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The Certified Community Behavioral Health Clinic (CCBHC) Policy Academy

Establishing a Roadmap for the CCBHC Model in Vermont

March 28, 2022

Welcome and Introductions

Simone Rueschemeyer, Executive Director, Vermont Care Network/Vermont Care Partners

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Statement of Purpose: Goals and Objectives for Vermont

Emily Hawes, Commissioner, Vermont Department of Mental Health

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Agenda

- **Overview of the CCBHC Model**, *Jane King, Senior Consultant, CCBHC Success Center*
  - CCBHC criteria & payment structure
  - State-level data and health care outcomes
  - Areas of state discretion and aligning CCBHC with current state-level efforts
- **CCBHC Success Across the Country**, *Brett Beckerson, Director, Policy, CCBHC Success Center*
  - Successes in Accountability, Parity, Workforce and Integration
- **Questions, Open Discussion, and Innovation Planning,** *Brett Beckerson, Director, Policy, CCBHC Success Center*
- **Next Steps and Policy Academy Plan**, *Brett Beckerson, Director, Policy, CCBHC Success Center*
  - Scheduling reoccurring meetings
  - Content to be covered
  - Things to know to be successful

Overview of CCBHC Certification

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States' levers of control

- **Certification of CCBHCs (only state-certified clinics may receive PPS)**
- Choice of PPS-1 vs. PPS-2 model
  - In PPS-1: whether to use QBPs (QBPs required in PPS-2)
  - In PPS-2: which special population groups will receive distinct PPS
- Quality bonus payment thresholds, amounts, reporting requirements (within parameters of CMS guidance)
- Review of clinics' cost reports
- Method for determining yearly rate adjustments
- Frequency of rebasing
- How to address payment in managed care context

It is a State-driven Model

The state certifies CCBHCs in accordance with the SAMHSA Certification Criteria that includes state discretionary items

The state reviews and approves the CCBHC cost reports and establishes the final provider-specific PPS reimbursement rates

Medicaid CCBHC & SAMHSA Expansion Grants

Medicaid CCBHC (Demonstration, SPA, or Waiver)	SAMHSA CCBHC Expansion Grants
Open to any state with CMS approval	Open to individual clinics in ALL states
Administered by state Medicaid and Behavioral Health authorities within guidelines set by SAMHSA/CMS	Administered by SAMHSA
States determine certification criteria using SAMHSA guidance as a baseline	Grantees must meet SAMHSA baseline CCBHC certification criteria
CCBHCs are certified by their states	CCBHCs attest to SAMHSA; do not receive state certification
CCBHCs receive special Medicaid payment methodology (known as PPS)	CCBHCs receive up to $4M; continue to bill Medicaid and other payers per usual

CCBHC Payment Structure (PPS)

CCBHC prospective payment system is unique to this model with specific instructions from CMS and SAMHSA

"PPS-1, the daily rate, and PPS-2, the monthly rate, **were designed for the CCBHC demonstration** to improve the alignment of financial incentives with provision of high-quality, patient-centered care." – *CCBHC Report to Congress*

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CCBHC Payment Methodology (PPS)

- **Clinic-specific Medicaid encounter rate delivered on daily (PPS-1) or monthly (PPS-2) basis**
  - The rate includes all allowable CCBHC services and activities*
  - Payment is only made when a "qualifying encounter" for a Medicaid client occurs
- **Cost-related**
  - Calculated from cost reports (including current and anticipated, direct and indirect costs)
  - Rates must be actuarially sound
  - Not a cost-reimbursable model
- Provides states with tools for periodic rate adjustment and ability to control cost growth year over year
- Opportunity to leverage federal Medicaid match for CCBHC services/activities previously funded through state general funds

*Allowable CCBHC services and activities are defined by SAMHSA in the CCBHC criteria, with areas for state discretion/decision-making

