NATIONAL COUNCIL for Mental Wellbeing

CCBHC Prospective Payment Cheat Sheet

CCBHCs in the Medicaid demonstration are paid using a prospective payment system, or PPS. PPS supports clinics' costs of expanding services and increasing the number of clients they serve, while improving clinics' flexibility to deliver client-centered care.

Typical Medicaid Payment	CCBHC PPS
•Typically, provider payment is determined by statewide fee schedules outlining a set rate for each particular unit of service. Historically, these rates have not been sufficient to cover mental health and substance use clinics' costs of delivering care. This leaves clinics scrambling to keep their doors open and limits their ability to invest in innovative approaches outside the fee-for-service structure.	•CCBHCs receive a single payment each day (or month) a client receives services, set at a level calculated to cover the clinic's anticipated costs of delivering care throughout the year. Each CCBHC has a unique payment rate based on its own care delivery and population served. The encounter-based rate structure allows flexibility in care delivery and supports innovative approaches aligned with clients' needs.

1. The aim of CCBHC PPS is not to simply pay clinics more for 'business as usual'—but to re-envision what we expect from community behavioral health care and enable this clinical transformation through effective financing.

- **The foundation of the CCBHC PPS is a new standard of care that raises the bar for service delivery.** CCBHCs are expected to be a one-stop shop for comprehensive, evidence-based mental health and substance use care, coordinated and integrated with primary care, hospitals, and other partners. They must provide access to care at times and places convenient to those served, including by delivering services outside the four walls of the clinic and meeting timeliness of access standards. CCBHCs are required to conduct client- and family-centered support activities that are not billable under typical payment systems—but which are critical to addressing clients' whole spectrum of needs. They must reach out into communities to engage with vulnerable or high-risk individuals and bring them into care. They are held accountable through state and national quality reporting standards.

2. To meet CCBHC criteria, participating clinics have had to add services, hire new providers, expand caseloads, reduce wait times, update technology systems, implement new partnerships, and make other improvements to the quality and scope of available care. The CCBHC PPS provides crucial funding to enable these service transformations.

- **CCBHCs' PPS rates are calculated to support the reasonable costs of these activities.** Clinics work with states to calculate their anticipated yearly costs of the expanded services and increased caseloads they will take on as a CCBHC—including costs not associated with direct services, such as care coordination, quality monitoring, and more. This total is used to calculate an average per-visit Medicaid payment rate, with visits defined as either a day or a month in which a client receives at least one service from a CCBHC. The payment rate does not vary based on number or intensity of services provided during the visit. There is no recoupment of costs for clinics at the end of the year, meaning those that do not efficiently manage service delivery may not see their costs covered.

3. CCBHC PPS removes the financial constraints that limit care availability under the typical payment models - improving clients' access to care that meets their whole needs and offering opportunities for states to better align payment with desired outcomes.

Traditional Medicaid Fee-for-Service (FFS)	CCBHC PPS
Availability of services is driven by financial incentives and constraints within the fee schedule rather than client needs. Direct services with lower margins (e.g., psychiatry) are more challenging for clinics to offer than services with higher margins (e.g., case management), resulting in a lack of access to these types of care.	Availability of services is driven by clients' and communities' needs. Clinics conduct a community needs assessment to determine the appropriate staffing and volume of services for their client population, with the associated costs built into their Medicaid payment rate.
Services vary from community to community based on unique factors like staffing or access to grant funding. Grants are time-limited and may be available only for certain services or populations.	All CCBHCs comply with a core set of federal and state standards. Clients can expect the same set of comprehensive services at any CCBHC. Individual clinics may still leverage grants for supplemental activities, but all core CCBHC activities are supported through a sustainable payment rate and available to all clients.
Workforce shortages contribute to delayed access or lack of access to services, particularly in rural areas. Clinics struggle to offer adequate pay to recruit and retain staff.	State-certified CCBHCs report an average 16% increase in their workforce, largely the result of being able to cover the costs of increased provider pay through their PPS. While CCBHCs still feel the effects of the workforce shortage, they are better positioned to recruit and retain staff. 71% exceed the federal standards for timeliness of access to routine services.
There is typically limited to no financial support for non-billable activities that are critical to achieving client health outcomes (e.g., outreach, engagement, efforts to leverage data to identify high-risk clients and manage health across subpopulations).	The cost of essential non-billable activities—with the scope determined by the community needs assessment—are built into the payment rate.
There is typically limited to no financial support for technology, facilities, and other capital expenditures. Clinics generally lack the capital to adopt new technologies for client care (e.g., mobile apps) or integration with the rest of the health care system (e.g., EHR upgrades to participate in health information exchange).	Costs associated with technologies, facilities, and other Medicaid-allowable expenditures are built into the payment rate, allowing CCBHCs to leverage these resources to improve client care.

4. States have many levers of control over PPS costs, both in the first year of CCBHC certification and over time.

- **PPS is not a 'blank check.'** In the first year of CCBHC implementation, states review and approve the costs that clinics propose to build into their PPS rate, with the ability to benchmark clinics against one another and work with clinics to ensure efficiency. States can choose to implement quality bonus payments to reward their highest performers. They can also determine the frequency with which rates will be recalculated based on historical cost data, ensuring alignment between true costs and rates over time and removing incentives for CCBHCs to maximize the volume of services delivered on different days rather than combining services in the same day when appropriate. Clinics bear the risk of effectively managing service utilization and costs over the course of the year, with no recoupment option for costs that exceed payments. States have full authority over clinic certification and compliance monitoring, and can de-certify clinics that don't meet standards, removing their ability to receive PPS.