CMS received comment dated October 13, 2015, from National Council's President and CEO, Linda Rosenberg. The comments and our response can be found below.

CMS also acknowledges receipt of the National Council's Privileged and Confidential memorandum dated October 12, 2015 from Charles Ingoglia, Senior Vice President, Public Policy and Practice Improvement. CMS believes the issues outlined in the memorandum are more closely related to the PPS-2 methodology for Certified Community Behavioral Health Clinics (CCBHC) which was published as part of the Demonstration Request for Application (RFA) issued on May 20, 2015. Therefore, CMS will address these concerns apart from the National Council's comments submitted on the CMS model cost report and will discuss these concerns as part of the November 16, 2015 meeting scheduled with the National Council.

Comment: The National Council for Behavioral Health (National Council) welcomes the opportunity to provide comments on CMS' cost reporting instructions for Certified Community Behavioral Health Clinics (CCBHCs) participating in the Section 223 demonstration program. This demonstration program provides an important opportunity to not only increase individuals' access to community mental health and substance use treatment services, but to also set new higher standards for behavioral health providers. The National Council is a non-profit association representing 2,500 community-based mental health and addiction treatment providers. Along with our member organizations, we are dedicated to fostering clinical and operational innovation and promoting policies that ensure that all Americans have access to high quality health care services.

CMS Response: We appreciate the opportunity to respond to the National Council's comments related to CMS's model cost report and instructions.

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Comment: We understand that the legislative intent of the CCBHC demonstration program is to increase access to and the quality of community behavioral health services. As designed in the statute, services are intended to be team-based, peer and recovery-focused. We are concerned that the model cost report structure does not support the overarching goals or assumptions of the demonstration program.

CMS Response: This cost report was developed in accordance with regulation at 45 CFR part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 CFR part 413 Principles of Reasonable Cost Reimbursement concerning the identification of allowed costs for the specific services authorized in statute for this demonstration. Section 4 of the PPS guidance contains cost reporting and documentation requirements. Moreover, in developing the CMS CCBHC cost report we reviewed cost reporting methods as shown in the Medicare FQHC Form 222 cost report and other cost reports such as the Medicare hospital cost report and subsequently created an adaptation of these reports with specific reporting fields for services authorized under this demonstration.

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Cost Report Instructions Comments

Section 2:
Provider Information Tab
Page 5, Line 9: RE: NPI
Comment: While it may seem straightforward to request a list of staff, this raises a question for us regarding the definition of visit and its differential treatment and implications under PPS-1 and PPS-2. The goal of the statute is to increase quality and access. The statute encourages new evidence-based mechanisms of delivering services; however, concerns arise when taking into consideration real life examples such as the one of a psychiatric nurse seeing a patient and administering an injection of Prolixin; this would presumably not count as a visit under PPS-1 or under PPS-2. If the same definition of "visit" is used, there will be disparities in reimbursements. Under PPS-1, the costs of this would clearly be counted in setting the all-inclusive rate, but would not be counted as an encounter. Under PPS-2 it would not count as an unduplicated monthly encounter since it is not a visit and therefore, the CCBHC would not receive payment.

CMS Response: The commenter appears to be making the point that a payable demonstration visit may not occur for all of the activities related to costs reimbursed through the PPS rate. CMS responds to this concern by re-stating that the CCBHC PPS rate is intended to reimburse the *expected* cost of care, which may vary from the actual cost of care. The CMS CCBHC cost report is designed to allow clinics to report all cost, including expected cost, necessary for the state to determine the rate for both PPS-1 and PPS-2. No change was made to the cost report in response to this comment.

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Page 5, Line 9: RE: NPI
Comment: The model cost report assumes that all practitioners in a CCBHC would have an NPI. This is inconsistent with current practice and with the required services that a CCBHC must provide. In most states, the facility is licensed and submits all claims for both the professional and para-professional staff that work for that organization under the organization NPI. It is highly unlikely that case aids, mobile crisis teams, drivers or peer providers would be able to obtain NPIs and the statute requires the utilization of these types of professionals. A CCBHC may not be able to submit a cost report with the required NPI information, thus making the desk audit of its cost report deemed incomplete.