CCBHC Rate Structure and Options

Table 1. Rate Elements of CC PPS-1 and CC PPS-2

Rate Element	CC PPS-1	CC PPS-2
Base rate	Daily rate	Monthly rate
Payments for services provided to clinic users with certain conditions[12]	NA	Separate monthly PPS rate to reimburse CCBHCs for the higher costs associated with providing all services necessary to meet the needs of special populations
Update factor for demonstration year 2	Medicare Economic Index (MEI)[13] or rebasing	MEI or rebasing
Outlier payments	NA	Reimbursement for portion of participant costs in excess of threshold
Quality bonus payment	Optional bonus payment for CCBHCs that meet quality measures detailed on page 7	Bonus payment for CCBHCs that meet quality measures detailed on page 7

Source: https://www.samhsa.gov/sites/default/files/grants/pdf/sm-16-001.pdf#page=94

PPS-1 Guidelines (Daily Encounter Payment)

- CCBHCs receive **a single daily reimbursement per client with a visit on that day**
- PPS rate is the same for all clients, regardless of level of complexity/need
- Payment does not vary with the number or intensity of services delivered during one encounter
- Quality bonus payments are optional under the demonstration

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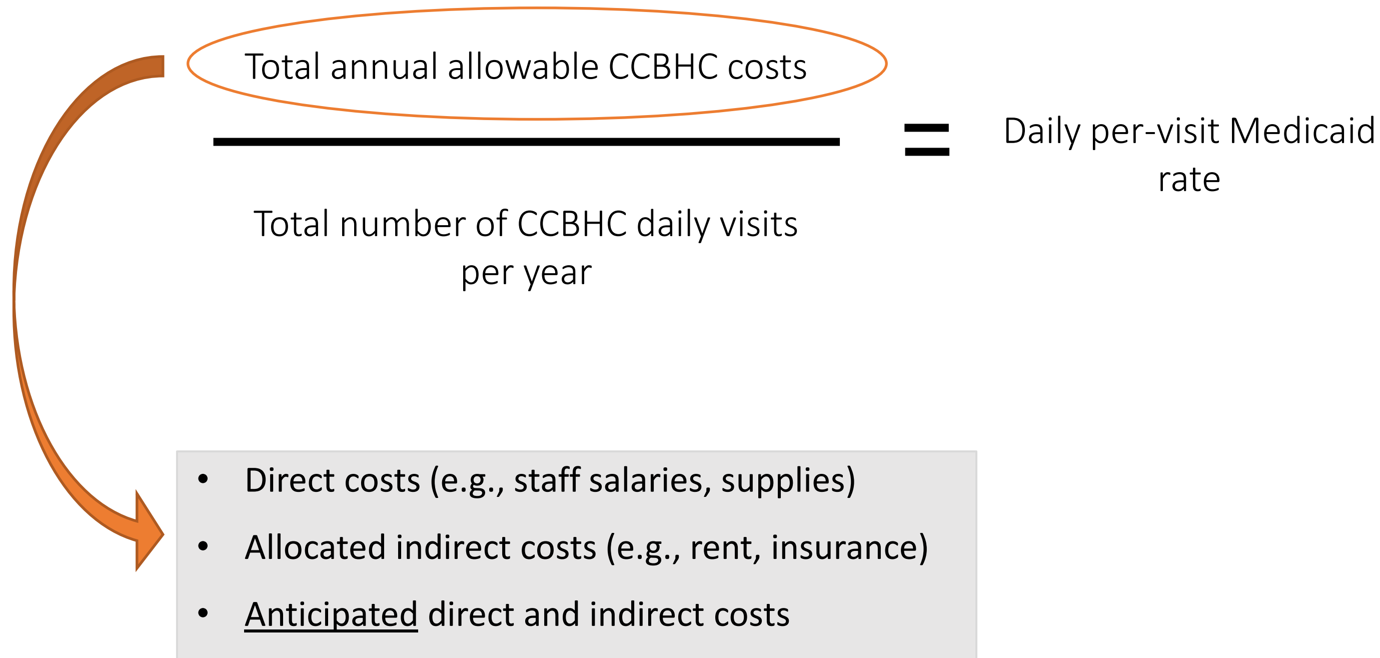
How is the PPS-1 rate calculated?



