Section 223 Certified Community Behavioral Health Clinic (CCBHC) Demonstration Prospective Payment System (PPS) Guidance

Updated February 2024

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Section 1: Introduction

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (P.L. 113–93, PAMA or "the statute") was signed into law with section 223 of the statute authorizing the Department of Health and Human Services (HHS) to select up to eight states to participate in a 2-year Demonstration program aimed at improving the availability, quality, and outcomes of ambulatory behavioral health services by establishing a standard definition and criteria for Certified Community Behavioral Health Clinics (CCBHCs) and developing new prospective payment systems (PPS) that account for the expected cost of providing comprehensive behavioral health services to all individuals who seek care. Since enactment of the original statute, the section 223 Demonstration (the Demonstration) has been extended several times. The Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136, CARES Act), signed into law on March 27, 2020, added two additional Demonstration states to the program. Most recently in June 2022, the Demonstration was extended and expanded under section 11001 of the Bipartisan Safer Communities Act (P.L. 117-159, BSCA) to include up to an additional ten states starting in 2024, and every two years thereafter.[1]

CCBHCs are statutorily required to offer nine services: (1) crisis mental health services; (2) screening, assessment, and diagnosis; (3) person-centered treatment planning; (4) outpatient mental health and substance use services; (5) outpatient clinic primary care screening and monitoring; (6) targeted case management (TCM); (7) psychiatric rehabilitation services; (8) peer support, counselor services, and family supports; and (9) intensive, community-based mental health care for members of the armed forces and veterans. The statute requires the use of a prospective payment system (PPS) methodology to pay participating clinics for the provision of the nine statutory services and requires the Centers for Medicare & Medicaid Services (CMS) to issue Guidance to states and clinics on the development of the PPS to be used Demonstration-wide. The CCBHC PPS applies to services delivered either directly by a CCBHC or through a formal relationship between a CCBHC and Designated Collaborating Organizations (DCOs), as that term is defined in the Substance Abuse and Mental Health Services Administration (SAMHSA)-developed CCBHC Criteria.

CMS developed the PPS Technical Guidance ("the Guidance") for CCBHC payment considering the CCBHC Criteria established by SAMHSA with regard to the six statutory program requirements developed for 1) staffing; 2) availability and accessibility of services; 3) care coordination; 4) scope of services; 5) quality and other reporting; and 6) organizational authority and governance. CMS held multiple listening sessions prior to issuing the PPS Technical Guidance in 2015 and in preparation to issue updated

[1] States must have received a planning grant at any time since 2015 in order to apply to participate in the Demonstration.

Guidance in 2023, provided a forum for states and stakeholders to comment on the newly proposed changes geared toward additional payment flexibilities and alignment with revisions to the CCBHC Criteria. This updated PPS Guidance is based on feedback that CMS received from states, providers, and other stakeholders, most notably to address the high-cost and specialized care delivered through mobile and on-site crisis intervention services provided directly to individuals who are experiencing a substance use-related or mental health crisis. As such, updates to the Guidance are to assist states with developing clinic-specific CCBHC PPS rates, cost reporting, and claiming Medicaid expenditures at the statutory enhanced Federal Medical Assistance Percentage (FMAP) rate throughout the statutory BSCA extension and expansion of the Demonstration program. This Guidance is effective on or after January 1, 2024 for existing CCBHC Demonstration states, and on or after July 1, 2024 for newly selected states added to the program in 2024 and 2026 as authorized under BSCA. Requests for technical assistance may be submitted to CCBHC-Demonstration@cms.hhs.gov.

Applicable CCBHC PPS Rates

Under this Demonstration, participating states must select from among four PPS rate methodologies to reimburse CCBHC providers the expected cost of delivering CCBHC services. The PPS methodology will be required Demonstration-wide for participating CCBHCs to set cost-based, clinic-specific rates. The PPS methodology the state selects when applying for the Demonstration must be the methodology used for the entire Demonstration year (DY) and may not be changed without approval from CMS. States are not permitted to make any additional payments to CCBHCs for services included within the scope of this Demonstration outside of the Certified Clinic (CC) PPS payment, outlier payments, or Quality Bonus Payments (QBPs) as applicable to the PPS methodology.

The first option, Certified Clinic Prospective Payment System 1 (CC PPS-1), is a Federally Qualified Health Center (FQHC) like PPS rate that provides reimbursement of the expected cost of providing CCBHC services on a daily basis with the state's option to provide QBPs to CCBHCs that meet quality measure performance thresholds established by the state. QBPs for CC PPS-1 are not required and changes to the QBP program should not be seen as changing the underlying PPS system.

The second option, CC PPS 2 (CC PPS-2), provides reimbursement of the expected cost of providing CCBHC services on a monthly basis and allows states the option to develop separate Special Population (SP) rates to cover the high cost of individuals with certain clinical conditions. Additionally, the state is required to incorporate QBPs and outlier payments as part of the CC PPS-2 methodology.

The third option, CC PPS 3 (CC PPS-3), provides reimbursement of the expected cost of providing CCBHC services on a daily basis. While CC PPS-3 mirrors CC PPS-1 with the requirement to set clinic-specific daily PPS rates and optional QBPs for CCBHCs that meet

state-defined quality metric thresholds for payment, it also includes the newly required daily Special Crisis Services (SCS) rates, which allows states to set separate PPS rates for crisis services provided by CCBHCs. SCS rates may be set for one or more of the following categories of crisis services: 1) mobile crisis services that meet the criteria for being qualifying community-based mobile crisis intervention services as authorized under section 9813 of the American Rescue Plan Act of 2021 (P.L. 117-2, ARP), 2) mobile crisis services that do not meet the qualifying criteria of ARP section 9813, and 3) on-site crisis stabilization services.

The fourth option, CC PPS 4 (CC PPS-4), is similar to CC PPS-2 in that it also has a monthly unit of payment, required outlier payments, and required QBPs for CCBHCs that meet state defined quality metric thresholds for payment, and optional SP rates for people with certain conditions. In addition to these elements, CC PPS-4 also requires the new separate monthly SCS rates similar to those required under the CC PPS-3 methodology.

Applicable Federal Medical Assistance Percentage (FMAP) Rates

PAMA permits states to claim expenditures related to payments made for CCBHC services at the enhanced Federal Medical Assistance Percentage (FMAP) rate equivalent to the standard Children's Health Insurance Program (CHIP) rate as specified in section 2105(b) of the Social Security Act (the Act). BSCA extends the enhanced FMAP to September 30, 2025, for the original eight Demonstration states authorized under PAMA, provides the two states authorized under the CARES Act with the increased FMAP for 24 quarters, and authorizes the enhanced FMAP for 16 quarters for each of the up to ten additional Demonstration states added to the program every two years, starting in 2024. The matching rates for amounts expended by the state to provide medical assistance for behavioral health services authorized by the Demonstration are as follows.

- Expenditures for CCBHC medical assistance services are matched at the FMAP rate equivalent to the CHIP match at section 2105(b) of the Act.
- Expenditures for CCBHC services provided to Medicaid beneficiaries enrolled in a Medicaid CHIP expansion program, are reimbursed the enhanced FMAP for CHIP expenditures as provided in section 2105(b) of the Act.
- 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 CCBHC services provided by certified clinics that are also Indian Health Service (IHS) or tribal facilities to American Indians and Alaskan Natives (AI/AN) are matched at 100 percent.
- CCBHC expenditures meeting the requirements of qualifying community-based mobile crisis intervention services as authorized under section 9813 of the ARP (also referred to in this document as "ARP 9813 CCBHC mobile crisis services"), may be claimed at an increased FMAP rate of 85 percent for the first 12 fiscal

quarters within the five-year period starting April 1, 2022, and ending March 31, 2027.

- Expenditures for CCBHC activities that are found necessary by the Secretary for the proper and efficient administration of the Medicaid program, per 42 Code of Federal Regulations (CFR) 433.15(b)(7), may be claimed at a rate of 50 percent.

Using authority as outlined under section 223 of PAMA, states may claim enhanced FMAP and do not need Medicaid state plan authority to implement payment for CCBHC services delivered by certified clinics participating in the Demonstration. Enhanced FMAP applies to expenditures for CCBHC Demonstration services provided to individuals eligible for and enrolled in Medicaid, including Medicaid expansion CHIP programs, but not separate CHIP programs. In order to ensure proper claiming of enhanced FMAP for Medicaid managed care entities, the state will need to develop a claiming methodology to identify the portion of the capitation rate attributable to the services/populations that are eligible for the enhanced match. States should reference the following Guidance issued in August 2023 on Medicaid managed care claiming methodologies: https://www.medicaid.gov/sites/default/files/2023-08/smd23005.pdf.

Under the Demonstration, states and localities continue to finance the non-federal share of payment and, as part of the CCBHC Demonstration application process, states will provide information to CMS on the non-federal share 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 CCBHC Demonstration.

Section 2: CCBHC PPS Rate-Setting Methodology Options

For the purposes of this Demonstration, CMS offers all Demonstration states the option of using one of four CC PPS methodologies, as described below. A state must elect one CC PPS methodology applicable to all CCBHCs participating in the Demonstration to determine the clinic-specific rate it will use to pay for CCBHC Demonstration services and activities delivered by a CCBHC, 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.[2] States must ensure non-duplication of payment to CCBHC providers and should follow instructions outlined in section 4.0, Payment to CCBHCs That Are FQHCs, Clinics, or Indian Health Facilities. This updated Guidance contains information to help states develop these rates and CMS is available to provide ongoing technical assistance to states on this topic.

[2] Actuarial soundness defined in 42 CFR 438.4.

