NATIONAL COUNCIL *for* Mental Wellbeing

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS:

An Alternative Payment Model for Comprehensive Care Delivery

Certified Community Behavioral Health Clinics (CCBHCs) represent an important new service delivery and payment model for behavioral health services that combine several alternative payment model (APM) methodologies and operational requirements. CCBHCs align with federal, state and payer priorities to improve health outcomes and patient experiences of care while reducing overall health care costs.

APM payment methodologies in the CCBHC requirements include[i]:

1. BUNDLED PAYMENT FOR ONE OR MORE CONDITION-SPECIFIC POPULATIONS.

Bundled payment, sometimes referred to as episode-based payment, is a single payment for all services related to a clinical episode of care for the patient. Clinics work with states to determine an actuarily-sound, Medicaid rate that covers projected costs, comparable to the methodology used to reimburse health plans in the Medicaid program. Payments are then made under a fixed daily rate (PPS-1) or a monthly rate (PPS-2). States can also offer a quality bonus payment tied to the selected measures, or additional measures proposed by the state and approved by the Centers for Medicare and Medicaid Services (CMS); states have option to include quality bonus payments under the PPS-1 methodology, and are required to establish them for the monthly, PPS-2 rate.

Unlike traditional fee-for-service, bundled payments for CCBHC services are a fixed payment for all services provided to a Medicaid beneficiary, regardless of the intensity of the services delivered that day or month. The payment methodology for the monthly PPS-2 option allows states to develop rates that vary according to patients' clinical conditions, but it is pre-determined rather than based on the volume or types of services delivered that month (provided there is at least one encounter).

To effectively manage the financial risk associated with fixed, bundled PPS payments, while still effectively managing care and achieving positive health outcomes, CCBHCs apply population health management approaches including risk stratification and utilization management to ensure each client receives the appropriate level of care.

2. REQUIRED REPORTING ON QUALITY MEASURES.

CCBHCs in the demonstration project are required to report on 9 quality measures, with states reporting on an additional 12. CCBHCs use continuous quality improvement strategies to gauge improvements in patients' health and identify opportunities to refine services to have the greatest impact. The CCBHC measure set is unique in behavioral health for several reasons. First, a nationally employed measure set defined by SAMHSA, it supports consistent measurement across systems, communities and states for service provided across the life span. Second, a blend of behavioral health and physical health measures, the CCBHC measure set supports the management of whole person care, rather than a singular focus on only one aspect of the body that bifurcates care. Finally, it includes measures that can be used at both the provider and systems levels, allowing for effective management of patient care at the site of delivery, as well as supporting payer- and regulatory-level oversight of the CCBHC system of care.

3. PAY FOR PERFORMANCE.

CCBHC quality measures help states, the public and the clinic itself assess treatment and document performance. State Medicaid agencies are able to select specific measures to incentivize with bonus payments. Certified organizations are incentivized to improve health outcomes, control costs and increase access to care in community-based behavioral health settings so clients avail themselves of preventive and lower cost services rather than seeking care in more costly settings such as emergency departments.

Payment reform is necessary, but not sufficient on its own, for transforming the current volume-based health care system into a system that rewards providers for delivering value-based, person-centered care. Because delivery system improvements drive the production of value in the health care system, it is important to identify evidence-based best practices for delivery components that have been demonstrated to improve care. Empirical evidence on the effectiveness of specific delivery components and competencies is still emerging, but several compendiums of best practices and essential components are beginning to be understood.

Evidence-based components of high-value APMs that are a part of CCBHC requirements include:

1. Improved access to care.

Nearly one in five Americans over the age of 18 experienced a mental illness in 2017, yet 57.4 percent did not receive treatment.ii Many communities face a severe shortage of behavioral health providers, particularly psychiatrists and psychiatric nurse prescribers. Additionally, many people with behavioral health disorders have untreated physical health conditions, causing many people with mental illness and/or substance use disorders to die decades earlier than other Americans.

Through the combination of their required service array and the bundled payment model, CCBHCs have been able to narrow the gap in access to care in their communities. CCBHCs are required to offer expanded hours on evenings and weekends and have increased their capacity to provide critical services and treatment, including for people with opioid use disorders and other substance use disorders (SUD).

Evidence to date shows[iii]:

- 96 percent of CCBHCs surveyed reported that they increased the number of patients they treat for SUD, and of those, 17 percent of organizations increased the number of new patients by more than 50 percent.
- 68 percent of CCBHCs have decreased patient wait times and 52 percent are now able to offer same day access.
- 90 percent of CCBHCs work with patients to establish emergency plans to prevent future hospitalization.
- Also, by using patient-centered, flexible access design such as mobile, in-home, telehealth/telemedicine, and online treatment services (to the extent possible within the state Medicaid program and as allowed by state law), CCBHCs are working to ensure even more patients have access to all required services.

2. **Comprehensive care.**

   CCBHCs offer high quality behavioral health care with a defined set of comprehensive, evidence-based services, enabling them to stabilize people in crisis; provide rapid access to necessary treatment for individuals with mental health and/or substance use disorders; and emphasize recovery, wellness, trauma-informed care and physical health screening and coordination with primary care providers. CCBHCs also address social determinants of health by connecting patients with needed community resources and supports, and by offering expanded care coordination with health care and social service providers as well as law enforcement.

3. **Coordinated care and integration of behavioral health and primary care.**

   Care coordination is the linchpin of the model, requiring CCBHCs to ensure appropriate levels of care in the least costly setting, including collaboration with primary care.

4. **Financial benchmarking.**

   CCBHCs are required to submit standardize financial reports that are the basis for their rate setting. Clinics work with states to determine an actuarily-sound, enhanced Medicaid rate that covers projected costs, comparable to the methodology used to reimburse health plans in the Medicaid program. Standardized cost reporting in combination with standardized quality measure reporting allows detailed value benchmarking across different CCBHCs. CCBHCs promote increased financial transparency and ties payment to value.

CCBHCs are a proven solution for bringing behavioral health providers into alternative payment models that support efficient, effective, patient-centered, and value-based care delivery. Simultaneously establishing a new national standard for comprehensive behavioral health care while still affording state flexibility in community-based requirements and prioritized quality measures, CCBHCs improve access, improve quality and manage costs in the health care system, keeping vulnerable populations in the community, rather than in the hospital.

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[i] The Health Care Payment Learning & Action Network. "Alternative Payment Model (APM) Framework Refresh," (2018, August 7). Retrieved from https://hcp-lan.org/apm-refresh-white-paper/.

[ii] Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 National Survey on Drug Use and Health, Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 National Survey on Drug Use and Health, (2018). Retrieved from https://store.samhsa.gov/product/Key-Substance-Use-and-Mental-Health-Indicators-in-the-United-States-Results-from-the-2017-National-Survey-on-Drug-Use-and-Health/SMA18-5068.

[iii] Simon, M., Choudhry, N.K., Frankfort, J., Margolius, D., Murphy, J. Luis Paita, Wang, T., & Milstein, A. "Exploring Attributes of High-Value Primary Care." The Annals of Family Medicine 15, no. 6 (2017): 529–34. Retrieved from https://doi.org/10.1370/afm.2153.