PPS-2 Guidelines (Monthly Encounter Payment)

- CCBHCs receive a **single payment per month** for every individual who has at least one visit in the month
  - Allows CCBHCs to establish **separate reimbursement rates for distinct populations with differing clinical conditions** in addition to a rate for the general population
- Payment is the same regardless of number of visits per month or intensity of services
- CCBHCs do NOT get paid in months when the patient does not receive any services
- Quality bonus payment methodology required
- Includes a process for addressing outlier costs

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How is the PPS-2 rate calculated?

- States define the parameters of "special population" groups based on clinical condition
- **Step 1: determine the base PPS rate** (for all clinic users not part of a special population)
- **Step 2: determine PPS rates for special populations**
- **Step 3: determine the outlier payment,** which provides reimbursement in excess of a threshold defined by a state not to exceed 100 percent of cost

Calculating PPS rate for each group:

Total annual allowable CCBHC costs, including only clinic users with specified conditions

Total number of CCBHC monthly visits per year, including only clinic users with specified conditions

Monthly per-visit Medicaid rate for special population group

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PPS-2 Examples, Demonstration Year 1

TABLE III.1. New Jersey Five-Level Classification for PPS-2 Rates					
	Standard Population	**Special Population 1**	**Special Population 2**	**Special Population 3**	**Special Population 4**
Population definition	Individuals who do not have an ICD-9 or ICD-10 diagnosis code corresponding to any of the following special populations	SMI	SUD	PTSD	SED

TABLE III.2. Oklahoma Six-Level Classification for PPS-2 Rates						
	Standard Population	**Special Population 1**	**Special Population 2**	**Special Population 3**	**Special Population 4**	**Special Population 5**
Population definition	Individuals who are not classified in any of the following special populations	High-risk SMI or co-occurring SUD	High-risk SED or co-occurring condition	Adults with significant SUD	Adolescents with significant SUD	Chronic homelessness or first time psychosis episode for children and adults

Source: https://aspe.hhs.gov/system/files/pdf/263976/CCBHCPreCost.pdf

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CCBHC Payment in Managed Care: 2 Options

- **Option 1: PPS pass-through via MCOs**
  - MCO capitation rate is adjusted by state to account for PPS
  - MCOs pass PPS rate through to providers
- **Option 2: PPS wraparound payment**
  - MCOs contract with and pay providers per usual
  - Providers report on actual payments received; state calculates what the payment would have been under a PPS and provides periodic wraparound payments to make up the difference

CCBHC Certification Criteria

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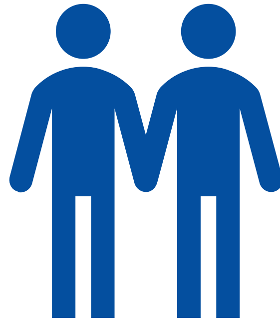

Person-centered and Family-centered Care

- All CCBHC services, including those supplied by its DCOs, are provided in a manner reflecting person and family-centered, recovery-oriented care, being respectful of the individual consumer's needs, preferences, and values, and ensuring both consumer involvement and self-direction of services received.
- Services for children and youth are family-centered, youth-guided, and developmentally appropriate.

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CCBHC Criteria Requirements

CCBHC Criteria Section	Key Requirements
Organizational Authority, Governance & Accreditation	• CCBHCs must be Nonprofits, Part of local government behavioral health authority OR Under the authority of Indian Health Service, Indian Tribe or Tribal organization • 51% of board are consumers, people in recovery or family members
Staffing	• Psychiatrist as Medical Director, DEA waivered prescriber, MH and SU providers • Training must address: Cultural competence; Person-centered and family-centered, recovery-oriented, evidence-based and trauma-informed care; Primary care/behavioral health integration; Risk assessment, suicide prevention and suicide response; and the roles of families and peers
Availability and Accessibility of Services	• Timely access to care (crisis, urgent, routine) • Access regardless of ability to pay and place of residence • Meaningful access to services for individuals with Limited English Proficiency

