



Certified Community Behavioral Health Clinics Demonstration Program

Report to Congress, 2017

SAMHSA
Substance Abuse and Mental Health



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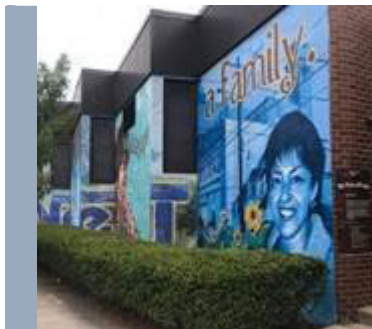
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NorthEast Treatment (NET) Center facility, a CCBHC in Pennsylvania

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EXECUTIVE SUMMARY

Millions of Americans and thousands of communities in the United States are affected by mental illness and substance use disorders. It is estimated that more than 10 million adults 18 and older had a serious mental illness (SMI) in the past year, more than 17 million adults misused prescription drugs in the past year, and about 20 million adults had an illicit drug or alcohol use disorder in the past year (SAMHSA, Center for Behavioral Health Statistics and Quality, September 2017). While effective treatment and supportive services exist, too few individuals with behavioral health conditions receive the help they need.

Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014 (Public Law 113-93) authorizes demonstration programs in up to eight states to improve community behavioral health services by establishing and evaluating certified community behavioral health clinics (CCBHCs). It is expected that the emphasis on quality of services will manifest in the following ways:



Syracuse Behavioral Healthcare in Syracuse, New York—one of six CCBHCs serving upstate New York

- **Service recipients will receive whole-person care, avoiding disjointed, duplicative services and services with potentially poor outcomes.**
 - Care coordination is the linchpin of the CCBHC model of integrating physical and behavioral health to serve the whole person. Constant and consistent communication among providers is the hallmark of care coordination.
- **Service recipients will have better access to services when they need them and where they need them.**
 - Individuals will have immediate and timely access to treatment through a single point of entry. Furthermore, CCBHCs cannot refuse services due to an individual’s place of residence or inability to pay. CCBHC service recipients include individuals who are eligible under Medicaid fee-for-service, managed care, and dually eligible programs. Section 223 calls for crisis management services that are available and accessible 24 hours a day.
- **Service recipients will choose from a comprehensive range of high-quality services.**
 - CCBHCs are required to provide substance use treatment and mental health services across the lifespan, either directly or through formal relationships with other high-quality providers known as designated collaborating organizations (DCOs).

-
- Emphasis is placed on quality and positive outcomes. As a condition of participating in the demonstration program, services must incorporate a minimum set of evidence-based practices (EBPs) established by states and based on community needs. Some states also recommended additional EBPs that their CCBHCs had the option to implement.
 - **Providers will receive payments that reimburse the expected cost of demonstration services.**
 - The services and supports noted above are paid using a Prospective Payment System (PPS) that is a clinic-specific encounter rate paid daily or monthly. The rate is intended to reimburse CCBHCs their expected cost of care. The Centers for Medicare & Medicaid Services (CMS) provided technical assistance to states on how to determine the PPS rates.

This report discusses these points in relation to the impetus of the demonstration program, its authorization, and its implementation. It provides a profile of the eight states awarded demonstration grants and spotlights participation in the demonstration program as the culmination of states' efforts to transform their behavioral health systems.

INTRODUCTION

The [Protecting Access to Medicare Act \(PAMA\) of 2014](#) (Public Law 113-93) authorizes the creation and evaluation of demonstration programs to improve behavioral health services¹ through certified community behavioral health clinics (CCBHCs).

CCBHCs provide a comprehensive range of services directly or through referral to designated collaborating organizations (DCOs) (see Figure A on page 3). The eight states conducting demonstration programs certified providers as CCBHCs based on their capacity to meet criteria authorized by Section 223. CCBHCs are expected to provide coordinated care using designated evidence-based practices (EBPs).

Certified clinics receive Medicaid payment through a daily or monthly Prospective Payment System (PPS) rate that is clinic-specific and reimburses the expected cost of demonstration services. Clinics must serve all clinic users, not just Medicaid beneficiaries, and cannot refuse services due to an individual's place of residence or ability to pay. The statute specifies that clinics must accept payment on a sliding fee scale basis (PAMA of 2014 Section 223, (a)(2)(B)).

This report focuses on the statutory requirements of Section 223, its implementation, the planning grant that helped states prepare, and the selection of the states to participate in demonstration programs, including activities associated with launching the demonstration programs. Because states launched their CCBHCs in mid-2017, more data will be included in future annual reports.

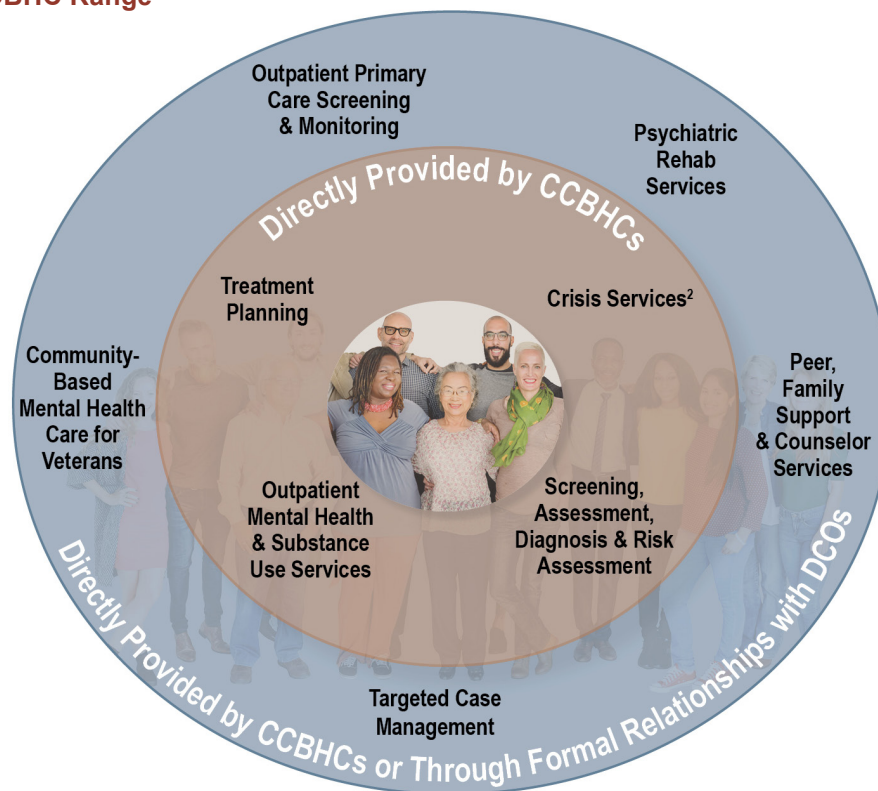
¹ Except in cases of direct quotes from other sources, the term "behavioral health" is used to inclusively refer to mental disorders, substance misuse, and co-occurring mental and substance use disorders.

Subsequent annual reports will include an analysis of available data demonstrating the impact of CCBHCs on the delivery of behavioral health care in the demonstration states. As required by statute, the reports will detail use of funds provided under Section 223, as well as an assessment of the following:

- access to community-based mental health services under the Medicaid program in the area or areas of a state targeted by a demonstration program compared to other areas of the state,
- quality and scope of services provided by CCBHCs compared to community-based mental health services provided in states not participating in a demonstration program and in areas of a demonstration state that are not participating in the demonstration program, and
- impact of the demonstration programs on the federal and state costs of a full range of mental health services (including inpatient, emergency, and ambulatory services).

In addition to the four annual reports to Congress, a final report with recommendations for continuation, expansion, modification, or termination of demonstration projects under Section 223 will be submitted to Congress no later than December 2021.

FIGURE A: CCBHC Range of Services



²As further defined in [Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics](#) (SAMHSA, n.d., p. 37): “Unless there is an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services that dictates otherwise, the CCBHC will directly provide robust and timely crisis behavioral health services. Whether provided directly by the CCBHC or by a state-sanctioned alternative acting as a DCO, available services must include 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.”

BACKGROUND

Nationwide, it is estimated that more than 10 million adults 18 and older had a serious mental illness (SMI) in the past year, more than 17 million adults misused prescription drugs in the past year, and about 20 million adults had an illicit drug or alcohol use disorder in the past year (Substance Abuse and Mental Health Services Administration [SAMHSA], Center for Behavioral Health Statistics and Quality, September 2017). Although alarming, these numbers fail to convey the full scope of the problem. Costs associated with mental and substance use disorders run into the hundreds of billions.

- At \$201 billion, mental disorder costs far exceed spending on heart conditions (\$147 billion), trauma in the form of fractures and wounds (\$143 billion), and cancer (\$122 billion) (Roehrig, 2016).
- Another \$417 billion in health care, lost work productivity, and crime is attributed to substance use (National Institute on Drug Abuse, 2015).

Suicide is the second-leading cause of death among youth and young adults (ages 10–34).

(Centers for Disease Control and Prevention, 2014)

The prevalence of serious emotional disturbance (SED) among youth is less well known than SMI among adults, but the National Comorbidity Survey Adolescent Cohort found that approximately 18 percent of youth (ages 13–17) experience mental disorders with moderate or severe impairment in any area of living (SAMHSA, Center for Behavioral Health Statistics and Quality, June 2016). Youth with SED have higher risk of substance use (Wu et al., 2008; Center for Mental Health Services, 2014), as do adults with SMI. Adults with SMI are significantly more likely to engage in heavy marijuana use, heavy alcohol use, and smoking than the general population (Hartz et al., 2014).

Co-occurring disorders—the coexistence of both a mental disorder and substance use disorder—affect more than 8 million adults 18 or older in the U.S. (SAMHSA, Center for Behavioral Health Statistics and Quality, September 2017).

Nearly 12 million adults in this country misuse opioids annually (SAMHSA, Center for Behavioral Health Statistics and Quality, January 2017). A study on using an interim buprenorphine treatment regime with individuals awaiting comprehensive treatment in an area where demand for treatment is greater than supply noted reductions among participants in not only opioid use but also in symptoms of anxiety and depression (Bercaw, 2016). Of note, almost all states and the District of Columbia report higher medication-assisted treatment (MAT) need than capacity (Jones, Campopiano, Baldwin, & McCance-Katz, 2015). Need exceeding capacity is not unique to this epidemic.

\$78.5 BILLION

Estimated economic burden of the opioid crisis to the U.S.

(Florence, Zhou, Luo, & Xu, 2016)

WHAT IS CARE COORDINATION?

“Deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care. This means that the patient’s needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.”

(Agency for Healthcare Research and Quality, 2014)

Coordination of Care

In the early 2000s, the President’s New Freedom Commission on Mental Health (2002) described the fragmented mental health delivery system in this country. Numerous providers (e.g., government and private sector, hospitals, community clinics, private offices, schools, businesses) offered various services and supports (e.g., treatment, rehabilitation, housing, employment) using multiple sources of funding (e.g., Medicaid, Medicare, state or local agency, foundation, private insurance). Services and supports were described by the Commission as disconnected and insufficient for meeting the needs of those with mental and substance use disorders.

The demand for coordinated, integrated, cost-effective, and quality health care has been growing and is being incorporated into delivery and payment systems. The current focus on value-based purchasing demands that services provide a higher quality of care for individuals and result in better health for populations at lower costs.

Coordinated care must involve providers of physical and behavioral healthcare services. Physical and behavioral conditions often go hand in hand but are seldom diagnosed and treated simultaneously. For example, some type of mental disorder was the primary diagnosis for 61.7 million individuals visiting physicians’ offices in a single year (Hing, Rui, & Palso, 2013), but many go undetected or unaddressed due to lack of provider training about overlapping symptoms or time to manage multiple issues (Druss & Walker, 2011). Lack of provider training was also cited in a study that found substance use services sometimes less well integrated with primary care than mental health services (Urada, Teruya, Gelberg, & Rawson, 2014). Aside from workforce development, policy suggestions emanating from this study call for restructured billing and payment reform, which are important aims of Section 223.



CCBHC staff of Berks Counseling Center in Pennsylvania

Care coordination is the linchpin holding together primary aspects of the CCBHC model, which include integration of behavioral health with physical health care (SAMHSA, n.d.). This movement toward integrated care is a reversal of a late-twentieth century trajectory of addressing substance use separately from primary care. [*Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*](#) commented that this separation “created unintended and enduring impediments to the quality and range of care options,” including rising negativity toward those living with substance use disorders and less aggressive development of new medicine to treat substance use. In some cases, primary care providers who did not recognize substance misuse in their patients prescribed medicine for a medical condition that proved to be deadly (Health and Human Services [HHS] Office of the Surgeon General, 2016, p. 1-19–1-20).

Access and Availability of Care

More than half of adults with any mental illness and approximately one-third of adults with SMI did not receive treatment in the past year (SAMHSA, Center for Behavioral Health Statistics and Quality, September 2017). Similarly, fewer than half of teens with mental disorders receive any form of service, with youth of color receiving fewer specialty mental health services than white youth (Costello, He, Sampson, Kessler, & Merikangas, 2014). In 2016, 10 percent (2 million people) of the 21 million people age 12 or older who needed substance use treatment received treatment at a specialty facility in the past year, which means that almost 90 percent of them did not receive specialty treatment (SAMHSA, Center for Behavioral Health Statistics and Quality, September 2017).

