Certified Community Behavioral Health Clinics (CCBHCs):
Overview of the National Demonstration Program to Improve Community Behavioral Health Services

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Emily Jones (Office of the Assistant Secretary of Planning and Evaluation, HHS)

ILC Meeting #45
July 22, 2015
Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
Section 223 Demonstration:
Improving Community Behavioral Health Services in the Nation
Cynthia Kemp, SAMHSA
Mary Cieslicki, CMS
Emily Jones, ASPE

Presentation to UCLA ISAP Integration Learning Collaborative
July 22, 2015
Section 223 Demonstration

- Protecting Access to Medicare Act of 2014 (H.R. 4302)
- **Section 223 Demonstration:** Improve the behavioral health of our citizens by expanding community-based mental health and substance use disorder treatment that further integrates behavioral health with physical health care, increases the use of evidence-based practices on a more consistent basis, and improves access and availability of high quality care. The statute ensures that those services are paid for Medicaid beneficiaries through a Prospective Payment System or PPS and that the Demonstration is evaluated.
Section 223 Requirements

• Six key pieces of the legislation include:

1. Establish demonstration program criteria,
2. Develop prospective payment system and pay the states participating
3. Award planning grants to states,
4. Select 8 states to participate in a demonstration program, and
5. Evaluate the Demonstration
6. Submit annual reports to Congress.
Two Main Demonstration Phases

• Planning Grant Phase – October 2015 to October 2016 (RFA is out Now)

• Demonstration Phase – January 2017 to January 2019.
Roles of Federal Partners

• **SAMHSA**
  – Developing the criteria
  – Awarding the planning grants
  – Producing annual reports

• **CMS**
  – Developing the prospective payment system and monitor payments.

• **ASPE**
  – Identifying quality measures
  – Evaluating the program.

Coordination with other HHS agencies
Demonstration 223 Funding

• **$2 million** in FY 2014 for criteria, annual reports, PPS guidance

• **$24+ million** in FY 2016 for planning grants to states

• **Federal funding for Medicaid payments** for behavioral health services provided by CCBHCs
Demonstration 223 Timeline

• **May 20, 2015**: RFA released for the planning grants to the states. RFA includes the Criteria and the PPS

• **June 8 and 10, 2015**: Pre-Application Webinars held

• **August 5, 2015**: Planning Grant Applications due from States

• **October 2015**: Award Planning Grants to the States

• **October 2016**: Proposals are due to participate in Demonstration

• **January 2017**: Select 8 states to participate in a 2-year demonstration.

• **January 2018**: Begin submitting annual reports to Congress.

• **December 31, 2021**: Submit final report with recommendations.

***Ahead of the Statute timeline***
Certified Community Behavioral Health Centers (CCBHCs)

CCBHCs provide care that is:

• Community-based
• Integrated
• Evidence-based
• Person- and family-centered
• Recovery-oriented
• Trauma-focused
• Culturally and linguistically competent
Criteria Development

• **Staffing**: Diverse, accredited, culturally competent

• **Available, Accessibility of Services**: 24/7 crisis services; sliding fees; everyone served, regardless of ability to pay

• **Care coordination**:
  – Across the full spectrum of health services
  – With FQHCs, inpatient psychiatric and substance abuse detox, other community providers, Department of Veterans Affairs facilities, acute care hospitals and outpatient clinics
Criteria Development (continued)

- **Scope of Services**: There are 9 service areas that include:
  - Crisis services (e.g., mobile crisis teams, crisis stabilization)
  - Screening and assessment
  - Patient-centered treatment planning
  - Outpatient mental health and substance abuse
  - Primary care screening and monitoring
  - Targeted case management
  - Psychiatric rehabilitation
  - Peer support, counselor services and family support
  - Mental health care for service members and veterans
A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. All encounter data are submitted through the CCBHC and PPS payment is directed through the CCBHC. The CCBHC is clinically responsible for the services provided for CCBHC consumers by the DCO.
Scope of Services

CCBHCs directly provide services in green***

Additional required services are provided directly or through formal relationships with Designated Collaborating Organizations (DCOs)

Referrals (R) are to providers outside the CCBHC and DCOs

*** “unless there is an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services that dictates otherwise.”
Care Coordination and Scope of Services

- Inpatient Acute Care Hospitals, EDs, Hospital Outpatient Clinics, Urgent Care
- Primary Care, Federally-Qualified Health Centers, Rural Health Clinics
- Inpatient Psychiatric, Detoxification, Post-Detox Step-Down, Residential
- VA Medical Centers & Other Facilities
- Community/Regional Supports