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CCBHC Criteria Requirements

CCBHC Criteria Section	Key Requirements

Scope of Services	• 9 required services
	• States have defined this differently:
	    • "Most" services are directly provided,
	    • 5 of the 9 services are directly provided

Care Coordination	• CCBHC coordinates care across the spectrum of health services, including physical and behavioral health and other social services • CCBHC establishes or maintains EHR and Health IT system • Care coordination agreements
Quality and Other Reporting	• 9 CCBHC Reported Measures • 12 State Reported Measures • CQI

CCBHC Certification Opportunities

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State Discretionary Items

Examples of State discretionary items within CCBHC criteria

- Staffing requirements
- Needs assessment requirements
- Cultural, linguistic, and treatment needs of the populations to be served
- Service area definition
- Directly provided services vs DCOs
- Evaluation and treatment planning element requirements
- State sanctioned crisis system
- Alternatives to 51% board participation by people served/family members

Demonstration States Evidence-based Practices

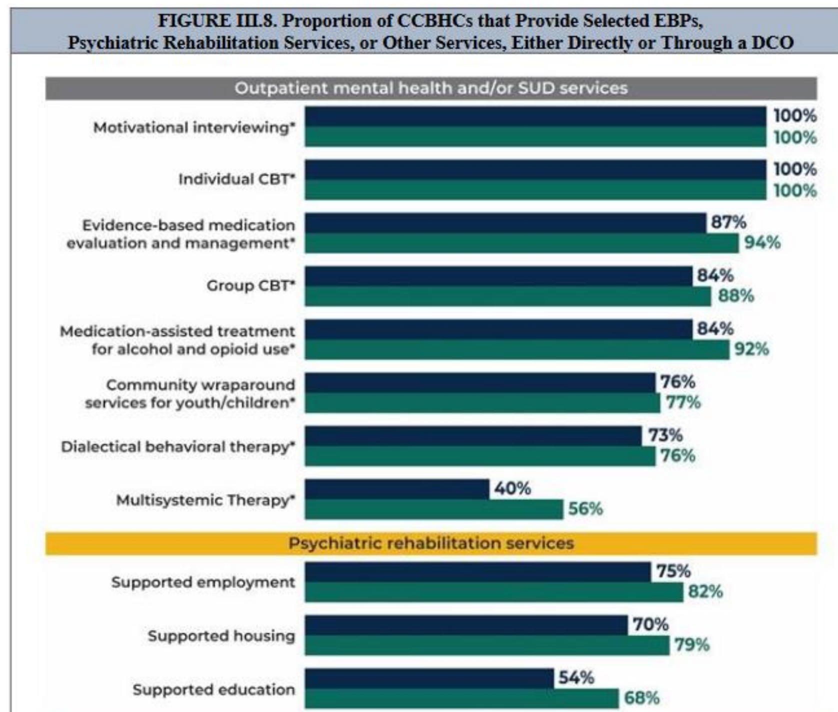
FIGURE III.8. Proportion of CCBHCs that Provide Selected EBPs, Psychiatric Rehabilitation Services, or Other Services, Either Directly or Through a DCO

- EBPs selected by states as part of certification
- 95% of CCBHCs provided training in trauma-informed care
- 60% of CCBHCs provided early intervention for first-episode psychosis

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Certification Opportunities

- Launch of new service lines to meet community need
- New initiatives designed to reach target populations or address key Medicaid agency goals
- Deploying outreach, chronic health management outside the four walls of the clinic
- Including previously 100% state-funded initiatives into Medicaid PPS

Care Coordination Partnerships

Schools	Criminal Justice	Other
• Provide direct services on site in schools or plan to do so • Engage in suicide prevention efforts targeted to children/youth • Provide Mental Health First Aid training to middle or high school teachers and staff • Provide Mental Health First Aid training to middle or high school students	• Participate in mental health court, drug court, or veterans' court • Train law enforcement or corrections officers in Mental Health First Aid, CIT, or other mental health/SUD awareness training • Provide pre-release screening, referrals, or other activities to ensure continuity of care upon re-entry to community from jail • Initiated data or information sharing with law enforcement or local jails to support improved collaboration • Embed a clinician or peer specialist with law enforcement officers responding to mental health/SUD calls • Provide telehealth support to law enforcement officers responding to mental health/SUD calls	• SUD residential treatment facilities • Withdrawal management facilities • MAT providers for SUD • Homeless shelters • Housing agencies • Employment services/supported employment • Consumer operated/peer service provider organizations

