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Washington Health Care Authority (HCA)
CCBHC Financial Information Request Frequently Asked Questions (FAQs)
Updated October 15, 2024

This document reflects questions asked during the previous live Financial Information Request (FIR) TA sessions as well as those submitted to the provider support inbox (AppleHealth.Info@milliman.com). *The following questions with accompanying answers have been added as of the last update: 6, 7, 15, 22, 23, and 24.*

A. Background

1. What is the purpose of the Financial Information Request (FIR)?

   The CCBHC Financial Information Request (FIR) has been developed to support the actuarial analysis required within this scope of work, which will estimate the state expenditures that would result from implementing a CCBHC model in Washington. Additionally, the FIR is intended to begin getting potential CCBHCs acclimated with the types of data and stratifications that are required in the federal CCBHC cost report. ***Information obtained through the FIR will not be used to develop Prospective Payment System (PPS) rates for the CCBHC program.***

2. What are the differences between the Financial Information Request (FIR) and the Request for Information (RFI)? Do we need to submit both the RFI and the FIR as part of the same process?

   The RFI is a separate request which has been developed to inform CCBHC program design decisions and determine the level of provider interest in CCBHC program participation.

   Providers interested in participating in the initial HCA-certified CCBHC cohort in Washington are strongly recommended to complete both requests. If your organization completes both, they should be submitted to the state as directed in each of the respective requests.

3. Is the FIR being requested from only BHAs who are currently operating as a CCBHC under a SAMHSA grant?

   Both current CCBHCs and other BHAs interested in participating in the initial HCA-certified CCBHC cohort in Washington are recommended to complete this request.

B. Provider Information

4. If an organization has multiple locations that they'd like to be considered for the initial HCA-certified CCBHC cohort in Washington, should a FIR submission be completed for each location in which CCBHC services are provided?

   FIR submissions should align to the provider's audited financial statement. If an audited financial statement is submitted separately for each site, the recommendation is to submit a FIR for each site. If an audited financial statement is submitted for multiple sites, then a FIR can reflect costs for all respective sites.

5. For Line 10 of the Provider Information tab, should this be individual providers or a list of provider types?

   This optional item requests a listing of names and the NPI of behavioral health professionals who directly provide CCBHC services. If your organization would like to provide NPIs for more than 15 behavioral health professionals, you may provide a supporting document alongside your FIR submission. This approach is similar to what's requested in the federal CCBHC cost report instructions (Certified Community Behavioral Health Clinic Cost Report Instructions (medicaid.gov), page 11).

   Note that, for purposes of the FIR, this item is optional to complete. This information is required when completing the federal CCBHC cost report, which will be used to develop PPS rates should Washington be selected to participate in the CCBHC demonstration.

6. On the first and each subsequent optional section, line 11 asks "Is the CCBHC dually certified as a 1905(a)(9) clinic?". How can we determine if our facility is a 1905(a)(9) clinic?

   A 1905(a)(9) clinic performs services under Section 1905(a)(9) of the Social Security Act, which are defined in 42 CFR 440.90 to include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided by a facility that is not part of a hospital but is organized to deliver outpatient care. These services must be directed by a physician or dentist and provided within the facility unless offered to eligible individuals without a permanent dwelling, fixed home, or mailing address.[1]

   If the definition above does not clear up your facility's understanding, please reach out to the Washington State Department of Social and Health Services to confirm your facility's status.

C. Financial Reconciliation

7. Is the FIR going to be updated to reflect the White House Office of Management and Budget's (OMB) revision of the federal de minimis cost rate from 10% to 15% which was effective October 1, 2024?

   No, the FIR document will not be updated to reflect the revision of the federal de minimis indirect cost rate from 10% to 15%. This is because the data collected in the FIR will not be used to build PPS rates. However, providers may use the new federal de minimis indirect cost rate, and this change will be considered in future cost reporting endeavors.

