

Certified Community Behavioral Health Clinics

An Introduction

June 2015



Why Pursue CCBHC?

- Improved care and enhanced access to care
- Opportunity to benefit from the largest single federal investment in community-based mental health in well over a generation
- Potential for secure on-going payment via a Prospective Payment System (PPS) for chronically underfunded, overwhelmed, and critical component of the delivery system
- Opportunity to leverage initiatives such as Health Homes, Balancing Incentive Programs, and Home and Community Based Services (HCBS) Transition plans



Authorizing Legislation: 2014 Excellence in Mental Health Act

- \$1.1 billion investment: The *largest* federal investment in community-based behavioral health in several generations
- Protecting Access to Medicare Act (H.R. 4302) created the criteria and authorized the two Phase CCBHC Demonstration Program:
 - **Planning Grant Phase:** 24 states received awards
 - 1 year grant to plan and develop CCBHC certification and prospective payment system (PPS) reimbursement requirements
 - Certify at least 2 sites
 - Establish the PPS for Medicaid reimbursable behavioral health services
 - Apply to participate in the 2 year demonstration program
 - **Demonstration Phase:** Up to 8 states will be selected to participate in the CCBHC demonstration
 - Bill Medicaid under established PPS approved by CMS under an enhanced Medicaid FMAP



The Vision: Certified Community Behavioral Health Clinics

- Improve overall health by providing improved community-based mental health and substance use disorder treatment
- Advance behavioral health care to the next stage of integration with physical health care
- Assimilate and utilize evidence-based practices on a more consistent basis



CCBHC Criteria is Designed to Address:

- Wide variation across States in regulating behavioral health organizations and in the scope and scale of Medicaid plans
- Lack of a common data set for behavioral health organizations



Key Dates

- Oct. 23, 2015
 - Planning grant funding awarded to 24 states
- October 23, 2016-Application deadline for the demonstration
- By January 2017
 - Demonstration states selected from among those that received planning grants



Minimum Standards

- The Act establishes standards in six areas that an organization must meet to achieve CCBHC designation:
 1. Staffing
 2. Accessibility
 3. Care coordination
 4. Service scope
 5. Quality/reporting
 6. Organizational authority



Impact of CCBHC

- Improved coordination and integration of care for all
- Special focus on care for those with Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), and chronic Substance Use Disorders (SUD)
- Expansion of person-centered, family-centered, trauma-informed, and recovery oriented care that integrates physical and behavioral health care to serve the “whole person”
- Expanded and improved data collection
- Long-lasting and beneficial effects beyond the realm of Medicaid enrollees



Planning Phase Activities

October 2015-October 2016

Once awarded the grant, planning grant recipients must:

- Solicit broad-based stakeholder input, including from providers and consumers
- Design the scope of the Medicaid-reimbursable CCBHC service package
- Certify a minimum of two CCBHCs—rural and underserved—that will participate in the pilot
 - Create and finalize application process for CCBHCs
 - Support clinics to meet standards (access to training and technical support)



Planning Phase Activities

October 2015-October 2016

Recipient requirements cont...

- Establish and Enact the Prospective Payment System (PPS) to reimburse CCBHC services
 - May select alternate payment methodologies to incentivize improvement on key access and quality of care metrics
 - Enhanced Medicaid match rate (cost based plus enhanced FMAP/CHIP rate or FMAP for expansion population)
 - Develop or enhance data collection and reporting capacity
 - Design or modify data collection systems that report on the costs and reimbursement of BH services
 - Assist CCBHCs to use data for continuous quality improvement, including fidelity to evidence based practices, during the demonstration
- Apply for the 2 year Demonstration by October 23, 2016
 - Only planning grant recipients can apply to participate in the demonstration



Evaluation Metrics

- Number of organizations or communities implementing mental health/substance use-related training programs as a result of the grant
- Number of people newly credentialed/certified to provide mental health/substance use-related practices/activities consistent with the goals of the grant
- Number of financing policy changes completed as a result of the grant
- Number of communities that establish management information/information technology system links across multiple agencies in order to share service population and service delivery data as a result of the grant



Evaluation Metrics (cont.)

- Number and percentage of work group/advisory group/council members who are consumers/family members
- Number of policy changes completed as a result of the grant
- Number of organizational changes made to support improvement of mental health/substance use-related practices/activities that are consistent with the goals of the grant
- Number of organizations collaborating/coordinating/sharing resources with other organizations as a result of the grant.



