Appendix III - Section 223 Demonstration Programs to Improve Community Mental Health Services Prospective Payment System (PPS) Guidance

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Section 1: Introduction

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA or "the statute") was signed into law. No later than September 1, 2017, the Department of Health and Human Services (HHS) will select up to eight states to participate in a 2-year demonstration program to improve community mental health services. The behavioral health clinics, in the selected states, that meet HHS established criteria to participate in this demonstration will be known as certified community behavioral health clinics (CCBHCs).

The statute requires the use of a prospective payment system (PPS) to pay the participating clinics for provision of CCBHC services and requires the Centers for Medicare & Medicaid Services (CMS) to issue guidance to states and clinics no later than September 1, 2015, on the development of the PPS to be used for the demonstration. The CCBHC PPS applies to services delivered either directly by a CCBHC or through a formal relationship between a CCBHC (including related sites eligible to participate) and Designated Collaborating Organizations (DCOs) as that term is defined in the criteria.

Under this demonstration, participating states will select one of two PPS rate methodologies for use in the demonstration. The PPS methodology selected will be used demonstration-wide to set CCBHC-specific rates. Designated as Certified Clinic Prospective Payment System (CC PPS-1), the first option is a FQHC-like PPS that provides reimbursement of cost on a daily basis (as does the current PPS used for FQHC services reimbursement) with the addition of a state option to provide quality bonus payments to CCBHCs that meet defined quality metrics. This is not a requirement and should not be seen as changing the underlying PPS system. It would only be there as a possibility for additional bonus payments and is at the option of the state. The second option, CC PPS Alternative (CC PPS-2) uses a monthly unit of payment, provides for quality bonus and provides for rates that vary, depending on the populations served by the certified clinic (e.g. patients who are seriously mentally ill and those with substance use disorders). Under the second option the state is required to incorporate quality bonus payments as part of the payment made using CC PPS-2.

PAMA permits states to claim expenditures related to payments made for CCBHC services at the enhanced Federal Medical Assistance Percentage (FMAP) equivalent to the standard Children's Health Insurance Program (CHIP) rate as specified in section 2105(b) of the Social Security Act (the Act), not including the 23 percentage point

applicable for the period beginning on October 1, 2015 and ending on September 30, 2019. With respect to expenditures for CCBHC services provided to certified clinic users who are Medicaid beneficiaries enrolled in a Medicaid CHIP expansion program, beginning on October 1, 2015 and ending on September 30, 2019, the enhanced FMAP for CHIP expenditures as provided in section 2105(b) of the Social Security Act will be increased by 23 percentage points (not to exceed 100 percent). For expenditures related to demonstration services provided to newly eligible individuals described in paragraph (2) of section 1905(y) of the Act, the matching rate applicable under paragraph (1) of that section will apply. Expenditures for services provided by IHS clinics that are also certified clinics to American Indians and Alaskan Natives (AI/AN) are matched at 100 percent. Using demonstration authority, states may claim enhanced FMAP and do not need Medicaid state plan authority to implement payment for CCBHC services delivered by certified clinics. Enhanced FMAP applies to expenditures for CCBHC services provided to individuals enrolled in Medicaid, including Medicaid expansion CHIP programs but not separate CHIP programs. Using demonstration authority, states may claim enhanced FMAP and do not need Medicaid state plan authority to implement payment for CCBHC services delivered by certified clinics. Under the demonstration, states and localities continue to finance the non-federal share of payment and, as part of the application process, will provide information to CMS on the source(s) of funding. Although there is no statutory authority to permit states to claim additional, non Medicaid expenditures, states may claim administrative expenditures that support the development and implementation of the demonstration.

CMS developed PPS guidance for CCBHC payment in light of the criteria established by the Substance Abuse and Mental Health Services Administration (SAMHSA) with regard to requirements developed for staffing; availability and accessibility of services; care coordination; scope of services; quality and other reporting; and, organizational authority, governance, and accreditation. CMS held multiple listening sessions prior to issuing this guidance, providing a forum for all interested parties to comment on what CMS should consider in developing payment parameters for the PPS applicable to CCBHC services. CMS made available an electronic mailbox to accept public comment. The PPS guidance is based on feedback that CMS received from states, providers and other stakeholders. This final guidance also reflects our experience with other PPS payment systems, particularly those used for Federally Qualified Health Center (FQHC) services in Medicaid.

CMS will support state's efforts in developing the PPS rates by providing technical assistance (TA) to states and clinics during the planning phase of this demonstration. Requests for assistance may be submitted to CCBHC-Demonstration@cms.hhs.gov.

To assist states in determining the PPS rate for individual CCBHCs, this guidance provides information on identifying, reporting, and allocating allowable costs for the CCBHC PPS methodologies.