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988 and State-Sanctioned Crisis System Implementation with CCBHC

Three Roles for CCBHCs in 988 Implementation	Establishing a State-Sanctioned Crisis System
• CCBHCs can serve as 988 call centers • CCBHCs can serve as partners to 988 call centers for services the call centers do not directly provide • CCBHCs can serve as referral partners to 988 call centers and other crisis responders for post-crisis or non-urgent needs	• CMS Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services • "Mobile crisis intervention services should be integrated with the national suicide prevention and mental health crisis hotline, state funding of core crisis care elements, and community-level efforts to implement CCBHC crisis management services." • The 85% mobile crisis match represents a pathway to finance a portion of the costs associated with CCBHC implementation

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Certification Development

- Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics
- Certification Guides and Resources
- State Certification Guide
- When is a person a CCBHC consumer

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CCBHC Success in States Across the Country

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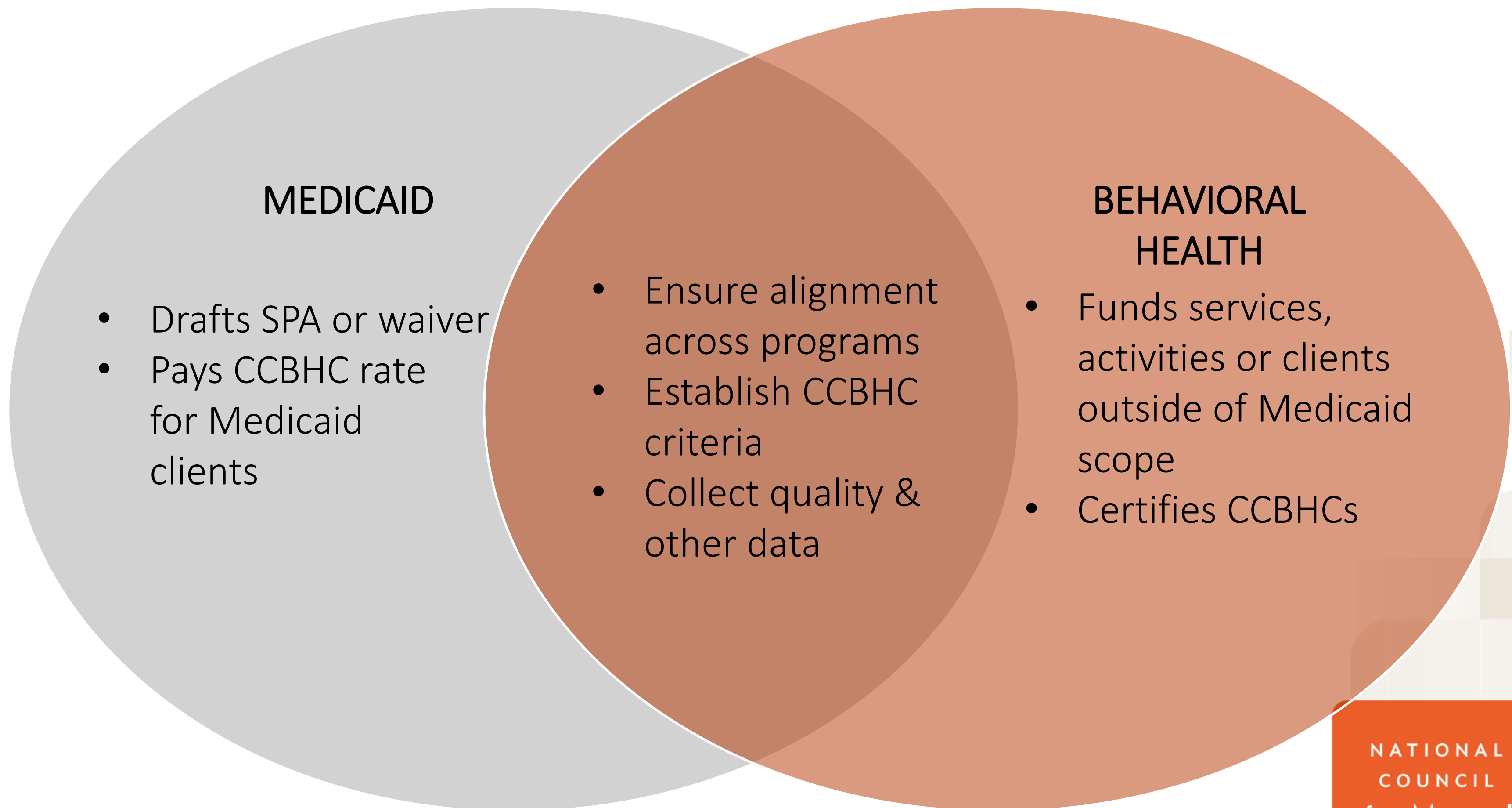
Options for States via Medicaid

