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The Certified Community Behavioral Health Clinic (CCBHC) Model

Vermont Policy Academy

May 19, 2022

Agenda

- Welcome and Questions from Certification (10 minutes)
- Overview of PPS and Financing (30 minutes)
- Open Discussion (15 minutes)
- Next Steps and Follow-up (5 minutes)

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"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.**"

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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

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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

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Demonstration States' PPS Choices

PPS-1 (Daily)	PPS-2 (Monthly)
Missouri (SPA approved)	New Jersey
Minnesota (SPA approved)	Oklahoma (SPA approved)
New York	
Nevada (SPA approved)	
Oregon	
Pennsylvania	
Michigan	
Kentucky	
Kansas* (SPA in process)	

* Non-demonstration state implementing CCBHC

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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 implement payment in managed care context

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PPS-1 Guidelines (Daily Encounter Payment)

- CCBHCs receive **a single daily reimbursement per Medicaid beneficiary 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 of services provided in one day
- Payment does not vary with intensity of services delivered during one encounter
- Quality bonus payments are optional under the demonstration

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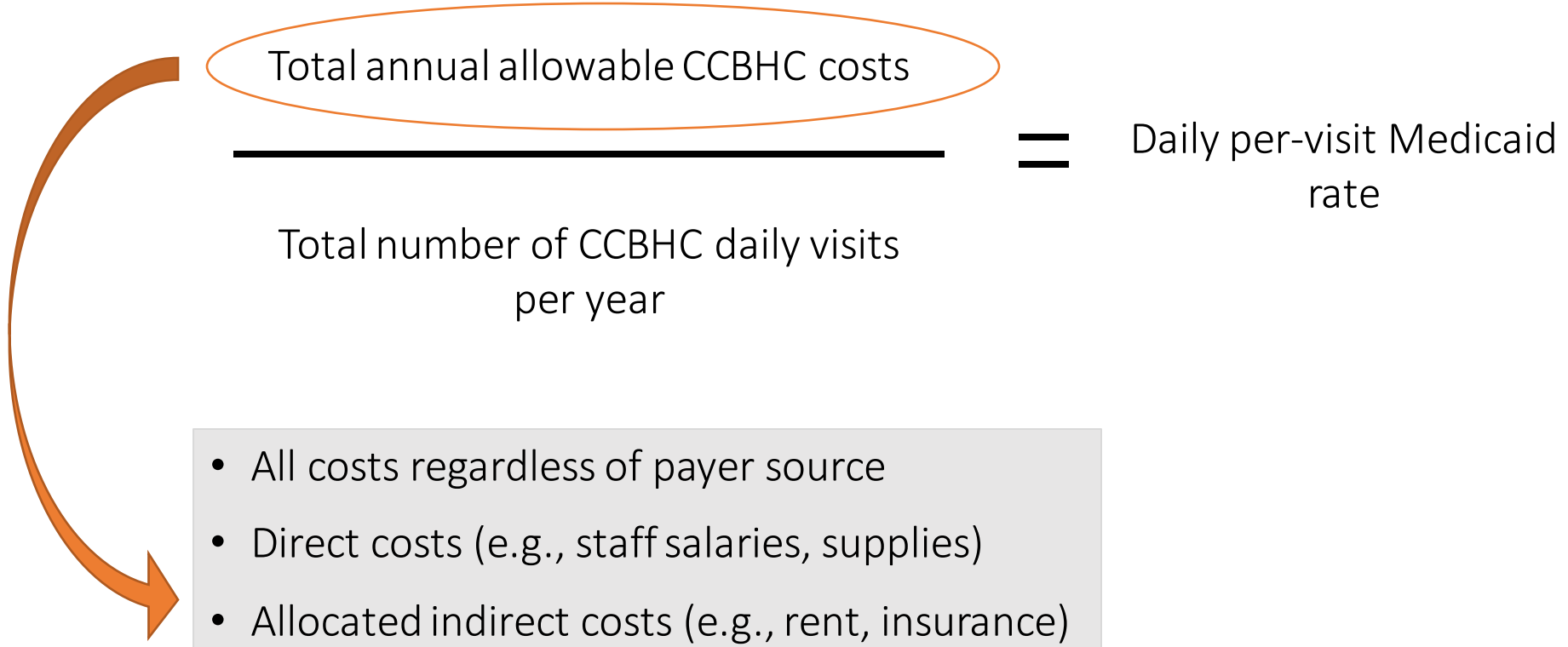
How is the PPS-1 rate calculated?