Table 1: Required Rate Elements of the Four CC PPS Methodologies (CC PPS-1, PPS-2, PPS-3, & PPS-4)

Rate Elements	CC PPS-1	CC PPS-2	CC PPS-3	CC PPS-4
Base Rate	**Daily**	**Monthly**	**Daily**	**Monthly**
Special Crisis Services (SCS) PPS Rates – Payments for crisis services	N/A	N/A	Separate, daily PPS rate(s) for at least one of the following crisis services: • ARP 9813 CCBHC mobile crisis services • Other CCBHC mobile crisis services (not ARP 9813 mobile crisis services) • On-site CCBHC crisis stabilization services	Separate, monthly PPS rate(s) for at least one of the following crisis services: • ARP 9813 CCBHC mobile crisis services • Other CCBHC mobile crisis services (not ARP 9813 mobile crisis services) • On-site CCBHC crisis stabilization services
Special Populations (SP) Payment Rates – Payments for services provided to people with certain conditions	N/A	**Optional** – separate monthly SP PPS rate(s) to reimburse CCBHCs for the costs associated with providing all services necessary to meet the needs of higher need SPs	N/A	**Optional** – separate monthly SP PPS rate(s) to reimburse CCBHCs for the costs associated with providing all services necessary to meet the needs of higher need SPs
Outlier payments	N/A	Separate payment for a portion of Medicaid beneficiary costs in excess of threshold	N/A	Separate payment for a portion of Medicaid beneficiary costs in excess of threshold
Quality bonus payments (QBP)	**Optional** bonus payment for CCBHCs that meet quality measure thresholds	Bonus payment for CCBHCs that meet quality measure thresholds	**Optional** bonus payment for CCBHCs that meet quality measure thresholds	Bonus payment for CCBHCs that meet quality measure thresholds
Annual Updates to the PPS Rates	Medicare Economic Index (MEI) or rebasing using cost reports	Medicare Economic Index (MEI) or rebasing using cost reports	Medicare Economic Index (MEI) or rebasing using cost reports	Medicare Economic Index (MEI) or rebasing using cost reports
Required Rebasing of PPS Rates	States must rebase PPS rates for DY3 using DY2 cost report data and rebase PPS rates at least once every 3 years	States must rebase PPS rates for DY3 using DY2 cost report data and rebase PPS rates at least once every 3 years	States must rebase PPS rates for DY3 using DY2 cost report data and rebase PPS rates at least once every 3 years	States must rebase PPS rates for DY3 using DY2 cost report data and rebase PPS rates at least once every 3 years

Abbreviations: CCBHC, certified community behavioral health clinic; CC PPS, Certified Clinic Prospective Payment System; N/A, not applicable; PPS, prospective payment system

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

Certified Clinic PPS-1 (CC PPS-1) is a cost-based, clinic-specific rate that applies uniformly to all CCBHC services rendered by a certified clinic, including those delivered by qualified satellite facilities of the CCBHC established prior to April 1, 2014. The CC PPS-1 methodology has one standard base PPS rate and pays CCBHCs a daily rate that is a fixed amount for all CCBHC services provided on any given day to a Medicaid beneficiary. QBPs are optional under the CC PPS-1 rate methodology. States are required to update the PPS rates under CC PPS-1 methodology by both (1) annually updating the PPS rates by the MEI or rebasing, and (2) rebasing the PPS rates in accordance with the timeframes outlined in Section 2.5 of this Guidance. The CC PPS-1 standard base PPS rate is calculated using the total annual allowable CCBHC costs, comprised of direct CCBHC costs plus an allocation of indirect costs, divided by the total annual number of CCBHC daily visits for the same reporting period. This results in a uniform payment amount per day, regardless of the intensity of services or individual needs of persons utilizing services on that day. Under the CC PPS-1 methodology, CCBHC PPS payments are limited to one CCBHC PPS payment each day, for a person receiving CCBHC Demonstration services. This pertains only to CCBHC services, not to other types of care outside the scope of CCBHC Demonstration services that also may be provided by a certified clinic.

CC PPS-1	
2.1a	The state must implement a daily standard base PPS rate under the CC PPS-1 methodology. The following formula is used for calculating the standard base PPS rate for 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. States may choose to update the DY1 rate for DY2 by also using the MEI to trend rates forward or by rebasing PPS rates. If the rate was trended in DY2, it must be updated for DY3 by rebasing the PPS rate with actual costs from DY2. PPS rates will need to be updated by rebasing every three years thereafter in alignment with section 2.5 of the Guidance. Please see section 2.6 of the Guidance for more details on rate setting for DY1. Section 2.1d contains a sample calculation that demonstrates the CC PPS-1 methodology. States should also include the applicable cost of care and visits associated with Designated Collaborating Organizations as outlined in section 5.1a of this Guidance. 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 5).

CC PPS-1	
2.1b	**Updates to the CC PPS-1 Rate** Under the CC PPS-1 rate methodology, states are required to both (1) annually update all PPS rates in accordance with the guidelines and requirements laid out in section 2.5a of this Guidance and (2) rebase all PPS rates after DY2 and at least once every three years in alignment with section 2.5b of this Guidance.
2.1c	**CC PPS-1 Quality Bonus Payments (QBPs)** Under the CC PPS-1 rate methodology, a state may elect to offer QBPs. States electing this option under the CC PPS-1 rate are required to provide QBPs in accordance with the guidelines and requirements laid out in section 3 of this Guidance.
2.1d	**CCBHC CC PPS-1 Rate Example** 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 standard base PPS rate, regardless of the participant type, CCBHC services provided, or overall costs associated with the visit.

Table 2: CC PPS-1 Rate Calculation Example

Person	Number of Daily Visits in a Year	Trended Annual Costs[i], $	CC PPS-1 Payment Per Daily Visit[ii], $	CC PPS-1 Payment[iii], $
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**

[i] Annual costs may be determined for each person.

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

[iii] CC PPS-1 Payment = 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 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

Section 2.2: Certified Clinic PPS 2 (CC PPS-2)

Certified Clinic PPS-2 (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 satellite facilities of the certified clinic established prior to April 1, 2014. 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. CC PPS-2 includes four elements: (1) a required monthly standard base PPS rate to reimburse the CCBHC for Demonstration services provided to the standard population, (2) optional separate monthly Special Population (SP) PPS rates to reimburse CCBHCs for higher costs associated with providing Demonstration services to people with certain conditions, (3) required outlier payments made in addition to the PPS for participant costs in excess of a threshold defined by the state, and (4) required QBPs made in addition to the PPS. States are required to update the PPS rates under the CC PPS-2 methodology by annually updating the PPS rates by the MEI or rebasing, and rebasing the PPS rates at least once every three years in accordance with the timeframes outlined in Section 2.5 of this Guidance. Under the CC PPS-2 methodology, there will be at least one PPS rate. States will develop a standard monthly base PPS rate and at the state's option, additional monthly PPS rates that vary according to a person's clinical condition(s). Special population designations are intended to incent CCBHCs to accept and retain patients with high-costs. States should designate the population category for each patient based on patient demographic information, diagnoses or the combination of diagnoses and utilization patterns. States should create special populations to reimburse CCBHCs for the higher cost of care associated with patients with higher complexity or needs. Prior to implementing special population rates, states should consider whether the monthly PPS rate adequately accounts for costs that would otherwise be separately identified as a special population to meet the high-cost needs of persons with certain clinical conditions. An example of how states could categorize SPs in their state would be a state that has 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 based on the special conditions they select for the SP rates.

Under the CC PPS-2 methodology, CCBHC PPS payments are limited to one CCBHC PPS payment each month a person receives a CCBHC Demonstration service. CCBHCs are eligible to receive either the standard monthly base PPS payment or one of the monthly SP PPS payments when eligible Demonstration services are provided in a month. Each CCBHC PPS rate must consist of unique costs and visits for each visit type and cannot duplicate the costs or visits used in the calculation of the other PPS rates under this methodology. While there is a payment limit of one CCBHC PPS payment per month, this limitation only pertains to payments for CCBHC Demonstration services and not to other

types of care outside the scope of CCBHC Demonstration services that also may be provided by a certified clinic.

The outlier payment is a required component of the CC PPS-2 rate and reimburses clinics for costs above a state-defined threshold. This helps to ensure that clinics are able to meet the cost of serving their users.

2.2a	**CC PPS-2 Rates and Outlier Payment** **Step 1:** Determine the monthly standard base PPS rate, excluding costs and visits for services to any person utilizing CCBHC services with certain conditions and outlier payments (as illustrated in the example in section 2.2d). The standard base PPS rate formula for PPS-2 is: **Total annual allowable CCBHC costs* *excluding* costs for services provided to persons with certain conditions and outlier payments** **Total number of CCBHC unduplicated monthly visits per year *excluding* visits of people 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 person utilizing CCBHC services. 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 monthly PPS rates for special populations using the formula below. **Total annual allowable CCBHC costs* *including only services provided to persons* with certain conditions *excluding* outlier payments** **Total number of CCBHC monthly visits per year *including only* visits of persons with certain conditions** Step 2 would be repeated to calculate the PPS rate for each SP that the state has elected to include in their PPS-2 methodology. ***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. States may choose to update the DY1 rate for DY2 by also using the MEI to trend rates forward or by rebasing PPS rates. If the rate was trended in DY2, it must be updated for DY3 by rebasing the PPS rate with actual costs from DY2. PPS rates will need to be updated by rebasing every three years thereafter in alignment with section 2.5 of the Guidance. Please see section 2.6 of the Guidance for more details on rate setting for DY1. Key considerations in determining PPS for optional special populations are: (1) identifying the population(s), (2) assessing utilization, and (3) allocating cost. States have flexibility in designating persons utilizing services with certain conditions for which separate special population 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 2.2d contains a sample calculation that demonstrates the CC PPS-2 methodology. This example includes considerations for both persons with certain conditions and outlier payments. States should also include the applicable cost of care and visits associated with Designated Collaborating Organization in the calculation of the PPS rates under this methodology, as outlined in section 5.1a of this Guidance. 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 5).
2.2b	**Updates to CC PPS-2 Rates** Under the CC PPS-2 rate methodology, states are required to both (1) annually update all PPS rates in accordance with the guidelines and requirements laid out in section 2.5a of this Guidance and (2) rebase all PPS rates after DY2 and at least once every three years in alignment with section 2.5b of this Guidance.
2.2c	**CC PPS-2 Quality Bonus Payments (QBPs)** Under the CC PPS-2 rate methodology, states are required to provide QBPs in accordance with the guidelines and requirements laid out in section 3 of this Guidance.

CCBHC CC PPS-2 Rate Example	
2.2d	**CCBHC CC PPS-2 Rate Example** The following example demonstrates the CC PPS-2 methodology calculations for a small sample facility with seven people per year. Table 3 illustrates how aggregate monthly allowed costs are translated into standard 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 the MEI to reflect changes in the underlying costs to provide treatment between the data collection period and the DY1 period. For

CCBHC CC PPS-2 Rate Example	
	subsequent DYs, PPS rates would be annually updated and rebased every three years in alignment with section 2.5 of this Guidance. In the example in Table 3, people are categorized on the basis of criteria the state has used to define the standard population and special populations. In our example, three distinct PPS rates are calculated—one for the people 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 PPS rates for the different populations. In all cases, the cost data should be fully attributed between the Standard and 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, with a reserve of 80 percent of costs in excess of that threshold. 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 during the Demonstration period. People A, E, and F each experience 1 month with costs that exceed the established threshold. Therefore, in addition to the applicable PPS rate for each person type, the facility will be paid a varying additional outlier payment. For instance, Person A in March has a $1,250 service that is above the outlier threshold. The amount of cost used in the standard 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, CC PPS-2 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 3: CC PPS-2 Rates, Special Population Rates, and Outlier Payments Calculation Example

Person	Month	Outlier?	Visit Type	Visit Months	*Trended* Allowed Monthly Costs, $	Non-outlier Payment Portion	Outlier Payment Reserve	Payment Per Monthly Visit, $
Standard Population								
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***
Special Population A								
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***
Special Population B								
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 3 is included for illustrative purposes only and does not reflect actual 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 2.3: Certified Clinic PPS 3 (CC PPS-3)

Certified Clinic PPS-3 (CC PPS-3) is a cost-based, per clinic daily rate that applies uniformly to all CCBHC services rendered by a certified clinic, including all qualifying satellite facilities of the certified clinic established prior to April 1, 2014. CC PPS-3 includes two required elements: (1) a standard daily PPS base rate to reimburse the CCBHC for Demonstration services not included in the Special Crisis Services (SCS) PPS rate(s), and (2) separate daily SCS PPS rate(s) to reimburse CCBHCs for the provision of crisis services. CCBHCs receive the applicable daily CC PPS-3 rates whenever at least one CCBHC service as part of an unduplicated rate bundle is delivered on the same or any given day to a Medicaid beneficiary. In addition to the minimum two required PPS rates, states also have the option to implement QBPs under the CC PPS-3 rate methodology. States are required to update the PPS rates under this methodology by annually trending rates by the MEI or rebasing the PPS rates at least once every three years in accordance with the timeframes outlined in Section 2.5 of this Guidance.