8. Where should care coordination costs be allocated within this template?

   Care coordination costs should be considered as direct costs. Allocate care coordination costs between "CCBHC-Crisis Services," "CCBHC Direct – All Others," and "Non-CCBHC Direct" categories as appropriate.

[1] Clinic Payment Methodology (medicaid.gov)

9. Is it acceptable to use a draft audited financial statement for SFY 2024?

   Providers are permitted to use their draft audited financial statement for SFY 2024 as the basis for completing the "Financial Reconciliation" request. Using the SFY 2024 draft audited financial statement may be the most appropriate basis as it reflects recent expenses. However, it may be more appropriate to use an audited financial statement from a previous fiscal year if reported expenses are likely to change from the current draft of the audited financial statement to the finalized version.

   Ultimately, organizations are permitted discretion to determine the most appropriate reporting period for completing the "Financial Reconciliation" request.

10. Our organization provides certain CCBHC services (as listed in Appendix B) but for grant-funded programs that have specific eligibility criteria (for instance, Trueblood or homelessness programs). Do we categorize these resulting expenditures from these programs as CCBHC-Direct (Crisis or All Other) or Non-CCBHC?

    If your intention is to continue providing these services through a separate program you may categorize resulting expenditures as "Non-CCBHC Direct." If you anticipate expanding this service as a CCBHC, for example by providing to a wider group of individuals, then expenditures can be reported as CCBHC Direct, making sure to offset salary costs by applicable revenues, such as grants received, in line with CMS CCBHC cost report instructions.[2]

11. If a non-crisis CCBHC service is provided as part of a mobile crisis response or crisis stabilization unit encounter, how should resulting CCBHC expenses be categorized (CCBHC-Crisis or CCBHC-All Other)?

    HCA is considering carving out mobile crisis and crisis stabilization unit expenditures when developing PPS rates. Non-crisis CCBHC services provided as part of a mobile crisis response or crisis stabilization unit encounter would not trigger a PPS payment. Thus, please categorize any CCBHC expenses provided through mobile crisis response or crisis stabilization units to "CCBHC Direct – Crisis Services"

12. If a crisis CCBHC service is provided outside of a mobile crisis response or crisis stabilization unit encounter, how should resulting CCBHC expenses be categorized?

    Crisis CCBHC services provided outside of a mobile crisis response or crisis stabilization unit encounter may be categorized as "CCBHC Direct – All Other." Settings that may be included as "CCBHC Direct – All Other" include, but are not limited to, the following:

    - Crisis call centers
    - Crisis urgent care centers
    - Crisis walk-in/expanded hours
    - Peer-run respite centers

    If your organization is uncertain on how certain crisis CCBHC expenses should be allocated, please include them within the category you believe is most appropriate and provide details in the "Comments" column.

[2] Certified Community Behavioral Health Clinic Cost Report Instructions (medicaid.gov)

13. Can housing utilities and rent expenses incurred from a psychiatric rehabilitation program be categorized as CCBHC expenditures?

    Please categorize these expenses as "Non-CCBHC." Per the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93), Section 223, the CCBHC demonstration prohibits payment for room and board.

    To clarify the CCBHC psychiatric rehabilitation benefit as described under item 4.i.1 of SAMHSA's CCBHC criteria,[3] services are intended to help individuals develop skills and functioning to facilitate community living, such as "navigating the complexity of finding housing or employment, filling out paperwork, securing identification documents, developing social networks, negotiating with property owners or property managers, paying bills, and interacting with neighbors." Rather than paying for rent, utilities, or other housing cost, the service is focused on providing supports to help individuals find and maintain housing.

14. Should only expenses incurred through services included in Appendix B be included when categorizing CCBHC expenses? What if our categorization of CCBHC services does not align with Appendix B?

    If your organization believes there are specific services that belong within the CCBHC service listing as defined in the CCBHC criteria[4] but are not included in Appendix B, you may categorize associated expenses to the CCBHC program. If you allocate any associated expenses from said services to the CCBHC program, please share the procedure code of each service as well as the amount of expenses pertaining to those codes within the "Comments" section.

