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

Proposed Updates May 2023

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CCBHC PPS Guidance Proposed Updates

The Centers for Medicare & Medicaid Services is seeking public comment on proposed updates to the Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment System (PPS) Technical Guidance published initially as part of the 2015 Substance Abuse and Mental Health Services (SAMSHA) CCBHC Notice of Funding Opportunity. Section 11001 of the Bipartisan Safer Communities Act (P.L. 117-159, BSCA), enacted in 2022, amended section 223 of the Protecting Access to Medicare Act of 2014 (P.L. 113-93, PAMA) that authorized the CCBHC Demonstration. This amendment expands the number of states allowed to participate in the CCBHC Demonstration, where effective July 1, 2024 and every two years thereafter, the Secretary may select up to 10 states to join the demonstration[1]. It also extends the program end date for the original eight demonstration states[2], to September 30, 2025, enables the additional two states added through the Coronavirus Aid, Relief, and Economic Security (CARES) Act, (P.L 116-136) to participate in the Demonstration for an additional 16 fiscal quarters (4 years), and allows the new demonstration states added as a result of the BSCA to participate in the Demonstration for 16 fiscal quarters (4 years) based on start date.

In preparation for, and to support the longer-term extension and expansion of the CCBHC Demonstration authorized under the BSCA, CMS held a total of eight (8) listening sessions with CCBHC Demonstration and non-Demonstration states, as well as other stakeholders to identify potential improvements to the existing daily (PPS-1) and monthly (PPS-2) CCBHC payment methodologies. Based on feedback obtained during the sessions and as outlined in detail in Table 1 below, CMS is proposing two additional PPS rate options, a new **daily rate, PPS-3**, and new **monthly rate, PPS-4**. Specifically, updates to the PPS methodology respond to states' comments in favor of simplifying the monthly PPS-2 components by making the special population rates "optional" and including additional flexibilities in the development of the special populations rate. In addition, CMS is proposing to add new rate options to support expansion of crisis intervention services and give states and clinics flexibility to address special characteristics of these types of services that may affect reimbursement.

Specifically, if a state participating in the CCBHC Demonstration opts to implement the newly proposed PPS-3 daily or PPS-4 monthly rate methodology, that state would choose at least one of the following three special crisis services (SCS) rates to reimburse its CCBHCs for providing the crisis behavioral health service ("crisis service") required under the SAMHSA Criteria for CCBHCs. The first rate option would allow states whose CCBHC provided crisis services meet the CMS requirements for qualifying community-based mobile crisis intervention services under section 9813 of the American Rescue Plan Act of 2021 (ARP) to receive the temporary increased Federal Medical Assistance Percentage (FMAP) of 85 percent. The second crisis services rate would reimburse CCBHCs for mobile crisis services that do not meet the section 9813 criteria, but are provided as authorized under the CCBHC Demonstration at the statutory[1] enhanced FMAP rate equivalent to the standard Children's Health Insurance Program (CHIP) matching rate as specified in section 2105(b) of the Social Security Act (the Act), or the newly eligible FMAP described in paragraph (2) of section 1905(y) of the Act for expansion adults. The third option would allow a separate payment rate for on-site crisis stabilization services at the CCBHC at the statutory enhanced CHIP match rate.

[1] To be eligible, states must receive a planning grant in order to apply to participate in the demonstration.

[2] Protecting Access to Medicare Act of 2014 (P.L. 113–93). Congress.gov, Library of Congress, 1 April 2014. https://www.congress.gov/113/plaws/publ93/PLAW-113publ93.pdf

CMS is also proposing updates to the quality bonus payment (QBP) measure-set as indicated below in Table 2, and will provide clarification and examples regarding flexibilities for quality payments. In addition, CMS is making updates to specific sections of the existing CCBHC PPS Guidance, as noted in the Table 3 cross-walk below, to bring the Guidance up to date, taking into account any statutory, regulatory, or other Medicaid policy changes to requirements and/or where additional flexibilities are allowable and may be applicable to the Demonstration. Finally, based on state and stakeholder feedback and to strengthen Federal oversight, CMS is proposing to establish a standard 3-year cadence for states to rebase clinic-specific PPS rates to ensure that payment rates are more routinely brought into alignment with Demonstration costs.