Under this methodology, states will develop at least two PPS rates, both a standard daily PPS rate and daily SCS PPS rate(s). The SCS rates under CC PPS-3 allow states to set at least one of three separate daily PPS rates for CCBHCs providing crisis services. The three categories of crisis services for which SCS rates can be set are for: 1) mobile crisis services meeting the requirements of section 9813 of ARP,[3] 2) CCBHC mobile crisis services that do not meet the ARP section 9813 requirements, 3) and on-site CCBHC crisis stabilization services. The CCBHC ARP 9813 mobile crisis services SCS PPS rate is only for services the CCBHC provides that comport with section 9813 of the ARP of 2021 and as outlined in CMS State Health Official Letter SHO #21-008[4] for mobile crisis services. The non-9813 CCBHC mobile crisis services SCS PPS rate is reserved for those mobile crisis services that do not fully meet the detailed requirements to comply with section 9813 of ARP, but which do meet the definition of crisis behavioral health services as outlined under PAMA at section 223(D) Scope of Services and as described in section 4.C of the updated SAMHSA CCBHC Criteria. The final category of SCS PPS rates is for on-site CCBHC crisis stabilization services meeting the definition as defined at SAMHSA Criteria 4.c.1 that are provided at the physical CCBHC location. As they are not performed onsite, mobile crisis stabilization services would not be included in this SCS rate. While

[3] American Rescue Plan Act of 2021 (ARP)

[4] CMS State Health Official Letter SHO #21-008

states selecting CC PPS-3 must have a least one daily SCS PPS rate, states have flexibility in determining how many of the three SCS PPS rates to implement under this methodology.

CCBHCs are eligible to receive the applicable CC PPS-3 PPS payment for each day they provide an eligible CCBHC Demonstration service to a beneficiary. Under this methodology, CCBHCs are eligible to receive one standard daily base CCBHC PPS payment in addition to one daily CCBHC SCS PPS payment for each category of SCS services implemented by the state if applicable Demonstration services are provided on the same day. CCBHC PPS payments of each type are limited to one unduplicated CC PPS-3 payment per visit type, each day, for a person receiving CCBHC Demonstration services. This pertains only to CCBHC services, not to other types of care outside the scope of CCBHC Demonstration services that also may be provided by a certified clinic.

CC PPS-3	
2.3a	**CC PPS-3 Rates** **Step 1:** Determine the daily standard base PPS rate, excluding costs and visits for crisis included in any of the SCS rates (as illustrated in the example in section 2.3d). The standard base PPS rate formula for CC PPS-3 is: $$\frac{\textbf{Total annual allowable CCBHC costs}^{*}\ \textbf{excluding costs for crisis services included under SCS services}}{\textbf{Total number of CCBHC daily visits per year excluding crisis services visits included under SCS services}}$$ **Step 2:** Determine PPS rates for each category of special crisis services the state has elected to implement under CC PPS-3 using the formula below. $$\frac{\textbf{Total annual allowable CCBHC costs*}\ \textit{including only those for one of the three categories of SCS services}}{\textbf{Total number of CCBHC daily visits per year } \textit{including only those} \textbf{ for same category of SCS services used in the numerator}}$$ Step 2 would be repeated to calculate a PPS rate for each category of SCS services a state has elected to include in their PPS-3 methodology. ***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. States may choose to update the DY1 rate for DY2 by also using the MEI to trend rates forward or by rebasing PPS rates. If the rate was trended in DY2, it must be updated for DY3 by rebasing the PPS rate with actual costs from DY2. PPS rates will need to be updated by rebasing every three years thereafter in alignment with section 2.5 of the Guidance. Please see section 2.6 of the Guidance for more details on rate setting for DY1. Key considerations in determining the PPS rate for SCS are: (1) identifying the number of SCS rates a state would like to create, (2) assessing utilization of those specific services, and (3) allocating cost. Though at least one SCS rate is

CC PPS-3	
	required for CC PPS-3, states have flexibility in designating the SCS categories for which separate PPS rates will be determined under this methodology. Section 2.3d contains a sample calculation that demonstrates the CC PPS-3 methodology. States should also include the applicable cost of care and visits associated with Designated Collaborating Organization in the calculation of the PPS rates under this methodology, as outlined in section 5.1a of this Guidance. 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 5).
2.3b	**Updates to CC PPS-3 Rates** Under the CC PPS-3 rate methodology, states are required to both (1) annually update all PPS rates in accordance with the guidelines and requirements laid out in section 2.5a of this Guidance and (2) rebase all PPS rates after DY2 and at least once every three years in alignment with section 2.5b of this Guidance.
2.3c	**CC PPS-3 Quality Bonus Payments (QBPs)** Under the CC PPS-3 rate methodology, states may elect to offer QBPs. States electing to use this option under the CC PPS-3 rate methodology are required to provide QBPs in accordance with the guidelines and requirements laid out in section 3 of this Guidance.
CCBHC CC PPS-3 Rate Example	
2.3d	**CCBHC CC PPS-3 Rate Example** The following example demonstrates the CC PPS-3 rate mechanics for a sample facility with seven people a year. Table 4 illustrates how allowable daily costs and visits are translated into standard and separate daily PPS rates to reimburse CCBHCs for two types of special crisis services (SCS), ARP 9813 CCBHC mobile crisis, and CCBHC on-site crisis stabilization services. Data to set these rates will be collected during the planning phase of the Demonstration and should be adjusted by the MEI to reflect changes in the underlying costs to provide treatment between the data collection period and the DY1 period. For subsequent DYs, PPS rates would be updated annually and rebased in alignment with section 2.5 of this Guidance. In the example in Table 4, visits are categorized on the basis of criteria the state has used to define the standard visit and the two categories of SCS they selected. In our example, three distinct PPS rates are calculated—one standard PPS rate for the people not receiving ARP 9813 CCBHC mobile crisis or CCBHC

CC PPS-3	
	on-site crisis stabilization services (standard) and two PPS rates for the people receiving special crisis services (ARP 9813 CCBHC mobile crisis SCS services and CCBHC on-site crisis stabilization SCS services). PPS rates for each of the visit types are calculated by dividing the visit-specific portion of the trended allowed annual costs, by the total daily visit amount for that visit type. For the standard population, this rate is $100 per daily visit (calculated as $8,500/85 daily visits); while it is $585 (calculated as $5,850/10 daily visits); and $300 (calculated as $1,500/5 daily visits); respectively, for the 9813 mobile crisis SCS and on-site crisis stabilization SCS daily visits. The state would pay the per visit PPS rate, dependent on the visit type, regardless of the person type, or overall costs associated with the visit.

Table 4: CC PPS-3 Rate Calculation Example

Person	Visit Type	Number of Daily Visits in a Year	Trended Annual Costs[i], $	CC PPS-3 Payment Per Daily Visit[ii], $	CC PPS-3 Payment[iii], $
Standard Visits					
A	Standard	21	2,550	100	2,100
B	Standard	19	1,700	100	1,900
C	Standard	7	850	100	700
D	Standard	15	1,000	100	1,500
E	Standard	5	650	100	500
F	Standard	15	1,250	100	1,500
G	Standard	3	500	100	300
Standard Visit Total		***85***	***8,500***		***8,500***
Special Crisis Services- ARP 9813 Mobile Crisis SCS Visit					
A	9813 Mobile Crisis SCS	2	1,250	585	1,170
D	9813 Mobile Crisis SCS	3	1,500	585	1,755
E	9813 Mobile Crisis SCS	4	2,450	585	2,340
F	9813 Mobile Crisis SCS	1	650	585	585
ARP 9813 Mobile Crisis SCS Visit Total		***10***	***5,850***		***5,850***
Special Crisis Services- On Site Crisis Stabilization Visits					
A	On Site Crisis Stabilization SCS	1	325	300	300
F	On Site Crisis Stabilization SCS	2	600	300	600
G	On Site Crisis Stabilization SCS	2	575	300	600
On Site Crisis Stabilization SCS Visit Total		***5***	***1,500***		***1,500***
Total for All CCBHC Services		**100**	**15,850**		15,850

[i] Annual costs may be determined for each person.

[ii] CC PPS-3 Payment Per Standard Daily Visit = Annual Costs ($8,500) / Number of Daily Visits in a Year (85) = $100; CC PPS-3 Payment Per ARP 9813 CCBHC Mobile Crisis SCS Daily Visit = Annual Costs ($5,850) / Number of Daily Visits in a Year (10) = $585; CC PPS-3 Payment Per CCBHC On Site Crisis Stabilization SCS Daily Visit = Annual Costs ($1,500) / Number of Daily Visits in a Year (5) = $300

[iii] CC PPS-3 Standard Payment = Number of Standard Daily Visits in a Year * CC PPS-3 Payment Per Standard Daily Visit ($100); CC PPS-3 ARP 9813 CCBHC Mobile Crisis SCS Payment = Number of Daily ARP 9813 CCBHC Mobile Crisis SCS Visits in a Year * CC PPS-3 ARP 9813 CCBHC Mobile Crisis SCS Payment Per Daily Visit ($585); CC PPS-3 CCBHC On Site Crisis Stabilization SCS Visit Payment = Number of Daily CCBHC On Site Crisis Stabilization SCS Visits in a Year * CC PPS-3 Payment Per CCBHC On Site Crisis Stabilization SCS Daily Visit ($300)

*Note: Table 4 is included for illustrative purposes only and does not reflect actual 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; SCS, Special Crisis Services

Section 2.4: Certified Clinic PPS 4 (CC PPS-4)

Certified Clinic PPS-4 (CC PPS-4) is a cost-based, per clinic monthly rate that applies uniformly to all CCBHC services rendered by a certified clinic, including all satellite facilities of the certified clinic established prior to April 1, 2014. CC PPS-4 includes these five elements: (1) a required standard monthly base PPS rate to reimburse the CCBHC for Demonstration services provided to the standard population, (2) optional separate monthly Special Populations (SP) PPS rates to reimburse CCBHCs for higher costs associated with providing Demonstration services to people with certain conditions, (3) required separate monthly Special Crisis Services (SCS) PPS rates to reimburse CCBHCs for the provision of crisis services, (4) required outlier payments made in addition to the PPS for participant costs in excess of a threshold defined by the state, and (5) required QBPs made in addition to the PPS. CCBHCs receive the applicable monthly PPS 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 the CC PPS-4 rate methodology, states are required to update the PPS rates by both annually trending the PPS rates by the MEI, rebasing after DY2, and rebasing the PPS rates at least once every three years in accordance with the timeframes outlined in Section 2.5 of this Guidance.