CMS Response: The commenter asserts that CMS wrongly assumes all practitioners will have an NPI and that, absent this information, a clinic's cost report would be "deemed incomplete."

In response to this comment CMS has modified the cost report instructions, though not the cost report, to clarify that a clinic must report all practitioner NPIs but only to the extent this information is available. We will continue to require reporting of NPIs for the following reasons.

Collecting the NPI on the CCBHC cost report promotes program integrity in two ways:

1. A state may use this information to identify duplicate billing for services.

2. Reporting the NPI facilitates the identification of practitioners excluded from Medicaid. Federal regulations at 42 CFR §1001.1901(b)(1) prohibit payment under Medicare, Medicaid, and other Federal health care programs for any item or service furnished by any provider during its exclusion period, and until such time that that provider is reinstated. Accordingly, these providers are prohibited from working during their exclusion period for any entity that receives Federal funding for health care programs.

Including the names and NPIs (when applicable) of employees working with the CCBHC can assist states in assuring the Federal funds are being properly safeguarded. By collecting this information, states can verify that providers are not employing persons excluded from participating in Federal programs.

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Page 5, Line 10:
Comment: "List the names of all supervisory behavioral health professionals..." What is the purpose of tracking the number of supervision hours? What is the relevance of this information to the statutory intent? Asking CCBHCS to track by minute supervision time for staff that are frequently shared between programs appears to only increase paperwork efforts, without adding any value or clarity. Additionally, there is quite a bit of discrepancy across states in how supervision is defined and most providers have not usually captured this information.

CMS Response: To meet SAMHSA's Program Requirement 1: Staffing, all clinics must submit information that demonstrates qualified practitioners will be providing demonstration services. CMS believes this information suffices and has modified the cost report by removing the names of supervisory personnel and their hours.

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Page 5, Line 14 – 15:
Comment: "Enter the hours of operation and the total hours for each day of the week that the site operates as a CCBHC."
The statute and implementing guidance from SAMHSA indicate that CCBHCs have 24-hour a day responsibilities and are not confined to delivering services within the four walls of the clinic. Therefore we do not understand why this information is being requested and suggest that these lines only increase the paperwork reporting process and burden with no statutory justification, or value add.

CMS Response: This information, which excludes the hours associated with mobile crisis team, will assist in the evaluation of access to behavioral health services made available through the demonstration. CMS has modified the cost report instructions to clarify the hour of the mobile crisis team are excluded.

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Section 5:
Trial Balance Tab
Page 15, Part 3A:
Comment: "Enter the subtotal of direct costs for non-CCBHC services covered by Medicaid, excluding overhead, such as physician visits for physical care, and specify

in the Comments tab." The statute requires CCBHCs to screen for primary care conditions and a physician has an obligation to treat medical conditions that are brought to their attention. It is unrealistic for a physician to allocate that cost by the minute. This is another example of a requirement that is not consistent with statutory intent and unnecessarily increases the paperwork burden for CCBHCs.

CMS Response: The intent of Part 3A is to capture total direct cost for non-demonstration services. States are expected to require that clinics appropriately allocate cost between demonstration and non-demonstration services. This may entail a type of time study, but not necessarily a random moment time study (RMTS), to apportion cost associated with a practitioner's time. CMS has modified the cost report instructions by removing this example cited above. CMS also plans to provide technical assistance to states specifically on indirect cost identification.

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Section 8:
Allocation Description Tab
Page 19:
Comment: The guidance provided regarding Random Moment Time Study is not reflected in the cost and time burden estimate provided by CMS. Such a RMTS would involve every staff member of the organization over a specified time and would be very costly to complete.

CMS Response: A random moment time study (RMTS) is not a requirement to complete the CMS CCBHC cost report. The RMTS is mentioned in the cost report instructions as an *example* of an allocation method for personnel service cost. A state may elect to permit a clinic to use another method to allocate personnel costs. CMS did not make any changes to the cost report instructions in response to this comment.