15. Should direct expenses incurred through providing CCBHC services from satellite sites be allocated as "CCBHC Direct" or "CCBHC Indirect" expenses?

    The Protecting Access to Medicare Act (PAMA), Section 223, authorizes the CCBHC Demonstration and states that no payments will be made to satellite facilities of Certified Community Behavioral Health Clinics (CCBHCs) established after April 1, 2014.[5] A satellite facility is defined as:

    1) Was established by the behavioral health agency that is certified by the state as a CCBHC
    2) Operated under the governance and financial control of that CCBHC
    3) Provides the following services (defined in the CCBHC Certification Criteria):
        a. Crisis services,
        b. Screening, diagnosis, and risk assessment,
        c. Person and family centered treatment planning, **and**
        d. Outpatient mental health and substance use services[6]

    Therefore, if a CCBHC's satellite facility does not perform all four of these services **or** was established after April 1, 2014, incurred direct expenses should be allocated as "Non-CCBHC Direct." *Only allocate satellite sites' expenses as "CCBHC Direct" if it meets the above criteria and the satellite was established before April 1, 2014*.

    Please note that CCBHCs are permitted to renovate, expand, and/or replace facilities after April 1, 2014, based on the needs determined in the state-prepared needs assessment.

[3] Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria Updated March 2023 (samhsa.gov)
[4] Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria Updated March 2023 (samhsa.gov)
[5] Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2019 | ASPE (hhs.gov)
[6] Definitions of Satellite and Other Facilities Under the Section 223 Demonstration Program for Certified Community Behavioral Health Clinics (CCBHCs) (samhsa.gov)

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D. CCBHC Service Capabilities

16. What level of fidelity is required for providing the required EBPs listed within this tab. For example, how many staff members should be trained in providing the service?

    An organization should assess the needs of their community and determine whether they are receiving support through a given EBP at an appropriate level. If not, please include changes that may be needed to fulfill community needs within the table provided to complete Question 1 of the "CCBHC Service Capabilities" tabs.

E. Personnel and Wages

17. What is the recommended approach for anticipating staffing and wage increases under the CCBHC program?

    Our recommendation is to begin by considering the additional expenses that may be realized due to providing an enhanced scope of services under the Demonstration:

    - Consult Appendix A of the instructions for the list of CCBHC service requirements. ***It is strongly recommended that you complete the "CCBHC Service Capabilities" request prior to beginning the "Personnel and Wages" request.***
        - What services does your organization not yet provide but are required to do so under the CCBHC Demonstration?
    - Consider the additional staffing needed to bridge the gap between your current program and an enhanced program that meets each CCBHC service requirement.
        - You may wish to consult with clinical staff familiar with the services not currently provided to understand what staffing may be needed.
    - Once additional staffing is identified, consider whether current wage levels are sufficient to hire and retain said staff.
    - If you anticipate increasing compensation of current clinical staff due to increased responsibilities resulting from the increased scope of services, you may consider increasing anticipated hourly wage levels to account for this.

    Following the above analysis, consider other anticipated staffing and hourly wage increases that may be realized as a result of being a CCBHC under the Demonstration:

    - Your organization may provide a required CCBHC service but not in a manner that fully meets the service requirements in Appendix A
        - Consider if your organization will hire additional staff or increase hourly wages in order meet the service requirements
    - Your organization may need to expand capacity to meet non-service requirements of being a CCBHC
        - Provision of care coordination in accordance with CCBHC criteria program requirement 3 may lead a CCBHC to hire more care coordinators Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria Updated March 2023 (samhsa.gov)
        - Meeting CCBHC requirements for quality reporting or other administrative activities may lead a CCBHC to hire additional administrative staff
    - Your organization may experience an increased demand for CCBHC services currently provided
        - Providing a broader array of services may spur demand due to the convenience of receiving a variety of services under one roof

    - If your organization has expanded your service array in the past, consider whether it resulted in increased utilization of services provided prior to the expansion
- CCBHCs under the Demonstration are required to provide services to anyone seeking help regardless of their diagnosis, place of residence, or ability to pay (Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria Updated March 2023 (samhsa.gov), page 1)
    - If your organization has not provided services to a person due to any of the above reasons, anticipate the staffing and/or hourly wage increases needed to provide care to said individuals

Once anticipated staffing and hourly wage increases are identified due to the two reasons stated above, include the anticipated staffing alongside current staffing within the Anticipated FTE column. Average hourly wages should reflect the average hourly wage across current and anticipated staffing based on the considerations above.