- All costs regardless of payer source
- Direct costs (e.g., staff salaries, supplies)
- Allocated indirect costs (e.g., rent, insurance)
- Anticipated direct and indirect costs

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PPS-2 Guidelines (Monthly Encounter Payment)

- CCBHCs receive a **single payment per month** for every Medicaid beneficiary 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 (different from PMPM)
- Quality bonus payment methodology required
- Includes a process for addressing outlier costs

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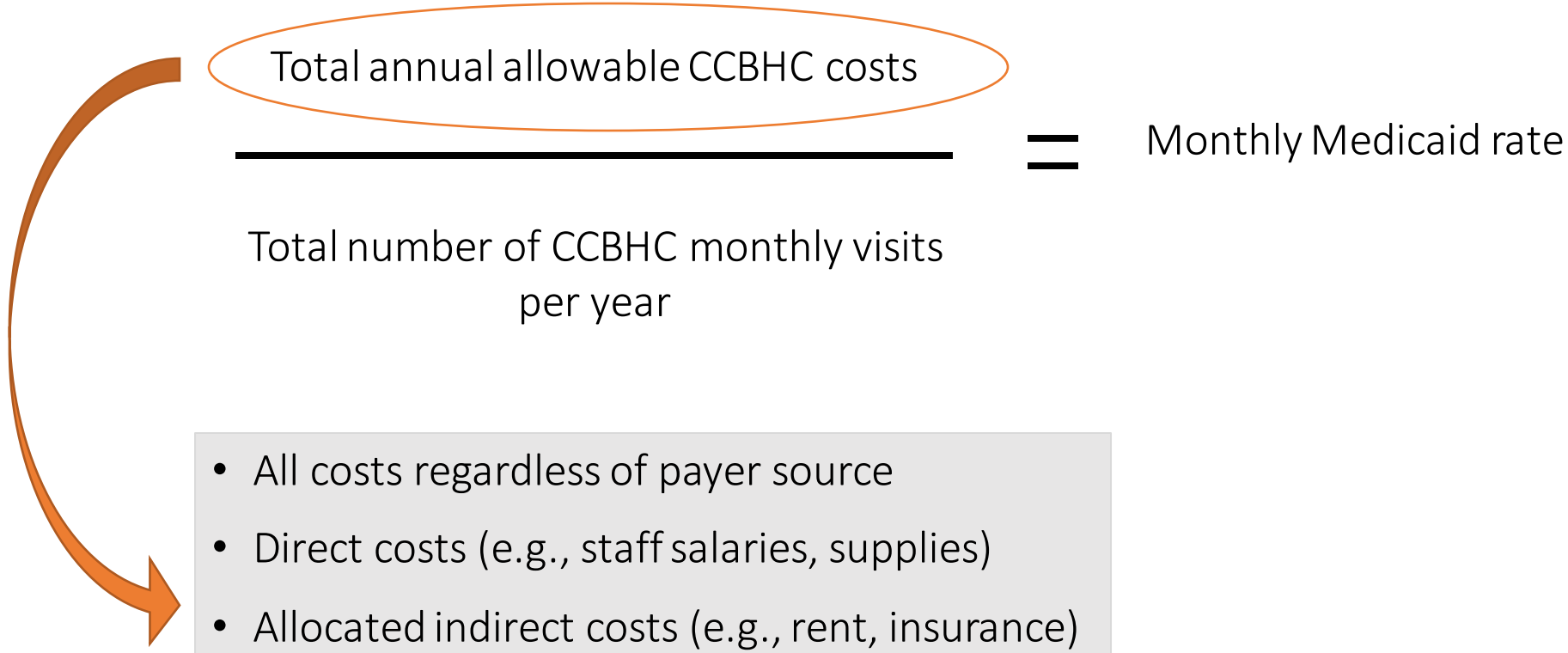
How is the PPS-1 base rate calculated?