Failure to access services when they are available may be partially attributable to long-standing public attitudes surrounding behavioral health. Approximately 9 percent of adults with a perceived need for mental disorder treatment or services and more than 12 percent of adults with a perceived need for substance use treatment reported not seeking services because it “might cause neighbors/community to have negative opinions.” Not knowing where to go for services was cited as a common reason for not receiving services for adults feeling a need for treatment for either mental health issues (26 percent) or substance use disorders (19 percent). Meanwhile, 11 percent of adults with a perceived unmet need for mental health services did not receive services because of confidentiality concerns. (SAMHSA, Center for Behavioral Health Statistics and Quality, September 2017). Co-locating services in a central location where patients receive multiple types of service, such as a CCBHC, may reduce patient concerns about inadvertently disclosing the nature of their visit.

“The CCBHC payment system is a historic development. Integrated payment models are essential to supporting expansion and sustainability of integrated treatment models.”

— Demonstration State Lead

“The change that has occurred as a result of being part of the CCBHC planning and demonstration program is remarkable. Our state was ripe for innovation, and the CCBHC initiative has been the conduit for the changes that were needed.”

— Demonstration State Lead

Quality of Care and Scope of Services

The U.S. Surgeon General echoed the call for “a cultural shift in how we think about addiction” while encouraging the use of evidence-based interventions (HHS Office of the Surgeon General, 2016, p. v) to increase scope of services and improve quality of care. In the years following deinstitutionalization and the rise in community care, various models of care emerged, some of which stood up to rigorous testing for effectiveness (Drake & Latimer, 2012).

The value of EBPs is well established, and states participating in the Section 223 demonstration program are expected to “ensure the continual integration of new evidence-based practices” (SAMHSA, n.d., p. 33). Instituting an EBP involves building support for change, revising policies and procedures, identifying funding issues, assessing training needs, and monitoring and evaluating implementation regularly, all of which can take a year or more (SAMHSA, 2009b; Drake & Latimer, 2012).

Consistent use of EBPs is one aspect of the drive to achieve excellence in behavioral health; another key aspect is breadth of services. On their journey to wellness, individuals with complex mental and substance use disorders require a comprehensive array of services and supports, such as crisis response, integrated health care, care coordination, and treatment. As required by statute, CCBHCs provide a continuum of coordinated services and supports, including rapid-response 24/7 crisis services in supportive settings, peer and family support, specific support for active and veteran military, targeted case management, clinical outpatient psychotherapeutic interventions, and timely screening and assessment of behavioral health and physical needs.

PART I: AUTHORIZATION OF SECTION 223

CCBHCs are the next step in the transformative effort states are pursuing to better meet the behavioral health, fiscal, and system needs of individuals, providers, and communities. The demonstration program authorized by Section 223 of PAMA offers states an opportunity to improve the quality, scope, and financing of community-based mental and substance use disorder supports and treatment. What distinguishes this program from other efforts to provide behavioral health services to Medicaid beneficiaries is its (1) emphasis on coordinated care across the full spectrum of high-quality and accessible behavioral and physical health care and (2) a restructured payment system allowing clinics to deliver high-quality services.

To implement Section 223, HHS was authorized to complete the following activities:

- By September 1, 2015, publish criteria that states would use to certify community behavioral health clinics for a 2-year demonstration program.
- By September 1, 2015, issue guidance to states on the development of a PPS for CCBHC services provided by certified clinics.
- By January 1, 2016, award planning grants to states for developing proposals to participate in demonstration programs.
- By September 1, 2017, select up to eight states to participate in 2-year demonstration programs.
- Pay states participating in demonstration programs federal matching funds equivalent to the standard used by the Children’s Health Insurance Program (CHIP) to pay for services provided to currently enrolled Medicaid beneficiaries.
- Evaluate the demonstration programs and prepare annual reports and a final report to Congress.

PENNSYLVANIA: ACHIEVING INTEGRATION

CCBHCs are the capstone of Pennsylvania’s behavioral health transformation efforts to focus on the whole person. Twenty years ago, Pennsylvania implemented [HealthChoices Behavioral Health](#) (HC-BH) to integrate mental health and substance use services in five counties. Ten years ago, the state announced that it had integrated the behavioral health system in all of its counties. Now, it is furthering the vision and goals of the HC-BH program through the CCBHC demonstration program’s emphasis on service integration with primary care.

“We are committed to getting individuals we serve the care they need,” says Dale K. Adair, M.D. and CCBHC Lead at Pennsylvania’s Office of Mental Health and Substance Abuse Services (OMHSAS). “Treating the whole person involves integrating behavioral and physical health care. The CCBHC demonstration program brings those two systems together.”

Passion for an integrated approach runs high throughout the state. When the opportunity to apply for a Section 223 planning grant was announced in 2015, state legislators wrote to the governor, formally expressing their desire for Pennsylvania to participate. During the planning year, hundreds

of stakeholders—community members, clinic representatives, consumers and their families, county representatives, managed care organizations (MCOs), and statewide groups—attended forums held in numerous locations. Pennsylvania also engaged a steering committee of 25 invited stakeholders representing consumers, families, youth, providers, counties, MCOs, and state entities representing veterans, substance use, child welfare, and corrections. Public meetings of the steering committee were regularly attended by 40 individuals. Stakeholders on the steering committee commented on the openness and transparency of the entire process, from planning to developing the application.

The demonstration program both harnesses this excitement and builds on other initiatives in Pennsylvania’s journey to integrated care, which includes the following:

- The [Serious Mental Illness \(SMI\) Innovations Project](#) piloted integrated healthcare services for adult Medicaid beneficiaries with SMI and co-occurring physical health conditions.
- Pennsylvania’s [Centers of Excellence](#), established to help people struggling with opioids, pursues the “explicit goal of integrating behavioral health and primary care” (Pennsylvania Department of Human Services, n.d.).
- Pennsylvania was one of six states to participate in CMS’ [Medicaid Innovation Accelerator Program – Substance Use Disorders High Intensity Learning Collaborative](#) to support integration of physical and mental health care.

Pennsylvania has laid the groundwork for several other aspects of the demonstration program by expanding the use of recovery-oriented services, initiating pay-for-performance programs, developing telemedicine payment policies, and promoting the Medicaid electronic health record incentive program.

Ellen DiDomenico, who assumed leadership of the demonstration program when it launched in July 2017, observes, “We have a robust system of services, typically falling within the top five states in terms of per capita spending on behavioral health issues. But there is always room for improvement to help more people more effectively. The CCBHC demonstration program provides an opportunity to make change and to show how the change makes a difference.”

The Pennsylvania team offers an innovative method for capturing this difference. It developed a “quality dashboard” for providers through which CCBHCs can upload process performance measures and receive near real-time feedback on their performance. Charts tracking data month to month are generated from the data elements of the dashboard. “We use dashboards in other OMHSAS work,” notes Adair, “so this is yet another example of the interconnectedness of our efforts to serve the whole person.”



A CCBHC in Pennsylvania

PART II: IMPLEMENTATION OF SECTION 223

Three HHS agencies partnered to ensure the success of the demonstration program: the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare & Medicaid Services (CMS), and the Office of the Assistant Secretary of Planning and Evaluation (ASPE). This section of the report describes combined efforts to implement Section 223 of [PAMA of 2014](#).

Established Criteria to Certify Community Behavioral Health Clinics

Over the past several decades, behavioral health centers adapted to the individual licensing laws within their states; funding priorities of state and local government; and requirements of commercial and government insurers, Medicare and Medicaid, CHIP, and managed care companies. As a result, community behavioral health centers are configured and operate differently in each state.

With this in mind, SAMHSA developed criteria for certifying community behavioral health clinics in compliance with the statutory requirements outlined under Section 223 of PAMA (a)2. They are based on a review of State Medicaid Plans, standards for federally qualified health centers (FQHCs) and Medicaid health homes, accreditation standards, and quality measures currently in use by states. Over a period of 5 months, SAMHSA gathered public input on the draft criteria through a national listening session, consultation with tribal leaders, written public comments, and solicitation for public response on its website. The [criteria](#) (Table 1 on page 11) were released as Appendix II to SAMHSA's [Planning Grants for Certified Community Behavioral Health Clinics \(CCBHCs Planning Grants\) Request for Applications \(RFA\)](#) in May 2015.



CPC Behavioral Healthcare, a CCBHC in New Jersey

TABLE 1: CCBHC CRITERIA AREAS

Staffing	Staff have diverse disciplinary backgrounds, have necessary state-required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population.
Availability & accessibility of services	The clinic provides 24-hour crisis management services, a sliding scale for payment, and does not reject or limit services by the patient's ability to pay or place of residence.
Care coordination	Coordinated care across settings and providers ensures seamless transitions for patients across the full spectrum of health services, including physical and behavioral health needs. The clinics maintain partnerships or formal contracts with the following: <ul style="list-style-type: none"> • FQHCs and rural health clinics (as applicable) • Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs • Schools, child welfare agencies, and juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, state-licensed and nationally accredited child-placing agencies for therapeutic foster care service, and other social and human services • U.S. Department of Veterans Affairs medical centers, independent outpatient clinics, and drop-in centers³ • Inpatient acute care hospitals and hospital outpatient clinics
Scope of services—delivered directly by CCBHCs only	<ul style="list-style-type: none"> • Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization⁴ • Screening, assessment, and diagnosis, including risk assessment • Patient-centered treatment planning or similar processes, including risk assessment and crisis planning • Outpatient mental health and substance use services
Scope of services—delivered directly by CCBHCs or through referral with DCOs	<ul style="list-style-type: none"> • 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 members and veterans located in rural areas
Quality and other reporting	The clinic reports encounter data, clinical outcomes data, quality data, and such other data as the Secretary requires.
Organizational authority	The clinic is a nonprofit or part of a local government behavioral health authority or operated under the authority of the Indian Health Service, an Indian tribe, or a tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act or an urban Indian organization pursuant to a grant or contract with the Indian Health Service.

³ In collaboration with SAMHSA, the U.S. Department of Veterans Affairs developed and distributed a template for coordination of care agreements with CCBHCs to their Veterans Integrated Service Networks.

⁴ As further defined in [Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics](#), “Unless there is an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services that dictates otherwise, the CCBHC will directly provide robust and timely crisis behavioral health services. Whether provided directly by the CCBHC or by a state-sanctioned alternative acting as a DCO, available services must include 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.”

Released Data and Reporting Requirements

Following extensive input from stakeholders, 21 quality measures were identified as required reporting elements under the demonstration program. To support state efforts to collect and submit the quality and other reporting criteria, the federal partners made available [Office of Management and Budget \(OMB\)-approved technical specifications and reporting templates for quality measures](#). The technical specifications provide states and other interested parties with detailed information regarding the calculation of the required quality measures, and the reporting template provides a standardized format for the reporting of the quality measures. To further support state efforts to plan for the collection and reporting of the quality measures, the federal partners have provided detailed technical assistance to states through a series of quality measurement webinars and individual responses to state queries.

Issued Guidance on the Development of a Prospective Payment System

As required under PAMA, Section 223, 2(b), CMS issued guidance for states to use in establishing PPS rates for payment of demonstration services. Under the PPS methodology, Medicaid payment is based on individual clinic's expected cost of care.

To support states in determining these clinic-specific rates, CMS provided extensive technical assistance through webinars, publicly posted questions and answers on Medicaid.gov, held calls with individual states, and responded to 1,100 detailed questions submitted to the CMS CCBHC PPS electronic mailbox. CMS also provided states the opportunity to use an OMB-approved [CCBHC Cost Report](#) and [CCBHC Cost Report Instructions](#) created expressly for this demonstration. Designed to allow providers to capture the expected cost of care as well as document current costs, the CCBHC Cost Report was finalized after obtaining public comment solicited through a notice in the Federal Register. States had the option of using this cost report or a state-developed reporting tool.

[Section 223 Demonstration Programs to Improve Community Mental Health Services Prospective Payment System \(PPS\) Guidance](#) was released as Appendix III to the CCBHCs Planning Grants RFA noted above. The guidance provided information on identifying, reporting, and allocating allowable costs for two CCBHC PPS methodology options:

- **Certified Clinic Prospective Payment System (CC PPS-1)** uses a daily PPS methodology, which means that CCBHCs receive a fixed daily, clinic-specific rate when at least one of the nine required demonstration services has been provided to a Medicaid beneficiary. The rate is intended to reimburse providers their expected cost of care.



Workgroup of staff members from CCBHCs and state offices in Minnesota

Under this methodology, a state may choose to offer a quality bonus payment (QBP). In order to receive a QBP, the CCBHC must demonstrate that it has achieved the required quality measures noted in Table 2 on page 13. The state can issue QBPs using additional measures but only after the certified clinic has met state-determined performance goals for the required set of bonus measures.