Staffing: Standards

- Medicaid-enrolled providers
- Credentialed, certified, and licensed professionals with adequate training in person-centered, family-centered, trauma-informed, culturally competent and recovery oriented care
- Individuals with expertise in addressing the needs of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI).
- Culturally and linguistically competent and appropriate
 - Including for Veterans and members of the Armed Services



Staffing: Positions

- Management team:
 - Chief Executive Officer or Executive Director/Project Director
 - Psychiatrist as Medical Director
- States will specify disciplines required for certification, but must include:
 - Medically trained BH provider able to prescribe and manage meds (i.e., opioid and alcohol treatment)
 - Credentialed substance abuse specialists
 - Individuals with trauma expertise able to promote recovery of children with SED, adults with SMI, and those with SUD



Staffing: Positions

- The following options are examples of staff a state might require:
 - Psychiatrists
 - Nurses
 - Licensed independent clinical social workers
 - Licensed mental health counselors
 - Licensed psychologists
 - Licensed marriage and family therapists
 - Licensed occupational therapists
 - Staff trained to provide case management
 - Peer specialists/Recovery coaches
 - Licensed addiction counselors
 - Staff trained to provide family support
 - Medical assistants
 - Community health workers
- Some services may be provided by contract or part-time or as needed.



Staff Training Requirements

- CCBHC Staff Training must address:
 - Cultural Competence related to:
 - culture, age, gender, gender identity, sexual orientation, military culture, spiritual beliefs and socioeconomic status
 - Person-centered and family-centered, recovery-oriented, evidence-based and trauma-informed care
 - Trauma-informed care, recovery-oriented care (incorporating the concept of shared decision-making), and health integration.
 - Primary care/behavioral health integration.
 - Risk assessment, suicide prevention, and suicide response
 - The roles of families and peers
 - Other trainings required by the state
- Training (in-person or on-line) are provided at orientation and annually thereafter



Staffing: Linguistic Competence

- If the CCBHC serves individuals with Limited English Proficiency (LEP) or with language-based disabilities, the CCBHC takes reasonable steps to provide meaningful access to their services
- Interpretation/translation service(s) are provided that are appropriate and timely for the size/needs of the population
- Auxiliary aids and services are readily available, Americans With Disabilities Act (ADA) compliant, and responsive to those with disabilities
- Vital documents/messages are available for consumers in languages common in the community served
- Policies include explicit provisions for ensuring that all providers and interpreters understand and adhere to confidentiality and privacy standards



Availability & Accessibility Standards

- Access is required at times and places convenient for those served
- Prompt intake and engagement in services
- Access regardless of ability to pay (sliding scale fees) and place of residence
- Crisis management services available 24 hours per day
- CCBHCs must have clearly established relationships with local EDs to facilitate care coordination, discharge and follow-up, as well as relationships with other sources of crisis care.
- Accessibility also promoted via peer, recovery, and clinical supports in the community and increased access through the use of telehealth/telemedicine, online treatment services and mobile in-home supports
- Transportation support is provided to the extent possible
- Further specificity is provided, see criteria.



Care Coordination: *The “Linchpin” of CCBHC*

- Partnerships (MOA, MOU) or care coordination agreements required with:
 - FQHCs/rural health clinics, unless the CCBHC provides comprehensive healthcare services
 - Inpatient psychiatry and detoxification
 - Post-detoxification step-down services
 - Residential programs
 - Other social services providers, including
 - Schools
 - Child welfare agencies
 - Juvenile and criminal justice agencies and facilities
 - Indian Health Service youth regional treatment centers
 - Child placing agencies for therapeutic foster care service
 - Department of Veterans Affairs facilities
 - Inpatient acute care hospitals and hospital outpatient clinics



Care Coordination: *The “Linchpin” of CCBHC*

- CCBHC coordinates care across the spectrum of health services, including physical and behavioral health and other social services
- CCBHC establishes or maintains electronic health records (EHR)
 - Health IT system is used to conduct population health management, quality improvement, reducing disparities, and for research and outreach



CCBHC Treatment Team

- The Treatment Team includes:
 - The consumer & families/caregivers
 - An interdisciplinary team composed of individuals who work together to coordinate medical, psychosocial, emotional, therapeutic, and recovery support needs of consumers
- Person and family centered treatment planning and care coordination activities are required



CCBHC Services

- Crisis mental health services
 - 24-hour mobile crisis teams
 - emergency crisis intervention services, and
 - crisis stabilization
- Screening, assessment and diagnosis, including risk assessment
- Person and Family-centered treatment planning
- Direct provision of outpatient mental health and substance use disorder services
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk
- Targeted case management
- Psychiatric rehabilitation services
- Peer support and counselor services and family supports
- Intensive, community-based mental health care for members of the armed forces and veterans, particularly those in rural areas



CCBHC Services

- The CCBHC ensures that the following services are provided directly:
 - Crisis mental health services—24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization (unless a state/county sanctioned systems for crisis services can act as a DCO):
 - Screening, assessment and diagnosis, including risk assessment
 - Person and Family-centered treatment planning
 - Direct provision of outpatient mental health and substance use disorder services
- All CCBHC services, if not available directly through the CCBHC, are provided through a Designated Collaborating Organization (DCO)
- DCO-provided services must meet the same quality standards as those provided by the CCBHC