Under this methodology states will develop at least two (2) PPS rates. States will develop a standard monthly base PPS rate, in addition to developing at least one monthly SCS rate for the provision of crisis services. At the state's option, they may also develop monthly special population (SP) PPS rates that vary according to a person's clinical condition(s). Special population designations are intended to incent CCBHCs to accept and retain patients with high-costs. States should designate the population category for each patient based on patient demographic information, diagnoses or the combination of diagnoses and utilization patterns. States should create special populations to reimburse CCBHCs for the higher cost of care associated with patients with higher complexity or needs, excluding costs for Special Crisis Services. Should a state choose to implement SP rates, the state should consider whether the monthly PPS rate adequately accounts for costs that would otherwise be separately identified as a special population to meet the high-cost needs of persons with certain clinical conditions. An example of how states could categorize special populations in their states would be a state that has 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 based on the special conditions they select for the SP rates.

Under CC PPS-4, as also indicated for PPS-3, the SCS rates allow states to set at least one of three separate monthly rates for CCBHCs providing crisis services. The three categories of crisis services for which SCS rates can be set are for mobile crisis services

as outlined under section 9813 of ARP,[5] non-ARP 9813 CCBHC mobile crisis services, and on-site CCBHC crisis stabilization services. The CCBHC ARP 9813 mobile crisis services SCS PPS rate can only be paid for services the CCBHC provides that comport with section 9813 of ARP and, as outlined in CMS State Health Official Letter SHO #21-008[6] for mobile crisis services. The non-9813 CCBHC mobile crisis services SCS PPS rate is reserved for those mobile crisis services that meet the definition of crisis behavioral health services as outlined under PAMA at section 223(D) Scope of Services and as described in section 4.C of the updated SAMHSA CCBHC Criteria that do not fully meet the detailed requirements to comply with section 9813 of ARP. The final category of SCS PPS rates is the on-site CCBHC crisis stabilization services which is specifically for crisis stabilization services meeting the definition of CCBHC crisis stabilization as defined at SAMHSA Criteria 4.c.1 that are provided at the physical CCBHC location. As they are not performed onsite, mobile crisis stabilization services would not be included in this SCS rate. While CCBHC Demonstration states selecting CC PPS-4 must have a least one SCS monthly PPS rate, CMS allows states flexibility to determine how many of the three SCS PPS rates they wish to implement under this methodology.

CCBHCs are eligible to receive the applicable CC PPS-4 PPS payments for each month they provide an eligible CCBHC Demonstration service to a Medicaid beneficiary. Under this methodology, CCBHCs are eligible to receive either one standard monthly base CCBHC PPS payment or one monthly SP PPS payment, if implemented. CCBHCs may also receive one monthly CCBHC SCS PPS payment for each category of SCS services implemented by the state when applicable Demonstration SCS services are provided in the same month. CCBHC PPS payments must be unduplicated payments for each person receiving CCBHC Demonstration services in a monthly time period. This pertains only to CCBHC services, not to other types of care outside the scope of CCBHC Demonstration services that also may be provided by a certified clinic.

The next component of CC PPS-4 is an outlier payment, which reimburses clinics for costs above a state-defined threshold. This helps to ensure that clinics are able to meet the cost of serving their users.

[5] American Rescue Plan Act of 2021 (ARP)

[6] CMS State Health Official Letter SHO #21-008

CC PPS-4	
2.4a	**CC PPS-4 Base Rates** **Step 1:** Determine the standard monthly PPS base rate, excluding costs and visits for services provided to any persons with certain conditions and crisis services included under SCS services (section 2.4), and outlier payments. The standard base PPS formula for CC PPS-4 is: **Total annual allowable CCBHC costs*** ***Excluding*** **the costs for services provided to persons with certain conditions, costs for crisis services included under SCS services, and outlier payments** **Total number of CCBHC unduplicated monthly visits per year** ***excluding*** **visits for persons with certain conditions and crisis services visits included under SCS services** **Step 2:** Determine PPS rates for special crisis services using the formula below. **Total annual allowable CCBHC costs* *including only* those costs associated with one of the three categories of SCS services and *excluding* the costs for services provided to the standard population, persons with certain conditions, costs for crisis services included under the other two SCS services categories.** **Total number of CCBHC unduplicated monthly visits per year *including only* visits for the same category of SCS services used in the numerator and excluding the visits for the standard population, persons with certain conditions, and visits for crisis services included under the other two SCS services categories** Step 2 would be repeated to calculate the PPS rate for each category of SCS services a state elects to include in their PPS-4 methodology. Key considerations in determining PPS for SCS are: (1) identifying the number of SCS rates a state would like to create, (2) assessing utilization of those specific services, and (3) allocating cost. Though at least one SCS rate is required for CC PPS-4, states have flexibility in designating the SCS categories for which separate PPS rates will be determined under the PPS-4 methodology. **Step 3: Determine PPS rates for special populations using the formula below (if applicable).** **Total annual allowable CCBHC costs* *including only* the costs for services to persons with certain conditions and *excluding* costs for the standard population, crisis services included under SCS services and outlier payments** **Total number of CCBHC unduplicated monthly visits per year *including* only the visits for services to persons with certain conditions *and excluding* visits *for the standard population and crisis services included under SCS services*** ***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. States may choose to update the DY1 rate for DY2 by also using the MEI to trend rates forward or by rebasing PPS rates. If the rate was trended in DY2, it must be updated for DY3 by rebasing the

CC PPS-4	
	PPS rate with actual costs from DY2. PPS rates will need to be updated by rebasing every three years thereafter in alignment with section 2.5 of the Guidance. Please see section 2.6 of the Guidance for more details on rate setting for DY1. Step 3 would be repeated to calculate the PPS rate for each SP that the state elects to include in their PPS-4 methodology. Key considerations in determining the PPS rate(s) for special populations are: (1) identifying the population(s), (2) assessing utilization, and (3) allocating cost. States have flexibility in designating the persons utilizing CCBHC services with certain conditions for which separate PPS rates will be determined. **Step 4**: 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 2.4d contains a sample calculation that demonstrates the CC PPS-4 methodology. This example includes considerations for people utilizing services with certain conditions, special crisis services, and outlier payments. States should also include the applicable cost of care and visits associated with Designated Collaborating Organization in the calculation of the PPS rates under this methodology, as outlined in section 5.1a of this Guidance. 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 5).
2.4b	**Updates to CC PPS-4 Rates** Under the CC PPS-4 rate methodology, states are required to both (1) annually update all PPS rates in accordance with the guidelines and requirements laid out in section 2.5a of this Guidance and (2) rebase all PPS rates after DY2 and at least once every three years in alignment with section 2.5b of this Guidance.
2.4c	**CC PPS-4 Quality Bonus Payments (QBPs)** Under the CC PPS-4 rate methodology, states are required to provide QBPs in accordance with the guidelines and requirements laid out in section 3 of this Guidance.

CCBHC CC PPS-4 Rate Example	
2.4d	**CCBHC CC PPS-4 Rate Example** The following example demonstrates the CC PPS-4 methodology calculations for a small sample facility with seven people per year. Table 5 illustrates how aggregate monthly allowable costs are translated into standard 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, and costs associated with crisis services. 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 the MEI to reflect changes in the underlying costs to provide treatment between the data collection period and the DY1 period. Payment rates for DY3 should be adjusted by rebasing and every three years thereafter. In the example in Table 5, people are categorized on the basis of criteria the state has used to define the standard population and special populations. The categorizations for special populations should be made at the person level based on clinical condition. In our example, four distinct PPS rates are calculated—one PPS rate for the people not in a special population, two PPS rates for the different special population groups (Special Population A and Special Population B), and one SCS PPS rate for people receiving ARP 9813 CCBHC Mobile Crisis Services. Note that the cost of providing crisis services does not matter by population categorization. SCS rates are specific to the service provided and calculated by creating a rate specific to the service, rather than the patient. All SCS rates remain constant regardless of population categorization, but those costs and visits are carved out of Standard and SP PPS rates. For Standard and SP PPS rates in CC PPS-4, states 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 for new states entering the program that span 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 exclude SCS costs, but should be fully attributed between the Standard and the Special Population PPS rate calculations and the amount reserved to pay for outliers. Note there is no outlier payment for Special Crisis Services. For this facility, the monthly outlier threshold is set at $900, with a reserve of 80 percent of costs in excess of that threshold. Therefore, in the rate setting period,

CCBHC CC PPS-4 Rate Example	
	80 percent of the costs above the $900 threshold would be held in reserve to make outlier payments during the Demonstration period. People C, E, and F each experience 1 month with costs that exceed the established threshold. Therefore, in addition to the PPS rate for each person type, the facility will be paid a varying additional outlier payment. For instance, Person E in April has costs equal to $1,200 for CCBHC services, exceeding the outlier threshold by $300. The amount of cost used in the Special Population A rate calculation would be $960; $900 (up to the threshold), plus $60 (20 percent of the remaining amount above the threshold). The remaining $240 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. Notice that People C and E also both received ARP 9813 Mobile Crisis services in one month. The cost of those services for the year was $900 divided by the monthly visit count of 2 equals a monthly SCS rate for ARP 9813 Mobile Crisis of $450. The outlier threshold is not applicable to SCS rates.

