NASMHPD

National Association of State Mental Health Program Directors
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Ms. Mary E. Cieslicki
Center for Medicare and Medicaid Services
Center for Medicaid and CHIP Services
Division of Reimbursement and State Financing
Mail Stop S3-14-28
7500 Security Boulevard
Baltimore, MD 21244

CCBHC-Demonstration@cms.hhs.gov

RE: NASMHPD Comments on Implementation of the Prospective Payment System for the Community Behavioral Health Clinic Demonstration Authorized under § 223 of the Protecting Access to Medicare Act of 2014 (Pub. L. 113-93)

Dear Ms. Cieslicki:

The National Association of State Mental Health Program Directors (NASMHPD) appreciates the opportunity to provide our comments on issues for consideration in establishing the prospective payment system (PPS) for certified community behavioral health clinics (CCBHCs) participating in the eight-state demonstration program authorized under § 223 of Pub. L. 113-93.

In this letter, NASMHPD—the member organization representing the state executives responsible for the $37 billion public mental health service delivery systems serving 7.2 million people annually in 50 states, 4 territories, and the District of Columbia—urges that the CMS guidelines governing state PPS payments to CCBHCs enable the states to reimburse Centers adequately for services not traditionally covered, but not excluded, under the broader Medicaid program.

NASMHPD recommends that CMS develop a cost-reporting template that is flexible enough to facilitate the submission of charges for those unique services. Most importantly, it is crucial—in order for the demonstration to work—that states be able to build the costs of uncompensated care provided by CCBHCs into the prospective payment rates paid to the CCBHCs.

In addition, it should be kept in mind that the duration of the demonstration will be a very short two years, and that any systems changes necessitated by the demonstration's PPS payment structure should be easy to implement and easy to

reverse, if necessary, at the end of the demonstration period, if not otherwise eligible to continue under existing CMS waiver authority.

Administrative Costs for Inclusion

NASMHPD agrees with witnesses at the SAMHSA and CMS Listening Sessions that all services specified in the statutory language of § 223 must be reimbursable in the PPS rate. However, it is also important that closely related administrative costs for ambulatory services be included in the PPS rate, even though those costs might not be attributable on a one-to-one basis to specific beneficiaries served. Those administrative costs should include at least the costs of:

- Implementing interoperable health information technologies and electronic health records, and the training of Center personnel in the use and maintenance of those technologies;
- Implementing screening procedures designed to facilitate the integration and coordination of care, not only for mental illness as specified in § 223, but also for co-occurring substance use disorders and co-morbid physical illnesses and conditions that might be engendering or aggravating mental conditions and illnesses or resulting from those conditions or illnesses;
- Implementing any additional appropriate quality measures not already in place for tracking by state programs;
- Implementation of and contracting for specific evidence-based programs, such as Assertive Community Treatment, that might need to be provided off-site; and
- In addition to the direct costs of peer support services, as specified in § 223, the costs of training additional peer support specialists where workforce shortages necessitate the hiring and training of additional specialists.

As to additional direct costs, although not specified within § 223, the costs of providing treatment and recovery services for co-occurring substance use disorders should be included in the reimbursement provided under the PPS system.

Value-Based Reimbursement for Quality Outcomes

We are in agreement with those who testified at the November Listening Session that states should be able to reward quality outcomes through separate incentive payments added onto the base PPS rate payment, if they choose to do so, rather than as part of the PPS rate. In addition, where state metrics are already in place for CCBHCs or similar entities operating within a state, those metrics should be the ones utilized in assessing a CCBHC's quality outcomes, to reduce the administrative burden of incorporating new metrics for what could be a very short-term program.

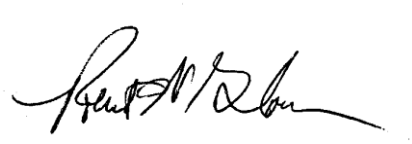
Block Grant Maintenance of Effort Considerations

Finally, NASMHPD notes that with the influx of funding from Medicaid expansion, states have been struggling with finding the most appropriate way to provide enhanced Medicaid services to newly covered populations while also continuing to meet the statutory maintenance of effort (MOE) conditions for receiving mental health and substance abuse prevention and treatment block grants. Those MOE requirements mandate that states be able to show that new federal funds are not supplanting existing state expenditures. Section 223 contains no similar MOE restrictions. NASMHPD hopes that CMS and SAMHSA will agree to jointly issue clarifying regulations that expressly state that no MOE restrictions will be applied to grant funds received under the

demonstration program, so that those funds can be used to deliver existing services in a more efficient and effective manner through the CCBHCs participating in the demonstration.

Thank you for your attention to our comments and concerns. If you have additional questions regarding the issues raised in this correspondence, please feel free to contact NASMHPD's Director of Policy and Health Care Reform, Stuart Gordon, at stuart.gordon@nasmhpd.org or 703-682-7552.

Sincerely,



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