TABLE 2: ELIGIBLE MEASURES FOR QUALITY BONUS PAYMENTS	REQUIRED
Follow-up After Hospitalization for Mental Illness (adult age groups)	Yes
Follow-up After Hospitalization for Mental Illness (child/adolescents)	Yes
Adherence to Antipsychotics for Individuals with Schizophrenia	Yes
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Yes
Adult Major Depressive Disorder: Suicide Risk Assessment	Yes
Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Yes
Follow-up Care for Children Prescribed ADHD Medication	No
Screening for Clinical Depression and Follow-up Plan	No
Antidepressant Medication Management	No
Plan All-cause Readmission Rate	No
Depression Remission at 12 Months-Adults	No

- CC PPS Alternative (CC PPS-2)** uses a monthly PPS methodology that is paid when at least one of the nine demonstration services has been delivered during the month. The rate is intended to reimburse CCBHCs their expected cost of care. Under the CC PPS-2 methodology, each clinic will be assigned at least two monthly PPS rates: (1) a monthly PPS rate for demonstration services provided to clinic users who are not necessarily part of a higher need population, and (2) a monthly PPS rate to reimburse CCBHCs for the increased costs associated with providing services to higher need/special populations. Higher need populations that a state may identify include: adults with SMI, children with SED, those with long-term and serious substance misuse, and those with mental and substance use disorders. States have flexibility in defining the populations for which separate CC PPS-2 rates will be established. Under CC PPS-2, the state is required to incorporate a QBP and make a separate outlier payment for reimbursement of costs more than the state’s identified threshold.

A state may choose to update demonstration year (DY) 2 CCBHC PPS rates by rebasing with data obtained during DY1 or by trending DY1 rates using the Medicare Economic Index (MEI). The state must use either CC PPS-1 or CC PPS-2 for its entire demonstration program, and payment may be made fee-for-service or through managed care.

CMS funds a portion of a state’s Medicaid costs according to federal medical assistance percentages (FMAPs) calculated by HHS. This rate varies by state and by types of services. During the demonstration, participating states’ demonstration expenditures will be eligible for an “enhanced FMAP” (the percentage equivalent to the state’s rates for CHIP services) for covered services delivered to Medicaid beneficiaries by CCBHCs. To the extent CCBHC services are provided to newly eligible Medicaid beneficiaries enrolled in the New Adult Eligibility Group, expenditures will be matched at the applicable FMAP. Expenditures for services to American Indians and Alaska Natives furnished by CCBHCs that are Indian Health Service or tribal facilities are matched at 100 percent. Finally, for services provided to targeted low-income children in a CHIP Medicaid expansion program, expenditures are matched at the enhanced FMAP, including the 23 percent point increase in effect October 1, 2015, to September 30, 2019. CMS has provided states detailed guidance on how to report demonstration expenditures.

Awarded Grants to States to Plan for the Demonstration Program

In May 2015, SAMHSA announced the availability of funding to support states in certifying community behavioral health clinics, establishing PPS rates for Section 223 reimbursable services, soliciting stakeholder input, preparing to collect data for the evaluation, and preparing applications to participate in a 2-year demonstration program. Many states applied for planning grants and their applications were reviewed by a panel of subject matter experts external to the federal government. In October 2015, HHS awarded a total of \$22.9 million in planning grants to 24 states based on the strength of their applications (Figure B).

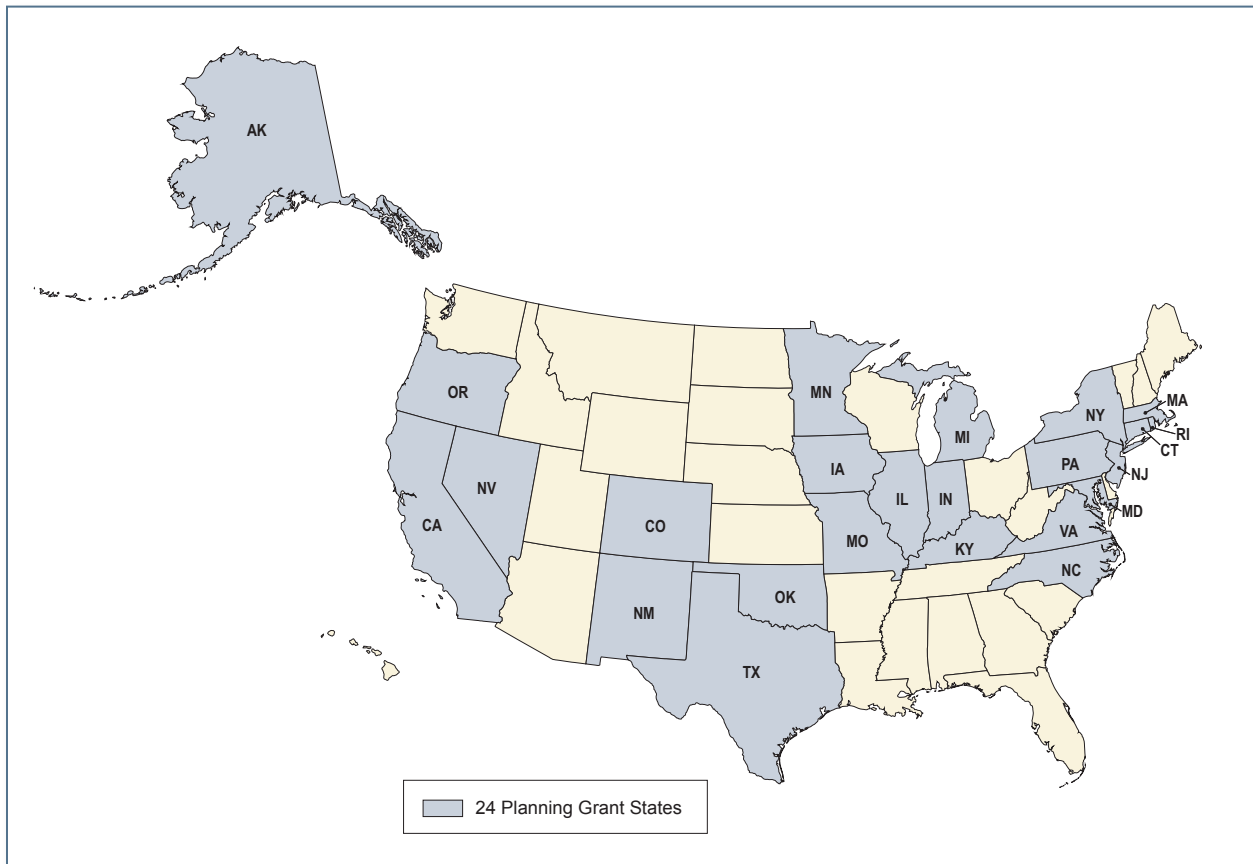


FIGURE B: States Awarded Planning Grants

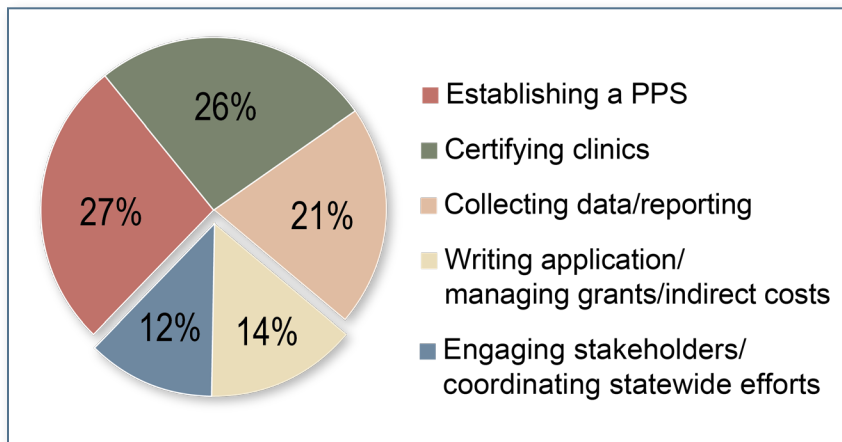


FIGURE C: Spending on CCBHC Planning Grant Activities

Figure C illustrates spending on activities as a proportion of total CCBHC planning grant spending for all 24 states. States spent most (27 percent) of their grant funding on hiring actuarial firms to establish the PPS and nearly the same (26 percent) on training staff and providing other support to clinics to prepare for certification.

The 24 planning grant states devoted 21 percent of their grant funds to data collection and reporting. This was primarily to enhance information technology (IT) capabilities for reporting on quality measures and other information required of the states participating in the demonstration. During the planning grant year, states were also required to electronically enter data on eight grant indicators. Results from that data reveal important accomplishments during the planning grant year, well before the CCBHC demonstration began.

Most of the planning grant states implemented behavioral health-related training programs during the planning grant year. Hundreds of organizations participated, increasing the number of credentialed or certified staff to provide mental and substance use disorder-related services to children and adults in community and mobile settings. Certifications/credentials were in the disciplines of psychiatry and psychiatric rehabilitation, social work, nursing, pharmacy, case management, and peer support.



Stakeholders participating in a round-table discussion of CCBHC work at a behavioral health integration event in Oregon

Twelve percent of planning grant funds were used to engage stakeholders and coordinate statewide efforts during the planning grant year. Notably, one-third of the members of the 24 states' workgroups and advisory groups were consumers or the family members of consumers.

During the 1-year planning period, HHS staff coordinated technical assistance to help states prepare for the demonstration program. Staff from ASPE, CMS, and SAMHSA delivered 34 webinars. One-third of the webinars were devoted to issues specific to PPS; another third to quality measures, data collection, and reporting; and the final third to certifying clinics. HHS staff also distributed 26 technical assistance briefs and instruments, hosted numerous cross-agency conference calls with states, and responded to more than 1,400 technical questions (combined across all three federal agencies) on a wide range of topics.

Prepared to Evaluate the Demonstration Program

With input from SAMHSA and CMS and reflecting comments received from stakeholders, ASPE developed plans to evaluate the demonstration program. As described in the *Analysis Plan for the Evaluation of the Certified Community Behavioral Health Clinic Demonstration* (Brown et al., 2017), the evaluation framework reflects structures and processes supporting intended outcomes of the demonstration (Figure D).

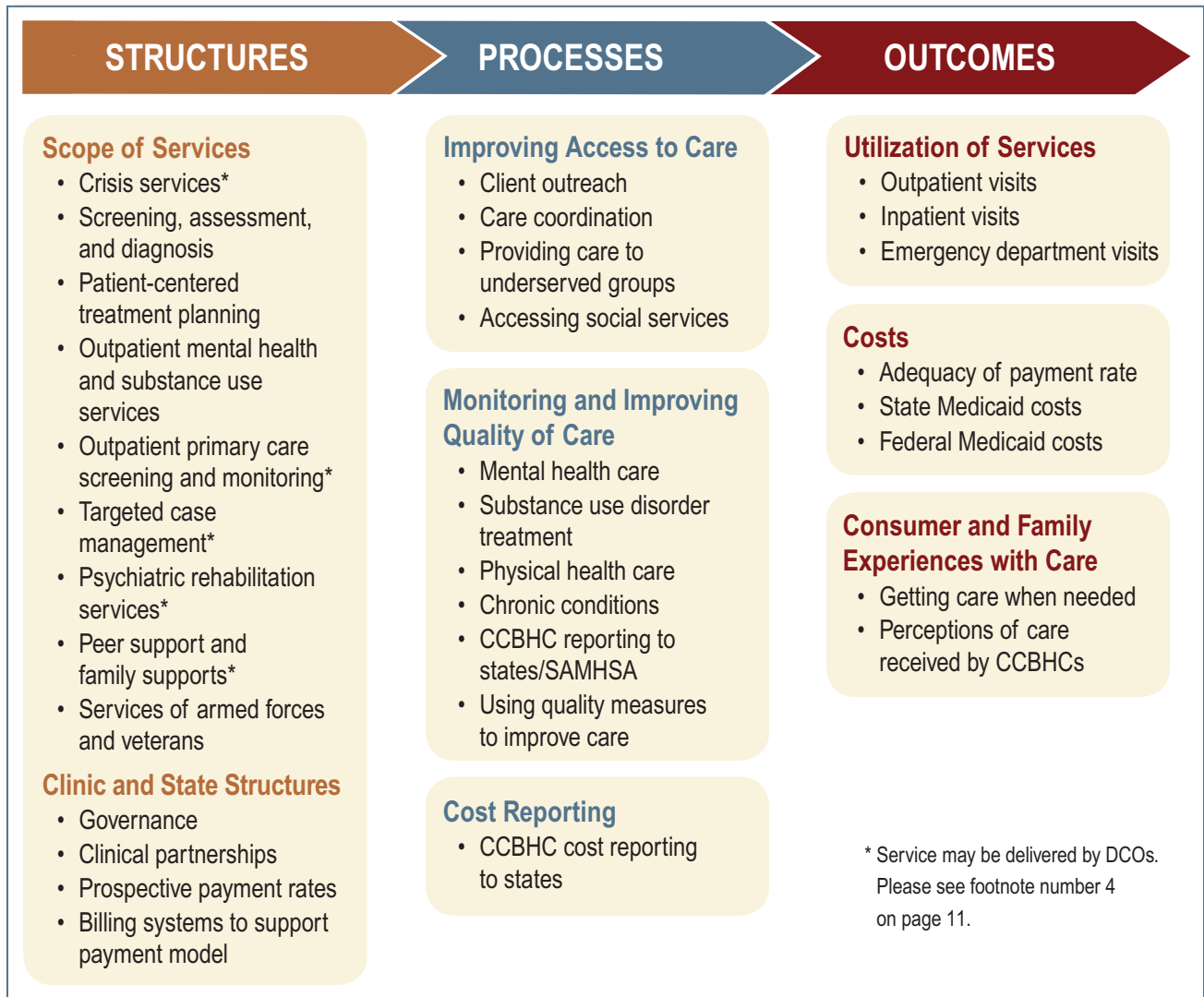


FIGURE D: Conceptual Model for CCBHC Demonstration Evaluation

The evaluation will respond to the following five overarching questions:

1. What activities do CCBHCs implement to improve access to care (including participation in assisted outpatient treatment)? How does access to care in the demonstration area(s) compare to access to care in other parts of the state?
2. How do CCBHCs implement the full scope of services and maintain the certification requirements throughout the demonstration? How does the scope of services provided to CCBHC service recipients compare with that provided to other populations and in other service settings?
3. What is the quality of care provided to CCBHC service recipients? How does the quality of care compare with that provided to other populations and in other service settings?
4. Do the PPS models cover the full cost of care for the CCBHCs? What changes do states make in their PPS rates over the course of the demonstration?
5. What is the impact of the demonstration on inpatient, emergency, and ambulatory service utilization rates and state and federal Medicaid costs relative to comparison groups?

