June 2, 2023

The National Council for Mental Wellbeing appreciates the opportunity to provide comments to CMS on the proposed updates to the Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment System (PPS) Guidance. The National Council is deeply appreciative of CMS’s continued commitment to the CCBHC model as more states look to join the demonstration in 2024 and beyond.

The revised payment guidance offers a number of helpful opportunities for states and clinics, including focusing attention on crisis services and supports, new flexibility for states in utilizing quality bonus payments, and a requirement for regular rebasing on three-year cycles. The clarification around MCO payments supports streamlining state processes and clinic payments within their current operations, as does the clarity around reporting requirements for MCOs. These updates are useful and appreciated.

We are grateful for CMS’ commitment to soliciting feedback on the proposed payment guidance. The proposed updates reference forthcoming text and further explanations on some of the updated guidance. We look forward to seeing the final language of the PPS guidance and cost report instructions and learning more about CMS’ plans to establish crisis-specific PPS rates, provide additional flexibility around QBPs, ensure non-duplication of Medicaid payment, and address payment for DCOs. We believe it would be helpful for stakeholders to have an additional comment period after CMS releases the full text of the proposed updated guidance in order to provide the most comprehensive feedback possible for CMS’ consideration.

The National Council respectfully offers the following comments for consideration as CMS finalizes the revisions to the payment guidance.

General Comments on PPS and Cost Reporting

- Ensure inclusion of all SAMHSA-required criteria are allowable within cost report. The National Council asks that CMS add clarification about CCBHC cost reporting, ensuring it is clear that all activities required through the SAMHSA criteria are allowed in the cost report. Of particular interest is clarification that ancillary expenses, like IT upgrades and infrastructure enhancements that are critical for clinics to be able to meet the SAMHSA criteria, are allowable in the cost report and the PPS.

PPS Methodologies and Flexibilities

The National Council thanks CMS for maintaining PPS-1 and PPS-2 while adding new options for states wanting to maximize their crisis system improvements and draw down the appropriate FMAP for that work. We appreciate the change to PPS-2 making special populations optional, which will provide flexibility to states who wish to adopt the monthly payment option but want to preserve the simplicity and risk structure of a single payment rate. The National Council also appreciates CMS’ attention to the important need for states and communities to invest in crisis response infrastructure. We are supportive of the concept of targeted PPS rates that support rapid transformation of the crisis continuum in the
United States and look forward to seeing more details about the new PPS-3 and PPS-4 payment options to better understand how these new payment methodologies may work in practice.

To further strengthen the new PPS options, we urge CMS to:

- **Provide technical assistance on the new PPS-3 and PPS-4 payment options.** The summary document outlines three Special Crisis Services (SCS) PPS rates associated with mobile crisis and crisis stabilization services, with other crisis services or activities to be wrapped into the base PPS rate and costs shared across programs to be allocated accordingly. We anticipate that states and clinics will need significant technical assistance on these new payment options and allocation formulas.

- **Permit two CCBHC payments on the same day for crisis and non-crisis services.** Many CCBHCs are moving toward same-day access to care, a move that has been hailed as “earth-shattering” by state officials overseeing the program. When an individual in crisis can be de-escalated and referred to ongoing treatment at a CCBHC – with same-day access to the initial appointment – CCBHCs must be able to receive payment for both the crisis and non-crisis services on that day. The National Council recommends that the final PPS guidance clearly indicate that a CCBHC PPS and SCS PPS can be drawn down on the same day.

- **Provide guidance on changing PPS methodology.** States may find value in additional CMS guidance or technical assistance on how to change payment methodologies should their state landscape and desired payment methodology change in the future.

### Quality Bonus Payment (QBP) Measures

The National Council appreciates CMS’ intent for states to use and set their own tiers and thresholds for quality bonus payments to clinics. We are supportive of giving states additional flexibility to tailor their CCBHC program to their unique behavioral health landscapes while ensuring standardization of QBP measures across states. We look forward to reviewing the forthcoming examples and clarifications referenced in this proposal to better understand the details of this new flexibility. Additionally, in conversations with multiple states and clinics, it has been difficult to assess the potential impact of the changes to the required QBP measures in the absence of full information on the technical specifications for each measure. As noted above, we recommend CMS engage in a second comment opportunity when the full details of the payment guidance and quality measures are released.