Section 2: CCBHC PPS Rate-Setting Methodology Options

For the purposes of this demonstration, CMS offers states the option of using either the Certified Clinic Prospective Payment System (CC PPS-1) or CC PPS Alternative (CC PPS-2) rate methodology, as described below. A state must elect one methodology demonstration-wide for use in determining the uniform per clinic rate it will use to pay for CCBHC services delivered by a clinic, including those delivered by qualified satellite facilities established prior to April 1, 2014. CMS expects states to develop rates using actuarially sound principles with respect to the data, assumptions, and calculation methodology used.[11]

Table 1. Rate Elements of CC PPS-1 and CC PPS-2

Rate Element	CC PPS-1	CC PPS-2
Base rate	Daily rate	Monthly rate
Payments for services provided to clinic users with certain conditions[12]	NA	Separate monthly PPS rate to reimburse CCBHCs for the higher costs associated with providing all services necessary to meet the needs of special populations
Update factor for demonstration year 2	Medicare Economic Index (MEI)[13] or rebasing	MEI or rebasing
Outlier payments	NA	Reimbursement for portion of participant costs in excess of threshold
Quality bonus payment	Optional bonus payment for CCBHCs that meet quality	Bonus payment for CCBHCs that meet quality measures detailed

[11] Actuarial soundness defined in 42 CFR 438.6(c)

[12] Examples of clinic users with certain conditions:

- Adults with serious mental illness
- Adults with serious mental illness and co-occurring substance use disorders
- Children and adolescents with serious emotional disturbance
- Individuals with a recent history of frequent hospitalizations related to behavioral health conditions
- Adults with significant substance abuse disorders (SUDs)

[13] CMS Medicare Program Rates and Statistics, Market Basket Data. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html

Rate Element	CC PPS-1	CC PPS-2
	measures detailed on page 7	on page 7

Abbreviations: CCBHC, certified community behavioral health center; CC PPS, Certified Clinic Prospective Payment System; NA, not applicable; PPS, prospective payment system

Section 2.1: Certified Clinic PPS (CC PPS-1)

The CC PPS-1 is a cost-based, per clinic rate that applies uniformly to all CCBHC services rendered by a certified clinic, including those delivered by qualified satellite facilities established prior to April 1, 2014. It pays CCBHCs a daily rate that is a fixed amount for all CCBHC services provided on any given day to a Medicaid beneficiary. In demonstration year one (DY1), the state will use cost and visit data from the demonstration planning phase, updated by the Medicare Economic Index (MEI) to create the rate for DY1. The DY1 rate will be updated again for DY2 by the MEI or by rebasing of the PPS rate. CMS requires the use of one full year of cost data and visit data, unless a state can justify the use of a shorter period of time. The CC PPS-1 rate is based on total annual allowable CCBHC costs divided by the total annual number of CCBHC daily visits and results in a uniform payment amount per day, regardless of the intensity of services or individual needs of clinic users on that day. In developing the rates, states may include estimated costs related to services or items not incurred during the planning phase but projected to be incurred during the demonstration. States also should include in CC PPS-1 the cost of care associated with Designated Collaborating Organizations (DCOs). A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. Services of a DCO are distinct from referred services in that the CCBHC is not financially and clinically responsible for referred services.

CC PPS-1	
2.1a	The state must implement CC PPS-1 as a daily rate. The following formula is used for calculating the DY1 rate for the CC PPS-1: $$\frac{\textbf{Total annual allowable CCBHC costs}^{*}}{\textbf{Total number of CCBHC daily visits per year}}$$ ***Note: For DY1, the total annual allowable CCBHC costs collected during the demonstration planning phase must be trended forward by the MEI to reflect changes due to inflation. The DY1 rate will be updated again for DY2 by the MEI or by rebasing of the**

CC PPS-1	
	PPS rate. To assist states in identifying and documenting allowable costs, CMS provides guidance in this document on cost principles, documentation requirements and select items of cost (See section 4).

The example in Table 2 illustrates the CC PPS-1 rate mechanics, in which the total allowable annual costs of $10,000 are divided by 100 total annual daily visits. This calculation results in a payment rate of $100 per visit. The state would pay this per visit base rate, regardless of the participant type, CCBHC services provided, or overall costs associated with the visit. Again, the daily payment cap of one per day for each clinic user pertains only to CCBHC services, not other types of care that also may be provided by a certified clinic.

Table 2. CC PPS-1 Rate Calculation Example

Participant	Number of Daily Visits in a Year	Trended Annual Costs[1], $	CC PPS-1 Payment Per Daily Visit[2], $	CC PPS-1 Payment[3,4], $
A	25	2,250	100	2,500
B	15	450	100	1,500
C	10	600	100	1,000
D	5	750	100	500
E	35	2,350	100	3,500
F	8	3,000	100	800
G	2	600	100	200
Total	**100**	**10,000**		**10,000**

[1]Annual costs may be determined for each participant.

[2] CC PPS-1 Payment Per Daily Visit = Annual Costs ($10,000) / Number of Daily Visits in a Year (100) = $100

[3] CC PPS-1 Payment = Participant Number of Daily Visits in a Year * CC PPS-1 Payment Per Daily Visit ($100)

*Note: Table 2 is included for illustrative purposes only, and does not reflect actual facility based costs. In determining actual base rates, a facility must meet reasonable credibility standards, to be established by the state, in accordance with Substance Abuse and Mental Health Services Administration guidance.

Abbreviations: CC PPS, Certified Clinic Prospective Payment System

CC PPS-1	
2.1b	**CC PPS-1 Quality Bonus Payment**

CC PPS-1	
	Under the CC PPS-1 rate methodology, a state may elect to offer Quality Bonus Payment (QBP). For the state to make QBP, the CCBHC must demonstrate that it has achieved all of the required quality measures shown below. The state can make QBP using the additional measures provided in this guidance but only after the certified clinic has met performance goals for the required set of bonus measures. States may propose additional quality measures for QBP; however, CMS approval is required. The QBP measures included in this guidance are derived primarily from the Medicaid adult and child core set measures. In applying to participate in this demonstration, the state must demonstrate how it plans to implement QBP if it plans to make such payments. . States have flexibility in determining the level of payment but must use a comprehensive methodology that specifies: (1) the factors that trigger payment (e.g., the percentage of improvement in a quality metric within a particular period), (2) the methodology for making the payment (e.g., on a per claim basis or a lump sum payment; and how often payment is made), and, (3) the amount of payment. When calculating the PPS rate, the QBP is not treated as revenue offset against cost. CMS is making QBP TA available to states in collecting, reporting, and using measures for the adult and child core sets of Medicaid/CHIP quality measures. States may submit requests to: MACQualityTA@cms.hhs.gov.