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Section 9:
Indirect Cost Allocation Plan
Page 20:
Comment: We do not believe that the allocation methodologies align with the required services in the statute. CCBHCs and states will be challenged to know what has to be excluded from the overhead calculation to ensure that they are not double counting. This section once again introduces a substantial paperwork effort for a process is not very well defined and with a cost reporting year that does not reconcile with the fiscal year.

This lack of clarity throughout the cost report instructions will likely create a conflict between the development of sufficient data set to allow for the evaluation of the CCBHC pilot on one hand, and the autonomy of states to use whichever cost report they may wish. If states are free to use whatever cost report they may wish, then the paperwork requirements of states transferring the data from their cost report to the information that would be required by CMS would clearly exceed the estimated 33 hours for a desk audit (See tables below).

CMS Response: The indirect cost allocation tab (not Plan) aligns with all of the methods permitted when identifying indirect cost for direct services, including demonstration services. In this tab CMS does not introduce an additional paperwork burden beyond what is already established in regulation with respect to the identification of indirect cost.

The commenter appears to be addressing apportionment of cost between fiscal years, rather than reconciliation. Responding to this concern, if a clinic intends to use cost from multiple fiscal years then it can work with the state to assure that methods to apportion cost are acceptable.

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Section 10:
Anticipated Costs Tab
Page 23:
Comment: In Column 2 "Enter the additional expenses associated with providing new or expanded CCBHC services. The amount entered should be the additional cost expected that is not already accounted for in the Trial Balance." This section is ambiguous. How are anticipated costs defined? We urge CMS to develop additional state guidance to facilitate rate setting in this area and to avoid problems with state desk audits.

CMS Response: We will develop additional guidance during the planning phase of the demonstration, based on questions and comments from states; the cost report instructions were not modified as a result of this comment.

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Section 12:
Monthly Visits Tab—Refer to Exhibit A
Page 25:
Comment: We provide substantial response to this section in the attached memo, "PPS-2 Methodology for Certified Community Behavioral Health Clinics," from Feldesman Tucker marked as Exhibit A. Given the statute's flexibility, we urge OMB to explore whether a reconciliation to actual costs, subject to a re-definition of costs as defined in Exhibit A, during the demonstration period might be a way in which PPS 2 could be developed in a way that is conformant with cost report principles.

CMS Response:

Burden Hour Deduction
Wage Estimate
CMS provided an estimate of 81.5 hours per CCBHC to compile all of the necessary data and documentation to complete the cost report – we estimate that it will take two times the amount of time to compile the information that is required to complete the cost report for clinics using the PPS-1 model and three times the amount of time for clinics using the PPS-2 model. The cost reporting year is not likely to reconcile with the fiscal year of the CCBHC, therefore the level of effort estimate appears vastly under-stated current community based behavioral health organizations have no expense completing cost reports and do not tend to have financial and accounting systems that segregate costs at the level of specificity needed to complete cost reports. This coupled with lack of alignment with fiscal years will result in significant worksheet and back up

documentation. Additionally, the level of reallocations, estimates based on the current cost reports would require much higher levels of staff. Therefore, we estimate that the cost for a CCBHC and states to complete and review one cost report is $19,811.44.

Chief Executives were not included in the review of the cost reports. To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2014 National Occupational Employment and Wage Estimates. We estimate that the Chief Executives would spend 10 hours reviewing the cost reports for a PPS-1 model and 15 hours for a PPS-2 model.

State desk audit.
As previously stated, since the reporting year and fiscal year are not likely to reconcile, CCBHCs will submit many worksheets and backup justification documents that will require significant time to review. We estimate that each desk audit will take at least twice as long for a PPS-1 state and up to three times longer for a PPS-2 state. This includes a desk audit of anticipated costs which will likewise involve substantial back up and review.

Based on the feedback we have received from the states applying for the planning grant, each state is looking to certify an average of six clinics. PPS rate development happens during the planning year and thus up to 23 states and 129 CCBHCs will be involved. This will change the costs projected, which were based on two clinics for each state. We have provided an updated chart below calculating the costs for six CCBHCs and a state to complete and review one cost report.