Medicaid Waiver (e.g., 1115)
Enables states to experiment with delivery system reforms
Requires budget neutrality
Must be renewed every 5 years
State must be sure to specify inclusion of selected CCBHC services (some may not otherwise be included in the plan)
With CMS approval, offers opportunity to continue or establish PPS

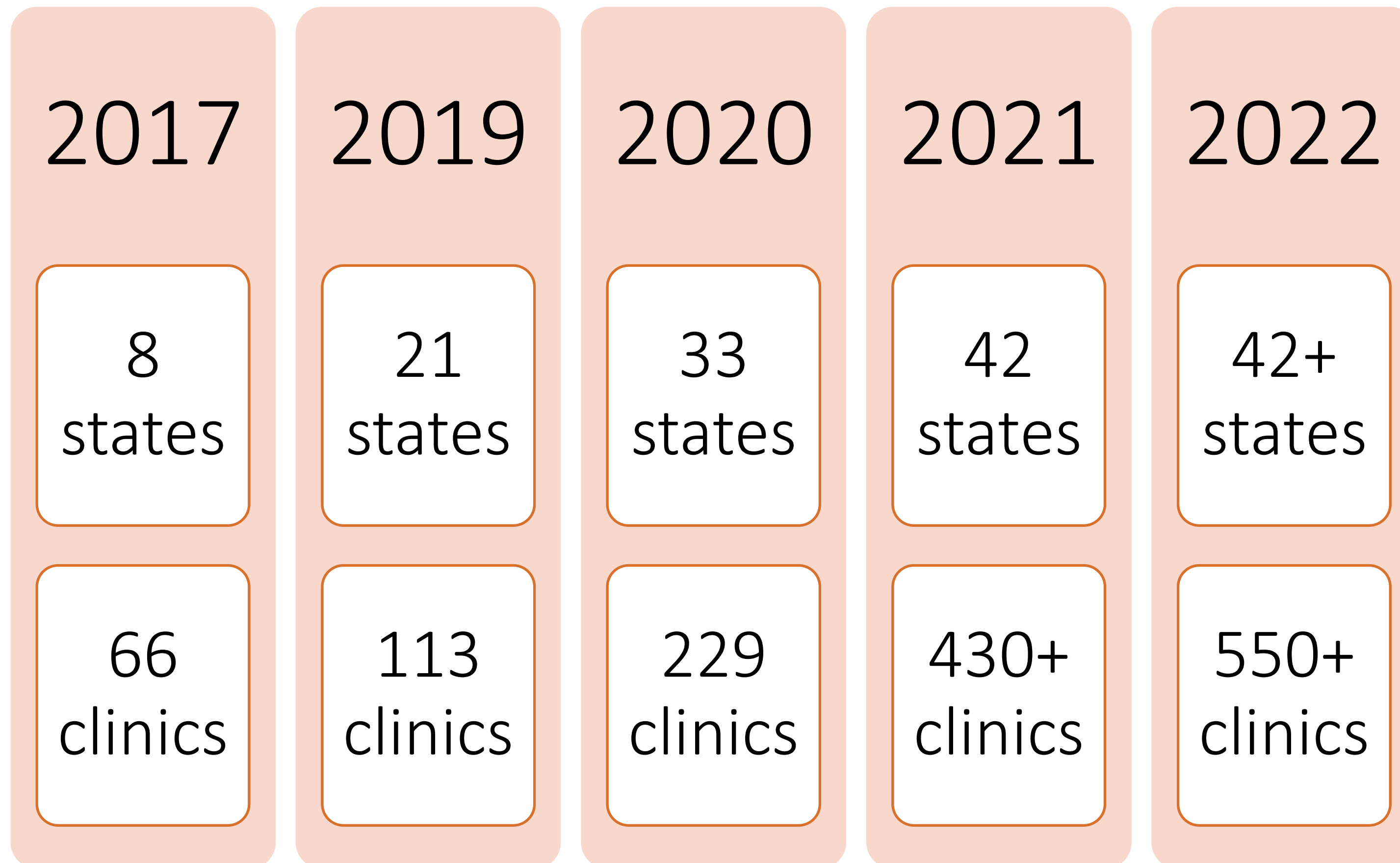
State Plan Amendment
Enables states to permanently amend Medicaid plans to include CCBHC as a provider type, with scope of services, criteria and requirements, etc.
Does not require budget neutrality
With CMS approval, can continue PPS
Cannot waive "state-wideness," may have to certify additional CCBHCs (future CCBHCs may be phased in)