### Rebasing

The National Council appreciates the new guidance on establishing a regular interval for rebasing, which is a helpful tool in keeping rates aligned with costs over time. We believe the call for rebasing at regular

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intervals will further support buy-in for the model and allay concerns of risk taken on by states and clinics early in the demonstration period. To further strengthen the rebasing guidance, we urge CMS to:

- **Provide clarity and flexibility on timeframe for initial rebase.** Table 1 on page 4 indicates that the initial rebasing must be conducted “with actual cost data for demonstration year 2.” Our interpretation of this language is that rebasing will occur after the end of DY2 based on DY2 data. The rebasing calculations will therefore take place during DY3 or as soon as DY2 cost reports are available. However, the text in Table 1 appears potentially out of alignment with text on pages 6 and 7, which state rebasing will occur “in” year 2 and “for” year 2, respectively—implying that the first rebase will be conducted using cost data from DY1 in order to set new PPS rates to be used for DY2. Although the National Council supports states having the flexibility to rebase at the end of DY1 when they deem it necessary, we believe they will be able to set more accurate PPS rates by rebasing at the end of DY2, given the demonstration states’ and clinics’ experiences indicating that DY2 data offers a more comprehensive and reliable picture of CCBHC costs than DY1 data, which covers only the ramp-up year and is unlikely to account for full staffing levels and service delivery volume. We recommend that CMS use clear and consistent language around the initial rebasing timeframes and also permit states flexibility to conduct the initial rebase after the end of DY2.

- **Ensure flexibility for states to permit mid-cycle rebasing.** The National Council recommends ensuring states have flexibility to allow mid-cycle rebasing for individual clinics experiencing significant cost changes. Mid-cycle rebasing is an important tool for states and clinics to ensure rates reflect costs if unexpected shifts happen in a clinic’s costs.

- **Clarify language regarding the effective dates for rebased rates.** The National Council recommends that CMS provide clarification to states around expectations for both completing rebasing calculations and when those rebased rates will take effect. For example, on page 6, row 2, CMS notes that if DY1 rates are set based on actual cost data, the state is expected to rebase rates “prior to” the start of DY4. However, if the rebase is meant to happen at the end of every three years (i.e., incorporating data from DY1, 2 and 3) – there would be no way to have the new rates in place prior to the start of DY4 simply due to the lag time in getting cost reports filed. States may also benefit from technical assistance and training on using interim rates during the rebasing period.

- **Clarify and reinforce that rebasing must be based only on clinics’ cost reports.** Although the proposed updates make numerous references to rebasing “using cost reports” and “with actual cost data,” the National Council is concerned that the guidance could be interpreted creatively to support the use of additional data points or methodologies for rebasing, with the result that the payment methodology would no longer be a true PPS. It would be helpful for CMS to reiterate its prior clarifications that states may not require clinics to return any portion of their payment.

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2 Centers for Medicare and Medicaid Services. (2015, October; updated 2016, May.) *Section 223 Demonstration Programs to Improve Community Mental Health Services Qs and As – Set II.* [Page 3].
retrospectively adjust clinics’ PPS, or recoup payments through the rebasing process or other adjustment to CCBHCs’ PPS rates. Additionally, we respectfully request that CMS provide guidance indicating that rebased rates may be calculated using only clinics’ cost and visit data as reflected in their cost reports.

Guidance on DCO Relationships and Payments

The SAMHSA CCBHC criteria establish the concept of a Designated Collaborating Organization (DCO), which delivers required CCBHC services on behalf of the CCBHC and enters into an arrangement with the CCBHC to support delivery of these services in compliance with the federal criteria. Data from our 2022 CCBHC Impact Survey indicates that Federally Qualified Health Centers (FQHCs) are among CCBHCs’ commonly used DCOs. FQHCs are unique among DCO partners in that they already receive their own PPS rate in Medicaid. Establishing the CCBHC as the payer for services that the FQHC would otherwise bill under its own PPS rate thus presents a challenge to the DCO partnership. In prior guidance,3 CMS acknowledged that a payment relationship with a DCO might not always be present, noting that CCBHCs may not incur contractual costs for providing crisis services when a state-sanctioned crisis system is the DCO. Permitting a similar structure for CCBHCs’ DCO relationships with FQHCs would be helpful to facilitating partnerships between these entities and streamlining collaboration. The National Council recommends that the revised payment guidance permit non-financial DCO partnerships between CCBHCs and FQHCs at state discretion, when the services the FQHC is providing on behalf of the CCBHC are already included in its own PPS rate.

Again, we greatly appreciate your release of these proposed updates and appreciate your consideration of our feedback here. Please do not hesitate to contact Rebecca Farley David on my staff (rebeccad@thenationalcouncil.org) with any questions about the National Council’s comments.

Sincerely,

Chuck Ingoglia
President and CEO
National Council for Mental Wellbeing

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3 Centers for Medicare and Medicaid Services. (2016, September.) Section 223 Demonstration Programs to Improve Community Mental Health Services Qs and As – Set IV. [Page 4].