FIGURE 1: CMS' DESK AUDIT ESTIMATE
This chart reflects the CMS' estimates for the desk audit. It does not provide separate estimates for PPS-1 and PPS-2. It is calculated on the assumption that each state will only certify 2 clinics.

Occupation Title	Occupation Code	Mean Hourly Wage	Fringe Benefit	Adjusted Hourly Wage	Hours per request
Staff Accountant	13-2011	35.42	35.42	70.84	81.5
Finance Manager	11-3031	62.61	62.61	125.22	33
Total		97.82	97.82	196.06	114.5

FIGURE 2: NATIONAL COUNCIL'S PPS 1 DESK AUDIT ESTIMATE
This chart looks at the amount of time it would take two CCBHCs to complete and review the cost report if working with a PPS-1 model. We estimate that it will take twice as long as CMS' estimate in Figure 1. In addition, we factored in the time it would take Chief Executives to review the cost report.

Occupation Title	Occupation Code	Mean Hourly Wage	Fringe Benefit	Adjusted Hourly Wage	Hours per request
Staff Accountant	13-2011	35.42	35.42	70.84	163
Finance Manager	11-3031	62.61	62.61	125.22	66
Chief Executives	11-1011	74.93	74.93	149.86	10
Total		172.96	172.96	345.92	239

The total combined cost for a CCBHC and states to complete and review one cost report is $21,310.04.

FIGURE 3: NATIONAL COUNCIL'S PPS 1 DESK AUDIT ESTIMATE—SIX CLINICS
This chart looks at the amount of time it would take six CCBHCs to complete and review the cost report if working with a PPS-1 model. Based on the feedback we have received from the states applying for the planning grant, each state is looking to certify an average of six clinics. We estimate that it will take three times as long as our estimates in Figure 2. In addition, we factored in the time it would take Chief Executives to review the cost report.

Occupation Title	Occupation Code	Mean Hourly Wage	Fringe Benefit	Adjusted Hourly Wage	Hours per request
Staff Accountant	13-2011	35.42	35.42	70.84	489
Finance Manager	11-3031	62.61	62.61	125.22	198
Chief Executives	11-1011	74.93	74.93	149.86	30
Total		172.96	172.96	345.92	717

The total combined cost for six CCBHCs and state to complete and review one cost report is $63,930.12.

FIGURE 4: NATIONAL COUNCIL'S PPS 2 DESK AUDIT ESTIMATE
This chart looks at the amount of time it would take two CCBHCs to complete and review the cost report if working with a PPS-2 model. We estimate that it will take three times as long as CMS' estimates in Figure 1. In addition, we factored in the time it would take Chief Executives to review the cost report.

Occupation Title	Occupation Code	Mean Hourly Wage	Fringe Benefit	Adjusted Hourly Wage	Hours per request
Staff Accountant	13-2011	35.42	35.42	70.84	244.5
Finance Manager	11-3031	62.61	62.61	125.22	99
Chief Executives	11-1011	74.93	74.93	149.86	15
Total		195.75	195.75	345.92	358.5

The total combined cost for a CCBHC and states to complete and review one cost report is $31,965.06.

FIGURE 5: NATIONAL COUNCIL'S PPS 2 DESK AUDIT ESTIMATE—SIX CLINICS
This chart looks at the amount of time it would take six CCBHCs to complete and review the cost report if working with a PPS-2 model. Based on the feedback we have received from the states applying for the planning grant, each state is looking to certify an average of six clinics. We estimate that it will take three times as long as our estimates in Figure 4. In addition, we factored in the time it would take Chief Executives to review the cost report.

Occupation Title	Occupation Code	Mean Hourly Wage	Fringe Benefit	Adjusted Hourly Wage	Hours per request
Staff Accountant	13-2011	35.42	35.42	70.84	733.5
Finance Manager	11-3031	62.61	62.61	125.22	297
Chief Executives	11-1011	74.93	74.93	149.86	45

Occupation Title	Occupation Code	Mean Hourly Wage	Fringe Benefit	Adjusted Hourly Wage	Hours per request
Total		172.75	172.75	345.92	1075.5

The total combined cost for six CCBHCs and a state to complete and review one cost report is $95,895.18.