18. Should current staffing levels be reported as of a particular date?

    Reflect staffing levels and wages as of January 1, 2024. It is acceptable if the staffing levels as of this date do not align with the staffing levels reflected in the audited financial statement used to complete the “Financial Reconciliation” request.

    Note that both current and anticipated staffing and wages should be reflected as of January 1, 2024. In other words, do not include any wage increases due to wage inflation; wage increases reflected should compensate for the increased responsibility of current and anticipated staffing due to participating in the CCBHC demonstration.

19. When calculating the number of Full Time Employees (FTEs) performing direct clinical services, should the administrative duties of direct clinical staff be excluded?

    FTE calculations should consider the distribution of time a staff member spends on direct clinical services versus administrative duties. For example, if a medical director works full-time and serves patients 10% of working hours, they may be allocated as 0.1 of a clinical FTE and 0.9 of an administrative FTE (likely categorized as “Executive”).

    Note that time spent as the direct supervisor of clinical staff may be categorized as clinical staffing time for purposes of the Financial Information Request.

20. How should staff who are not traditional 'office' staff but are essential due to their support of direct care clinical staff (e.g., outpatient program managers) be reported?

    The 'Other staff costs' section is intended to capture staffing that do not clearly fit into one of the predefined staffing categories. If a CCBHC staffing position is not defined through any of the available options, please develop a line item for the staffing position in question. Please also share a description of the staffing position within the “Comments” section.

21. Should current wages be adjusted to reflect the 15% Medicaid behavioral health benefit rate increase effective January 1, 2024?

    Reflect actual wages as of January 1, 2024 when reporting current wages regardless of whether or not they reflected the benefit increase. To the extent employee wages were increased later in 2024 to account for the benefit increase, you may share details within Question 3 of the “Personnel and Wages” request.

22. How should the below staff be categorized within the 'Personnel and Wages' tab:
    a. Master's degree with an associate license (e.g., LMHCA)
    b. Individuals with an AAC who are an MHP
    c. SUDP providing crisis services which requires they provide services under their AAC vs SUDP

    We recommend that staffing categorization be based on taxonomy code as available using Appendix C. If a staff members taxonomy code is not available, consider whether their wages more closely resemble one capacity or the other (e.g., for example an individual with an AAC who are an MHP, whether wages more closely resemble an AAC or an MHP) for staff within your organization and allocate their wages accordingly.

23. Must executive salaries be at or under the federal executive schedule?

    CCBHCs are not required to adhere to the federal executive schedule for executive salaries. However, they must comply with federal guidelines on reasonable compensation as required in 2 CFR 200.430. CCBHCs executive salaries should be reasonable, consistent between funding sources, and appropriately allocated to the CCBHC program. Executive salaries should be reported in the indirect/administrative column of the 'Financial Reconciliation' tab.

24. How should new CCBHC costs—those that did not arise until after a clinic received a SAMHSA CCBHC grant—be accounted for?

    Please refer to the answer to question 17 above for a detailed explanation of how to account for anticipated staffing costs within the 'personnel and wages' tab. For non-personnel costs, apply a similar approach as described in the answer to question 17 to identify additional needs that bridge the gap between your current non-personnel costs and the expected non-personnel costs. Increased utilization may also necessitate additional square footage to accommodate more visits and additional staff. Additionally, consider the need for additional equipment and resources required from the enhanced CCBHC service array. For types of costs considered to be non-personnel costs, please see Appendix D.

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