Approved 1115 waivers: Texas
Approved SPAs: Missouri, Nevada, Oklahoma, and Minnesota

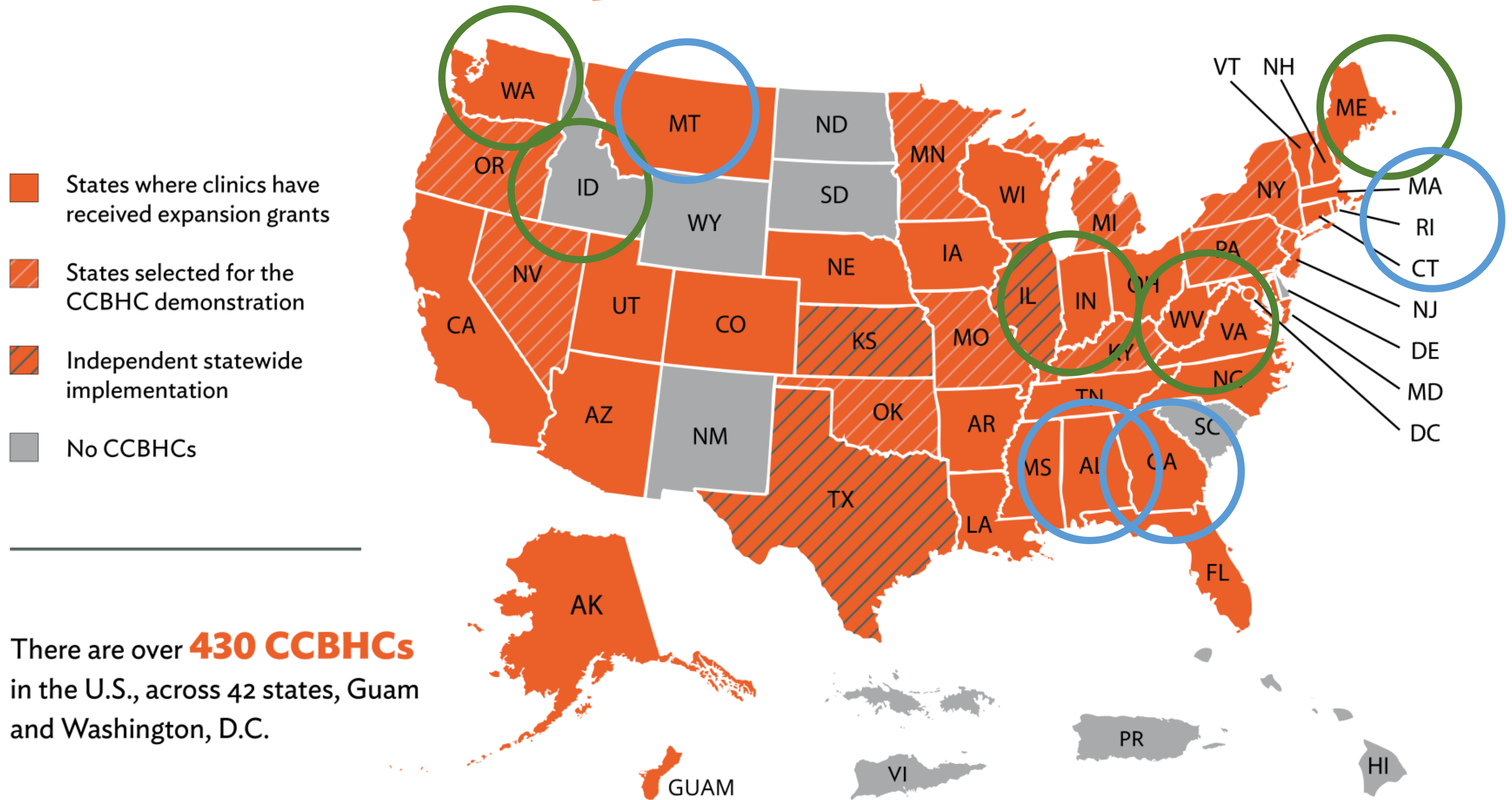
State Agency Collaboration Example for CCBHC Implementation



