The New York State Council for Community Behavioral Healthcare ('The NYS Council') appreciates the opportunity to provide comments to CMS on the proposed updates to the Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment System (PPS) Guidance. We are very appreciative of CMS's continued commitment to the CCBHC model as more states look to join the demonstration in 2024 and beyond.

The revised payment guidance offers a number of helpful opportunities for the individuals served by CCBHC clinics, as well as the providers themselves,, including focusing attention on crisis services and supports, new flexibility for states in utilizing quality bonus payments, and a requirement for regular rebasing on three-year cycles. These updates are useful and appreciated.

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

The New York State Council for Community Behavioral Healthcare respectfully offers the following comments for consideration as CMS finalizes the revisions to the payment guidance.

General Comments on PPS and Cost Reporting

Ensure inclusion of all SAMHSA-required criteria are allowable within cost report. The New York State Council asks that CMS add clarification about CCBHC cost reporting, ensuring it is clear that all activities required through the SAMHSA criteria are allowed in the cost report. *Of particular interest is clarification that ancillary expenses, like IT upgrades and infrastructure enhancements that are critical for clinics to be able to meet the SAMHSA criteria, are allowable in the cost report and the PPS.* This topic is obviously quite complicated. As such, and if Cost Reports are going to change, we would strongly recommend that states, CCBHC providers and accounting experts be consulted in the development of such revisions.

PPS Methodologies and Flexibilities

The New York State Council thanks CMS for maintaining PPS-1 and PPS-2. We appreciate the change to PPS-2 making special populations optional, which will provide flexibility to states who wish to adopt the monthly payment option but want to preserve the simplicity and risk structure of a single payment rate. We also appreciate CMS' attention to the important need for states and communities to invest in crisis

response infrastructure. We are supportive of the concept of targeted PPS rates that support rapid transformation of the crisis continuum.

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

- **Permit two CCBHC payments on the same day for crisis and non-crisis services.** Many CCBHCs have moved toward same-day access to care. We see this development as a game changer; however, when an individual in crisis can be de-escalated and referred to ongoing treatment at a CCBHC – with same-day access to the initial appointment – CCBHCs must be able to receive payment for both the crisis and non-crisis services on that day. The New York State Council recommends that the final PPS guidance clearly indicate that a CCBHC PPS and SCS PPS can be drawn down on the same day.

Quality Bonus Payment (QBP) Measures

- The New York State Council appreciates CMS' intent for states to use and set their own tiers and thresholds for quality bonus payments to clinics. We are supportive of giving New York State additional flexibility to tailor our CCBHC program to the New York behavioral health landscape while ensuring standardization of QBP measures across states. Having said this, clarification is required when a state chooses to add optional metric(s) to the determination of eligibility for a QBP whether all of the optional metrics must also be met, in addition to the specified required metrics, in order for a QBP to be made.
- We urge CMS to require states that participate in the Quality Bonus Payment Measurement Program to provide quarterly feedback (in the form of data related to achievement of required metrics), to providers participating in the Program. States should collect performance data but also be required to share results along the way, to include an explanation of the methodology used to calculate whether a provider met the standards necessary to earn a payment.
- We look forward to reviewing the forthcoming examples and clarifications referenced in this proposal to better understand the details of this new flexibility. We recommend CMS engage in a second comment opportunity when the full details of the payment guidance and quality measures are released.

Rebasing

The New York State Council appreciates the new guidance on establishing a regular interval for rebasing, which is a helpful tool in keeping rates aligned with costs over time.

To further strengthen the rebasing guidance, we urge CMS to:

- **Provide clarity and flexibility on timeframe for initial rebase.** Table 1 on page 4 indicates that the initial rebasing must be conducted "with actual cost data for demonstration year 2." Our interpretation of this language is that rebasing will occur **after the end of DY2** based on DY2 data. The rebasing calculations will therefore take **place during DY3 or as soon as DY2 cost reports are available.** However, the text in Table 1 appears potentially out of alignment with text on pages 6 and 7, which state rebasing will occur "in" year 2 and "for" year 2, respectively implying that the first rebase will be conducted using cost data from DY1 in order to set new PPS rates to be used for DY2.

- We believe states will be able to set more accurate PPS rates by rebasing **at the end** of DY2. DY2 data offers a more comprehensive and reliable picture of CCBHC costs than DY1 data, which covers only the ramp-up year and is unlikely to account for full staffing levels and service delivery volume. As such, **we recommend that CMS use clear and consistent language around the initial rebasing timeframes and also permit states flexibility to conduct the initial rebase after the end of DY2.**
- **Clarify language regarding the effective dates for rebased rates.** The New York State Council recommends that CMS provide clarification to states around expectations for both completing rebasing calculations and when those rebased rates will take effect. For example, on page 6, row 2, CMS notes that if DY1 rates are set based on actual cost data, the state is expected to rebase rates "prior to" the start of DY4. However, if the rebase is meant to happen at the end of every three years (i.e., incorporating data from DY1, 2 and 3) – there would be no way to have the new rates in place prior to the start of DY4 simply due to the lag time in getting cost reports filed. States may also benefit from technical assistance and training on using interim rates during the rebasing period.
- **Clarify and reinforce that rebasing must be based only on clinics' cost reports.** Although the proposed updates make numerous references to rebasing "using cost reports" and "with actual cost data," the New York State Council is concerned that the guidance could be interpreted creatively to support the use of additional data points or methodologies for rebasing, with the result that the payment methodology would no longer be a true PPS rate. It is critical that CMS reiterate its prior clarifications that states may not require clinics to return any portion of their pay, retrospectively adjust clinics' PPS, or recoup payments through the rebasing process or other adjustment to CCBHCs' PPS rates. Additionally, we respectfully request that CMS provide guidance indicating that rebased rates may be calculated using only clinics' cost and visit data as reflected in their cost reports.

Guidance on DCO Relationships and Payments

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

Again, we greatly appreciate your release of these proposed updates and appreciate your consideration of our feedback here. Please do not hesitate to contact Lauri Cole at 518 461-8200 or lauri@nyscouncil.org with any questions about our comments.