Table 5. CC PPS-4 Rates, Special Population Rates and Outlier Payments Calculation Example

Person	Month	Outlier?	Population Type	Visit Months	SCS?	*Trended* Allowed Monthly Costs, $	Non-outlier Payment Portion, $	Outlier Payment Reserve, $	Payment Per Monthly Visit, $
Standard Population									
A	Jan		Standard	1	No	50	50	-	225
A	May		Standard	1	No	75	75	-	225
B	Mar		Standard	1	No	150	150	-	225
C	June		Standard	1	No	50	50	-	225
C	Aug	Yes	Standard	1	No	950	910	40	225
D	Sept		Standard	1	No	115	115	-	225
Standard Population Subtotal			***Standard***	***6***		***1,400***	***1,350***	***40***	***1,350***
Special Population A									
E	Apr	Yes	Special Population A	1	No	1,200	960	240	805
E	Dec		Special Population A	1	No	650	650	-	805
Special Population A Subtotal			***Special Population A***	***2***		***1,850***	***1,610***	***240***	***1,610***
Special Population B									
F	May	Yes	Special Population B	1	No	975	915	60	620
G	Oct		Special Population B	1	No	325	325	-	620
Special Population B Subtotal			***Special Population B***	***2***		***1,300***	***1,240***	***60***	***1,240***
Special Crisis Services- 9813 Mobile Crisis Services									
C	Aug	N/A	All	1	Yes	600	600	-	450
E	Nov	N/A	All	1	Yes	300	300	-	450
Special Crisis Services- 9813 Mobile Crisis Services Subtotal			***All***	***2***		***900***	***900***	***0***	***900***
Total			Total	**12**		**5,450**	**5,100**	**340**	**5,100**

Note: Table 5 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.

Section 2.5: Updates to the CC PPS Rates

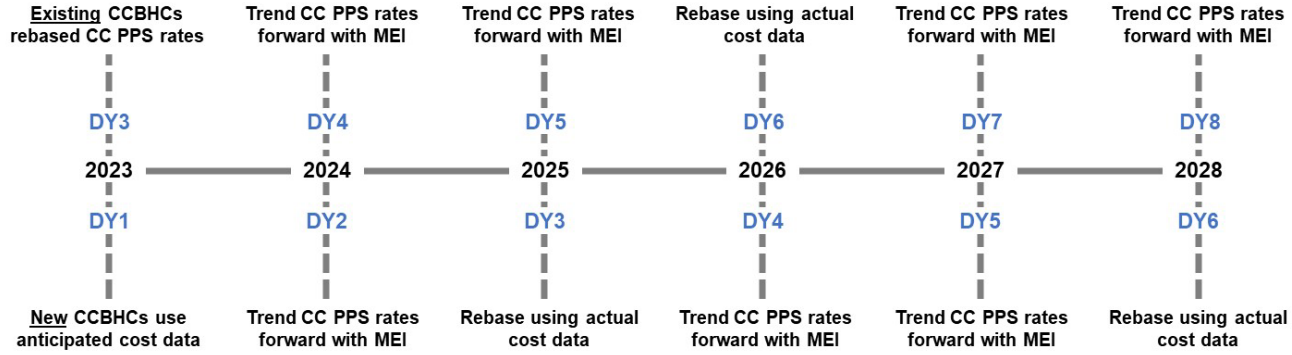
2.5a	**Annual Updates to the CC PPS Rates** PPS rates are updated annually to allow the CC PPS rates to keep pace with inflationary increases to healthcare costs. States are required to annually update their CCBHCs PPS rates by either trending them by the MEI or rebasing them using actual cost and visit data from the CCBHC cost reports. Each DY, states must consistently use the same methodology across all Demonstration CCBHCs in their state to annually update the PPS rates, unless a CCBHC's PPS rate is being rebased in alignment with the required timeframes outlines in 2.5b. CMS requires states to use one full year of actual cost and visit data to rebase rates unless a state has CMS' approval and can justify the use of a shorter time period. CMS allows states to use the prior DY's CC PPS rates trended forward by the MEI as an interim PPS rate, until the state can review the cost reports and calculate the final current DY's CC PPS rate. All claims for CCBHC Demonstration services paid at the interim rate for the current DY will be reconciled against that DY's final PPS rate set by the state. This will result in the final calculated clinic-specific PPS rate paid for all CCBHC Demonstration services rendered by the CCBHC for the entirety of the current DY. Demonstration states are expected to prospectively follow these rebasing requirements and should not retrospectively rebase PPS rates for past DYs.
2.5b	**Required Rebasing Timeframes for the CC PPS Rates** In addition to the requirement to annually update CC PPS rates by either trending by the MEI or rebasing using actual cost and visit data from CCBHC cost reports in 2.5a, states are required to: • Rebase the CC PPS rate for DY3 using actual DY2 cost and visit data from cost reports submitted to the state to bring CCBHC payments into alignment with actual costs and visits using actual cost and visit data from CCBHC cost reports; and • Rebase the PPS rates for all CCBHCs at least every 3 years from the last DY in which their rates were rebased using actual costs and visits from the provider's CCBHC cost report. States should use data from the CCBHC's prior DY cost report submission to the state to rebase their clinic-specific PPS rates. These scheduled rebases of the CC PPS rates allow the rates to be more closely aligned with the cost of providing CCBHC Demonstration services and provides more consistency in PPS rate updates given the Demonstration timeframe has extended beyond the original two-year timeframe authorized by Congress. CMS requires states to use one full year of actual cost and visit data to rebase rates unless a state has CMS approval and can justify the use of a shorter time

	period. CMS allows states to use the prior DY's CC PPS rates trended forward by the MEI as an interim PPS rate for the current DY, until the state can review the cost reports and calculate the final current DY CC PPS rate. All claims for CCBHC Demonstration services paid at the interim rate for the current DY will be reconciled to that DY's final PPS rate set by the state. This will result in the final calculated PPS rate paid for all CCBHC Demonstration services rendered for the entirety of the current DY. Demonstration states are expected to prospectively follow these rebasing requirements and should not retrospectively rebase PPS rates for past DYs. States may not rebase rates in the middle of a DY and all rebased rates must be final rate paid for Demonstration services the entire DY in which they are in effect.
2.5c	**Annual Settlement or Reconciliation to "Actual" Cost** Annual settlement or reconciliation of the PPS rates to "actual" cost is not allowed under the CCBHC Demonstration as the PPS rate is a cost-based rate that reimburses providers their expected cost of care and not actual cost. If a state pays a CCBHC more than its actual cost, it cannot require the CCBHC to return any portion of the payments made for Demonstration payment, retrospectively adjust the final CCBHC PPS rate for a DY, or recoup such payment through adjustment to the following year's PPS rate.
2.5d	**PPS Rate Update Examples** The following provides an example of how the annual CC PPS rate updates should be implemented by states. <u>Example 1: Unaligned Required Rate Updates for New and Existing CCBCs</u> Sample State X is a current participant in the CCBHC Demonstration with a DY that runs January 1- December 31. They have added CCBHCs to their state Demonstration as allowable under the SAMHSA "Guidance on Addition of CCBHCs to Section 223 State Demonstration Programs[7]." While the state added new CCBHCs in their 2023 DY, they also rebased rates for their existing CCBHCs effective for the same DY. New CCBHC providers used anticipated costs in the calculation of their CC PPS rates for their first Demonstration year (DY1) in 2023. The state decides to annually update the PPS rates for all CCBHCs by trending by the MEI for the next DY in 2024. The CCBHCs added in 2023 would be required to have their PPS rates rebased in accordance with the required timeframes for rebasing rates as outlined in Section 2.5b of this updated PPS Technical Guidance. These rebased rates for the new providers would be effective in the new providers' DY3 (2025) and would result in the recalculation of the new provider's PPS rate using actual costs and visits reported in their DY2

[7] SAMHSA Addition of CCBHCs to State Demonstration Programs guidance issued February 22, 2022.

	(2024) cost report that have been trended forward by the MEI to 2025 (DY3). After rebasing the new providers' PPS rates for their third DY in 2025, the state would not be required to rebase their rates and have them effective for another three years in 2028 (their DY6). As the state decided to annually update the PPS rates for all their CCBHCs by trending by the MEI for the 2024 DY, they will also continue to trend the PPS rate by the MEI for the existing CCBHCs for the 2025 DY. Since the PPS rates for the existing CCBHCs were rebased for the 2023 DY (DY3) they would not be required to rebase their PPS rates again until the 2026 DY (DY6). In the intervening years between rebasing, the state would trend their CCBHC's PPS rate by the MEI.

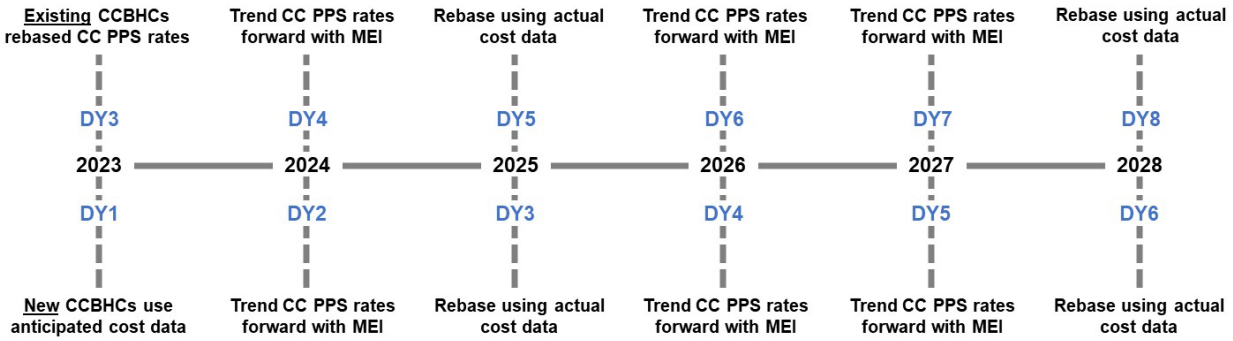
Figure 1: Rebasing of PPS Rates for Example 1



2.5e	Example 2: Aligned Required Rate Updates for New and Existing CCBCs This second example uses the same sample State X as in the previous example (DY that runs January 1- December 31, added CCBHCs to their state Demonstration in 2023 DY, rebased PPS rates for existing CCBHCs in 2023 DY). In this scenario the state uses the flexibility in how they may annually update the PPS rates to eventually align the rebasing timeframes for the new and existing CCBHCs. Similar to the previous example, the new CCBHC providers use anticipated costs in the calculation of their CC PPS rates for their first Demonstration year (DY1) in 2023 and the state decides to annually update the PPS rates for all CCBHCs by trending by the MEI for the next DY in 2024. Instead of the existing CCBHCs continuing to have their rates trended by the MEI for the 2025 DY, the state decided to update the PPS rates for all CCBHCs in their state for the 2025 DY. This would result in the new CCBHCs added in 2023 updating their PPS rates as required for their DY3 as well as an early PPS rebase for the existing CCBHCs. Rebasing the PPS rates for existing CCBHCs in their DY5 (2025) instead of waiting until their DY6 (2026) to rebase them, aligns with the requirement in Section 2.5b of rebasing PPS rates at least once every three

	years. Since the PPS rates for both the new and existing CCBHCs were rebased in the 2025 DY, then all the state's CCBHCs would not be required to be rebased and would be effective until the 2028 DY. In the intervening years in this example, the state has elected to trend all their state's CCBHC PPS rates by the MEI.