To answer these questions, the evaluation team will conduct telephone interviews with state officials and representatives of service recipients and family organizations, as well as visit clinics in several states and review cost reports, CCBHC quality measures, and Medicaid fee-for-service claims and managed care encounters.



The Puerto Rican Organization to Motivate, Enlighten, and Serve Addicts, Inc. (Promesa) — a CCBHC serving downstate New York

Selected States to Participate in the Demonstration Program

Planning grant states were expected to apply to participate in the 2-year 223 demonstration program by October 31, 2016. In January 2016, HHS provided planning grantees guidance as they completed their applications. The guidance included specific criteria HHS would use to evaluate and score applications. At the end of the planning grant period, 19 of the 24 states submitted competitive applications to participate in the demonstration program.⁵

Applications consisted of three parts, as noted in Table 3.

Component	Contents
1: Required Attachments	<ul style="list-style-type: none"> • Verification that CCBHCs will be compliant with CCBHC criteria • Description of Medicaid populations to be served • List of participating CCBHCs and DCOs • Verification of state agreement to pay for services at the PPS rate • Description of the scope of services • Projection of unexpended funds and how they will be used
2: Program Narrative	<ul style="list-style-type: none"> • State's readiness to participate in the demonstration program • Solicitation of input by stakeholders in developing CCBHCs • Certification of clinics as CCBHCs • Development of enhanced data collection and reporting capacity • Participation in the national evaluation • Projection of the impact of participating in the demonstration program
3: PPS Methodology Description	<ul style="list-style-type: none"> • CCBHC PPS rate-setting methodology options • Payment to CCBHCs that are FQHCs, clinics, or tribal facilities • Cost reporting and documentation requirements • Managed care considerations • Funding question

⁵ Five of the original planning grant states did not pursue the demonstration phase of the grant, citing reasons of discrepancies between the CCHBC model and efforts currently underway in the state, too few personnel for an expanded service population, too little time for crisis services development, inadequate funding and time to establish and maintain the CCBHC model, infeasibility of integrating CCBHCs into managed care, and unanticipated staff turnover.

A team of 21 staff from SAMHSA, CMS, and ASPE with expertise in behavioral health service delivery, payment, and evaluation objectively reviewed the applications to participate in the demonstration program with respect to the criteria provided in the evaluation and scoring guidance. Reviewers assessed strengths and weaknesses of each application. The eight states with the highest scores were selected to participate in the demonstration program. A key consideration in the selection process was that participating states represented a diverse selection of geographic areas, including rural and underserved areas as required by statute. SAMHSA notified all applicants about the outcome and provided each applicant a document summarizing the application’s strengths and weaknesses. In December 2016, HHS announced the states selected to participate in the demonstration: Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania (Figure E).

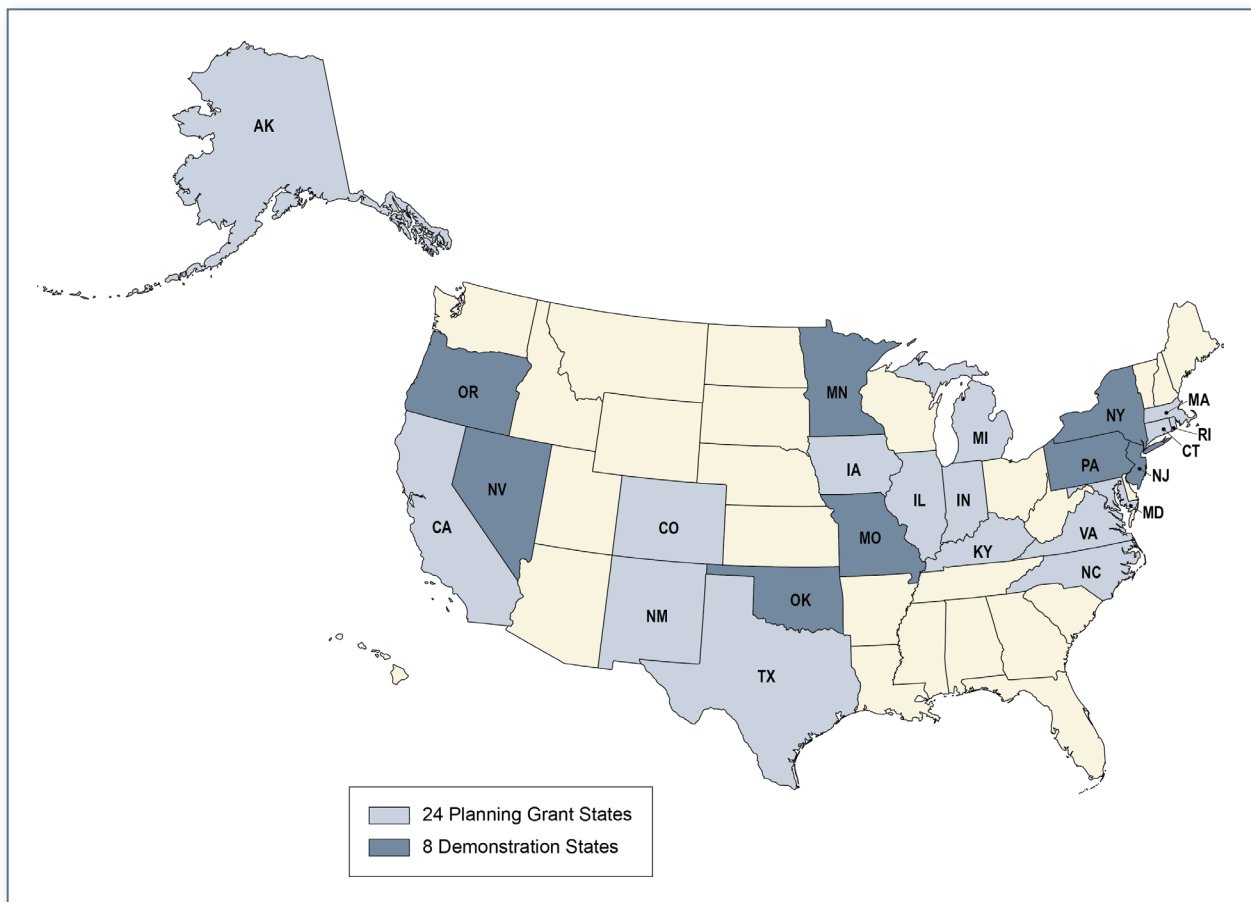


FIGURE E: States Selected to Participate in the Demonstration Program

OKLAHOMA: A DECADE-LONG QUEST

With a launch date 3 months earlier than most of the demonstration states, Oklahoma was one of two states to initiate CCBHC services on April 1, 2017. “Our clinics were eager and ready to go,” notes Jackie Shipp, CCBHC Project Director at the Oklahoma Department of Mental Health and Substance Abuse Services, “but remember, this has been a decade-long quest for us. We’ve been working at a system-wide level to change our operations *and* culture for years. Our successes and our lessons learned, combined with strong leadership, let us run with new initiatives.”

The implementation of health homes in January 2015 paved the way for Oklahoma’s participation in the CCBHC demonstration. Their CCBHCs are health homes that have now been implementing integrated care for over 2 years. The three Oklahoma CCBHCs together manage 19 service locations covering one-third of the state. Under the CMS-approved model for CCBHCs, they can receive bonus payments based on treatment outcomes. This change has promoted a “do whatever it takes” approach to improving treatment outcomes for clients and their families. CCBHCs will allow the state and its providers to take

this philosophy to the next level. Shipp stated, “We chose the payment methodology that pushes the hardest on providers to really change the business model.”

Two of Oklahoma’s community mental health centers now operating as CCBHCs—Grand Lake and NorthCare—are also recipients of SAMHSA Primary and Behavioral Health Care Integration Grants, which seek to improve the overall wellness of people with serious mental illness (SMI) through provision of primary care services in community behavioral health settings. To allow clients to easily connect with providers in times of crisis or to initiate therapy, the Grand Lake clinic distributes Health Insurance Portability and Accountability Act (HIPAA)-compliant tablet computers configured for that purpose



*North Care Adult Services in Oklahoma City—
one of three CCBHCs in Oklahoma*

only. Law enforcement agencies, juvenile detention facilities, and hospital emergency departments also receive the specially configured tablet computers to consult with Grand Lake staff.

Building on a long-standing tradition of training its clinical staff on trauma-focused cognitive behavioral therapy, Oklahoma included it as a required treatment practice to be available at all CCBHCs. Clinics are now required to screen for trauma among children *and* adults.

Providers’ commitment to change and excitement about the CCBHC demonstration program have strengthened in the months since its launch. Informal feedback from provider agencies reveals that staff are trained on new processes to ensure the paradigm shift and on the client report card as a tool for tracking consumer and agency progress. The report card provides key health indicators, including a toxicology/hematology lab test. If results indicate that medication regimes are either not effective or not being followed, changes can be implemented in a timely and responsive fashion.

Staff now feel empowered to provide people with what they need. Most importantly, consumer satisfaction of services is higher than ever. Shipp observes, “Consumers *and* staff have given us positive feedback since the CCBHC demonstration program began.”

PART III: THE DEMONSTRATION PROGRAM

This section of the report highlights the applications of the eight states awarded demonstration grants, as well as activities associated with the launch of the demonstration programs. For more information about the demonstration program in each state, see Appendix A: State Snapshots.

Anticipated Impact of Participation

In their demonstration applications, states were required to identify one or more impacts the program will have on their system, provider organizations, and individuals receiving services as related to the following goals listed in the statute (PAMA of 2014 Section 223, (d)(4)):

1. Provide the most complete scope of services to individuals eligible for medical assistance under the state Medicaid program.
2. Improve availability of, access to, and participation in services to individuals eligible for medical assistance under the state Medicaid program.
3. Improve availability of, access to, and participation in assisted outpatient mental health treatment in the state.
4. Demonstrate the potential to expand available mental health services in a demonstration area and increase the quality of such services without increasing net federal spending.

States were asked to project the impact of their participation in the demonstration program by listing specific measures to show impact, providing baseline data on these measures, explaining the data collection and analysis plan, and projecting the impact from baseline to the completion of the demonstration program. As depicted in Table 4, most of the demonstration states will show the impact of their participation on providing the most complete scope of services (Goal 1) and improving availability and access to services (Goal 2).

GOAL	STATE						
Goal 1: Complete Scope	Minnesota	Missouri	New Jersey	Oklahoma	Oregon	Pennsylvania	
Goal 2: Improve Access	Minnesota	Missouri	Nevada	New Jersey	Oklahoma	Oregon	Pennsylvania
Goal 3: Improve Access to AOT*	Missouri	Oklahoma					
Goal 4: Contain Costs	New York	Pennsylvania					

*Assisted Outpatient Treatment

Data and Reporting Requirements

In their applications to participate in the demonstration program, states were required to outline plans to collect and report data related to 21 required quality measures relevant to the CCBHC criteria. Twelve of the quality measures will be calculated by the states using claims and encounter data, and 9 of the quality measures will be collected and calculated by participating CCBHCs.

CCBHC Service Recipients Projected to be Served

All states awarded demonstration grants included adults with SMI, children with SED, and those with substance use disorders in their targeted Medicaid population for CCBHC services. Several states further specifically identified subpopulations to receive priority.

- People with opioid use disorders, individuals experiencing homelessness, and veterans are noted in several applications.
- Three of the eight demonstration states focus on the vulnerability of youth who are either in state custody, of transition age and at risk of or experiencing an initial onset of psychiatric illnesses and substance misuse, or involved with the juvenile justice system.
- States note the importance of serving individuals with comorbid health conditions by screening for multiple key health indicators, including obesity, diabetes, hypertension, and cardiovascular conditions in children and adults.