- All costs regardless of payer source
- Direct costs (e.g., staff salaries, supplies)
- Allocated indirect costs (e.g., rent, insurance)
- Anticipated direct and indirect costs

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How is the PPS-2 special population 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:

$$\frac{\text{Total annual allowable CCBHC costs, including only clinic users with specified conditions}}{\text{Total number of CCBHC monthly visits per year, including only clinic users with specified conditions}} = \text{Monthly per-visit Medicaid rate for special population group}$$

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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

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
  - Some demonstration states chose this method as a short-term solution and moved to MCO payment over time or within their approved SPAs

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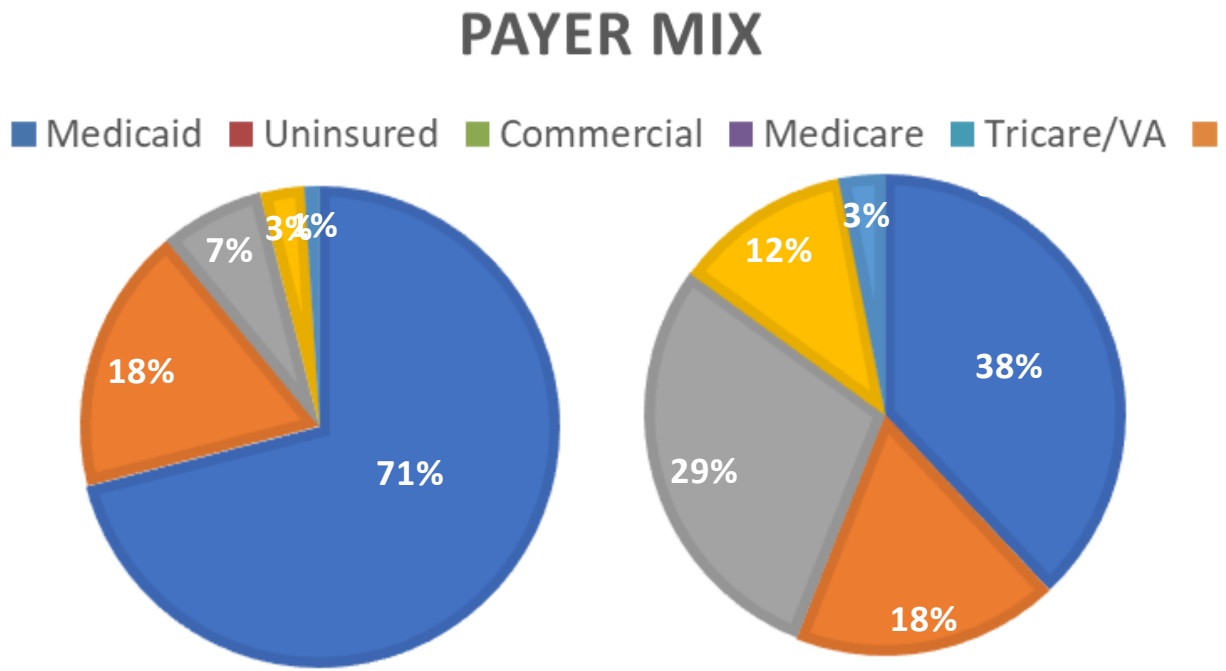
Role of Other Payers

- PPS not available; not all CCBHC services covered
- Planning for your unique payer mix is critical for success
- CCBHC as a springboard to negotiating more favorable rates?



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Quality Bonus Payments

- Optional in PPS-1; required in PPS-2
- For states that opted to implement QBPs, CMS specified:
  - 6 required quality measures
  - 5 additional measures states could choose from (or ask for approval of non-listed measures)
- States determined their criteria for awarding QBPs and QBP amounts
  - Pay-for-reporting?
  - Baseline period used to set improvement goals?
  - Weighted some measures more heavily than others?

Quality Bonus Payment Measures

TABLE ES.2. Quality Measures Used for Determining Quality Bonus Payments		
	Required or Optional for Determining QBPs[a]	**States with QBPs that Used the Measure to Determine QBPs[b]**
CCBHC-Reported Measures		
Child and adolescent major depressive disorder: SRA (SRA-BH-C)	Required	All
Adult major depressive disorder: SRA (SRA-BH-A; NQF-0104)	Required	All
CDF-A	Optional	MN
Depression Remission at 12 months (NQF-0710)	Optional	None
State-Reported Measures		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)	Required	All
Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (FUH-BH-A)	Required	All
FUH, ages 6-21 (child/adolescent) (FUH-BH-C)	Required	All
Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET-BH)	Required	All
PCR-AD	Optional	MN, NV, NY
Follow-up Care for Children Prescribed ADHD Medication (ADD-C)	Optional	None
Antidepressant Medication Management (AMM-A)	Optional	None