Figure 2: Rebasing of PPS Rates for Example 2



Section 2.6: Rate Setting for DY1

To set rates for DY1, states will use cost and visit data from the Demonstration planning phase, updated by the Medicare Economic Index (MEI) to determine the CC PPS-1, CC PPS-2, CC PPS-3, or CC PPS-4 rate for DY1. 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. Costs used from the Demonstration planning period should have the MEI applied to them to trend these costs to the DY1 rate period. Rate calculations must be documented in an approved cost report as outlined in Section 5.

Section 3: Quality Bonus Payments (QBPs)

3.1	**CC PPS Quality Bonus Payments** The Quality Bonus Payment (QBP) quality measures included in this Guidance are a subset of the Behavioral Health Clinic Quality Measures included in Appendix B of SAMHSA's CCBHC Certification Criteria. These measures are derived primarily from the Medicaid Adult and Child Core Set quality measures. Demonstration states have flexibility to use all measures outlined in Table 6 of this Guidance; however, for purposes of the national evaluation of the CCBHC Demonstration and comparative analysis of quality measure results across Demonstration states, CMS requires that states implementing QBPs as part of the PPS methodology used for the CCBHC Demonstration in their state, include the first seven, or comparative measures in their QBP measure-set to assist with the ASPE evaluation and analysis across states to determine the impact of a defined set of measures on quality in the CCBHC program. QBPs are optional under the daily CC PPS-1 and CC PPS-3 but required under the monthly CC PPS-2 and CC PPS-4. States have flexibility to design the CCBHC QBP program in their state; however, for a state to make a QBP to a CCBHC provider, the clinic must first demonstrate that it has attained or exceeded the state-defined threshold assigned to the quality measure in accordance with the state's written quality measurement guidelines for payment. Those guidelines allow for state flexibility as indicated in section 3.2. States should ensure that no payment is made solely based on reporting CCBHC quality measures which is a general requirement for all participating states as outlined under the updated SAMHSA CCBHC Criteria at section 5.a.2, but QBPs shall be made for achieving quality-related targets within a specified timeframe and also year-over-year improvements in quality outcomes. As states set payment thresholds and parameters for QBPs, states should regularly engage with CCBHCs throughout the measurement period to gauge the CCBHC's progress and address any questions clinics might have regarding achieving quality goals established by the state. We encourage states to provide CCBHCs with data on their performance relative to the thresholds for each measure during the performance year to allow them an opportunity to make adjustments prior to the final calculation of their threshold achievement for QBPs. In applying to participate in this Demonstration, the state must demonstrate as part of its formal CCBHC Demonstration application submission, how it plans to implement QBPs if it plans to make such payments.

Table 6: Comparative and Optional Quality Bonus Payment Quality Measures

Type of Measure	QBP Measure Number	SAMHSA Required CCBHC Reported Measure	Acronym[8]	Measure	Measure Steward[9]	State or Clinic Collected
CCBHC comparative QBP quality measures	1	Yes	HBD-AD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control for Patients with Diabetes	NCQA	State Collected
	2	Yes	DEP-REM-6	Depression Remission at Six Months	MN Community Measurement	Clinic Collected
	3	Yes	I-SERV	Time to Services	SAMHSA	Clinic Collected
	4	Yes	FUH-AD	Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult)	NCQA	State Collected
	5	Yes	FUH-CH	Follow-Up After Hospitalization for Mental Illness; ages 6 to 17 (child/adolescent)	NCQA	State Collected
	6	Yes	IET-AD	Initiation and Engagement of Substance Use Disorder Treatment	NCQA	State Collected
	7	Yes	PCR-AD	Plan All-Cause Readmissions Rate	NCQA	State Collected
Optional QBP quality measures	8	Yes	FUA-CH and FUA-AD	Follow-Up After Emergency Department Visit for Substance Use	NCQA	State Collected
	9	Yes	ADD-CH	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)	NCQA	State Collected
	10	Yes	ASC	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	NCQA	Clinic Collected
	11	Yes	CDF-CH and CDF-AD	Screening for Depression and Follow-Up Plan	CMS	Clinic Collected
	12	No	SRA-C	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA)	Mathematica	Clinic Collected
	13	No	SRA-A	Adult Major Depressive Disorder: Suicide Risk Assessment (SRA)	Mathematica	Clinic Collected
	14	No	CBP-AD	Controlling High Blood Pressure	NCQA	Clinic Collected
	15	No	WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	Clinic Collected

Abbreviations: CMS, Centers for Medicare & Medicaid Services; NCQA, National Committee for Quality Assurance; SAMHSA, Substance Abuse and Mental Health Services Administration

[8] 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.
[9] 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

Section 3.2: Flexibilities in Setting Thresholds and Payments for Quality Bonus Payments

States have flexibility in determining the performance goals, or thresholds, and amount of quality payment of each measure, but must use a comprehensive methodology that specifies: (1) the threshold that triggers payment on each individual measure (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 as 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 a revenue offset against cost.

QBP quality measure thresholds are targets the state sets to measure CCBHC performance on a quality measure. While states have flexibility to determine the quality measure thresholds their CCBHCs must achieve in order to receive a QBP, the thresholds should be set in such a way where these payments are made to CCBHCs who are providing a high quality of care, addressing health equity issues, improving beneficiary health, and are part of the solution to reduce health disparities. States should consider their priorities and goals when developing the thresholds for QBPs as well as different ways to measure improved performance, such as improvement in a CCBHC's year over year performance, exceeding state or national performance targets on a measure, meeting another high threshold set by the state to advance quality of care in accordance with state initiatives, or to further promote quality of care and state priorities. States have flexibility when setting their QBP thresholds to have different targets for each individual measure based on national, statewide or provider specific data. In addition to single numeric thresholds, states can also set thresholds based on a provider specific amount of improvement in a performance year. States also have the ability to make weighted QBPs to CCBHCs who achieve on quality measures, where the amount providers receive varies by quality measure. States may also tier QBPs made to providers where different payments can be made based on the level of achievement at or above the threshold for each measure. As the purpose of the QBPs under the Demonstration are to promote a higher level of care through the CCBHCs, states are unable make QBP that pay for reporting. Examples of how states can use these flexibilities in setting thresholds and making weighted QBP and tiered quality payments are included below.

QBP Threshold and Tiered Payment Examples	
3.2a	Example 1 In this first example, in addition to the seven comparative QBP quality measures, a state is also including the optional Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH) measure and a state-developed quality measure they had approved by CMS as part of their QBP program. The state has set the threshold for each of the quality measures at the statewide performance mean and has tiered the quality payments so that the amount paid for achievement on the measures varies based on what level the providers achieve, with a maximum QBP equivalent to 15% of the provider's claims for CCBHC services during the performance year. In this scenario, each of the quality measures would have a different threshold since the threshold for each measure is equivalent to its statewide mean. In order for a QBP to be made, the CCBHC provider would need to achieve the statewide mean on a measure in order to receive the QBP amount for that QBP quality measure. As the state has opted to tier their QBPs, once a provider meets the threshold on the tiered measures within a defined measurement period, the CCBHC provider could be paid for achievement on each of those measures. Using the example below, you can see where the CCBHC achieved the thresholds on each of the seven comparative QBP quality measures. As such, they are eligible to receive the QBP associated with each of those seven measures. As the provider achieved on the seven comparative measures and a state-developed measure, but not the optional WCC-CH quality measure, they are eligible to receive a QBP equal to 9.25% of their claims for CCBHC services for the performance year.

Table 7: Quality Bonus Payment Program Design for Example 1 Utilizing Flexibilities Available for Threshold Setting and Tiering of Quality Bonus Payments

QBP Measure	**Threshold** (state average)	**State QBP Payment** (paid when CCBHCs achieve the threshold on each QBP measure)	CCBHC Performance	QBP Received by CCBHC
Comparative Measure A*	55%	• 55%-65% Achievement: 1% of CCBHC claims • >65-75% achievement: 2% of CCBHC claims • >75% achievement: 2.5% of CCBHC claims	55%	1% of CCBHC claims
Comparative Measure B*	75%	• 75%-85% Achievement: 1% of CCBHC claims • >85 achievement: 2% of CCBHC claims	76%	1% of CCBHC claims
Comparative Measure C*	65%	• 65%-70% Achievement: 0.5% of CCBHC claims • >70-80% achievement: 0.75% of CCBHC claims • >80% achievement: 1% of CCBHC claims	73%	0.75% of CCBHC claims
Comparative Measure D*	80%	• 80%-85% Achievement: 1% of CCBHC claims • >85% achievement: 2% of CCBHC claims	86%	2% of CCBHC claims
Comparative Measure E*	65%	• 65%-75% Achievement: 0.25% of CCBHC claims • >75-85% achievement: 0.5% of CCBHC claims • >85% achievement: 1% of CCBHC claims	86%	1% of CCBHC claims
Comparative Measure F*	60%	• 60%-75% Achievement: 0.5% of CCBHC claims • >75% achievement: 2% of CCBHC claims	74%	0.5% of CCBHC claims
Comparative Measure G*	90%	• 90%-95% Achievement: 0.5% of CCBHC claims • >95% achievement: 2% of CCBHC claims	96%	2% of CCBHC claims
Optional QBP measure-WCC-CH	55%	• 55%-65% Achievement: 0.25% of CCBHC claims • >65-75% achievement: 0.5% of CCBHC claims • >75% achievement: 1% of CCBHC claims	54%	Not eligible for QBP
State-Developed Quality Measure	70%	• 70%-80% Achievement: 0.5% of CCBHC claims • >80-85% achievement: 1% of CCBHC claims • >85% achievement: 1.5% of CCBHC claims	80%	0.5% of CCBHC claims
			Total QBP Provider Will Receive	8.75% of CCBHC claims

3.2b	Example 2 In the second example, a state opted to only use the seven comparative QBP quality measures for their QBP program. The state has set a 5% provider specific year over year improvement threshold for each of the quality measures and has weighted the QBPs so CCBHCs receive a larger QBP for achievement on certain measures. The amount paid for achievement on the measures varies based on the quality measure selected, with a maximum QBP of $200,000 per provider. In this scenario, each of the quality measures have a different threshold since each measure's target is equivalent to a provider specific performance improvement of 5% from the previous year. In order for a QBP to be made, the CCBHC provider would need to achieve the 5% improvement on a measure in order to receive its corresponding QBP amount. As the state has existing initiatives to improve on the areas measured by comparative measures C and D, they have opted to make the QBPs larger for those providers who meet the performance improvement threshold on these measures. As the state has opted to weight their QBPs, there are different QBP amounts that can be paid for each measure once a provider meets the threshold. Using the example below, you can see where the CCBHC achieved the thresholds on four of the comparative QBP quality measures. As such, they are eligible to receive the QBP associated with each of those seven measures. As the provider only achieved on four out of the seven comparative QBP quality measures, they are eligible to receive a total QBP of $110,000, equivalent to the sum of the QBP for each of the four measures for which they achieved the 5% threshold.