State and stakeholder input on proposed PPS options and Technical Guidance updates help CMS ensure that payment rate structures and payment policies under the Demonstration are clear and adequate to support states' ability to reimburse providers the expected cost of care for CCBHC behavioral health services, and also claim at allowable FMAP rates for services. CMS appreciates your feedback and looks forward to continuing to work in partnership with states to shape the future of CCBHC PPS rate methodologies. You may submit public comments to CCBHC- Demonstration@cms.hhs.gov, with the subject "Public Comment on Updated PPS Guidance" by Friday, June 2, 2023.

Table 1: Proposed PPS Rate Methodologies and Flexibilities

(N/A)	CC PPS-1 Methodology	CC PPS-2 Methodology	New- Proposed PPS-3 Methodology	New - Proposed PPS-4 Methodology
Number of PPS Encounter Rates	1	At least 1	At least 2	At least 2
PPS Rate for CCBHC Services	Daily clinic- specific PPS rate composed of all CCBHC costs and visits for CCBHC services	Monthly clinic-specific PPS rate composed of all CCBHC costs and visits not included in the Special Populations PPS rate(s)	Daily clinic-specific PPS rate composed of all CCBHC costs and visits not included in the Special Crisis Services PPS rate(s)	Monthly clinic-specific PPS rate composed of all CCBHC costs and visits not included in the Special Crisis Services or Special Populations PPS rates
New- Special Crisis Services (SCS) PPS Rate(s)	N/A	N/A	**Required- At least one daily PPS rate for one of the following Special Crisis Services (SCS) rates:** 1. 9813 CCBHC mobile crisis services 2. CCBHC Demo Mobile Crisis services (non-9813 Mobile Crisis Services) 3. Crisis stabilization services occurring at the CCBHC	**Required- At least one monthly PPS rate for one of the following Special Crisis Services (SCS) rates:** 1. 9813 CCBHC mobile crisis services 2. CCBHC Demo Mobile Crisis services (non-9813 Mobile Crisis Services) 3. Crisis stabilization services occurring at the CCBHC
Special Populations (SP) Payment Rates- Payments for services provided to clinic users with certain conditions	N/A	**New: "Optimal" SP Rate** Separate monthly Special Population (SP) PPS rate(s) to reimburse CCBHCs for the costs associated with providing all services necessary to meet the needs of higher needs special populations	N/A	**"Optional" SP Rate** Separate monthly Special Populations (SP) PPS rate(s) to reimburse CCBHCs for the costs associated with providing all services necessary to meet the needs of higher needs special populations
Outlier payments	N/A	**Required-** Reimbursement for portion of participant costs in excess of threshold	N/A	**Required-** Reimbursement for portion of participant costs in excess of threshold
Quality bonus payment	There are quality bonus payments (QBPs) under the PPS methodology that allow states to reward clinics for achieving quality improvement targets set using CCBHC quality measures established in the SAMHSA Criteria. **New- Optional for daily PPS rates (PPS-1 and PPS-3); required for monthly PPS rates (PPS-2 and PPS-4)** **New- Flexibilities to allow tiered quality payments (TQP) on individual QBP measures once CCBHCs have met the quality measure thresholds on all required QBP measures**			
Annual Updates to PPS Rate	*Current Requirement is that PPS rates must be updated annually for all demonstration CCBHCs in a state either trending by the Medicare Economic Index (MEI) or rebasing using cost reports.* **New: In addition to annual trending by the MEI or rebasing using cost reports, states must also rebase rates for CCBHCs with actual cost data for demonstration year two (DY2) and at least every three years thereafter.**			

Proposed Quality Bonus Payment (QBP) Measures

CMS is proposing to update the quality bonus payment measure-set under the CCBHC Demonstration using a subset of measures outlined in the updated SAMHSA Criteria found here on pages 58-60. CMS is seeking public comment on the selected list of proposed QBP measures inclusive of new QBP measures, and existing QBP measures which have moved bidirectionally between optional and required for both state and clinic measurement data. The first 6 proposed quality measures represent the **required QBP measures whose thresholds must be achieved in order to make a QBP payment** to a CCBHC. Measures 7-15 are proposed optional measures, any of which, states may elect to add to their QBP program, in addition to the six proposed required QBP measures. CMS is also updating the PPS Technical Guidance to provide clarity and examples of state flexibility to set reward thresholds for clinics that achieve on required measures.