Service Scope: Evidence-based practices

- Based on required needs assessment, states must establish a minimum set of required evidence based practices, such as:
 - Motivational Interviewing
 - Cognitive Behavioral individual, group, and on-line therapies (CBT)
 - Dialectical Behavioral Therapy (DBT)
 - Addiction technologies
 - Recovery supports
 - First episode early intervention for psychosis
 - Multi-systemic therapy
 - Assertive Community Treatment (ACT)
 - Forensic Assertive Community Treatment (F-ACT)
 - Evidence-based medication evaluation and management (including but not limited to medications for psychiatric conditions, medication assisted treatment for alcohol and opioid substance use disorders, prescription long-acting injectable medications for both mental and substance use disorders, and smoking cessation medications)
 - Community wrap-around services for youth and children
 - Specialty clinical interventions to treat mental and substance use disorders experienced by youth (including youth in therapeutic foster care)



Quality and Other Reporting Standards

- Standardized data elements modeled on the FQHC Uniform Data System:
 - Encounter data
 - Consumer demographics
 - Staffing
 - Service usage
 - Service access
 - Care coordination
 - Clinical outcomes data
 - Quality data
 - Other data as requested



Organizational Authority Governance and Accreditation

- CCBHCs will be:
 - Nonprofits
 - Part of local government behavioral health authority
 - Under the authority of Indian Health Service, Indian Tribe or Tribal organization
 - Urban Indian organization
- Governing board members reasonably represent those served in terms of “geographic areas, race, ethnicity, sex, gender identity, disability, age, and sexual orientation”
 - Either by at least 51% being consumers with mental illness or adults recovering from SUD *or* a substantial number representing these groups plus other specific methods for consumer and family input
- States are encouraged to require accreditation by an appropriate nationally-recognized organizations (CARF, COA, AAAHC)



PPS Guidance

- PPS applies to services delivered either directly by a CCBHC or through a formal relationship between a CCBHC and Designated Collaborating Organizations (DCOs)
- PAMA permits states to claim expenditures related to payments made for CCBHC services at the enhanced Federal Medical Assistance Percentage (FMAP) equivalent to the standard Children's Health Insurance Program (CHIP) rate



PPS Option 1

Certified Clinic PPS (CC PPS-1) is an FQHC-like PPS that provides reimbursement on a daily basis

- Cost-based, per clinic rate that applies uniformly to all CCBHC services rendered by a certified clinic, including those delivered by qualified satellite facilities
- Pays CCBHCs a daily rate that is a fixed amount for all CCBHC services provided on any given day to a Medicaid beneficiary
- Cost and visit data from the demonstration planning phase will be updated by the Medicare Economic Index (MEI) to create the rate for DY1. The DY1 rate will be updated again for DY2 by the MEI or by rebasing of the PPS rate
- Based on total annual allowable CCBHC costs divided by the total annual number of CCBHC daily visits and results in a uniform payment amount per day, regardless of the intensity of services or individual needs of clinic users on that day
- State may elect to offer Quality Bonus Payment (QBP)



PPS Option 2

- Certified Clinic PPS Alternative (CC PPS-2) is a monthly rate that applies uniformly to all CCBHC services rendered by a certified clinic, including all qualifying sites of the certified clinic.
- Required elements:
 - A monthly rate to reimburse the CCBHC for services (paid once per month for each unduplicated client who had one or more visits at the CCBHC in that month)
 - Separate monthly PPS rates to reimburse CCBHCs for higher costs associated with providing all services needed to meet the needs of clinic users with certain conditions
 - Cost updates from the demonstration planning period to DY1 using the MEI and from DY1 to DY2 using the MEI or by rebasing
 - Outlier payments made in addition to PPS for participant costs in excess of a threshold defined by the state, and
 - Requires the state to select quality measure(s) as permitted and make bonus payments to incentivize improvements in quality of care
- States will develop a standard monthly rate and also will develop monthly PPS rates that vary according to users' clinical conditions
 - State has flexibility in determining how PPS rates could vary
 - An outlier payment is part of the CC PPS-2 and reimburses clinics for costs above a state-defined threshold (either on a monthly or annual basis)



Quality Bonus Payment

- Optional for daily (PPS Option 1)
- Required for monthly (PPS Option 2)
- Required measures are shown in Table 3 of PPS Guidance
 - Option for state to include more upon CMS' approval



Quality Measures

Required Measures for Quality Bonus Payments:

1. Follow-Up after Hospitalization for Mental Illness (adult age groups)
2. Follow-Up after Hospitalization for Mental Illness (child/adolescents)
3. Adherence to Antipsychotics for Individuals with Schizophrenia
4. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
5. Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
6. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment



Quality Measures

Eligible Measures for Quality Bonus Payments:

1. Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication
2. Screening for Clinical Depression and Follow-Up Plan
3. Antidepressant Medication Management
4. Plan All-Cause Readmission Rate
5. Depression Remission at Twelve Months-Adults

States may propose quality measures for QBP; however, CMS approval is required.



Additional CCBHC Resources

- National Council for Behavioral Health
<http://www.thenationalcouncil.org/>
 - Chuck Ingoglia
chucki@thenationalcouncil.org
 - Rebecca Farley
rebeccaf@thenationalcouncil.org
- SAMHSA's Grant Page:
<http://www.samhsa.gov/grants/grant-announcements/sm-16-001>