Table 3. Quality Bonus Payment Medicaid Adult and Core Set Measures

For the state to make QBP the CCBHC must demonstrate that it has achieved all of the required quality measures shown in Table 3. The state can make QBP using the additional measures provided in this guidance but only after the certified clinic has met performance goals for the required set of measures. States may propose quality measures for QBP; however, CMS approval is required. The QBP measures included in this guidance are derived primarily from the Medicaid adult and child core set measures. In applying to participate in this demonstration the state must demonstrate how it plans to implement QBP if it plans to make such payments.

Acronym[1]	Measure	Measure Steward[2]	QBP Eligible Measures	Required QBP Measures
FUH-AD	Follow-Up After Hospitalization for Mental Illness (adult age groups)	NCQA/HEDIS	Yes	Yes
FUH-CH	Follow-Up After Hospitalization for Mental Illness (child/adolescents)	NCQA/HEDIS	Yes	Yes

Acronym[1]	Measure	Measure Steward[2]	QBP Eligible Measures	Required QBP Measures
SAA-AD	Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA/HEDIS	Yes	Yes
IET-AD	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA/HEDIS	Yes	Yes
NQF-0104	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	Yes	Yes
SRA-CH	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	Yes	Yes
ADD-CH	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA/HEDIS	Yes	No
CDF-AD	Screening for Clinical Depression and Follow-Up Plan	CMS	Yes	No
AMM-AD	Antidepressant Medication Management	NCQA/HEDIS	Yes	No
PCR-AD	Plan All-Cause Readmission Rate	NCQA/HEDIS	Yes	No
NQF-0710	Depression Remission at Twelve Months-Adults	MPC	Yes	No

[1]CMS-developed acronyms, except NQF-0104 and NQF-0710. CH refers to measures in the 2015 Medicaid Child Core Set, AD refers to measures in the 2015 Medicaid Adult Core Set.

[2] The measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities of the measure steward include updating the codes that are tied to technical specifications and adjusting measures as the clinical evidence changes. This list may change based on the current measurement landscape. The steward websites are provided below:

- http://www.ncqa.org
- www.usqualitymeasures.org
- http://www.ama-assn.org/ama/pub/physician-resources/physician-consortium-performance-improvement.page

Abbreviations: AMA, American Medical Association; CMS, Centers for Medicare & Medicaid Services; HEDIS, Healthcare Effectiveness Data and Information Set; MPC, Measurement Policy Council; NCQA, National Committee for Quality Assurance; PCPI, Physician Consortium for Performance Improvement

Section 2.2: CC PPS Alternative (CC PPS-2)

The CC PPS-2 is a cost-based, per clinic monthly rate that applies uniformly to all CCBHC services rendered by a certified clinic, including all qualifying sites of the certified clinic established prior to April 1, 2014. CC PPS-2 includes these required elements: (1) a monthly rate to reimburse the CCBHC for services, (2) separate monthly PPS rates to reimburse CCBHCs for higher costs associated with providing all services needed to meet the needs of clinic users with certain conditions, (3) cost updates from the demonstration planning period to DY1 using the MEI and from DY1 to DY2 using the MEI or by rebasing, (4) outlier payments made in addition to PPS for participant costs in excess of a threshold defined by the state, and (5) QBP made in addition to the PPS

rates. A CCBHC receives the monthly rate whenever at least one CCBHC service is delivered during the month to a Medicaid beneficiary by the CCBHC; states may pay this rate only after a CCBHC service has been delivered.

Under this methodology states will develop a standard monthly rate and also will develop monthly PPS rates that vary according to users' clinical conditions. For example, states could set different rates for adults with serious mental illness and co-occurring substance use disorders and children and adolescents with serious emotional disturbance who require higher intensity services. The state has flexibility in determining how PPS rates could vary. An outlier payment is part of the CC PPS-2 and reimburses clinics for costs above a state-defined threshold. This helps to enssure that clinics are able to meet the cost of serving their users. Finally, the CC PPS-2 rate methodology requires the state to select quality measure(s) as permitted and make bonus payments to incentivize improvements in quality of care.

States should include in CC PPS-2 the cost of care associated with DCOs. A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. Services of a DCO are distinct from referred services in that the CCBHC is not financially and clinically responsible for referred services.

This guidance contains information to help states develop these rates and CMS is available to provide state-specific technical assistance on this topic.