DCO
Crisis Services
***
Screening, Assessment, Diagnosis & Risk Assessment
Outpatient Mental Health & Substance Use Services
Treatment Planning
Criteria Development (continued)

• Quality Reporting
  – Encounter data
  – Clinical outcomes data
  – Quality data

• Organizational Authority
  – Nonprofit
  – Local government behavioral health authority
  – Indian tribe or tribal organization
Further Information on Demonstration 223

- SAMHSA Website – Under “Grants”
- Cynthia Kemp - Demonstration 223 Lead
cynthia.kemp@samhsa.hhs.gov
- Dave Morrissette - 223 Planning Grant Government Project Officer
david.morrissette@samhsa.hhs.gov
(240) 276-1912
 Agenda

- PPS Background
- Summary of PPS Guidance
- FMAP for Demonstration Expenditures
CCBHC PPS Guidance

- The statute* requires the use of PPS to pay participating clinics for CCBHC services
- Provides guidance to states and clinics on the development of the PPS to be used for the 2-year demonstration
- Covers all services described in the criteria and delivered by:
  - CCBHCs
  - Qualified Satellite Facilities (established prior to April 1, 2014)
  - Designated Collaborating Organizations (DCOs)

* Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA)
CCBHC PPS Rate-Setting Methodology Options

• States will select one of two PPS rate methodologies
• Selected method to be applied demonstration-wide
• Selected method used to develop CCBHC-specific rates
1. Certified Clinic PPS (CC PPS-1)
   • Cost based, per clinic *daily* rate
   • *Optional* quality bonus payments (QBPs)

2. CC PPS Alternative (CC PPS-2)
   • Cost based, per clinic *monthly* rate
   • Different PPS rates for services to clinic users with certain conditions
   • Required inclusion of QBPs
   • Outlier payments
PPS Rate Update Factor

- For CC PPS-1 and CC PPS-2
  - Demonstration year (DY) 1 rates are created using cost and visit data from the planning grant year, updated by the Medicare Economic Index (MEI)
  - DY2 rates are updated by the MEI or by rebasing
<table>
<thead>
<tr>
<th>Rate Element</th>
<th>CC PPS-1</th>
<th>CC PPS-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base rate</td>
<td>Daily rate</td>
<td>Monthly rate</td>
</tr>
<tr>
<td>Payments for services provided to clinic users with certain conditions</td>
<td>NA</td>
<td>Separate monthly PPS rate to reimburse CCBHCs for the higher costs associated with providing all services necessary to meet the needs of special populations</td>
</tr>
<tr>
<td>Update factor for DY2</td>
<td>MEI or rebasing</td>
<td>MEI or rebasing</td>
</tr>
<tr>
<td>Outlier payments</td>
<td>NA</td>
<td>Reimbursement for portion of participant costs in excess of threshold</td>
</tr>
<tr>
<td>Quality bonus payment</td>
<td>Optional bonus payment for CCBHCs that meet quality measures</td>
<td>Bonus payment for CCBHCs that meet quality measures</td>
</tr>
</tbody>
</table>
• **Required Measures**
  o CCBHC must demonstrate achievement of all 6 required quality measures to receive a QBP

• **Additional Measures**
  o States can make QBP using additional measures specified by CMS after meeting goals of required set of measures

• **Proposed Measures**
  o CMS approval required for additional quality measures not specified in the PPS guidance
  o States must describe implementation of additional QBP in their application if it plans to include additional measures
# QBP Medicaid Adult and Core Set Measures

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Measure</th>
<th>Measure Steward</th>
<th>QBP Eligible Measures</th>
<th>Required QBP Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>FUH-AD</td>
<td>Follow-Up After Hospitalization for Mental Illness (adult age groups)</td>
<td>NCQA/HEDIS</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>FUH-CH</td>
<td>Follow-Up After Hospitalization for Mental Illness (child/adolescents)</td>
<td>NCQA/HEDIS</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>SAA-AD</td>
<td>Adherence to Antipsychotics for Individuals with Schizophrenia</td>
<td>NCQA/HEDIS</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>IET-AD</td>
<td>Initiation and Engagement of Alcohol &amp; Other Drug Dependence Treatment</td>
<td>NCQA/HEDIS</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>NQF-0104</td>
<td>Adult Major Depressive Disorder (MDD): Suicide Risk Assessment</td>
<td>AMA-PCPI</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>SRA-CH</td>
<td>Child and Adolescent MDD: Suicide Risk Assessment</td>
<td>AMA-PCPI</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>ADD-CH</td>
<td>Follow-Up Care for Children Prescribed ADHD Medication</td>
<td>NCQA/HEDIS</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>CDF-AD</td>
<td>Screening for Clinical Depression and Follow-Up Plan</td>
<td>CMS</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>AMM-AD</td>
<td>Antidepressant Medication Management</td>
<td>NCQA/HEDIS</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>PCR-AD</td>
<td>Plan All-Cause Readmission Rate</td>
<td>NCQA/HEDIS</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>NQF-0710</td>
<td>Depression Remission at Twelve Months-Adults</td>
<td>MPC</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

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1 CMS-developed acronyms, except NQF-0104 and NQF-0710. CH refers to measures in the 2015 Medicaid Child Core Set, AD refers to measures in the 2015 Medicaid Adult Core Set.