Table 2: Proposed Quality Bonus Payment (QBP) Measures[3]

QBP Measure Number	SAMHSA Required CCBHC Reported Measure	Measure Name and Designated Abbreviation	Clinic or State Collected	Appearance of QBP measure in current PPS Guidance	Appearance of QBP measure in Proposed Updates to PPS Guidance
1	Yes	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD-AD)	State Collected	N/A	**New Measure,** Required for QBP
2	Yes	Depression Remission at Six Months (DEP-REM-6)	Clinic Collected	Optional QBP measure (12 mo.)	Measure changed from 12-month version, **changed to required** QBP measure
3	Yes	Time to Services (I-SERV)	Clinic Collected	N/A	**New Measure,** Required for QBP
4	Yes	Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)	State Collected	Required QBP measure	Unchanged, required QBP measure
5	Yes	Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)	State Collected	Required QBP measure	Unchanged, required QBP measure
6	Yes	Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	State Collected	Required QBP measure	Unchanged, required QBP measure
7	Yes	Follow-Up After Emergency Department Visit for Substance Use (FUA-CH and FUA-AD)	State Collected	N/A	**New Measure, Optional QBP Measure**
8	Yes	Plan All-Cause Readmissions Rate (PCR-AD)	State Collected	Optional QBP measure	Unchanged, optional QBP measure
9	Yes	Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)	State Collected	Optional QBP measure	Unchanged, optional QBP measure
10	Yes	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	Clinic Collected	N/A	**New optional QBP measure**
11	Yes	Screening for Depression and Follow-Up Plan (CDF-CH and CDF-AD)	Clinic Collected	Optional QBP measure	Child measure added, optional QBP measure
12	No	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA) (SRA-C)	Clinic Collected	Required QBP measure	**Changed to optional** QBP measure
13	No	Adult Major Depressive Disorder: Suicide Risk Assessment (SRA) (SRA-A)	Clinic Collected	Required QBP measure	**Changed to optional** QBP measure
14	No	Controlling High Blood Pressure (CBP-AD)	Clinic Collected	N/A	**New** Optional QBP measure
15	No	Weight Assessment and Counseling for Nutrition and Physical Activity for children/Adolescents (WCC-CH)	Clinic Collected	N/A	**New** Optional QBP measure

[3] Note: Gray shaded measures represent the six newly proposed required QBP quality measures, and the non-shaded measures represent optional QBP quality measures.

PPS Technical Guide Proposed Updates

In addition to proposing additional CCBHC PPS rate development options, CMS is proposing updates to sections of the CCBHC PPS Technical Guidance published as part of the 2015 Substance Abuse and Mental Health Services (SAMSHA) CCBHC Notice of Funding Opportunity that are highlighted in the below cross-walk document. CMS is seeking public comment and feedback on proposed changes to specific sections of the Guidance.

Table 3: PPS Technical Guide Proposed Updates

Page(s)	PPS Guidance Section	Current Guidance	Proposed Update
Page 2 and 3	**Introduction**	Current language in the last paragraph indicates expenditures for CCBHC services provided to Medicaid CHIP expansion beneficiaries will receive the enhanced CHIP FMAP plus 23 percentage points, from 10/1/2015- 9/30/2019.	This introduction will be updated to remove this language as the provision expired September 30, 2019.
Page 3 to 5	**Introduction**	Includes background on section 223 of the Protecting Access to Medicare Act of 2014 (PAMA), statutory prospective payment system (PPS) requirements, and allowable Federal Medical Assistance Percentage (FMAP) rates under the CCBHC Demonstration.	Background section updated to include applicable enacted legislation and any associated Federal Medical Assistance Percentage (FMAP) rates that would apply to the CCBHC program. • section 11001 of the Bipartisan Safer Communities Act (BSCA) which expands the CCBHC Demonstration to up to 10 new states beginning July 1, 2024 and every two years thereafter, and extends the program end date for existing participating states; • section 3814 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), under which two additional states were added to the program; • section 9813 of the American Rescue Plan Act (ARP) which provided an enhanced match of 85 percent for qualifying community- based mobile crisis intervention services. This section will also address administrative claiming for 988 National Suicide Crisis lines service. In addition, FMAP associated with allowable Information Technology, Medicaid Enterprise System (MES) costs associated with the CCBHC Demonstration will be included in the background section.