CC PPS-2	
2.2a	**CC PPS-2 Base Rate and Outlier Payment** **Step1:** Determine the base PPS rate, excluding costs for services to any clinic users with certain conditions and outlier payment (section 2.2c). The base PPS formula is: $$\frac{\textbf{Total annual allowable CCBHC costs}^{*} \textbf{ } \textit{excluding} \textbf{ costs for services to clinic users with certain conditions and outlier payments}}{\textbf{Total number of CCBHC unduplicated monthly visits per year}}$$

CC PPS-2	
	***excluding* clinic users with certain conditions** ***The number of unduplicated monthly visits per year equals the total number of months that a member received at least one service in a month from a clinic. The state may count up to 12 monthly visits over the course of the year for each clinic user. A qualifying service is one defined in Section 223 (a)(2)(D) Scope of Services. CMS requires the use of 1 full year of cost data and visit data, unless a state can justify a shorter period of time. **Step 2:** Determine PPS rates for special populations using the formula below. **Total annual allowable CCBHC costs* *including only* clinic users with certain conditions *excluding* outlier payments** **Total number of CCBHC monthly visits per year *including only* clinic users with certain conditions** *The total annual allowable CCBHC costs collected during the demonstration planning phase must be updated by the MEI to reflect changes due to inflation. The DY1 rate will be updated again for DY2 by the MEI or by rebasing of the PPS rate. Key considerations in determining PPS for special populations are: (1) identifying the population(s), (2) assessing utilization, and (3) allocating cost. States have flexibility in designating the clinic users with certain conditions for which separate PPS rates will be determined. **Step 3:** Determine the outlier payment, which provides reimbursement in excess of a threshold defined by a state not to exceed 100 percent of cost. The outlier payment may be calculated monthly or annually, depending on the state's ability to accurately determine the payment. The threshold can be expressed as an absolute dollar amount (e.g., $10,000) or as a function of the facility's distribution of costs (e.g., three standard deviations above the mean facility costs). The state has flexibility in setting the threshold for outlier payment. Section 2.3 contains a sample calculation that demonstrates the CC PPS-2 methodology. This example includes considerations for both clinic users with certain conditions and outlier payments.
2.2b	**CC PPS-2 Quality Bonus Payments** Under the CC PPS-2 rate methodology, a state must make a QBP whenever a CCBHC has demonstrated that it has achieved all of the required quality measures shown on page 7 of this guidance. The state can make payment using additional measures provided in this guidance but only after the certified clinic

CC PPS-2	
	has met performance goals for the required set of measures. The QBP measures, shown on page 7, are derived primarily from the Medicaid adult and child core set measures. States may propose additional quality measures, but CMS approval must be obtained. In applying to participate in this demonstration the state must demonstrate how it plans to implement QBP. States have flexibility in determining the level of payment but must use a comprehensive methodology that specifies: (1) the factors that trigger payment (e.g., the percentage of improvement in a quality metric within a particular period), (2) the methodology for making the payment (e.g., on a per claim basis or a lump sum payment; and how often payment is made), and (3) the amount of the payment. In applying to participate in this demonstration, the state must demonstrate how they plan to implement QBP. When calculating the PPS rate, the QBP is not treated as revenue offset against cost. CMS is making available TA and analytic support to states in collecting, reporting, and using measures for the adult and child core sets of Medicaid/CHIP quality measures. States may submit requests for QBP TA and analytic support to the TA mailbox: MACQualityTA@cms.hhs.gov.

Section 2.3: CCBHC CC PPS-2 Rate Example

CCBHC CC PPS-2 Rate Example	
2.3	The following example demonstrates the CC PPS-2 method calculations for a small sample facility with seven participants per year. Table 4 illustrates how aggregate monthly allowed costs are translated into base and separate monthly PPS rates to reimburse CCBHCs for the higher costs associated with providing all services necessary to meet the needs of special populations. It also shows how funds are allocated or reserved to pay for outliers. Data to set these rates will be collected during the planning phase of the demonstration and should be adjusted by MEI to reflect changes in the underlying costs to provide treatment between the data collection period and the DY1 period. Payment rates for DY2 can be adjusted by MEI or by rebasing. In the example in Table 4, participants are categorized on the basis of criteria the

state has used to define the base population and any other clinic users with certain conditions. These categorizations should be made at the participant level— not tied to services delivered. In our example, three distinct base rates are calculated —one for the participants not in the special population (Standard) and two for the different special population groups (Special Population A and Special Population B).

A state can choose to make outlier payments on either a monthly or an annual basis. The methodology used to define outlier payments should include planning phase cost experience that spans all populations. Outlier payments are commonly calculated by setting a threshold above which a certain percentage of costs should be kept in reserve to account for anticipated outlier costs during the demonstration. This threshold should be set based on statistically and actuarially sound principles, by studying the distribution of costs at the facility level. Some portion of costs above the outlier threshold is captured in the rates for the different populations. In all cases, the cost data should be fully attributed between the Standard or Special Population payment rate calculation and the amount reserved to pay for outliers.

For this facility, the monthly outlier threshold is set at $1,000. Therefore, in the rate setting period, 80 percent of the anticipated costs above the $1,000 threshold would be held in reserve to make outlier payments in during the demonstration period. Participants A, E, and F each experience 1 month with costs that exceed the established threshold. Therefore, in addition to a base rate for each participant type, the facility will be paid a varying additional outlier payment. For instance, Participant A in March has a $1,250 service that is above the outlier threshold. The amount of cost used in the base rate calculation would be $1,050; $1,000 (up to the threshold), plus $50 (20 percent of the remaining amount above the threshold). The remaining $200 should be held back as a reserve to pay for future anticipated outlier payments. Finally, payment rates for each of the populations are calculated by dividing the population-specific portion of the trended allowed annual costs, by the participant months for the population. For the Standard population, this rate is $250 per participant month (calculated as $1,500/6 participant months).