2 The measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities of the measure steward include updating the codes that are tied to technical specifications and adjusting measures as the clinical evidence changes. This list may change based on the current measurement landscape.

Abbreviations: AMA, American Medical Association; CMS, Centers for Medicare & Medicaid Services; HEDIS, Healthcare Effectiveness Data and Information Set; MPC, Measurement Policy Council; NCQA, National Committee for Quality Assurance; PCPI, Physician Consortium for Performance Improvement.
Quality Bonus Payments

- States have flexibility in determining the level of payment
- States must specify:
  1. Factors that trigger payment
  2. Methodology for making the payment
  3. Amount of payment
- QBP Technical Assistance is available to states in collecting, reporting, and using measures for the adult and child core sets of Medicaid/CHIP quality measures

Email: MACQualityTA@cms.hhs.gov
Managed Care Considerations

1. Identify PPS methodology state will use in its managed care delivery system
   • Must be same methodology demonstration-wide

2. Choose option for incorporating CCBHC rate into managed care payment methodology
   • Full incorporation of the PPS payment into the managed care capitation rate
   • Use a wraparound reconciliation process

3. Account for duplicate services and reduce duplicative payments from PIHP or PAHP and MCO
4. State must collect data for oversight of managed care contract. In state’s contract with managed care entity, include:
   • CCBHC data to be reported
   • Data collection period
   • Reporting requirements method
   • Entity responsible entity for data collection

5. Revise actuarial certification letters to ensure proper enhanced FMAP claims and attribute the actual portion of managed care rates to CCBHC services
FMAP for Demonstration Expenditures

• Enhanced FMAP equivalent to CHIP
• Enhanced FMAP plus 23% for services provided to beneficiaries in a Medicaid CHIP expansion program
• FMAP for newly eligible MA beneficiaries
• 100% FMAP for CCBHC services provided to American Indian and Alaskan Natives
CMS will be providing technical assistance to states and clinics on developing PPS rates via the following resources:

- CMS mailbox for PPS guidance-related questions: CCBHC-Demonstration@cms.hhs.gov
- CMS mailbox for QBP-related questions: MACQualityTA@cms.hhs.gov
- CMS PPS page: Section 223 Landing Page in Medicaid.gov
CCBHC Demo:
Program Evaluation Overview

HHS Office of the Assistant Secretary for Planning and Evaluation
CCBHC Demonstration Evaluation

* An independent national program evaluation will be conducted

* The HHS Office of the Assistant Secretary for Planning and Evaluation will oversee the evaluation contract, in partnership with SAMHSA and CMS

* The evaluation contract will run for five years, from Fall 2016 through Fall 2021
Evaluation activities will be used to generate annual Reports to Congress, as required by the Protecting Access to Medicare Act of 2014.

Reports will start a year after the demonstration is launched.

A final report is due by the end of 2021:

“...The Secretary shall submit to Congress recommendations concerning whether the demonstration programs under this section should be continued, expanded, modified, or terminated…”
Focus Areas for the Evaluation

The evaluation will examine the impact of the demonstration on:

- Access to community-based behavioral health services
- The quality and scope of services provided by CCBHCs
- Federal and State costs for a range of services including inpatient, emergency, and ambulatory services
Potential Data Sources: CCBHC Patients + Comparison Group

* Medicaid claims and managed care encounter data
* CCBHC quality measures in the clinic certification criteria: reported by CCBHCs and states
* Cost reports
* Data reported from State Behavioral Health Authorities to SAMHSA for MH Block Grants
* Qualitative data collected from interviews with state officials and CCBHC staff, providers, and leadership
Planning Grant Activities

- Planning grant funding will be used to build performance measurement infrastructure
  - Evaluation activities leverage extant data sources to minimize burden on states
- During the planning grant phase, states will assist the evaluation planning team with selecting appropriate comparison groups
For more information on the ILC…

Meeting Summaries

Archived Recordings
http://vimeo.com/channels/ilcintegration

Mailing List
http://lists.ucla.edu/cgi-bin/mailman/listinfo/ilc

E-mail cteruya@ucla.edu with additional questions!