want to see them drop their FQHC status. By virtue of being an FQHC, they receive technical assistance funding from HRSA and have community boards and incentives, which are an important piece of the model.	MNACHC agrees with this recommendation. The FQHC designation is the foundation of the delivery model employed by FQHCs for over five-decades in Minnesota. MNACHC and FQHCs place high-priority on complying with HRSA program regulations and are continually evaluated by HRSA to fulfill those compliance requirements. It is important to note that FQHCs hold multiple designations, such as an FQHC in Minnesota that is also a Rule 29 certified clinic. Lastly, FQHC designation has many benefits such as access to the National Health Service Corps (NSHC) program and PPS/APM Medical Assistance payment.
2	As part of the overall analysis, important goals surfaced: Maintain the integrity of the FQHC's payment and not disrupt the one-rate model Avoid creating any disincentives for one service model versus another	MNACHC agrees with this recommendation. The Medical Assistance PPS/APM4 payment methodology is essential to maintaining the financial sustainability of FQHCs.

3	Recognition that there is not anything in the CCBHC scope of services that does not currently align with the FQHC service model. CCBHC PPS is limited to the costs of behavioral health services/activities in the CCBHC scope of services FQHC PPS includes the cost of all primary care and behavioral health services/activities	MNACHC does not have any opinion on this recommendation. MNACHC does encourage DHS to evaluate the Medical Assistance PPS/APM4 methodology to ensure "all primary and behavioral health services/activities" are an "allowable cost" for FQHCs. Many services provided by FQHCs to address the social drivers of health are not included in the MA reimbursement calculation. MNACHC encourages DHS to ensure that FQHCs can offer, and receive payment for, key services our communities need such as targeted mental health case management services and other behavioral health services.
4	Cost reporting rules and formats are different for FQHCs and CCBHCs; integrating all costs into one FQHC cost report is simpler, more efficient and less prone to error.	MNACHC agrees with this position and encourages adoption of the FQHC cost report as the standard in the state. The Medicare Cost Report is widely accepted.
5	Billing and claims processing rules are also different for FQHCs and CCBHCs; a single, all-inclusive encounter rate is more efficient and less expensive to administer.	MNACHC would like to clarify that FQHCs receive one organization-wide medical PPS/APM4 rate and one organization-wide dental PPS/APM4 rate. MNACHC agrees that an organization-wide, all-inclusive Medical Assistance encounter rate versus site-specific rate is preferred.
6	Since the FQHC rate and the CCBHC rate are both cost-based rates, there is no financial advantage to the provider to have two rates instead of one.	MNACHC understands that if an FQHC were to secure CCBHC certification, any resultant costs the delivery model changes would be included in the FQHC's Medical Assistance PPS/APM4 rate.

		MNACHC also understands that FQHCs receive PPS/APM4 payment for services offered at HRSA-approved "in-scope" service locations.
7	An integrated FQHC cost report and rate supports better integration of primary and behavioral health care.	MNACHC has no opinion on this recommendation as it appears to impact CCBHCs.
8	Separating behavioral health costs into a CCBHC cost report could raise questions regarding use of FQHC grants for behavioral health costs of uninsured patients.	MNACHC prefers that a single cost report based on the Medicare Cost Report, is used as opposed to a CCBHC cost report in lieu of or in addition to the Medicare Cost Report.

Again, MNACHC appreciates the work of DHS on this topic and engaging the Association and members during the process. As always, our goal as Community Health Centers is to meet the medical, dental and behavioral health care needs of 200,000 low-income Minnesotans. We are continually evaluating opportunities to expand and deepen our commitment to our communities. The recommendations, in general, in this report provide CHCs with an understanding of a potential pathway to further our collective missions.

Please do not hesitate to reach out to me jonathan.watson@mnachc.org or at (612) 253-4715, ext. 1, if you have any questions about our feedback or Community Health Centers in general.

Respectfully submitted,

Jonathan B. Watson
CEO