Based on statute, CCBHCs have a no-refusal policy, meaning that anyone who needs services cannot be refused service based on their inability to pay or place of residence.



Adolescent room at a Nevada CCBHC

The projected number of individuals expected to be served by CCBHCs in each state that received a demonstration grant is noted in Table 5.

TABLE 5: PROJECTED NUMBER OF INDIVIDUALS TO BE SERVED BY CCBHCS					
State	State Population (in millions)	CCBHCs	CCBHC Service Locations	DY1 – Total to Receive CCBHC Services (all pay sources)	DY1 – Projected CCBHC Consumers who are Medicaid Recipients*
Minnesota	5.52	6	22	17,600	15,000
Missouri	6.09	15	201	127,083	87,284
Nevada	2.94	4	5	7,305	5,844
New Jersey	8.94	7	20	79,782	50,882
New York	19.75	13	77	40,000	32,000
Oklahoma	3.92	3	19	23,076	11,077
Oregon	4.09	12	21	61,700	50,000
Pennsylvania	12.80	7	7	24,800	17,800
Total:	64.05	67	372	381,346	269,887

*These estimates may include dual-eligible Medicaid and Medicare recipients.



Bridge Counseling Associates in Las Vegas—one of four CCBHCs in Nevada

Diversity of Proposed CCBHCs and Service Areas

The total number of CCBHCs launched is 67, ranging from three to 15 per state. These numbers belie the true magnitude of service delivery, however, since CCBHC services are provided at 372 locations in 190 counties in the eight states (Figure F).

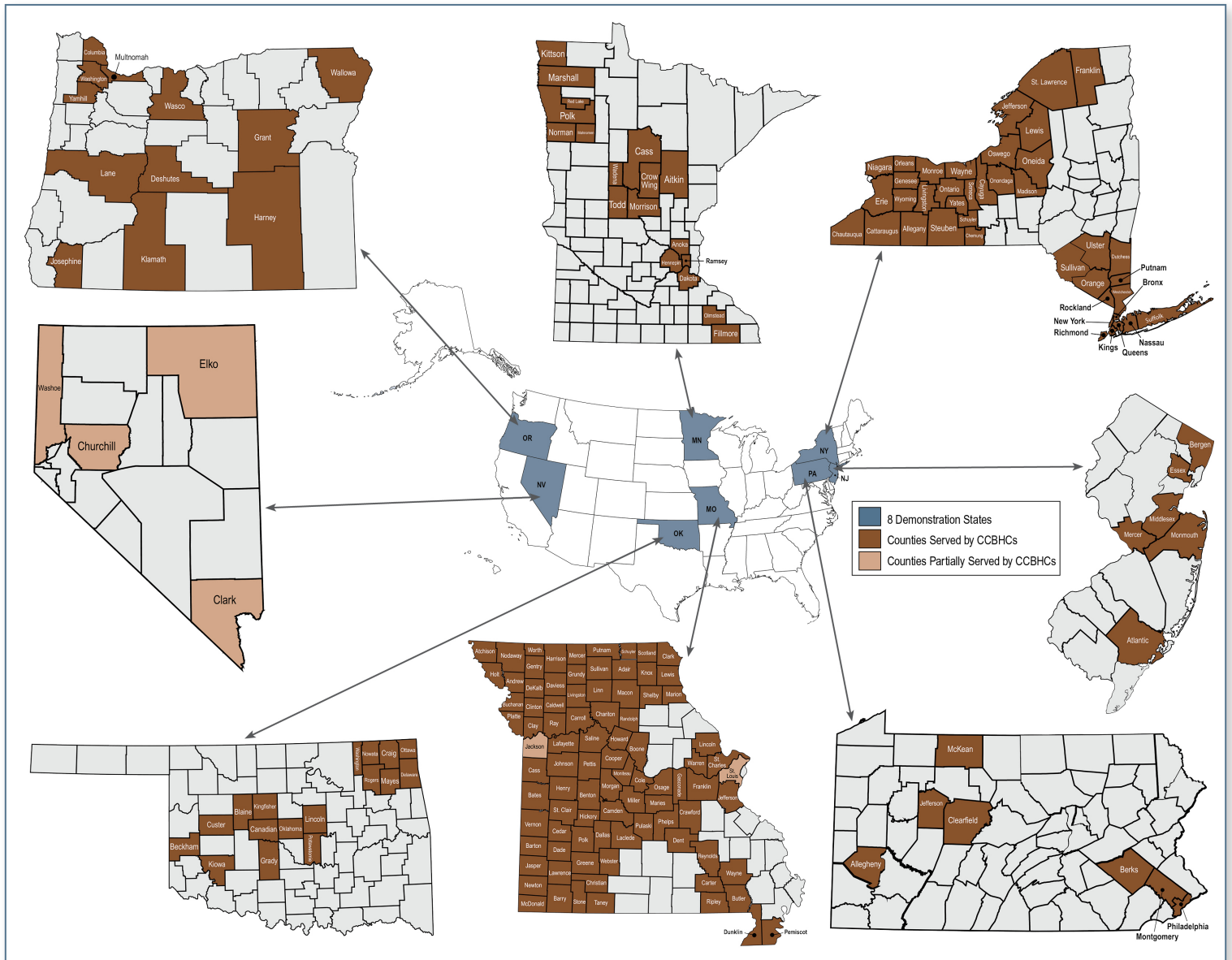


FIGURE F: Map of State Areas Covered by CCBHCs

The CCBHCs include nonprofit and government entities, and many of them are also qualified as health homes. Likewise, the number of DCOs engaged by CCBHCs varies across the states. Two states list eight DCOs, whereas another state has none. Table 6 lists CCBHCs by type and population density.

TABLE 6: CCBHC PROFILES BY DEMONSTRATION STATE

Demonstration State	Number of CCBHCs*	Population Density of Clinic Service Area			Organizational Structure		CCBHCs that are also certified as...		Number of DCOs in State (numbers may change)
		Urban	Urban/Rural	Rural/Frontier	Gov't-run	Nonprofit Organizations	Federally Qualified Health Centers	Health Homes	
Minnesota (CC PPS-1)	6	3	1	2	1	5	0	4	5
Missouri (CC PPS-1)	15	4	5	6	0	15	4	15	3
Nevada (CC PPS-1)	4	2	0	2	0	4	0	0	0
New Jersey (CC PPS-2)	7	6	1	0	1	6	0	5	8
New York (CC PPS-1)	13	6	6	1	0	13	0	0	4
Oklahoma (CC PPS-2)	3	1	1	1	0	3	0	3	2
Oregon (CC PPS-1)	12	4	5	3	3	9	0	0	5
Pennsylvania (CC PPS-1)	7	4	3	0	0	7	0	0	8
Total: 8	67	30	22	15	5	62	4	27	35

*Number in state as of launch date

The selected states included CCBHCs in areas designated by the Health Resources and Services Administration (HRSA) as a medically underserved area (MUA), medically underserved population (MUP), or mental health professional shortage area (MHPSA). Several states had far greater representation of geographic diversity than required. In addition to urban and rural areas, three states—Nevada, Oregon, and Minnesota—identified frontier areas that will be served by CCBHCs.⁶

- All CCBHCs in three of the funded states (Minnesota, New York, and Oklahoma) will provide services to counties designated as either MUA or MUP.
- In Missouri, 81 percent of the CCBHCs are associated with service areas designated as MUA, just under 60 percent of Oregon’s CCBHCs are in a MUA, and 50 percent of the counties where CCBHCs operate in New Jersey are in a MUA.
- All prospective CCBHCs in Nevada are in areas where the entire population lives in a MHPSA. Three of Pennsylvania’s CCBHCs are in MHPSAs.

⁶The U.S. Department of Agriculture’s Economic Research Service defines frontier as “territory characterized by some combination of low population size and high geographic remoteness.”

Withdrawal of Clinics

Originally, states proposed certifying 76 clinics by their respective launch dates. In the months between application and launch, a few clinics withdrew from participation for various reasons, including the following:

- A hospital-affiliated clinic concluded that it would receive lower reimbursement rates under a PPS than it currently receives through the hospital.
- A clinic with multiple service locations was unable to certify them all by the launch date.
- Two clinics experienced financial losses preventing them from risking involvement in a demonstration program.
- Several clinics were unable to institute IT systems sufficient for billing and data collection by the launch date.
- Several clinics were unable to provide services across the life span and to include both substance use and mental disorder treatment by the launch date.

Scope of Services

Requirement 4 of the *Criteria for the Demonstration Program* addresses the scope of services to be provided by CCBHCs, either directly or through referral to or formal partnerships with DCOs. Building on the common assumption that services will be delivered “in a person-centered and family-centered manner,” states conducted needs assessments of the communities to be served by prospective CCBHCs to identify cultural and linguistic needs, as well as the types of EBPs that will best meet the needs of their population of focus.

Under the criteria, EBPs that CCBHCs were required to deliver were to be determined by the state. The number of EBPs associated with treatment required by each state ranged from two to 18, averaging seven per state. In total, 47 different EBPs (31 associated with treatment and 16 associated with assessment) were required by the demonstration states; an additional 27 were made optional by the demonstration states. EBPs required or made optional by at least half of the demonstration states are described in Table 7.



A CCBHC in Trenton, Missouri

TABLE 7: EBPS MOST COMMONLY USED BY NUMBER OF DEMONSTRATION STATES

Evidence-based Practice (EBP)	# of States Requiring EBP	# of States with EBP Optional
Motivational interviewing helps clinicians engage people with mental and substance use disorders by expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy (SAMHSA-HRSA Center for Integrated Health Solutions, n.d. a).	8	0
Cognitive behavioral therapy teaches individuals in treatment how to recognize and stop negative patterns of thinking and behavior (SAMHSA, August 2016).	6	1
Trauma treatment that meets the needs of the population of focus includes the following: <ul style="list-style-type: none"> • Trauma-focused cognitive behavioral therapy integrates trauma interventions with cognitive, behavioral, interpersonal, and family therapy principles to treat posttraumatic stress and related emotional and behavioral problems. • Trauma-informed care teaches service providers and their organizations about the triggers and vulnerabilities of trauma survivors and effective interventions. 	5	2
Integrated treatment for co-occurring disorders addresses both mental illness and substance use, each in the context of the other disorder, through consumer-centered treatment planning (SAMHSA, October 2015).	4	0
Medication-assisted treatment combines behavioral therapy and medications to treat substance use, such as opioids (SAMHSA, November 2016).	4	0
Illness management and recovery incorporates strategies for avoiding illness, dealing with symptoms, and working with providers on growing beyond mental illness (SAMHSA, 2009a).	2	3
Assertive Community Treatment offers community-based treatment and support to individuals with SMI (SAMHSA, 2008).	1	3
Four states required or recommended EBPs on suicide and suicidality, including Collaborative Assessment and Management of Suicidality (assesses suicidal risk and manages “driver-oriented” treatment), Zero Suicide (relies on a system-wide approach to patient safety), and Cognitive Therapy for Suicide Prevention (teaches alternative ways of thinking during crises and helps build supportive networks).	3	1

PPS Methodology of Demonstration States

As noted above, two PPS rate methodologies were offered to applicants: the daily rate CC PPS-1 and the monthly rate CC PPS-2. All but two of the demonstration states chose CC PPS-1. Five of the six states pursuing CC PPS-1 are offering QBPs based on a variety of formulas, including the following:

- at least 1 percent of total PPS payments;
- approximately 3 percent of total PPS payments;
- 5 percent of total CCBHC payments;

- 3.84 percent of total PPS payments for CCBHC services, MCO payments for CCBHC services, and applicable wraparound payments; or
- 10 percent of annual PPS payments in DY1 and up to 15 percent in DY2.

In addition to meeting the required set of quality measures noted in Table 2, three of the CC PPS-1 demonstration states offering QBPs require other measures, such as adult major depressive disorder (suicide risk assessment), adherence to antipsychotics for individuals with schizophrenia, plan all-cause readmission rate, suicide attempts, and deaths by suicide.

The two states pursuing CC PPS-2 do not require additional quality measures. One of those states weighs *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* more heavily than the other required quality measures.

In their PPS methodology discussions, states also explained the source(s) of cost and visit data used to determine the rate for DY1 and how those rates would be updated in DY2. Half of the states (Minnesota, Missouri, New York, and Oregon) will update their rates per the MEI; the other half (Nevada, Pennsylvania, New Jersey, and Oklahoma) will rebase their PPS rates.

Another aspect of PPS methodology is how the PPS rate will be incorporated into managed care. With some exceptions,⁷ states selected the choice noted in Table 8.

TABLE 8: METHODS FOR INCORPORATING CC PPS RATES INTO MANAGED CARE CAPITATION	
Method	State
Require managed care plans to pay a rate to the CCBHCs that other providers would receive for similar services and then use a supplemental payment (wraparound) to ensure payment to CCBHCs is equal to the PPS.	Minnesota Nevada New York Oregon
Fully incorporate the PPS payment into the managed care capitation rate and require the managed care plans to pay the full PPS or its actuarial equivalent.	Missouri Pennsylvania

Launch of Demonstration Programs

Following the selection and announcement of the demonstration states in December 2016, states needed time to complete planning and begin implementing the demonstration program. For some states, that meant revising their fiscal year state Medicaid budget and obtaining legislative approval before launching the program. To align with the fiscal year calendar, HHS permitted states flexibility in selecting a start date of the demonstration program up to July 1, 2017. Oklahoma and Oregon launched their CCBHC programs statewide on April 1, and the remaining six states launched theirs on July 1, 2017. Activities associated with the launch are described in Appendix A.