Table 4. CC PPS-2 Rates, Special Population Rates and Outlier Payments Calculation Example

Participant	Month	Outlier?	Participant Type	Participant Months	*Trended* Allowed Monthly Costs, $	Non-outlier Payment Portion	Outlier Payment Reserve	Payment Per Monthly Visit, $
A	Jan		Standard	1	50	50	-	250
A	Feb		Standard	1	150	150	-	250
A	Mar	Yes	Standard	1	1,250	1,050	200	250
B	June		Standard	1	50	50	-	250
C	Aug		Standard	1	100	100	-	250
D	Sept		Standard	1	100	100	-	250
Standard Population Subtotal			*Standard*	*6*	*1,700*	*1,500*	*200*	*1,500*
E	Nov		Special Population A	1	300	300	-	700
E	Dec	Yes	Special Population A	1	1,500	1,100	400	700
Special Population A Subtotal			*Special Population A*	*2*	*1,800*	*1,400*	*400*	*1,400*
F	Apr	Yes	Special Population B	1	2,000	1,200	800	900
G	Aug		Special Population B	1	600	600	-	900
Special Population B Subtotal			*Special Population B*	*2*	*2,600*	*1,800*	*800*	*1,800*
Total			Total	**10**	**6,100**	**4,700**	**1,400**	**4,700**

Note: Table 4 is included for illustrative purposes only, and does not reflect actual facility based costs. In determining actual base rates, a facility must meet reasonable credibility standards, to be established by the state, in accordance with Substance Abuse and Mental Health Services Administration guidance.

If an annual outlier threshold were used, the calculation would be nearly the same. The total annual allowed participant costs would be used to compare against a higher annual threshold. The outlier reserve would be calculated as the total annual costs for a participant over the annual threshold multiplied by the set percentage that applies to the outlier.

Section 3: Payment to CCBHCs That Are FQHCs, Clinics, or Tribal Facilities

In some instances a CCBHC may already participate in the Medicaid program as an FQHC, clinic services provider or Indian Health Service (IHS) facility that receives payment authorized through the Medicaid state plan. This guidance provides information on how these Medicaid providers would be paid when a clinic user receives a service authorized under both the state plan and this demonstration.

Payment to CCBHCs That Are FQHCs, Clinics, or Tribal Facilities	
3.0a	**FQHCs** A clinic that participates in the Medicaid program as both a FQHC and CCBHC should receive the CCBHC PPS rate whenever it provides any of the services covered by this demonstration, even if there is an overlap with services included in the clinic's FQHC PPS rate. The state should continue to pay the health center its established FQHC PPS rate and does not need to modify the payment amount. If a clinic user received a CCBHC service and FQHC service during one encounter/visit the provider is eligible to receive both the CCBHC PPS and the FQHC PPS.
3.0b	**Clinics** A clinic that is dually certified as a CCBHC and provides clinic services in the Medicaid program should be paid the CCBHC PPS rate whenever a demonstration-covered service is provided. The state should continue to pay the clinic services rate authorized through the Medicaid state plan whenever a non-CCBHC service is delivered. The provider is eligible for payment of the CCBHC PPS and the clinic services rate, depending on the type of service provided. States will follow the established process for reporting expenditures for Medicaid clinic services. CMS plans to provide technical assistance to states on reporting Medicaid clinic services provided by clinics that also are CCBHCs.
3.0c	**Tribal Facilities** The statute at subsection (a)(2)(F) Organizational Authority establishes criteria for the types of clinics that may become CCBHCs. Among the various eligible providers specified in the statute are clinics operated under the authority of the Indian Health Service (his) or an Indian tribe or tribal organization pursuant to a

Payment to CCBHCs That Are FQHCs, Clinics, or Tribal Facilities	
	contract, grant, cooperative agreement, or contract with the IHS. With respect to tribal facilities that become CCBHCs, IHS facilities and 638 clinics may be paid an encounter rate by the Medicaid program under an approved state plan. That encounter rate is determined based on national cost data and not individual facility data. To the extent that an IHS clinic provides CCBHC services, it is paid the CCBHC rate. Federal financial participation (FFP) will be available at the 100 percent matching rate for services furnished to Medicaid-eligible American Indians or Alaskan Natives by an IHS facility or a 638 clinic.

Section 4: Cost Reporting and Documentation Requirements

To determine CCBHC PPS rates, states must identify allowable costs necessary to support the provision of services. States must use a cost report that adheres to the cost principles and documentation requirements described in this section. CMS expects states to use a uniform cost report demonstration-wide. In reporting cost, the state and providers must adhere to 45 CFR §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards[14] and 42 CFR §413 Principles of Reasonable Cost Reimbursement.[15]

Pursuant to 45 CFR §75.302(a), a state must have proper fiscal control and accounting procedures in place to permit the tracing of funds to a level of expenditures adequate to establish that such funds have not been used in violation of applicable statutes. Additionally, the cost report package and source documentation (e.g., invoices, patient records, cancelled checks) must adhere to federal and state record retention requirements.[16] To demonstrate how costs will be assigned to the different cost centers, the state may elect to provide a trial balance that is reconciled to the cost centers on the cost report.

[14] Administrative requirements and cost principles for Medicaid grants formerly were defined at 45 CFR §92 and OMB A-87.

