

Certified Community Behavioral Health Clinics: A New Type of Prospective Payment System

Certified Community Behavioral Health Clinics (CCBHCs) are transforming access to addiction and mental illness care. CCBHCs must meet stringent criteria regarding timeliness of access, care coordination, quality reporting, staffing and scope of services. In return, they receive Medicaid payment based on a prospective payment system (PPS).

States and the federal government have substantial experience with PPS across many health care programs. PPS in its many variations provides a critical financial foundation across the safety net and deserves continued support from policymakers. As more states consider adopting the CCBHC model, it is important for state officials to understand how CCBHC PPS operates and the levers of state control available to them in the CCBHC PPS model.

How does PPS work for CCBHCs?

A Medicaid per-encounter rate is set based on a cost report that documents a clinic’s allowable costs and qualifying patient encounters (either on a monthly or daily basis) over a year. The costs are divided by the number of qualifying encounters to arrive at a single rate which is paid to the clinic each time a monthly or daily encounter occurs, regardless of the number or intensity of services provided. In places with Medicaid managed care, states may either make up the difference between managed care payments and PPS through a periodic reconciliation process or require managed care organizations to pay the PPS rate.

The CCBHC Medicaid demonstration is governed primarily at the state level within a framework set by SAMHSA and CMS. The CCBHC initiative requires the active involvement of Medicaid agencies to tailor payment and scope of services to their own states’ needs. Among the key elements:

- **CCBHCs are certified by states**, not by a federal agency. Beyond a floor set by SAMHSA, states define CCBHC requirements and may require CCBHCs to prioritize specific difficult-to-serve populations, such as those with a history of emergency department use or on parole.
- **CCBHC rates are set by state Medicaid agencies** through a cost reporting process that provides opportunities for Medicaid Directors to benchmark clinics’ anticipated costs against one another.
- The CCBHC PPS methodology **explicitly permits and encourages options aligned with states’ movement toward value-based purchasing**, such as a monthly (instead of daily) PPS that allows stratified payment rates for patient subgroups with varying levels of need.

CCBHC PPS	
Clinic Certification	CCBHCs are certified by state Medicaid agencies. Participating states may choose whether or not to certify SAMHSA CCBHC Expansion grantees.

Scope of Services	Within a framework set by SAMHSA, states make final decisions about CCBHCs' scope of services and other certification criteria. Based on their own needs, states have significant authorities to require enhanced services or prioritize care delivery to targeted, difficult-to-serve populations.
Authority for Coverage of Services in Medicaid	States elected to apply for the current CCBHC demonstration; additional authorities exist for implementation at state option outside the demonstration.
Cost Reports and PPS Rate Setting	CCBHCs complete a cost report including both current costs and anticipated future costs associated becoming a CCBHC. Rates are clinic-specific, but through the process of documenting anticipated costs, state Medicaid agencies have an opportunity to benchmark clinics against one another and ensure comparable services are being provided at comparable cost.
Payment on the Same Day	CCBHCs receive one PPS payment for each daily (or monthly, at state option) encounter. They cannot bill multiple PPS encounters for the same day/month.
APM/VBP Features	States have the option to implement a monthly PPS which increases the potential downside risk for providers and captures elements of capitation, pay-for-performance, and other value-based payment (VBP) models. States can require their own performance measures as a condition of certification.
Quality Bonus Payments	Quality bonus payments are mandatory under the monthly PPS and have been voluntarily adopted by nearly all states using the daily PPS.
Rebasing	States choose whether they will engage in a rebasing process at the end of the first demonstration year and with what frequency thereafter.

“PPS-2”: the monthly Prospective Payment System

When establishing guidelines for CCBHC prospective payment, CMS provided states with two options: a daily rate (known as PPS-1) or a monthly rate (PPS-2). The monthly option captures many elements of value-based payment (VBP).

In the monthly PPS, a clinic's rate is set by dividing its allowable costs by the number of monthly encounters in a year. Monthly encounters are calculated as the number of months in which a patient has at least one encounter, regardless of the number of days or quantity of services received. Monthly PPS is similar to per-member-per-month capitated payment, except that clinics do not receive payment in a month in which a patient did not access services. Under the monthly PPS option, states define “special populations” of patients based on level of complexity or need and set different rates for the general population and each special population. States must implement quality bonus payments based on state-defined metrics and include a process for addressing outlier costs.

Implications for states and providers

The monthly PPS option combines upside opportunity and downside risk for providers, making it ideal for states wishing to incorporate both approaches into their VBP efforts. Among the implications of this model:

- **Providers experience substantially more downside risk than in a daily PPS model.** Because rates are set based on anticipated monthly client volume, clinics experience a financial loss if

costs or intensity of services during a month exceed targets—for example, if a patient experiences a crisis due to a poorly controlled condition.

- **Clinics are incentivized to provide care efficiently while in alignment with the patient’s treatment plan.** To effectively manage the financial risk associated with fixed monthly payments, clinics have an incentive to meet the goals and scope of the required patient-centered treatment plan as efficiently as possible. CCBHCs apply population health management approaches including risk stratification and utilization management to ensure each client receives the appropriate level of care.
- **States pay a rate aligned with the level of need for each population served.** Rather than paying a fixed rate for all patients, including those with minimal needs, states specify targeted subpopulations with higher rates reflective of their higher complexity, while paying a lower rate for the general population. States do not pay in a month when a client does not receive services.
- **States can use differentiated rates to target services to specific difficult-to-serve populations.** The stratified rate structure allows states to create higher rates for subpopulations with higher costs, incentivizing clinics to target care to those groups and resulting in decreased utilization elsewhere in the system.
- **The monthly PPS includes pay-for-performance.** State Medicaid agencies can select specific quality measures to incentivize with bonus payments.

Monthly PPS: the Oklahoma Example

Oklahoma is grappling with high costs attributable to Medicaid patients with complex needs who frequently receive care in hospitals and emergency departments (ED). In its CCBHC State Plan Amendment approved in 2019, Oklahoma established a monthly PPS with two rates: one for the general population and one for a targeted group of individuals identified by the state Medicaid agency as being particularly high utilizers of inpatient and ED services. Some of these individuals have previously received mental health or addiction services, but most are not engaged in care.

Each CCBHC was given a list of the targeted group residing within its region. Monthly rates were set at a level that assumed specified benchmarks for engaging these patients in services, meaning clinics will experience downside risk if they fail to bring enough patients into care. This incentivizes CCBHCs to conduct assertive outreach and engage the targeted population to reduce their reliance on higher-cost services. Oklahoma plans to issue quality bonus payments to CCBHCs that exceed state-specified performance metrics regarding quality of care.
