Schaeffer Initiative on Health Policy
at BROOKINGS

June 2, 2023

Chiquita Brooks-LaSure

Administrator, Centers for Medicare and Medicaid Services

7500 Security Boulevard, Baltimore, MD 21244

**RE: Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment System (PPS) Technical Guidance**

Dear Administrator Brooks-LaSure:

Thank you for inviting comments on the *Certified Community Behavioral Health Clinic Prospective Payment Guidance*. The document reflects an evolving program and issues that have arisen during the first years of the program. Our comments will focus on four issues: 1) the optional use of Special Crisis Service rates; 2) the option under PPS 4 to discontinue the special population rate; 3) the quality bonus payment metrics, and 4) the proposed schedule for payment rebasing.

## 1. Multiple PPS options

The guidance proposes to offer states a choice of four potential payment arrangements. Two are per diem all-inclusive rates (PPS-1 and PPS-3). PPS-2 and PPS-4 make monthly payments for all services but also include a separate monthly payment for the care of special populations. PPS-3 and PPS-4 include a new requirement for a separate Special Crisis Service rate, which is an important step towards improving responses to behavioral health crises. Recent years have seen elevated suicide rates,[1] rising drug overdose deaths,[2] and criminalization of disturbed and disturbing behavior as reflected in the disproportional number of police shootings that involve people with mental illnesses[3] and the over-representation of people with mental illnesses in jails and prisons.[4] These trends reflect both a growing need for robust crisis services and the inadequacy of many existing responses to behavioral health crises. Congress and the

[1] https://www.cdc.gov/nchs/products/databriefs/db464.htm#:~:text=The%20total%20age%2Dadjusted%20suicide,the%20period%20(Figure%201)
[2] https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates#:~:text=More%20than%20106%2C000%20persons%20in,drugs%20from%201999%20to%202021
[3] https://www.nami.org/Advocacy/Policy-Priorities/Stopping-Harmful-Practices/Police-Use-of-Force
[4] https://cops.usdoj.gov/html/dispatch/05-2022/mental_health_reentry.html

administration have made commitments to improve crisis response throughout the nation. The new payment proposals PPS-3 and PPS-4 reflect this commitment to expanding crisis services by creating financial incentives for CCBHCs to create robust crisis responses services like mobile crisis teams and crisis stabilization services. However, by permitting CCBHCs to choose payment options that do not provide targeted rewards for the supply of crisis services, the commitment to promoting those services is diluted. We therefore suggest that the new crisis payments be required of all CCBHCs, which would have the added benefit of simplifying the administration and oversight of the program.

**2. Option to discontinue special population payments under PPS-2 and PPS-4**

Payment and treatment in the mental health field has long been affected by so-called "biased selection." That is, providers and insurers face strong incentives to enroll and treat less sick and less costly patients when they receive prospective payments that do not account for differences in patients' diagnoses and illness severity. The special population payment under PPS-2 was a simple approach to recognizing that CCBHCs treating sicker patients will often incur higher costs. This approach is entirely consistent with the CCBHC's mission of treating people regardless of means or location. Eliminating the special population payment under PPS-2 and PPS-4 restores the incentive to engage in practices that result in biased selection of lower-need, lower-cost patients. While we recognize concerns of states about the complexity of multiple payment systems, history shows us that biased selection is important in mental health and substance use disorder care. Therefore, one might address the biased selection issue by creating a risk adjustment mechanism that could be incorporated into PPS-2 and PPS-4. In such a system, monthly payments to the CCBHC would be adjusted according to the case mix of the CCHBC. As a result, CCBHCs would be paid more for treating sicker, more costly people.