Page(s)	PPS Guidance Section	Current Guidance	Proposed Update
Page 6	**Section 2- PPS Methodology Rate Setting Options**	Narrative and Table 1 describe PPS-1 and PPS-2	Narrative and Table 1 in the existing PPS Guidance will be updated to include, if implemented, a description of PPS-3 and PPS-4 as proposed in the above updated Table 1.
Page 7	**Section 2.1- Certified Clinic PPS (CC PPS-1)**	Current language in the first paragraph requires for Demonstration Year one (DY1), that the total annual allowable CCBHC costs collected during the Demonstration planning phase be trended forward by the Medicare Economic Index (MEI) to reflect changes due to inflation. DY1 rates are then updated for DY2 by trending to the MEI or rebasing the PPS rate.	Updated language will be added to reflect the newly proposed rebasing timeframe, i.e. if the state included anticipated costs in the DY1 rate, the state is expected to rebase CCBHC rates in DY2 to align with actual costs and every three years thereafter. If the state set DY1 rates using actual CCBHC cost data, the state is expected to rebase rates three years following DY1, prior to the start of DY4 (see Table 1).
Page 7	**Section 2.1a- Certified Clinic PPS (CC PPS-1)**	Current CC PPS-1 formula indicates that For DY1, the total annual allowable CCBHC costs collected during the Demonstration planning phase must be trended forward by the MEI to reflect changes due to inflation. The DY1 rate will be updated again for DY2 by the MEI or by rebasing of the PPS rate.	Updated language in the formula will read: 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. DY1 rate will be updated again for DY2 by rebasing to adjust for any anticipated costs, and every three years thereafter. If the state set DY1 rates using actual CCBHC cost data, the state is expected to rebase rates three years following DY1, prior to the start of DY4 (see Table 1).
Page 7	**NEW- Certified Clinic PPS (CC PPS-3)**	N/A	Daily crisis services rates where states choose at least one from among three rate options to reimburse CCBHCs the high cost of providing crisis services. (See Table 1 above). All other crisis services outside of the three crisis rate options should be included in the base PPS rate.
Pages 8 & 9	**Section 2.1b- CC PPS-1 Bonus Payments**	Current language indicates that the clinic must achieve on all of the required quality measures.	Updated language will provide flexibilities based on tiered thresholds for payment, and examples of other allowable methods of setting targets to reward clinics for improved outcomes. QBPs cannot be made for reporting alone.

Page(s)	PPS Guidance Section	Current Guidance	Proposed Update
Pages 9 and 10	**Section 2.1b- Quality Bonus Payments Medicaid Adult/Core Set**	Current Table 3: Quality Bonus Payment Medicaid Core Set Measures reflects CCBHC 2016 QBPs	Updated list of newly proposed state-collected and clinic-collected QBPs derived from a sub-set of the measures outlined in the SAMHSA 2023 updated CCBHC Criteria.
Page 10	**Section 2.2- CC PPS Alternative (CC PPS-2)**	Current language describes the monthly PPS-2 cost-based rate, required special populations rates, outlier payments and required QBPs, including language that monthly cost updates from the demonstration planning period to DY1are to be updated using the MEI and from DY1 to DY2 using the MEI or by rebasing.	Updated language will make special populations rates "optional" and will reflect the newly proposed rebasing timeframe, i.e., if the state included monthly anticipated costs in the DY1 monthly rate, the state is expected to rebase CCBHC rates in DY2 to align with actual costs and every three years thereafter. If the state set DY1 rates using actual CCBHC cost data, the state is expected to rebase rates three years following DY1, prior to the start of DY4 (see Table 1).
Page 11	**2.2a- CC PPS-2 Base Rate and Outlier Payment**	Current PPS-2 rate calculation formula references "clinic users with certain conditions"…	Updated language will indicate clinic users with certain conditions "if applicable".
Page 12	**2.2a- CC PPS-2 Base Rate and Outlier Payment**	Current Step 2: Determine PPS rates for special populations using formula below: Current language below the formula indicates, the total annual allowable CCBHC costs collected during the Demonstration planning phase must be trended forward by the MEI to reflect changes due to inflation. The DY1 rate will be updated again for DY2 by the MEI or by rebasing of the PPS rate.	Updated Step 2: Determine PPS rates for "optional" special populations using formula below: Updated language below the formula will read: 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. DY1 rate will be updated again for DY2 by rebasing to adjust for any anticipated costs, and every three years thereafter.
Page 12	**NEW- Certified Clinic PPS (CC PPS-4)**	N/A	Proposed monthly crisis services rates where states choose at least one from among three rate options to reimburse CCBHCs the high cost of providing crisis services. (see Table 1)