[15] Additional guidance on Medicare principles of reasonable cost reimbursement can be found in the Medicare Provider Reimbursement Manual (PRM), which is used to guide Medicaid policy. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html

[16] See 45 CFR §75.361 Retention Requirements for Records and 42 CFR §433.32 Fiscal Policies and Accountability for the Federal Requirements. http://www.msha.gov/regs/fedreg/informationcollection/1219-0088.pdf

Section 4.1: Treatment of Select Costs

Treatment of Select Costs	
4.1a	**Uncompensated Care** Section 223 (a)(2)(B) requires that CCBHCs not reject or limit services based on a participant's ability to pay but does not authorize Medicaid expenditures for services furnished to individuals who are not eligible for Medicaid. Under this demonstration, federal financial participation will continue to be provided only when there is a corresponding state expenditure for a covered Medicaid service provided to a Medicaid recipient.
4.1b	**Telehealth** If a state chooses to provide CCBHC services via telehealth, costs related to those services should be included in the PPS. We note that individual Medicaid MCOs may have policies that offer reimbursement that differs from the fee-for-service system reflected in state Medicaid policy documents. Therefore, states must consider the implications of managed care service coverage in rate calculation. For more information about telehealth see: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html.
4.1c	**Interpretation and Translation** States may claim federal matching funds for translation or interpretation service costs either as an administration expense or as a medical assistance-related expense. This means the PPS rate may include the costs of interpretation and translation services. If the translation or interpretation service was provided by a Medicaid agency employee, a contractor of the Medicaid agency, or the provider of the medical service using a separate unit or separate employees performing solely translation or interpretation functions, then such costs may be claimed as administration. An increased matching rate is available under the Children's Health Insurance Program Reauthorization Act (CHIPRA) for translation and interpretation services claimed as administration that are provided to "children or families for whom English is not their primary language," and family members of these children. For Medicaid, the increased CHIPRA matching rate is 75 percent. For CHIP, the increased CHIPRA match is 75 percent, or the state's enhanced FMAP plus 5 percent, whichever is higher. Expenditures associated with the provision of translation and interpretation services to Medicaid enrollees

Treatment of Select Costs	
	that do not fit into the CHIPRA category are still reimbursable at the standard 50 percent Medicaid administrative matching rate. If, however, the state builds the costs of translation or interpretation services into the rate paid for the covered benefit, then the expenditure is matched at the state's applicable federal medical assistance percentage rate. In State Health Official (SHO) letter #10-007, CMS provides more detailed guidance on how states may claim these costs which support use of services by beneficiaries for whom English is not their primary language: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO10007.pdf.

Section 4.2: CCBHC Cost Report Elements and Data Essentials

The statute requires payment of PPS for behavioral health services provided under this demonstration. This means states must have cost reports to determine the uniform rate paid for CCBHC services delivered by a clinic, including those delivered by qualified satellite facilities established prior to April 1, 2014. Program Requirement 5.A of the CCBHC criteria for a clinic to participate as a CCBHC in this demonstration also specifies annual submission of a cost report with supporting data by no later than 6 months after the end of each demonstration year. The purpose of this document is to describe all of the types of data that must be reported. States will submit their cost report packages when applying to participate in the demonstration. They should include the cost report template, instructions, sample data sources such as a trial balance, and any narratives explaining the calculations included in determining the PPS rate.

The cost report template and instructions must contain the following key elements:

a. Provider Information
b. Direct and Indirect Cost-Identification
c. Direct and Overhead Cost-Allocations
d. Number of Visits
e. Rate Calculations

Additional details are in the chart below.

Key Elements in a Cost Report	
4.2a	**Provider Information** *This first section should contain following identifying attributes:* a. CCBHC name b. Organizational authority (non-profit organization, Part of a local government behavioral health authority, Tribal) c. State-assigned Medicaid ID and National Provider Identifier (NPI) (if available) for identifying the CCBHC as a whole, regardless of the number of satellite facilities d. Cost report period with start and end dates e. Whether there are non-CCBHC covered activities performed by the facility or providers f. Whether the CCBHC is dually- certified as a FQHC, clinic or operates under the authority of the IHS g. CCBHC services provided for which the PPS rate will be calculated h. Whether the cost report contains consolidated satellite facilities or not i. Whether each satellite facility was in existence prior to April 1, 2014 ii. Operating hours of each satellite facility iii. CCBHC services provided at each satellite facility i. Positions for which direct salary and fringe benefits are claimed j. Licensed or credentialed practitioners who provide CCBHC services and their full-time equivalents (FTEs) k. Certification statement
4.2b	**Direct and Indirect Cost – Identification** To support the cost centers shown, the submitted narrative should explain how expenses are mapped to the cost centers from the trial balance that is provided. Cost centers should be grouped by: a. Direct costs – staff b. Direct costs – other c. Overhead costs – facility and administrative

Key Elements in a Cost Report	
	d. Costs incurred for non-CCBHC services e. Costs incurred that are not reimbursable by Medicaid[17] As necessary, costs must be reclassified and adjusted to accurately reflect the cost of providing CCBHC services. An example of a reclassified cost is salary and fringe cost for a psychiatrist who provides direct services and performs administrative tasks. In this instance, a portion of total compensation must be reclassified from direct staffing costs under the psychiatrist cost center to indirect staffing costs. Examples of adjustments include: a rebate or refund, rental income and allocated home office costs. **Direct Costs – Staff** Staffing includes costs for those practitioner types identified in the state staffing plan pursuant to CCBHC criteria Program Requirement 1.A. Additional support staff may also be considered direct, including interpreters or linguistic counselors, case managers, and care coordinators. Adjustments and reclassifications of cost center expenses should be reflected in this section to detail changes to the adjusted cost center balances. Individual support for each adjustment and reclassification should also be provided in accompanying documents. The direct staff costs would contain all the cost centers, reclassifications, and adjustments. Supporting schedules would contain information pertaining to reclassifications and adjustments. An example of a reclassification might be a psychiatrist who performs administrative duties. The appropriate portion of his/her compensation, payroll taxes, and fringe benefits must be reclassified from direct staffing costs under the Psychiatrist cost center to indirect staffing costs. An example of an adjustment is recovery of an expense item, such as a refund of health insurance premiums. Cost reclassifications and adjustments should be included in the cost report and narrative that supports the entire cost report.