Incredible Growth with the CCBHC Demonstration and with Grantees



Status of Participation in the CCBHC Model



CCBHCs' State Impact Over Time

Missouri

- Hospitalizations **dropped 20%** after 3 years, ED visits **dropped 36%**
- Overall access to BH services **increased 23% in 3 years,** with veteran services **increasing 19%**
- **In 1 year, 20% decrease** in cholesterol; **1.48-point Hgb A1c decrease**
- Justice involvement with BH populations **decreased 55%** in 1 year

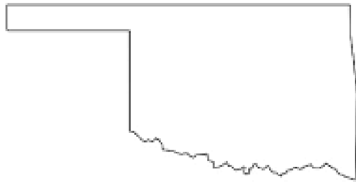
Texas

- The CCBHC model in Texas is projected to save **$10 billion by 2030**
- In 2 years, there were **no wait lists** at any CCBHC clinic
- **40% of clients** treated for cooccurring SUD and SMI needs, compared to 25% of other clinics

CCBHCs' State Impact Over Time (cont.)

New York

- All-cause readmission dropped **55%** after year 1
- BH inpatient services show a **27% decrease** in monthly cost
- BH ED services show a **26% decrease** in monthly cost
- Inpatient health services **decreased 20%** in monthly cost
- ED health services **decreased 30%** in monthly cost
- **24% increase** in BH services for children and youth



Oklahoma

- Launched the model with just three (3) CCBHCs, now 15 clinics.
- **Brought in nearly 1,000 new jobs to health care**
- **Seen an economic impact of $35 million dollars** and an overall reduction in unemployment.
- Just one (1) rural Oklahoma reduced emergency psychiatric hospitalizations (**an estimated $14.9 million savings)**

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Open Discussion

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Next Steps

Planning for the CCBHC Policy Academy

- Scheduling reoccurring meetings
- Content to be covered
- Things to know to be successful

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Questions?

All questions should be sent to CCBHC@thenationalcouncil.org and please copy Simone Rueschemeyer Simone@vermontcarepartners.org

Key Reports and Links

Recently released reports from National Council:

- CCBHC National Impact Report
- CCBHC State Impact Report
- CCBHCs and the Justice Systems
- Connection between 988 and CCBHC

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