Table 8: Quality Bonus Payment Program Design for Example 2 Utilizing Flexibilities Available for Threshold Setting and Weighted Quality Bonus Payments

QBP Measure	**Threshold** (provider specific improvement)	**State QBP Payment Per Measure** (paid for CCBHC achievement on each QBP measure threshold)	**CCBHC Performance**	**QBP Received by CCBHC**
Comparative Measure A*	5% improvement	$20,000 QBP	2% improvement	No QBP received
Comparative Measure B*	5% improvement	$20,000 QBP	6% improvement	$20,000 QBP received
Comparative Measure C*	5% improvement	$50,000 QBP	4% improvement	No QBP received
Comparative Measure D*	5% improvement	$50,000 QBP	10% improvement	$50,000 QBP received
Comparative Measure E*	5% improvement	$20,000 QBP	5% improvement	$20,000 QBP received
Comparative Measure F*	5% improvement	$20,000 QBP	8% improvement	$20,000 QBP received
Comparative Measure G*	5% improvement	$20,000 QBP	4% improvement	No QBP received
			Total QBP Provider Will Receive	$110,000 total QBP received by CCBHC

Section 4: Payment to CCBHCs That Are FQHCs, Clinics, or Indian Health Facilities and Payment Based on Medicaid Eligibility

In some instances, a CCBHC may already participate in the Medicaid program as another provider type such as an FQHC, clinic services provider, or Indian Health Service (IHS)/638 facility that receives payment authorized through the Medicaid state plan. This section provides information on how these Medicaid providers would be paid when a clinic user receives a service authorized under both the state plan and the CCBHC Demonstration, as well as Medicaid payment distinctions based on a patient's Medicaid eligibility.

Payment to CCBHCs That Are FQHCs, Clinics, or Indian Health Facilities	
4.0a	**Duplication of Payment** States should avoid duplication of payment to CCBHCs when the provider is dually certified to provide services under CCBHC Demonstration authority and another separate Medicaid program and payment authority.
4.0b	**FQHCs** States should avoid duplication of payment to CCBHCs when the provider is certified under the CCBHC demonstration and is also a qualified, enrolled provider of Medicaid services under separate program and payment authorities. A clinic that both participates in the Medicaid program as a FQHC and is also a CCBHC demonstration provider should receive payment under the CCBHC demonstration, as described below, whenever it provides any of the nine statutory CCBHC services covered by this demonstration as allowable under the state's scope of CCBHC demonstration services during an encounter, even if those services are also Medicaid FQHC services. A provider that is both a CCBHC and a FQHC should receive a separate Medicaid FQHC services payment for an encounter during which CCBHC services were provided only if it also furnished at least one distinct non-CCBHC FQHC service during that encounter. In very limited circumstances, when all of the services provided to a clinic patient during the same encounter/visit are both CCBHC demonstration services and state plan Medicaid FQHC services, the payment rate for these services under the demonstration should be the higher of the payment that would otherwise have been paid under the state plan for Medicaid FQHC services (either the FQHC PPS rate or the rate under an alternative payment methodology) or the CCBHC PPS rate. In either case, this payment is considered a payment made under the CCBHC demonstration for CCBHC demonstration services, and can be federally matched at the CCBHC federal matching rate. This policy will help ensure that FQHC providers are not disincentivized from participating in the CCBHC demonstration due to potential financial losses when the FQHC Medicaid state plan payment for a service that is both an FQHC service and a CCBHC demonstration service would exceed the CCBHC PPS rate for the same service.

Payment to CCBHCs That Are FQHCs, Clinics, or Indian Health Facilities	
4.0c	**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 CCBHC provides any of the nine statutory CCBHC services covered by this Demonstration as allowable under the state's scope of CCBHC demonstration services, even if there is an overlap with services included in the clinic's rate. The state should continue to pay the clinic services rate authorized through the Medicaid state plan or waiver whenever a non-CCBHC, clinic service is delivered. The provider is eligible for payment of the CCBHC PPS and the clinic services rate whenever a CCBHC service and distinct non-CCBHC clinic service is provided during one encounter/visit.
4.0d	**Indian Health Facilities** Subsection (a)(2)(F) of the PAMA (as amended), "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 (IHS); clinics operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with IHS pursuant to the Indian Self-Determination Act; and clinics operated by an urban Indian organization pursuant to a grant or contract with the IHS under title V of the Indian Health Care Improvement Act. When these entities are certified as CCBHC demonstration services providers, states should avoid duplication of payment.

Payment to CCBHCs Based on Medicaid Eligibility	
4.1a	**Dually Eligible Beneficiaries** PAMA section 223(d)(2)(B)(v) requires the state to pay up to the PPS rate for all Demonstration services delivered to Medicaid beneficiaries. This payment requirement applies to services provided to dually eligible beneficiaries for whom the state must share in the cost of direct services, rather than just Medicare cost sharing. • For Full Benefit Dually Eligible (FBDE) individuals, the statute requires payment up to the PPS rate after accounting for the Medicare payment. • For Qualified Medicare Beneficiaries (QMB), states must pay Medicare cost sharing, but may adopt a methodology that pays the lesser of the Medicare cost sharing amount that would result in a total payment equal to the PPS. • Specified Low-Income Medicare Beneficiaries (SLMB) are generally eligible only for payment of Medicare premiums, but there is a state option to pay Medicare Part B cost sharing. To the extent that the state elects that option, CCBHC Demonstration services for SLMBs would be treated the same way as services for QMBs (otherwise, no Medicaid payment would be due for Demonstration services). • For Qualifying Individuals (QI) and Qualified Disabled and Working Individuals (QDWI), Medicaid pays some or all of their Medicare premiums, but does not pay for services. Under the Demonstration, no Medicaid payment would be made for services provided by CCBHCs to QDWI beneficiaries. In summary, PPS is not required to be paid for services provided to the following dual eligible Medicaid beneficiaries: • Specified Low-Income Medicare Beneficiaries (SLMB) • Qualifying Individuals (QI) • Qualified Disabled and Working Individuals (QDWI)
4.1b	**Out-of-State Medicaid Beneficiaries** States participating in the Demonstration are not required to pay a CCBHC or DCO the PPS rate for Demonstration services furnished to any client who is not enrolled in that state's Medicaid program.

Section 5: Cost Reporting and Documentation Requirements

As part of CCBHC PPS rate development, states must identify allowable costs necessary to support the provision of Demonstration services. In addition, states should ensure that PPS rates under the Demonstration meet requirements for economy and efficiency as outlined under section 1902(a)(30)(A) of the Act, which requires payment rates to be sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. States must use a cost report that adheres to the cost principles and documentation requirements described in this section to properly account for costs and visits associated with allowable CCBHC services and to calculate clinic-specific PPS rate paid to participating providers. CMS expects states to use a uniform cost report Demonstration-wide to report costs. In reporting cost, state and providers must adhere to 2 CFR 200 Uniform Administrative Requirements, Cost Principles, And Audit Requirements For Federal Awards[10] and 45 CFR 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards.[11]

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.[12] 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.

States should publish a scope of services and activities (SOSA) list identifying the activities and procedures covered in their CC PPS rates, as well as which services align with the nine required CCBHC services that ultimately trigger a visit. The SOSA list should identify the services whose cost is allowable as a direct cost in the CC PPS rate calculation. CCBHCs should use the SOSA list to determine classification of costs pursuant to 2 CFR 200 Uniform Administrative Requirements, Cost Principles, And Audit Requirements For

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[10] 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

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

[12] See 45 CFR 75.361 Retention Requirements for Records and 42 CFR 433.32 Fiscal Policies and Accountability for the Federal Requirements.

Federal Awards[13] and 45 CFR 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards.[14]

In 2024, CMS updated the federally approved CCBHC cost report developed in 2015 to reflect the additional PPS payment methodologies that included PPS rates for special crisis services. CCBHC providers under the Demonstration may use the updated CMS cost report to calculate clinic-specific PPS rates using cost and visit data and annually report Demonstration costs. CCBHCs are required to submit their annual CCBHC cost report along with supporting data to the state no later than 6 months after the end of each DY as outlined under Program Requirement 5.a.4 of the CCBHC Criteria. In addition, after review of the CCBHCs' cost reports for completeness, states are required to annually submit them to CMS along with any clarifying information within nine months after the end of each DY in which they participate in the CCBHC Demonstration. States are required to annually submit cost reports to CMS regardless of whether the state has annually updated their CCBHC PPS rates by trending by the MEI or rebasing. While states are encouraged to use the federally approved CCBHC cost report, they also have flexibility to modify it or use a state-level cost report that aligns with the key elements of the CMS CCBHC cost report as outlined in section 5.2, CCBHC Cost Report Elements and Data Essentials, with CMS' review and approval.

[13] Additional guidance on Medicare principles for 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.

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

Section 5.1: Treatment of Select Costs

Treatment of Select Costs	
5.1a	**Designated Collaborating Organizations (DCOs)** States should include the applicable cost of care and visits associated with Designated Collaborating Organizations (DCOs) in the calculation of the PPS rates. 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. The applicable cost of DCO services is included within the scope of the CCBHC PPS, and these included DCO encounters will be treated as CCBHC encounters for purposes of the PPS. Services of a DCO differ from referred services in that the CCBHC may not be financially and clinically responsible for all referred services but may be financially responsible for paying the DCO for the service rendered**.**
5.1b	**Uncompensated Care** PAMA section 223 (a)(2)(B) requires that CCBHCs not reject or limit services based on a person'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. While the costs for all CCBHC services and visits must be included in the cost report, no additional costs that reflect shortfalls from reimbursement of uncompensated care should be included in the calculation of the PPS rate.
5.1c	**Telehealth** If a state chooses to provide CCBHC services via telehealth, costs related to these CCBHC 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 systems reflected in state Medicaid policy documents. Therefore, states must consider the implications of managed care service coverage in the state's rate calculation. For more information about telehealth see: https://www.medicaid.gov/medicaid/benefits/telehealth/index.html.[15]

[15] The Medicaid Telehealth Toolkit and Medicaid Telehealth Toolkit Supplement available on Medicaid.gov. The Medicaid.gov site referenced in Section 5.1c should be consulted for updated telehealth guidance.

Treatment of Select Costs	
5.1d	**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 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.
5.1e	**988 National Suicide Prevention Hotline** In accordance with CMS Guidance[16], states may claim federal matching funds for the 988 hotlines only as an administration expense. As these costs associated with 988 hotlines are reported at the state level, these costs may not be included in the CCBHC PPS rate. To the extent that a 988 call results in the delivery of one of the nine CCBHC services, the costs related to the delivery of the CCBHC service, which cannot include the costs associated with the 988 line may be included in the PPS rate.

[16] CMS provided administrative claiming guidance for 988 hotlines through a presentation at the January 25, 2022 All-State Call and through State Health Official (SHO) Letter 21-008.