⁷ Oklahoma indicated that it does not currently have managed care arrangements in its Medicaid program. New Jersey does not include behavioral health in most managed care contracts. Medicaid enrollees receiving behavioral health benefits through managed Long Term Services and Supports or the Division of Developmental Disabilities in New Jersey who do receive services through managed care represent less than 0.5 percent of Medicaid enrollees and were thereby excluded from the CCBHC demonstration.

FURTHER CONSIDERATIONS

The Section 223 demonstration program, slated to end by July 1, 2019, provides states with enhanced federal funding to support the provision of EBPs and a comprehensive package of services that are key to reducing the burden of care for Medicaid beneficiaries with SMI and substance use disorders. Moreover, enhanced funding supports improved quality of care through payment to providers for the achievement of quality measures. Carefully selected by a team of quality and behavioral health experts, the measures used for this demonstration quantify the improvement in quality. In turn, providers receive payment for better care, not just more care. There is good reason to be optimistic as the demonstration features a comprehensive and integrated array of evidence-based services, reimbursed through a PPS.

Community-Based, Whole-Person Care

The CCBHC demonstration program is a unique opportunity for participating states to provide coordinated community-based mental and substance use disorder services that treat the whole person, using a bundled payment methodology and applying EBPs on a consistent basis. Clinic users have access to a broad range of primary care and behavioral health services that are comprehensive and integrated.

Comprehensive

The uniquely broad range of services offered by CCBHCs—from 24-hour crisis services to treatment planning, from screening to psychiatric rehabilitation—helps ensure that individuals of all ages and at all points in their wellness journey receive the help they need. Comprehensive approaches such as this have proven effective. For example, participants of a comprehensive approach to first-episode psychosis that incorporates medication management, family psychoeducation, resilience-focused individual therapy, and supported employment and education were more likely to remain in treatment, have an improved quality of life, and be engaged in work and school than those receiving standard care (Kane et al., 2016). A system of care framework—one that offers “a comprehensive spectrum of mental health and other necessary services and supports organized into a coordinated network”—for children with SEDs has a demonstrated impact on multiple levels. Individually, children receiving these services experienced improvements in behavioral and emotional symptoms (e.g., aggression, rule-breaking, depression, anxiety), as well as in school attendance and academic performance (Center for Mental Health Services, 2014, p. 2). At the family level, caregiving became less burdensome. Community-wide, expenses associated with juvenile justice services, residential treatment, and hospitalization decreased.

Integrated

In the 1980s, studies of co-occurring mental and substance use disorders resulted in recommendations for integrated treatment that addressed both disorders (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998). After years of evolution, *integrated care* is now increasingly used to describe the coordination of mental health and substance use care with primary care, noted as “the most effective approach to caring for people with multiple healthcare needs” (SAMHSA–HRSA Center for Integrated Health Solutions, n.d. b).

- The American Hospital Association (2012) reported that adults receiving integrated care had 42 percent fewer visits to the emergency department. Integrated care reduced readmission rates to psychiatric hospitals from 17.7 percent to 10.4 percent. Patients with SMI who received integrated care instead of usual care were more likely to be screened for cholesterol, hypertension, and diabetes; to have their blood pressure tested; to have received a flu vaccine; to be educated about smoking, nutrition, and exercise; and to have their medications listed in their chart. Patients with depressive disorders who received collaborative care had better functional outcomes than those who received usual care.
- A long-term study of more than 100,000 adult patients who received care from team-based providers versus traditional practices revealed that team-based care resulted in higher rates of screening for depression, greater adherence to diabetes care protocols, and greater use of self-care plans. Patients receiving team-based care experienced fewer emergency room visits, hospital admissions, and primary care physician encounters (Reiss-Brennan et al., 2016).

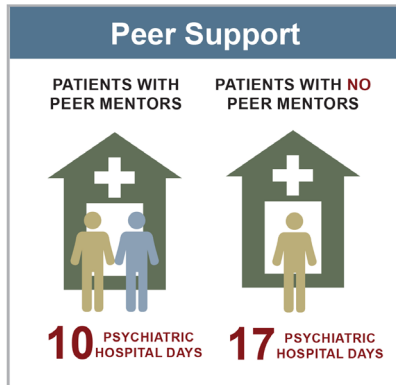
As noted in the *Criteria for the Demonstration Program*, CCBHCs seek to advance the integration of behavioral health and physical health care.

Value-based Purchasing

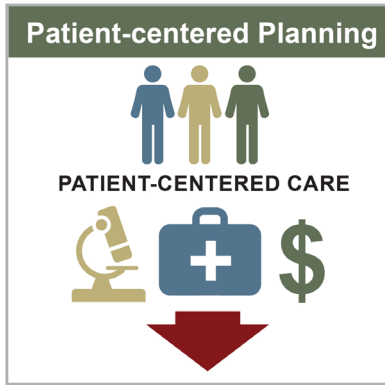
The eight states selected to participate in the Section 223 demonstration program are regarded as early adopters of an approach to behavioral health care that is made possible, in part, by a payment methodology long used in physical health care that promotes value over volume. Building on its initial use of PPS with hospitals in 1983, Medicare now applies PPS to a host of settings: acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities. Regardless of the setting, a PPS promotes equity by ensuring that providers are reimbursed according to the resources actually used in providing care. The PPS-2 also limits disincentives to provide care to more costly patients because these individuals are allocated more resources. Likewise, access to treatment may improve when incentives to turn away patients that may require more resources are removed. Quality is also promoted using QBP that incentivize appropriate treatment and limit disincentives to skimp on treatment.

Effective Practices

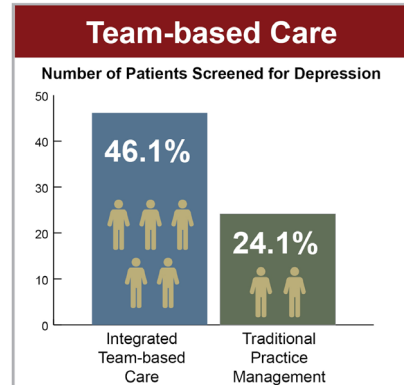
CCBHCs' scope of services draws on a history of what works. In an analysis of lessons learned from the evolution of community mental health care over the past 50 years, Drake and Latimer (2012) identify several "robust and durable concepts." These include *psychiatric rehabilitation* and *peer support*—both of which are incorporated in the CCBHC criteria. The authors list recovery as another lesson learned, singling out the role of choice and self-determination. These concepts are intrinsic to the patient-centered care in CCBHC criteria. *Team-based care* speaks to two CCBHC criteria areas: staffing and care coordination.



Patients with histories of recurring psychiatric hospitalizations who were assigned a recovery mentor with lived experience had fewer readmissions than those who were not assigned a mentor.



Patient-centered care resulted in decreased annual number of visits for specialty care, fewer laboratory and diagnostic tests, and reduced total medical charges and charges for specialty care clinic visits.



Team-based practices screened far more patients for depression than traditional practices, which facilitated early intervention.

EBPs do not go unmentioned in the list of lessons learned. In the mission to provide high-quality services, states participating in the CCBHC demonstration program have established required and optional EBPs that best meet the needs of the people the CCBHCs serve. The majority of the commonly selected EBPs noted in this report (see page 27) have been considered essential community mental health for the past 20 years (Drake & Latimer, 2012) and are backed by substantive research.

- **Motivational interviewing** positively contributes to the treatment of alcohol, tobacco, and cannabis use; depression, anxiety, and mood disorders; and numerous physical health issues, including medication adherence. Studies show motivational interviewing to be effective for a range of ages, from adolescent to elderly patients (Riper et al., 2014; Satre et al., 2016; Dean, Britt, Bell, Stanley, & Collings, 2016; Lundah et al., 2013; Moral et al., 2015).
- A review of more than 100 meta-analytic studies on **cognitive behavioral therapy** revealed its significant positive effects on anxiety disorders, somatoform disorders, bulimia, anger control problems, and general stress, as well as effectiveness in treating some addiction disorders, positive symptoms and secondary outcomes of schizophrenia, and depression (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012).
- Najavits and Hien’s review of the treatment outcome literature on substance use and posttraumatic stress disorder (PTSD) cites more than 20 research studies of **trauma-focused cognitive behavioral therapy** bringing about improvement in PTSD symptoms (2013). Trauma-informed care is a cost-effective approach associated with decreases in psychiatric symptoms and substance use, improvements in daily functioning, and decreases in hospitalizations and crisis interventions (Hopper, Bassuk, & Oliver, 2010).
- Since the 1990s, evidence of the value of **integrated treatment for co-occurring disorders** has grown steadily (McGovern, Lambert-Harris, Gotham, Claus, & Xie, 2014). A 2017 study of residential integrated treatment shows a drop in emergency room visits and hospital admissions for medical, mental health, and substance use problems from 2,725 visits in the 6 months prior to receiving treatment to 901 visits and admissions in the 6 months following treatment. Healthcare costs decreased by approximately \$3 million (Morse & Bride, 2017).

- Randomized trials, meta-analyses, and large-scale longitudinal studies show that **medication-assisted treatment** reduces illicit drug use, is cost-effective, and leads to better health (Nosyk et al., 2013). A study of deaths from heroin overdose over a 14-year period indicated a statistically significant drop in such deaths upon the expansion of opioid agonist treatment (Schwartz et al., 2013).
- A review of 40 controlled studies summarizes that **illness management and recovery (IMR)** has been successfully implemented in a variety of treatment settings, improves service recipients' ability to manage illness more readily than other services, and reduces the use of high-cost psychiatric services (Mueser, 2013). Hospitalizations for psychiatric or physical reasons were significantly fewer among studied adults over 50 with SMI who participated in IMR than those who received regular care (Bartels et al., 2014).
- **Assertive Community Treatment** was found most effective in terms of cutting hospital use and promoting community reintegration among service recipients with SMI who had frequent psychiatric hospitalizations (Bond & Drake, 2015). Another study found assertive community treatment was instrumental in increasing service recipients' ability to navigate a fragmented mental health system (Drukker et al., 2014).

Sustaining Excellence in Mental Health

Although the demonstration states are currently focused on successfully implementing the demonstration, many of them are planning to sustain certain aspects of the model beyond the demonstration period. This may require additional state funding and changes to a state's Medicaid program, as the enhanced FMAP will expire. The EBPs and services implemented by CCBHCs will no longer be supported by Medicaid unless they are covered in the state Medicaid plan. States will no longer be compelled to collect quality measures on CCBHCs or use them for QBPs. Lastly, states will no longer need to adhere to practice standards for CCBHCs as intended by Congress. To reduce these impacts, state behavioral health agencies are meeting with Medicaid officials to extend Medicaid payment for services beyond the demonstration period through waiver authority or amending the Medicaid state plan, seeking state legislative appropriation to continue state Medicaid matching funds for 2019, and collecting return-on-investment data, particularly on electronic patient registries, data collection, and service costs.

APPENDIX A: STATE SNAPSHOTS

Snapshot of Minnesota's Demonstration Program and Measurement of its Impact

The CCBHCs

Minnesota's six CCBHCs offer services at 22 locations, covering 18 urban, rural, and frontier counties. Nearly all sites are in medically underserved areas (MUAs) and mental health professional shortage areas (MHPSAs). Five of the CCBHCs are operated by nonprofit organizations, and one is operated by a local government agency.

Improving Quality and Access

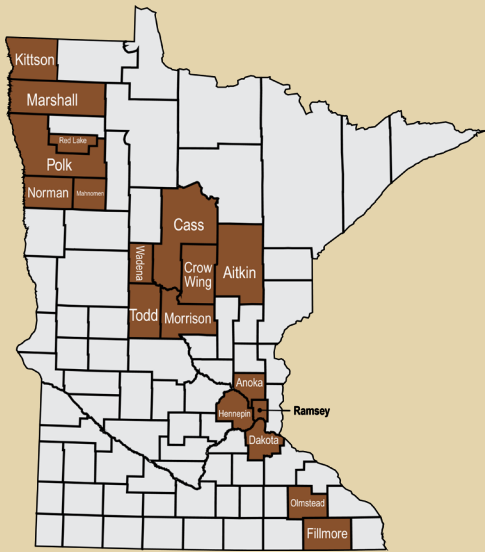
Minnesota hopes to improve behavioral healthcare access to veterans, tribal entities, persons of color, and non-native English speakers during the demonstration. Minnesota's goal is to provide access to all nine CCBHC services within 10 days. It is expected that the number of consumers served will increase by approximately 10 percent with the launch of CCBHCs. To meet CCBHC standards, one of the clinics added children's services and two sought state certification in children's therapeutic treatment, another became licensed to provide treatment for substance use disorders, and all six clinics added substance use withdrawal management services. The CCBHCs hired many licensed professionals and certified peer specialists, increased the use of telemedicine in rural and urban clinics, and engaged more providers to deliver additional services, such as primary care screening and care coordination.