Page(s)	PPS Guidance Section	Current Guidance	Proposed Update
Page 12	**2.2b -CC PPS-2 Quality Bonus Payments**	Current language indicates that the clinic must achieve on all of the required quality measures in order to receive a QBP.	Updated language will continue to require CCBHCs to achieve on all of the updated 6 core quality measures under Table 2 above in order to receive a QBP, but will provide clarification and examples of types of thresholds states can set, including tiered thresholds for payment, and other allowable methods of setting targets to reward clinics for improved health outcomes. QBPs cannot be made for reporting alone.
Pages 13 to 15	**Section 2.3- CCBHC CC PPS-2 Rate Example**	Currently provides a PPS-2 rate-setting example simulating the monthly payment methodology including required special populations, outlier payments, and required QBPs.	Updated PPS-2 rate setting example will reference optional special populations.
Page 18	**Section 4- Cost Reporting Documentation Requirements**	Currently provides summary language to address the need for states to use a uniform cost report Demonstration-wide, and requires states to have proper fiscal controls and accounting procedures.	Updated to include statutory language to address efficiency and economy of rates - as outlined under section 1902(a)(30)(A) of the Social Security Act, states must "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."
Page 19	**Section 4.1b Telehealth**	Currently addresses the need for costs related to telehealth to be included in FFS and Managed care PPS rates.	Updated language will include CMS website links to the most current CMS policy on telehealth including the telehealth toolkit. https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf And Toolkit supplement: https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf

Page(s)	PPS Guidance Section	Current Guidance	Proposed Update
Page 20	**<u>NEW</u> Section 4.1d- 988 National Suicide Prevention Hotline**	N/A	New language added for 988 National Suicide Prevention Hotline to indicate that states may claim federal matching funds for the 988 hotlines only as an administration expense and that these costs may not be included in the PPS rate. To the extent that these calls result in the delivery of one of the nine CCBHC services, the costs related to the delivery of the CCBHC service may be included in the PPS rate.
Page 20	**Section 4.2- CCBHC Cost Report Elements and Data Essentials**	Currently reflects cost reporting elements for PPS-1 and PPS-2.	Updates will be made based on proposed new daily PPS-3 and monthly PPS-4 options outlined in Table 1 of this document, to include any additional cost reporting elements that support costs for the newly proposed daily and monthly crisis services rate options.

Page(s)	PPS Guidance Section	Current Guidance	Proposed Update
Page 25	**Section 5. Managed Care Considerations**	Currently describes CCBHC PPS-1 and PPS-2 payments made through managed care systems and requires states to understand how behavioral health services are treated in managed care, and to conduct review of managed care arrangements to determine which services are covered.	Updated narrative language adds a "new" and third paragraph that reads: 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 managed care organizations' (MCOs'), prepaid inpatient health plans' (PIHPs'), or prepaid ambulatory health plans' (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. This section will also be updated to describe, if adopted, new daily PPS-3 and monthly PPS-4 payments made through managed care systems.
Page 25	**Section 5.0b Building CCBHC PPS Rates into Managed Care Capitation**	Currently describes two options for incorporating the CCBHC rate into managed care: 1) fully incorporate the PPS payment into the managed care capitation rate, or (2) use a reconciliation process to make a wraparound supplemental payment to ensure that the total payment is equivalent to CCBHC PPS.	Updated language reads: The state has two options for incorporating the CCBHC rate into the managed care capitation rate development: (1) Require 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, or (2) use a reconciliation process in which the State would make a wraparound supplemental payment directly to the CCBHC outside of the risk-based contract for the difference between the payment received from the MCO, PIHP, or PAHP and the PPS.