[17] The PRM 15-1 and 45 CFR Part 75 Subpart E further defines various types of allowable and non-allowable costs

Key Elements in a Cost Report	
4.2c	**Direct Costs – Other** Non personnel costs for providing CCBHC services may include the following items: supplies, training, telehealth, translation or interpretation services, transportation, depreciation on equipment used to provide CCBHC services, liability insurance and other costs incurred as a direct result of providing CCBHC services. If a state is claiming translation or interpretation services as an administrative expenditure, these costs should be reflected in the cost report as costs incurred for *non-CCBHC services*. See Item 4.1c for more information about translation and interpretation cost. **Overhead Costs – Facility and Administrative** Overhead facility costs are costs incurred by the CCBHC but not directly attributable to providing CCBHC services. Facility costs include rent, property insurance, interest on mortgage or loans, utilities, maintenance, property tax, and depreciation on the building or furniture. Overhead administrative expenses include costs of running the business such as legal, accounting, telephone, depreciation on office equipment, and general office supplies. Corporate overhead allocations are considered indirect administrative expenses, should be scrutinized to ensure that costs are reimbursable by Medicaid, and accounted for by including the amount as a home office costs adjustment. **Costs Incurred for non-CCBHC Services** States must identify and remove all non-CCBHC allowable costs in order to determine PPS. The statute implementing this demonstration prohibits payment for the following non-CCBHC services: inpatient care, residential treatment, room and board, or any other non-ambulatory expenses, as determined by the Secretary. The statute also excludes the cost of any satellite facility of a CCBHC established after April 1, 2014. Guidance provided in Item 4.2a confirms that the cost of uncompensated care may not be treated as an allowable CCBHC cost. Examples of additional types of costs incurred for non-CCBHC services include costs to support the provision of dental and optometry services.

Key Elements in a Cost Report	
	Cost Incurred that are not Reimbursable by Medicaid Certain overhead costs must be excluded from the PPS rate calculation. For more information about specific exclusions see 45 CFR §75.420-475. Examples of non reimbursable costs include those related to lobbying expenses, organization costs, or entertainment costs.
4.2d	**Direct and Overhead Cost – Allocations** This section should contain worksheets that detail the necessary allocations of costs between the direct CCBHC, direct non-CCBHC, and overhead cost centers. The statistics and methodologies used should match the narrative submitted. If an indirect cost rate (IDR) has been established, the rate and authorization may be used to allocate indirect expenses. At the facility level, providers can elect to directly assign indirect costs to cost centers. To do this, allocations may be done through a statistical measure including, but not limited to: square feet, dollar value, meals served, time spent, number housed, or pounds of laundry. Other methods of allocation could include worker day logs or random moment time studies. These two methods also can be used to allocate direct care workers costs to CCBHC.
4.2e	**Number of Visits** CC PPS-1 – Requires the total number of CCBHC daily visits per year CC PPS-2 • Total number of unduplicated monthly visits per year excluding clinic users with certain conditions • Total number of CCBHC monthly visits per year including only clinic users with certain conditions
4.2f	**Rate Calculations** There must be a summary worksheet that demonstrates how the rate was calculated using either the CC PPS-1 or the CC PPS-2 methodology. The rate may include only those costs necessary to support the provision of CCBHC services.

Section 5: Managed Care Considerations

The statute requires payment of PPS and allows such payment to be made fee for service and through managed care systems for demonstration services. Further, the state may claim enhanced FMAP for the portion of managed care payment attributable to CCBHC services. To meet the requirement of PPS payment and properly claim CCBHC expenditures eligible for enhanced federal matching funds, the state first must understand how behavioral health services are treated in existing managed care payments. This entails a state-specific review of managed care arrangements to determine which services are covered and the level of payment being made. Review of managed care arrangements is outside the scope of this guidance. In implementing managed care payment, we assume states already have an understanding of behavioral health services within their Medicaid programs.

Managed Care Considerations	
5.0a	The first consideration in determining managed care payment is to identify which PPS methodology the state will use in its managed care delivery system. CMS requires the state to use the same PPS methodology demonstration-wide for FFS and managed care payment. • ***CC PPS-1*** pays providers a daily rate for all CCBHC services and requires rate updates from the demonstration planning phase to DY1 using the MEI and from DY1 to DY2 using the MEI or by rebasing. • ***CC PPS-2*** includes these required elements: (1) a monthly rate to reimburse the CCBHC for services, (2) separate monthly PPS rates to reimburse CCBHCs for higher costs associated with providing all services needed to meet the needs of clinic users with certain conditions, (3) cost updates from the demonstration planning period to DY1 using the MEI and from DY1 to DY2 using the MEI or by rebasing; (4) outlier payments made in addition to PPS for participant costs in excess of a threshold defined by the state, and (5) QBP made in addition to the PPS rates.