Paying for CCBHC Services

Minnesota chose the Certified Clinic Prospective Payment System (CC PPS-1) for the demonstration and will offer quality bonus payments to CCBHCs that achieve six required quality measures. The state recently added \$50 million in funding for behavioral health services and is developing legislation to support the continuation of CCBHCs when the 2-year demonstration ends.

Concurrent State Initiatives

Four of Minnesota's CCBHCs are certified as health homes. CCBHC consumers who also receive services through the health homes will be identified through the state's Mental Health Information System. This reporting system measures changes in employment and living situation, diagnostic information, and health indicators. Other concurrent state initiatives include training on person-centered planning and the integration of the state mental health and substance use disorder authority.



MINNESOTA

Projecting the Impact of the State's Participation in Demonstration Program

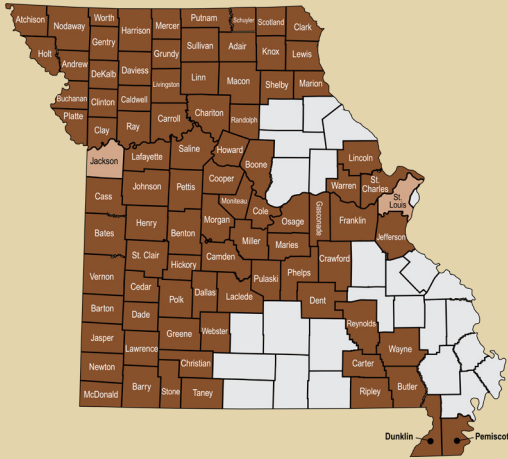
In response to the state's CCBHC needs assessment, Minnesota will demonstrate the impact of CCBHCs on the scope of and access to behavioral health services using the measures below.

Scope of services:

- The proportion of encounters and persons served by peer services in CCBHCs

Access:

- The percentage of persons of color and Latinos/Hispanics receiving CCBHC services versus the percentage of Medicaid population in the CCBHC service areas
- The percentage of non-primary English speakers receiving CCBHC services versus the percentage of Medicaid population in the CCBHC service area
- The number of persons served by telemedicine for allowable services in CCBHCs
- The mean number of days between initial contact and evaluation of new clients
- The percentage of all clients receiving two or more services within 2 months of initial assessment
- The percentage of clients who are persons of color and Latinos/Hispanics receiving two or more services within 2 months of initial assessment
- The percentage of non-primary English speaking clients receiving two or more services within 2 months of initial assessment



MISSOURI

Snapshot of Missouri’s Demonstration Program and Measurement of its Impact

The CCBHCs

The Missouri Department of Behavioral Health (DBH) certified 15 CCBHCs covering both rural and urban service areas. Three designated collaborating organizations (DCOs) are working with CCBHCs in the state to deliver the full scope of services.

Improving Quality and Access

Through outreach and improved access to services, Missouri estimates a 4 percent growth in number of people served. All CCBHCs are required to adopt a trauma-informed approach to care by participating in a state-led Trauma-informed Care Learning Collaborative or by participating in a related DBH-approved initiative.

Paying for CCBHC Services

Missouri selected the Certified Clinic Prospective Payment System (CC PPS-1) and will make quality bonus payments to CCBHCs contingent upon their meeting goals for six measures that demonstrate quality and access to care. Clinics that meet or exceed the measures will be eligible to receive at least an additional 1 percent of the total PPS payments. A PPS daily blended rate provides the specialized array of services used to treat adults with serious mental illness (SMI) and children and adolescents with serious emotional disturbance (SED).

Concurrent State Initiatives

To meet the CCBHC primary care screening and monitoring certification criteria, the state required that all clinics be recognized as community mental health center healthcare homes under the Medicaid health home option. Three of Missouri CCBHCs are also grantees of SAMHSA’s Primary and Behavioral Health Care Integration Grants.

Projecting the Impact of the State’s Participation in Demonstration Program

Missouri will demonstrate the impact of CCBHCs on the scope and availability of, access to, and participation in community behavioral health services. The state will also demonstrate the impact of CCBHCs on the goal of assisted outpatient treatment “to reduce hospitalizations, homelessness, incarceration, and interaction with the criminal justice system while improving the health and social outcomes of the patient.”

The following measures will be used to demonstrate impact.

Scope of services:

The percentage of CCBHC service areas where

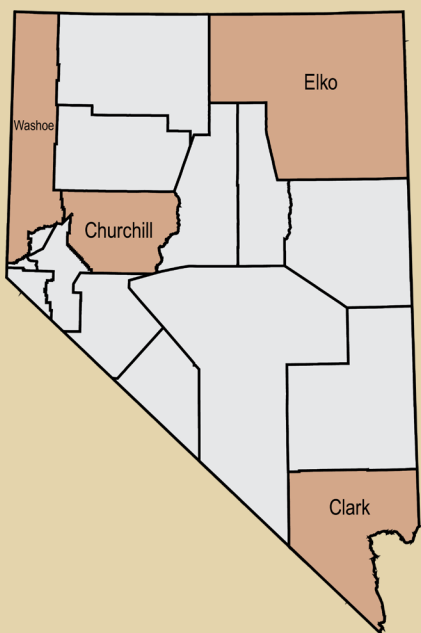
- certified peer specialists are employed by a CCBHC;
- family support providers are employed by a CCBHC;
- outpatient substance use treatment services are accredited or comply with state certification standards;
- physicians are trained in providing medication-assisted treatment (MAT);
- buprenorphine prescription billings occur;
- the CCBHC is adopting or has adopted Integrated Treatment for Co-occurring Disorders to fidelity;
- clinicians are trained in the use of Eye Movement Desensitization and Reprocessing (an evidence-based practice to treat trauma disorders);
- a clinician is trained as a tobacco treatment specialist;
- CCBHCs are engaged in a state-approved Trauma-informed Care Initiative; and
- CCBHCs are engaged in the Suicide Prevention Learning Collaborative.

Access:

- The number of certified peer specialists employed by CCBHCs
- The number of family support providers employed by CCBHCs
- The number of unduplicated persons receiving individual peer support services
- The number of unduplicated families receiving individual family support services
- The number of individuals receiving outpatient substance use disorder treatment
- The number of individuals prescribed buprenorphine
- The number of individuals who received metabolic screening
- The number of individuals served with Medicaid, Medicare, and state funding

Availability of, access to, and participation in services that meet assisted outpatient treatment goals:

- Number of individuals engaged in treatment
- Reduced emergency room visits
- Reduced hospitalizations
- Reduced homelessness
- Reduced unemployment
- Reduced number of arrests



NEVADA

Snapshot of Nevada's Demonstration Program and Measurement of its Impact

The CCBHCs

Nevada's multi-phase application process culminated in the selection of four clinics to be certified as CCBHCs and participate in the demonstration program—two serve urban counties and two serve rural/frontier counties.

Improving Quality and Access

Staff training and core treatment requirements of Nevada's CCBHCs have emphasized quality of care and delivery of evidence-based practices. Participation in the demonstration program has enabled Nevada, through CCBHCs, to increase access to whole health care through integrated primary and behavioral health services onsite and through the expanded use of telemedicine.

Paying for CCBHC Services

Nevada selected the Certified Clinic Prospective Payment System (CC PPS-1) and offers quality bonus payments to CCBHCs that meet or exceed the six PPS-required quality measures, plus one of the following:

- child and adolescent major depressive disorder suicide risk assessment,
- major depressive disorder suicide risk assessment,
- antipsychotic medication adherence,
- adult follow-up after hospital,
- child follow-up after hospital,
- initiating and engaging in alcohol and other drug dependence treatment, or
- hospitalization readmission rates.

Nevada requires its managed care plans to pay a rate to CCBHCs that other providers would receive for similar services. To reach the level of the PPS rate, CCBHCs are paid the base managed care plan rate plus a supplemental or wraparound payment to ensure that payments are equivalent to the PPS rate.

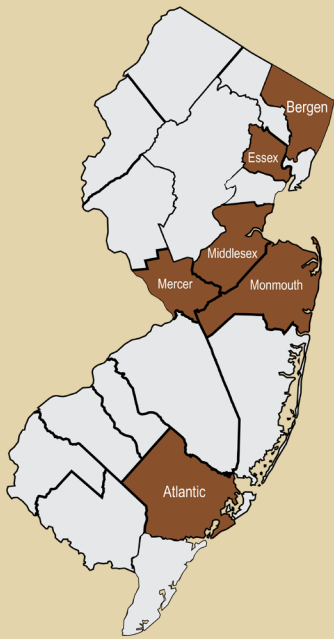
Concurrent State Initiatives

Several initiatives have prepared and continue to support Nevada and its CCBHCs for the integration of care, payment reform, and data collection systems required for the demonstration. In 2014, Nevada received a \$2 million State Innovation Model (SIM) Grant through the Center for Medicare and Medicaid Innovation. The SIM Project focused on whole-health integrated care across a multipayer system. In 2015, Nevada's Division of Child and Family Services received a Children's Behavioral Health System of Care Grant to help develop a comprehensive behavioral health service delivery model for improving outcomes through care coordination and evidence-based practices (EBPs). In 2016, Nevada was awarded intensive technical assistance on integrating primary and mental health care through the Medicaid Innovation Accelerator Program.

Projecting the Impact of the State's Participation in Demonstration Program

Nevada will demonstrate the impact of CCBHCs on the availability of, access to, and participation in behavioral health services. The state will measure the

- number of individuals with substance use disorders who have received targeted case management services and who report positive outcomes, improved functioning, social connectedness, positive quality and appropriateness of care, general satisfaction with services, as well as including status, living arrangements, number of arrests in the past 30 days, and frequency of attendance to self-help programs;
- number and percent of new clients with an initial evaluation provided within 10 business days and the mean number of days until initial evaluation for new clients;
- frequency of use of crisis services and number of emergency room visits by adult and child consumers of the CCBHC;
- percentage of CCBHC members who received follow-up within 7 days and within 30 days of discharge following hospitalization for mental illness;
- number of inpatient psychiatric discharges that were followed by an unplanned acute readmission for any diagnosis within 30 days of the initial discharge; and
- percentage of individuals and families who rate their participation in treatment as positive.



NEW JERSEY

Snapshot of New Jersey's Demonstration Program and Measurement of its Impact

The CCBHCs

New Jersey's seven CCBHCs are in five urban counties and one mixed urban and rural county. CCBHCs collaborate with eight designated collaborating organizations (DCOs) that provide mobile crisis services, supported education and employment services, and specialty substance use treatment.

Improving Quality and Access

New Jersey's CCBHC design and scope of services align with the state's vision to develop an integrated model of care providing comprehensive physical and behavioral health services to children, youth, and adults with mental and substance use disorders and to improve the availability of, access to, and participation in CCBHC services for populations of focus. New Jersey's CCBHCs are also expected to meet service gaps for individuals with substance use disorders, expand the use of peer support specialists among that population, and increase use of evidence-based practices (EBPs) in the counties they serve.

Paying for CCBHC Services

New Jersey is one of two states that selected the monthly selected the monthly Certified Clinic Prospective Payment System Alternative (CC PPS-2). CCBHCs must report all six quality bonus payment (QBP) measures to be eligible for a payment and will receive a QBP for meeting or exceeding national standards established by the Healthcare Effectiveness Data and Information Set. To address the state's broader goal of addressing addictions, New Jersey will weigh measures related to the initiation and treatment of substance use more heavily in the calculation for QBPs. The cumulative funding of QBPs for all clinics is \$350,000.

Concurrent State Initiatives

New Jersey received \$1 million from SAMHSA's Grants to Prevent Prescription Drug/Opioid Overdose-related Deaths in 2016. The state is leveraging this opportunity to provide training to the CCBHC staff and make naloxone kits available. New Jersey implemented an opioid overdose recovery program (OORP) in 11 counties and will expand the program to 10 more through SAMHSA's State Targeted Response to the Opioid Crisis Grant. CCBHCs operate in six counties where the OORPs are located. Two CCBHCs have received grants to integrate care under SAMHSA's Primary and Behavioral Health Care Integration Program.

Projecting the Impact of the State’s Participation in Demonstration Program

New Jersey chose to demonstrate impact in terms of scope of services and access to services. The following measures will be used to demonstrate impact.

Scope of services:

- Preventive care and screening: tobacco use—screening and cessation intervention
- Preventive care and screening: unhealthy alcohol use—screening and brief counseling
- Number/percent of consumers receiving primary health screens on key indicators
- Number/percent of consumers receiving a peer recovery support service while in treatment
- Number/percent of consumers receiving targeted case management
- Number/percent of families receiving intensive family support services
- Number/percent of consumers receiving supported employment services
- Number/percent of peers employed by agency for mental illness and substance use treatment
- Number/percent of opiate-addicted individuals receiving medication-assisted treatment (MAT)

Access:

- Number of new consumers with initial evaluations provided within 10 business days
- Initiation and engagement of alcohol and other drug dependence treatment
- Follow-up after emergency department visit for mental health-related issues
- Follow-up after emergency department visit for alcohol or other dependence
- Number/percent of treatment admissions into CCBHCs from opioid overdose recovery programs
- Number/percent of treatment admissions by target group
- Percent of opioid-addicted individuals receiving MAT
- Number/percent of consumers remaining in treatment for 21 days (engagement)
- Number/percent of consumers remaining in treatment for 90 days (retention)
- Number/percent of consumers who drop out of treatment



NEW YORK

Snapshot of New York’s Demonstration Program and Measurement of its Impact

The CCBHCs

Twenty-nine provider agencies applied to become CCBHCs in the state and 13 completed the process to become certified. Of the 13 CCBHCs, one serves a rural area, six serve urban areas, and six serve mixed urban and rural areas of the state.