Page(s)	PPS Guidance Section	Current Guidance	Proposed Update
Page 26	**Section 5.0b Building CCBHC PPS Rates into Managed Care Capitation Rates**	Currently reads: The first option—incorporation of the PPS payment into the managed care capitation rate—gives the state greater budget predictability for CCBHC expenditures at the beginning of the demonstration. The state will need to provide adequate oversight in the following areas:	Restructuring with new section header added above paragraph that begins: The first option--… New section header reads: <u>Option 1 - Incorporation of the PPS Payment into the Risk-Based Managed Care Contracts and Related Capitation Rates.</u>
Page 26	**Section 5.0b Building CCBHC PPS Rates into Managed Care Capitation Rates**	Bulleted section currently titled: "PPS rates incorporated into managed care payments to CCBHCs" Current language reads: The state will need to ascertain the size and timing of payments to CCBHCs. Managed care plans will be required to pay CCBHCs the actual, or the actuarial equivalent of, PPS rates. The state will need to review managed care rates throughout the demonstration period to ensure that payments are sufficient compared with actual utilization. Managed care plans should be required contractually to compensate for any shortfall between rates and actual utilization.	Bulleted section updated and retitled as: <u>PPS Rates Paid by Managed Care Plans to CCBHCs.</u> Updated language reads: States will have to work with their actuaries to ensure that capitation rate development accounts for the full PPS rates. Managed care plans will be required to pay CCBHCs the actual PPS rates. The state will need to review managed care capitation rates throughout the demonstration period to ensure that they are sufficient compared with actual utilization.
Page 26	**Section 5.0b Building CCBHC PPS Rates into Managed Care Capitation Rates**	Currently reads: The second option—a wraparound reconciliation process—will require oversight related to reconciling managed care payments with full PPS rates.	Restructuring with new section header added above section that begins: The second option-- New section header reds: <u>Option 2 – Wraparound Supplemental Payments Using a Reconciliation Process.</u>

Page(s)	PPS Guidance Section	Current Guidance	Proposed Update
Page 26	**Section 5.0b Building CCBHC PPS Rates into Managed Care Capitation Rates**	Current bullet under "The second option—" reads: Reconciliation of payments to ensure actuarial equivalence of PPS rates Current language under bullet titled, "Reconciliation of payments to ensure actuarial equivalence of PPS rates" reads: If the state chooses a supplemental or wraparound payment for CCBHC services, it will reconcile managed care payments to CCBHCs with the full PPS rates for covered services to determine whether the minimum payment was achieved. If the minimum payment was not achieved the state (or the managed care entity, as a pass-through from the state) will make payments to CCBHCs to make up the shortfall.	Bullet revised to read: Reconciliation of Payment Updated language under bullet retitled "Reconciliation of Payment" will read: 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.
Page 27	**Section 5.0b Building CCBHC PPS Rates into Managed Care Capitation Rates**	Current language under the second to last paragraph reads: The state should take into account any CCBHC demonstration services that are already included in managed care capitation rates and the state's strategies for avoiding duplication of payment.	Updated word to replace "avoiding" with "<u>eliminating</u>," i.e., the state should take into account any CCBHC demonstration services that are already included in managed care capitation rates and the state's strategies for <u>eliminating</u> duplication of payment.
Page 28	**Section 5.0c PIHP, and PAHP Coverage areas in managed care states**	Current language references managed care entity or managed care contractor	Updated language references: managed care "<u>plans</u>"

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Page 28	**Section 5.0d Data Reporting and Managed Care Contract Requirements**	Currently, first paragraph of 5.0d reads: The state's contract with the managed care entity must contain requirements for reporting CCBHC data. We recommend the state include the following items in its contract: (1) data to be reported; (2) the period during which data must be collected; (3) the method to meet reporting requirements; and, (4) the entity responsible entity for data collection.	Updated first paragraph of 5.0d will read: 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.
Page 29	**Section 5.0e Identification of Expenditures Eligible for Enhanced Federal Medical Percentage (FMAP)**	Current language reads: To ensure proper claiming of enhanced FMAP, the state will need to revise its actuarial certification letters to show how much of the capitation payment(s) is associated with CCBHC services for the new adult group rate cells and for the existing managed care population rate cells. At agreed-upon intervals, the state or the managed care entity will provide actual encounter data or other adequate data sources to verify services that are eligible for enhanced FMAP. The state should report CCBHC services in a separate section for payments through managed care. The claims should attribute the actual portion of the managed care rates to CCBHC services.	Updates language will read: To ensure proper claiming of enhanced FMAP, 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.