Section 5.2: 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. The purpose of this section is to describe all of the types of data that must be reported. States have the option to use the Federal CMS CCBHC cost report or a state-level cost report that conforms to the elements outlined below with CMS review and approval. 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	
5.2a	**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 IHS or 638 authority 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
5.2b	**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 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

[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	
	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 and are aligned with the Scope of Services and Activities list. 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. **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 5.1d 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

Key Elements in a Cost Report	
	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 5.1a 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. **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, charitable contributions, and entertainment costs.
5.2c	**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.

Key Elements in a Cost Report	
5.2d	**Number of Visits** CC PPS-1 – Requires the total number of CCBHC daily visits per year CC PPS-2 • Standard Population Visit: Total number of unduplicated monthly visits per year excluding visits provided to people with certain conditions • Special Population Visit: Total number of unduplicated CCBHC monthly visits per year including only persons utilizing CCBHC services with certain conditions, if applicable CC PPS-3 • Standard Population Visit: Total number of daily visits per year excluding SCS crisis services • Special Crisis Services Visit: Total number of CCBHC daily visits per year including only SCS crisis services CC PPS-4 • Standard Population Visit: Total number of unduplicated monthly visits per year excluding visits provided to people with certain conditions and SCS crisis services • Special Population Visit ::Total number of unduplicated CCBHC monthly visits per year including only visits to people with certain conditions, if applicable • Special Crisis Services Visit: Total number of unduplicated CCBHC monthly visits per year including only SCS services
5.2e	**Rate Calculations** There must be a summary worksheet that demonstrates how the rate was calculated using either the CC PPS-1, CC PPS-2, CC PPS-3, or CC PPS-4 methodology. The rate may include only those costs necessary to support the provision of CCBHC services.

Section 6: Managed Care Considerations

The statute requires payment of PPS for Demonstration services and allows such payment to be made through fee-for-service and managed care delivery systems. Further, for states paying for CCBHC services through managed care, the state may claim enhanced FMAP for the portion of managed care capitation rate 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 capitation rates. This entails a state-specific review of managed care arrangements to determine which services are covered under contract(s) with the managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs). 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	
6.0a	The first consideration in determining managed care payment to the CCBHC 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*** includes (1) a daily rate for all CCBHC services and (2) Optional QBPs made in addition to the PPS rates. • ***CC PPS-2*** includes: (1) a required monthly rate to reimburse the CCBHC for services, (2) optional separate monthly PPS rates to reimburse CCBHCs for higher costs associated with providing all services needed to meet the needs of persons utilizing CCBHC services with certain conditions, (3) required outlier payments made in addition to PPS for participant costs in excess of a threshold defined by the state, and (4) required QBP made in addition to the PPS rates. • ***CC PPS-3*** includes two required elements: (1) a daily rate to reimburse the CCBHC for services, and (2) separate daily PPS rates to reimburse CCBHCs for the provision of Special Crisis Services (SCS), and (3) optional QBPs paid in addition to the PPS rates. • ***CC PPS-4*** includes: (1) a required monthly rate to reimburse the CCBHC for services, (2) optional separate monthly Special Populations (SP) PPS rates to reimburse CCBHCs for higher costs associated with providing all services needed to meet the needs of persons utilizing CCBHC services with certain conditions, (3) required separate monthly Special Crisis Services (SCS) rates to reimburse CCBHCs for the provision of crisis services, (4) required outlier payments made in addition to PPS for participant costs in excess of a threshold defined by the state, and (5) required QBP made in addition to the PPS rates.

Managed Care Considerations	
6.0b	**Building CCBHC PPS Rates Into Managed Care Capitation** The state has two options for incorporating the CCBHC rate into the managed care capitation rate development: (1) require the MCO, PIHP, and/or PAHP to pay the full PPS to the CCBHC by fully incorporating the PPS rate into the risk-based managed care contracts and related capitation rates; (2) use a reconciliation process in which the State would make a wraparound supplemental payment directly to the CCBHCs outside the risk-based contract for the difference between the payment received from the MCO, PIHP, or PAHP, and the CCBHC PPS. Regardless of the option selected by the state, the PPS rate development guidelines (see section 2) must be used to determine the minimum reimbursement to CCBHCs under the Demonstration. The actuarial certifications should describe how the capitation rates appropriately account for CCBHC Demonstration services in the risk-based contract, including those that are already included in the base data or other aspects of the rate development, and should consider how the inclusion of CCBHC payments may impact other covered services. The state should also ensure that there are no duplication of payments. Any change in services that would necessitate a change to the capitation rates paid to MCOs, PIHPs, and PAHPs may require either a new or amended actuarial certification for CMS' approval that demonstrates the data, assumptions, and methodology used to account for the change to CCBHC services. **Option 1- Incorporation of the PPS payment into the managed care contracts and related capitation rates** The first option gives the state greater budget predictability for CCBHC expenditures at the beginning of the Demonstration. The state will need to provide adequate oversight to ensure managed care plans reimburse CCBHCs in accordance with the established PPS rate: • **PPS rates paid by managed care plans to CCBHCs** Managed care plans will be required to pay CCBHCs the actual CCBHC PPS rates. States are obligated to monitor managed care plan compliance during the DY to ensure CCBHCs receive the clinic-specific PPS rate. States should establish managed care contract requirements for regular reporting on valid CCBHC encounters, corresponding clinic-specific payments, and mandated timeframes for managed care plans to remedy any reimbursement errors. States will have to work with their actuaries to ensure that capitation rate development accounts for the full CCBHC PPS rates. Capitation rates should consider how

Managed Care Considerations	
	the inclusion of CCBHC payments may impact other covered services as well as any other MCP(s) in the delivery system. **Applicability of Directed Payments** States that elect to require their managed care plans to make the full PPS payment as part of the CCBHC Demonstration are permitted to do so without obtaining written prior approval under 42 CFR 438.6(c) (often referred to as state directed payments) because the PPS is a statutory requirement of the CCBHC Demonstration. States electing to direct the MCOs', PIHPs', or PAHPs' expenditures outside of the payment requirements of this Demonstration must comply with the regulatory requirements at 42 CFR 438.6(c); for more information, please see https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/index.html. In the case of payment for QBPs under monthly CC PPS-2 and CC PPS-4, since QBPs are mandatory for both of these PPS rate options, implementation would also not require compliance with 42 CFR 438.6(c) directed payments requirements. As QBPs under both daily CC PPS-1 and CC PPS-3 are optional under the Demonstration, implementation would require compliance with 42 CFR 438.6(c). **Option 2 – Wraparound Supplemental Payments Using a Reconciliation Process** The second option will require oversight related to reconciling managed care CCBHC payments with full PPS rates: • **Reconciliation of payments to ensure payment of the full PPS** If the state chooses a wraparound supplemental payment for CCBHC services, it will have to reconcile managed care payments to CCBHCs with the full PPS rates for covered services to ensure that the full PPS was received by the CCBHC. If the full PPS was not paid by the managed care plan, the state will directly make wraparound supplemental payments to CCBHCs to make up the shortfall. As PPS reimbursement is required a federal statutory requirement under the Demonstration, the state's direct payment of the wraparound supplemental amount to CCBHCs does not violate 42 CFR 438.60, which otherwise prohibits the state from making payments to network providers for services under a risk-based contract. The frequency of wraparound supplemental payments to CCBHCs during each DY is not dictated by any statutory requirement. However, we suggest that states consider making wraparound supplemental payments at least every four months and reconciling annually, similar to the process used for Federally Qualified Health Center (FQHC) wraparound payments as required in 1902(bb)(5) of the Act.

Managed Care Considerations	
	Applicability of Directed Payments Directed payment requirements do not apply to the wrap around supplemental payment option as the managed care plans negotiate reimbursement rates for distinct CCBHC services. If the state requires the MCO, PIHP, or PAHP to distribute QBPs to eligible CCBHCs, QBPs under monthly CC PPS-2 and CC PPS-4 would not require compliance with 42 CFR 438.6(c) as these payments are mandatory under the Demonstration. However, as QBPs under both daily CC PPS-1 and CC PPS-3 are optional under the Demonstration, implementation would require compliance with 42 CFR 438.6(c).
6.0c	**Managed Care Delivery System Operational Considerations** While this Guidance document is primarily focused on CCBHC PPS methodology development and implementation under the Demonstration, this section addresses managed care delivery system operational and oversight requirements that have been the subject of consistent inquiry. **MCO, PIHP, and PAHP Contracting with CCBHCs** States are required at 42 CFR 438.68(b)(1)(iii) to establish minimum quantitative network adequacy standards for adult and pediatric behavioral health (mental health and substance use disorder services). While this requirement applies to behavioral health services more broadly; states can elect to establish additional network adequacy standards specific to CCBHCs in addition to or in alignment with the standards established for behavioral health. CMS recommends states consider establishing such network adequacy standards or explicitly allow out of network access, in the managed care contract(s) to protect enrollee access to CCBHC services and support the goals of the Demonstration. In developing quantitative network standards for CCBHCs, states should consult the elements in 42 CFR 438.68(c) and determine if standards should vary based on geographic distinctions within the service area (i.e., urban versus rural). **Timely Claims Payment Requirements for CCBHCs** As Demonstration services are eligible for Medicaid reimbursement, states and managed care organizations are reminded that the timely payment requirements for clean claims in 42 CFR 447.46 apply. Consistent with this regulation, an alternative payment schedule mutually agreed to between the CCBHC and managed care organization must be stipulated in the state's managed care contract. **Assignment of CCBHC to a Managed Care Entity (MCO, PIHP or PAHP)** Several states contract with PIHPs and PAHPs that specialize in behavioral health services. Medicaid enrollees may be members of a PIHP or PAHP *and*

Managed Care Considerations	
	MCO at the same time. As such, a CCBHC may not be aware which managed care plan is responsible for payment of behavioral health services. To make transparent which payer is responsible and to meet reporting requirements of this Demonstration, States can consider assigning all CCBHCs to one managed care plan that is capable of collecting all of the data pertinent to Demonstration payment. Use of a single managed care plan could help states reduce duplicate payment. States must account for duplicate services provided through these different managed care plans. If one plan is chosen to provide CCBHC services, the capitation rate may need to be adjusted upward, and the remaining plan 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 managed care plan will need to define clearly how it will ensure that (1) services between plans 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 PIHP or PAHP arrangements should take additional steps to avoid duplicative payments.
6.0d	**Data Reporting and Managed Care Contract Requirements** The state's contract with the managed care plan(s) must contain requirements for reporting CCBHC data. We recommend the state include any specifications for capturing the necessary information in encounter data and any other data reporting requirements the state chooses to require. At agreed-upon intervals the state or the managed care plan will provide encounter data or other adequate data sources to verify the provision of services that are eligible for enhanced FMAP. The data that must be reported for this Demonstration is specified in Appendix B of SAMHSA's *Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria.* 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.

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