**3. Quality Bonus Payment Metrics**

The requirement of 6 mandatory quality indicators is a practical approach to quality measurement. In considering which quality measures to require, however, one might more clearly link performance measures to priorities of the CCBHC program. Specifically, integration of behavioral health and other medical care has been set out as a priority issue for the program. Yet only one required metric involves an indicator related to integration activity (Comprehensive Diabetes Care: Hemoglobin A1c Control for Patients with Diabetes). We would suggest requiring an additional clinic-specific measure that reflects integration activities. Such measures have been included in the measure set for CCBHCs. They include cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications, and diabetes screening for people with Schizophrenia or bipolar disorder.

The optional QBP bonus measures also include Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH). Weight is often used as a health indicator, based on the reasoning that 1) high weight is itself bad for health and 2) weight is a

proxy for other important health outcomes (e.g., heart attack risk).[5] However, the negative health effects of high weight itself – as opposed to health behaviors, conditions, and social determinants associated with high weight – have been debated[6] and more precise measures exist to measure health and health risks (e.g., screening for cardiometabolic health: blood pressure, fasting blood glucose, etc.).[7]

Furthermore, weight stigma, which is prevalent among healthcare providers,[8,9] can negatively impact high-weight individuals' health. Higher perceived weight stigma is associated with negative health outcomes such as increased allostatic load,[10,11] elevated rates of disordered eating,[12] and increased symptoms of anxiety and depression.[13] Weight screening and counseling can be an acutely stigmatizing experience, particularly when a patient is not seeking care for a weight-related health concern.[14] Experiencing weight stigma in a medical setting may also deteriorate patients' experiences of care, potentially causing them to delay or avoid future health care services.[15,16] For example, survey evidence suggests that experiences of weight stigma directly impact some patients' future decisions regarding medical care: "19% of participants reported they would avoid future medical appointments and 21% would seek a new doctor if they felt stigmatized about their weight from their doctor."[17]

We endorse the goal of integrating primary care into the CCBHC setting. However, given the fact that weight screening is an imprecise health measure and that it may directly negatively impact patients, we would recommend against using the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH) measure to improve primary care integration. Instead, we suggest using more targeted and less stigmatized primary care quality measures such as cardiovascular health screening.

Finally, the proposed Prospective Payment Guidance would also make optional the Suicide Risk Assessment metrics for both adults and children/adolescents. Given the emphasis on crisis care in the proposed guidance (as demonstrated by the addition of Special Crisis Service rates), we view it as important that CCBHCs maintain robust crisis screening capabilities including routine screens for suicide risk. As such, we suggest that the suicide risk assessment metrics should be required for QBP.

---

[5] https://aspenjournals.onlinelibrary.wiley.com/doi/10.1002/ncp.10885
[6] https://spssi.onlinelibrary.wiley.com/doi/abs/10.1111/sipr.12062
[7] https://aspenjournals.onlinelibrary.wiley.com/doi/10.1002/ncp.10885
[8] https://www.nature.com/articles/ijo2010173
[9] https://onlinelibrary.wiley.com/doi/full/10.1002/oby.20687
[10] https://psycnet.apa.org/record/2014-30548-004
[11] https://psycnet.apa.org/record/2018-55683-011
[12] https://link.springer.com/article/10.1007/s13679-015-0153-z
[13] https://onlinelibrary.wiley.com/doi/full/10.1111/obr.12935
[14] https://onlinelibrary.wiley.com/doi/full/10.1002/osp4.40
[15] https://www.cambridge.org/core/journals/primary-health-care-research-and-development/article/weight-bias-and-health-care-utilization-a-scoping-review/1FC4C7CF66473AB6CFB6ED5AD2C8DD43
[16] https://onlinelibrary.wiley.com/doi/10.1111/obr.12266
[17] https://www.nature.com/articles/ijo2012110

**4. Payment Rebasing**

The guidance proposes that payment rates be rebased every three years. This is a sensible approach, especially during a period of flux in labor markets in the health sector.

Thank you again for the opportunity to provide comments on this important issue and for taking steps to improve care for individuals with mental illness and substance use disorders across the country.

Sincerely,

**Richard G. Frank** and **Julia Paris**

Brookings Institution, Schaeffer Initiative on Health Policy