Improving Quality and Access

New York’s 13 CCBHCs include 77 service locations assisted by four designated collaborating organizations to deliver comprehensive behavioral health care. Planning grant funds were used to provide training to CCBHC staff on evidence-based services and culturally appropriate practices. With training and preparation, CCBHCs and their staff obtained additional certifications to provide treatment for mental and substance use disorders across the life cycle.

Paying for CCBHC Services

The state selected the Certified Clinic Prospective Payment System (CC PPS-1) and will offer quality bonus payments to CCBHCs that meet or exceed the six required quality measures plus three state-required additional measures. CCBHCs will receive reimbursement equal to the PPS rate through a negotiated managed care rate supplemented by a state wraparound payment.

Concurrent State Initiatives

New York’s 1115 Medicaid waiver includes housing, education, and employment for adults with serious mental illness (SMI) and for children with serious emotional disturbance (SED). These are the same groups of individuals to be served by CCBHCs. New York is strengthening its behavioral health safety net by establishing Health and Recovery Plans that improve care management for those with SMI (also a population of focus for CCBHCs). The state is developing health homes with care coordination, which also underpins CCBHCs, facilitating strong partnerships with hospitals, primary care providers, and community-based behavioral health agencies.

Projecting the Impact of the State's Participation in Demonstration Program

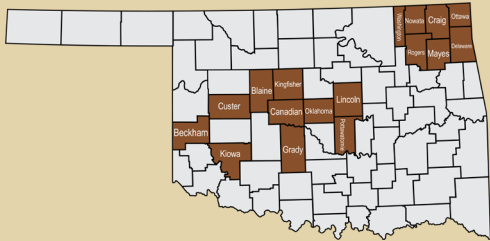
New York will demonstrate the impact of CCBHCs to expand available services and increase their quality without increasing net federal spending. Specific measures related to this goal include the following.

Expand available services:

- Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients
- Number of buprenorphine treatment slots
- Number of consumers maintained on medication-assisted treatment (MAT)
- Number of emergency department visits for mental and substance use disorders

Increase service quality:

- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications
- Follow-up after hospitalization for mental illness
- Follow-up care for children prescribed attention-deficit hyperactivity disorder (ADHD) medication
- Antidepressant medication management
- Initiation and engagement of alcohol and other drug dependence treatment



OKLAHOMA

Snapshot of Oklahoma’s Demonstration Program and Measurement of its Impact

The CCBHCs

Oklahoma selected three community mental health centers in areas with the highest population densities in the state: two in the central region and one in the northeastern region of the state. These three CCBHCs cover 17 counties through 19 service locations, including one urban, four urban/rural, and 13 rural/frontier areas.

Improving Quality and Access

CCBHCs have undertaken several important steps to improve access and quality of services for Oklahomans who are American Indians; veterans; Hispanic; or lesbian, gay, bisexual, or transgender, including staff training, expanding the bilingual workforce and use of translation services, and establishing processes for referrals and linkage with the Indian Health Service. CCBHCs are making changes to improve the physical accessibility of sites, such as installing automated doors for people in wheelchairs. Two of the three CCBHCs are issuing specially configured and HIPAA-compliant tablet computers to consumers, emergency rooms, and police departments to enhance coordinated care and connectedness.

Paying for CCBHC Services

Oklahoma selected the Certified Clinic Prospective Payment System Alternative (CC PPS-2) and set aside \$1 million for quality bonus payments (QBPs). Under the PPS-2 methodology, QBPs will be paid to CCBHCs that meet or exceed PPS-required quality measures.

Concurrent State Initiatives

Health home services were authorized under a state plan amendment approved by CMS in January 2015 for adults with a serious mental illness (SMI) and for children with serious emotional disturbance (SED). Clinics had begun implementing integrated care approaches as health homes or through SAMHSA Primary and Behavioral Health Care Integration Grants before they became CCBHCs.

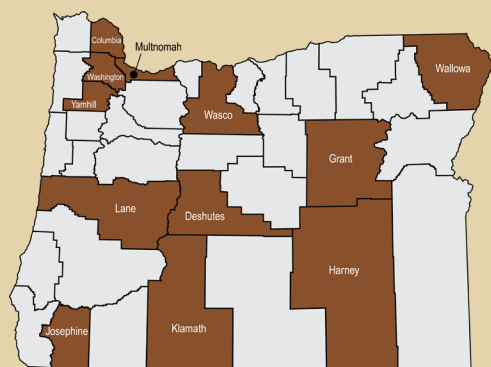
Projecting the Impact of the State’s Participation in Demonstration Program

Oklahoma chose three demonstration goals for its program. The first two goals—complete scope of services and availability of, access to, and participation in services—are being evaluated in tandem:

- Increase the number of services to adults age 16–25, ensuring age-appropriate services are being provided and addressing gaps identified through the needs assessments.
- Increase the number of substance use services provided.
- Increase the number of mobile crisis services, targeting the span of services that the needs assessment identified as lacking in the treatment system.
- Increase the number of memoranda of understanding or other formal agreements with consulting physicians, ensuring coordination with and inclusion of primary care in the CCBHCs.
- Increase the number of clients served, demonstrating the improved availability to persons who may not have been able to access services in the past.
- Increase the number of clients receiving peer recovery support services.
- Increase the number of clients engaging in treatment as defined by a third and fourth service within 30 days of the second service, ensuring improved participation in services.
- Increase the number of veterans and military personnel served.
- Increase the number of Hispanics served.
- Increase the number of LGBT individuals served, addressing underserved populations identified through the needs assessments.

The third goal—improving the availability of, access to, and participation in assisted outpatient mental health treatment—will be measured separately by the following data elements:

- increase in treatment adherence for persons served through the assisted outpatient treatment (AOT) program,
- reduction of inpatient hospitalizations for persons served through the AOT program,
- reduction in homelessness for persons served through the AOT program, and
- reduction in arrests/incarceration for persons served through the AOT program to address treatment adherence and the desired outcomes of the AOT programs.



OREGON

Snapshot of Oregon's Demonstration Program and Measurement of its Impact

The CCBHCs

Oregon added nine state standards adapted from the health home model to the federal CCBHC criteria to certify clinics in the state. Through extensive site visits and interviews, 12 clinics were selected and certified as CCBHCs. The 12 CCBHCs have 21 service locations in 12 counties: four urban, five rural, and three frontier counties. One of the CCBHCs is using five designated collaborating organizations (DCOs) to deliver services.

Improving Quality and Access

Oregon expects their CCBHCs to serve 20 to 30 percent more individuals than in previous years. The state will focus on providing new services at all CCBHCs, including outreach and primary care.

Paying for CCBHC Services

The state is using the Certified Clinic Prospective Payment System (CC PPS-1). Managed care organizations (MCOs) will pay CCBHCs the same rates as other providers and the state will reimburse CCBHCs up to the PPS rate. The state did not opt to provide quality bonus payments (QBPs) to clinics.

Concurrent State Initiatives

The CCBHC demonstration program aligns with Oregon's Behavioral Health Strategic Plan, with a shared focus on the integration of behavioral health and primary health care and the use of peer services.

Projecting the Impact of the State's Participation in Demonstration Program

Oregon selected goals of providing the most complete scope of services and improving availability of, access to, and participation in services.

Scope of services:

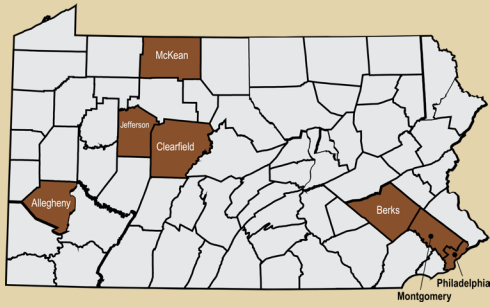
Oregon will measure the number and type of services offered by each CCBHC. By tracking both total claims and claims per consumer for each clinic by category, Oregon will determine how service types have expanded throughout the course of the CCBHC demonstration program. The types of services to be tracked are

- crisis;
- screening, assessment, and diagnosis, including risk assessment;

- patient-centered treatment planning or similar processes, including risk assessment and crisis planning;
- outpatient mental health and substance use services;
- outpatient clinic primary care screening and monitoring of key health indicators and health risk;
- targeted case management;
- psychiatric rehabilitation services; and
- peer support and counselor services and family supports.

Access:

- Number of Medicaid patients served (through billing claims)
- Number of staff by clinic and number of staff added as a result of the needs assessment
- Number of new clients who received an initial evaluation within 10 business days
- The mean number of days a client had to wait until receiving an initial evaluation



PENNSYLVANIA

Snapshot of Pennsylvania's Demonstration Program and Measurement of its Impact

The CCBHCs

Pennsylvania selected 16 clinics to participate in the planning grant from the 76 that were interested in becoming CCBHCs. Of those, seven clinics were certified as CCBHCs. CCBHCs are in urban and in mixed urban/rural areas of the state. Some of the CCBHCs have formal agreements with designated collaborating organizations (DCOs) to provide services.

Improving Quality and Access

The vision of Pennsylvania's behavioral health program is to increase access to services, improve quality of care, and contain costs. The state will assess the value and cost effectiveness of CCBHCs during the demonstration program to test whether primary care screening and integrated care with value-based purchasing strategies should be extended statewide.

Paying for CCBHC Services

Pennsylvania is using the Certified Clinic Prospective Payment System (CC PPS-1). The state is implementing quality bonus payments (QBPs) for CCBHCs. CCBHCs must meet or exceed PPS quality measures as validated by an external quality review organization. The state's share of the PPS rate and QBPs will be funded from an appropriation by the state legislature to the state Medicaid agency.

Concurrent State Initiatives

The demonstration provides Pennsylvania with an exceptional opportunity to test its vision of improving access and quality while containing costs.

Projecting the Impact of the State's Participation in Demonstration Program

Pennsylvania seeks to demonstrate improved scope of services and access to services while expanding mental health services and containing costs by measuring improvements in the following areas.

Scope of services:

- Number of clinical staff providing the nine core services per quarter
- Number of full-time equivalent clinical staff by professional category providing the nine core services per quarter
- Number of referrals to specialty providers per month
- Number of referrals for veterans per month

Access:

- Number of hours of service provided outside of core business hours per month
- Number of units of each service provided per month, including peer support services, certified recovery specialist services, and telehealth
- Number of children who receive at least one CCBHC service in most recent 12 months
- Number of adults who receive at least one CCBHC service in most recent 12 months
- Number of new individuals contacting the CCBHC per month
- Number of new individuals per month who receive an initial evaluation within 10 days
- Percentage of timely initial evaluations per month
- Average number of days between contact and initial evaluation per month
- Number of initial depression screenings per month for members 12–17 years using a standardized/validated child depression tool
- Number of initial depression screenings per month for CCBHC members over age 18 using a standardized/validated adult depression tool
- Number of initial depression screenings with positive results (members over 12 years)
- Number of initial positive screens (members over age 12) with a follow-up plan documented the same day in the record
- Number of unique individuals receiving outpatient drug and alcohol services per month
- Percentage of drug and alcohol outpatient services recipients per month
- Number of unique individuals receiving intensive outpatient drug and alcohol services per month
- Percentage of intensive outpatient drug and alcohol service recipients per month

Expand and increase quality of services without increasing net federal spending:

- Individual and family satisfaction with services received at the CCBHC, including convenience of provider location, satisfaction with provider services, and timeliness and availability of appointments
- Number of evidence-based practices (EBPs) provided each month
- Number of individuals receiving EBPs per month
- Number of staff credentialed to practice each of the EBPs

APPENDIX B: GLOSSARY OF ACRONYMS

ADHD	Attention-deficit hyperactivity disorder
AOT	Assisted outpatient treatment
ASPE	Assistant Secretary of Planning and Evaluation
CCBHC	Certified community behavioral health clinic
CC PPS	Certified Clinic Prospective Payment System
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DCO	Designated collaborating organizations
DY	Demonstration year
EBP	Evidence-based practice
FMAP	Federal medical assistance percentage
FQHC	Federally qualified health center
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
IT	Information technology
MAT	Medication-assisted treatment
MCO	Managed care organization
MEI	Medicare Economic Index
MHPSA	Mental health professional shortage area
MUA	Medically underserved area
MUP	Medically underserved population
OMB	Office of Management and Budget
OMHSAS	Office of Mental Health and Substance Abuse Services
PAMA	Protecting Access to Medicare Act
PPS	Prospective Payment System
QBP	Quality bonus payment
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious emotional disturbance
SMI	Serious mental illness

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