5.0b	**Building CCBHC PPS Rates Into Managed Care Capitation** The state has two options for incorporating the CCBHC rate into the managed care payment methodology: (1) fully incorporate the PPS payment into the managed care capitation rate, or (2) use a reconciliation process to make a wraparound supplemental payment to ensure that the total payment is equivalent to CCBHC PPS. The first option—incorporation of the PPS payment into the managed care capitation rate—gives the state greater budget predictability for CCBHC expenditures at the beginning of the demonstration. The state will need to provide adequate oversight in the following areas: • **Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP) contract with CCBHCs** The state will need to develop and implement processes to ensure that managed care enrollees have access to services provided by CCBHCs. To satisfy this requirement, managed care contracts may need to include specific network adequacy requirements or explicit requirements allowing out-of-network access to other CCBHCs. • **PPS rates incorporated into managed care payments to CCBHCs** The state will need to ascertain the size and timing of payments to CCBHCs. Managed care plans will be required to pay CCBHCs the actual, or the actuarial equivalent of, PPS rates. The state will need to review managed care rates throughout the demonstration period to ensure that payments are sufficient compared with actual utilization. Managed care plans should be required contractually to compensate for any shortfall between rates and actual utilization. The second option—a wraparound reconciliation process—will require oversight related to reconciling managed care payments with full PPS rates: • **Reconciliation of payments to ensure actuarial equivalence of PPS rates** If the state chooses a supplemental or wraparound payment for CCBHC services, it will reconcile managed care payments to CCBHCs with the full

	PPS rates for covered services to determine whether the minimum payment was achieved. If the minimum payment was not achieved, the state (or the managed care entity, as a pass-through from the state) will make payments to CCBHCs to make up the shortfall. The frequency of wraparound payments to CCHBCs during each demonstration year is not dictated by any statutory requirement. However, we suggest that states consider making supplemental/wraparound payment at least every four months and reconciling annually, similar to the process used for Federally Qualified Health Center (FQHC) wraparound payments. Regardless of whether the state chooses the full PPS methodology or a supplemental or wraparound payment methodology, it will use PPS rate development guidelines (see section 2) to determine the minimum reimbursement to CCBHCs under the demonstration project. The state should take into account any CCBHC demonstration services that are already included in managed care capitation rates and the state's strategies for avoiding duplication of payment. The state also will need to account for any duplication in the actuarial certification(s) of the rates paid to MCOs, PIHPs, or PAHPs delivering services to enrollees included in the demonstration. Any change in services delivered under the capitation that would change the rates paid to MCOs, PIHPs, and PAHPs may require either a new or amended actuarial certification of the capitation rates to CMS demonstrating how the CCBHC services are represented in the methodology.

5.0c	**PIHP and PAHP Coverage Areas in Managed Care States** Several states contract with PIHPs and PAHPs that specialize in behavioral health services. Medicaid enrollees may be members of a PIHP or PAHP *and* an MCO at the same time. As such, a CCBHC may not be aware which entity is responsible for payment of behavioral health services. To make transparent which payer is responsible and to meet reporting requirements of this demonstration, CMS recommends that states consider assigning all CCBHCs to one managed care entity that is capable of collecting all of the data pertinent to demonstration payment. Use of a single managed care provider could help states reduce duplicate payment. States must account for duplicate services provided through these different entities. If one entity is chosen to provide CCBHC services, the capitation rate may need to be adjusted upward, and the remaining entities may need to adjust the capitation downward. Any resulting new rates must be determined to be actuarially sound. A state that chooses not to include all demonstration services under one contractor will need to define clearly how it will ensure that (1) services between contractors will be delineated, and (2) no duplication of services or payments will occur. The rate development guidelines (section 2) explain the requirements for ensuring that states develop rates without duplicating expenses. States with PHIP or PHAP arrangements should take additional steps to avoid duplicative payments.
5.0d	**Data Reporting and Managed Care Contract Requirements** The state's contract with the managed care entity must contain requirements for reporting CCBHC data. We recommend the state include the following items in its contract: (1) data to be reported; (2) the period during which data must be collected; (3) the method to meet reporting requirements; and, (4) the entity responsible entity for data collection. The data that must be reported for this demonstration is specified in Appendix A of SAMHSA's *Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish CCBHCs*. Further requirements also may be found in Program Requirement 5.A of those criteria. States also must collect data to allow for oversight of managed care contract

	execution with CCBHCs and to remedy performance issues.
5.0e	**Identification of Expenditures Eligible for Enhanced Federal Medical Percentage (FMAP)** To ensure proper claiming of enhanced FMAP, the state will need to revise its actuarial certification letters to show how much of the capitation payment(s) is associated with CCBHC services for the new adult group rate cells and for the existing managed care population rate cells. At agreed-upon intervals, the state or the managed care entity will provide actual encounter data or other adequate data sources to verify services that are eligible for enhanced FMAP. The state should report CCBHC services in a separate section for payments through managed care. The claims should attribute the actual portion of managed care rates to CCBHC services.

Appendix IV – Statement of Assurance

If selected, as the Authorized Representative of [insert name of applicant state] _____, I agree to pay for services at the rate established under the prospective payment system during the demonstration program. I agree that no payments will be made for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, or to satellite facilities of CCBHCs if such facilities were established after April 1, 2014.

_____ _____

Signature of Authorized Representative Date