Source: https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//196041/CCBHCPreCost.pdf

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States' Quality Bonus Payments, DY1

TABLE 17. QBPs Amounts Planned and Distributed		
State (Number of Clinics)	**Amount state initially estimated for QBPs per DY**	**DY1 QBPs distributed**
Minnesota (6)	5% of total payments, or approximately $2.5 million	2 of 6 CCBHCs received QBP. Total bonus payments: $740,049.
Missouri (15)	1% of total payments, or approximately $4.2 million	15 of 15 CCBHCs received QBP. Total bonus payments: $17,210,855 (5% of Medicaid claims).
Nevada (3)	10% of DY1 payments and 15% of DY2 payments, or approximately $1.5 million	3 of 3 CCBHCs received QBP. Total bonus payments: 10% of DY1 payments (assumed).[a]
New Jersey (7)	Approximately $350,000	State had not yet made final decisions about awarding of QBPs at time of report.
New York (13)	Approximately $2 million	No payments distributed; thresholds not met.
Oklahoma (3)	1% of total payments, or approximately $1 million	No payments distributed; thresholds not met.
Pennsylvania (7)	3% of total payments, or approximately $2.1 million	6 of 7 CCBHCs received QBP. Total bonus payments: $568,000.

Source: https://aspe.hhs.gov/sites/default/files/documents/1faadf771e9567b0926e33739341cb50/ccbhc-report-congress-2020.pdf

States' PPS Experiences: Year 1

- States and clinics did not have experience with cost-reporting and PPS in the community BH context.
- During the initial rate-setting process, uncertainty around:
  - Volume of clients CCBHCs would serve in Year 1
  - Lack of historical cost data for making projections
  - Speed with which clinics would be able to staff up
  - And more…

Source: https://aspe.hhs.gov/sites/default/files/documents/1faadf771e9567b0926e33739341cb50/ccbhc-report-congress-2020.pdf

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Changes from Year 1 to Year 2

- 6 states chose to rebase rates; 2 preferred to wait until at least 2 years of cost data was available
- Rebasing substantially lowered rates in states where the first-year difference between rates and costs was highest
- "Among the PPS-1 states, the percentage differences between the rates and costs were less in DY2 than in DY1, **indicating a move toward convergence of rates and costs over time**."*

* https://aspe.hhs.gov/sites/default/files/documents/1faadf771e9567b0926e33739341cb50/ccbhc-report-congress-2020.pdf

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PPS updates approved through approved SPAs

- Referred to as “bundled rate” rather than “PPS” in SPA language
- Provisional certification with “initial rate” for first year and mandatory rebase based on actual costs for ongoing rate
- Systems for updating Quality Bonus Measures and requirements
- Systems for rebasing PPS rates
- Adding services to Medicaid state plan only for CCBHCs

Targeting Population Health

PPS provides resources and incentives to target population health. CCBHCs are:

- Hiring **dedicated population health** analysts, clinicians, other staff
- Using **data analysis** to understand utilization and risk among client population
- Developing **care pathways** to ensure comprehensive, assertive service delivery to high-risk populations
- Strengthening **integration with primary care** to help clients manage chronic physical health conditions that are cost drivers
- Partnering with hospitals to **streamline care transitions** and prevent readmission
- Assessing for **non-health needs** that are determinants of health (e.g. housing, food, etc.)
- And much, **much more**!

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Reflections on Cost to States

- Multiple sources of variation in total cost; states have many levers of control
- "ROI" is a balance between costs and savings
  - Some states report savings from reduced hospitalization/emergency department utilization…
  - …at the same time they report increases to the number of Medicaid clients served
- Attainment of cost savings contingent upon fully resourcing CCBHCs' activities designed to reduce costly health service utilization
- Participating states perceive value for their investment; some are making additional investments to bring more CCBHCs online (NV, OK, MN, MO) while others are exploring options to do so in the future

"In a field that has been severely underfunded for years, just increasing access to behavioral health services IS a huge return on investment."

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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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Questions/Discussion