Certified Community Behavioral Health Clinic (CCHBC) 101

On April 1, 2014, the President signed the Protecting Access to Medicare Act (PAMA) into law, which included a provision authorizing a two part Certified Community Behavioral Health Clinic (CCBHC) Demonstration program. The law allowed for a $1.1 billion investment in community based mental health services for Medicaid recipients – the largest of its kind for several generations - over the course of the demonstration.

The CCBHC initiative is designed to streamline and improve the way that states deliver behavioral health services for Medicaid beneficiaries. It is a pilot program sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Medicare and Medicaid Services (CMS) that is intended to establish a federal prospective payment methodology for comprehensive behavioral health care delivery, similar to the approach used by Federally Qualified Health Centers, although the CCBHC PPM rate will be customized based on state needs, and certified and monitored by each state.

A Certified Community Behavioral Health Center (CCBHC) will be required to provide services to all who seek help, but there is a specific focus on individuals with serious mental illness (SMI), severe substance use disorders, children and adolescents with serious emotional disturbances (SED), and people with co-occurring mental, substance use, or physical health disorders. CCBHCs represent an opportunity for states to improve the behavioral health of their residents by:

- providing and coordinating care via a comprehensive array of community-based mental and substance use disorder services;
- advancing integration of behavioral health with physical health care;
- assimilating and utilizing evidence-based practices on a more consistent basis; and
- promoting improved access to high quality care.

In October of 2015, SAMHSA and CMS announced that 24 states have been awarded one-year CCBHC Planning Grants. Applicants had applied for $2 million grants, but the amounts awarded were far less than that maximum. Recipients will be required to certify community behavioral health clinics, solicit input from stakeholders, establish prospective payment systems for demonstration reimbursable services, and prepare an application to participate in the demonstration program. Eight of these states will then be selected as demonstration sites for enhanced federal matching funds based on payment via a Prospective Payment System (PPS) for Medicaid services during the CCBHC two year Demonstration. State awardees include:

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The ultimate Demonstration application will be submitted to SAMHSA by each State Planning recipient by October of 2016 in order to be considered to participate in the CCBHC demonstration program. CCBHC Implementation will begin in January of 2017.

Planning Grant Requirements

States that have received CCBHC Planning Grants must accomplish a number of activities in just under one year. These include:

- Convene a Steering Committee to direct the planning effort;
- Facilitate a robust stakeholder input process inform the certification criteria;
- Design the PPS rates/payment methodology;
- Provide the training and technical support necessary to actually certify at least two clinics based on their planned model;
- Certify at least two CCBHCs that represent diverse geographic areas (i.e., urban and rural); and
- Develop an application for the CCBHC Demonstration.
## CCBHC Services

There are standards across six areas that an organization must meet to achieve CCBHC designation. These standards will be slightly different for each applicant state:

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Requisite Standards</th>
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<tbody>
<tr>
<td><strong>Staffing</strong></td>
<td>Each state has the flexibility to determine the staffing patterns required for CCBHCs, based on each state’s needs assessment. Occupational therapists are mentioned by name as a possible member of the CCBHC interdisciplinary team.</td>
</tr>
<tr>
<td><strong>Accessibility</strong></td>
<td>Services must be accessible at times and places convenient for those served. Requirements include prompt intake and engagement in services, access regardless of ability to pay and place of residence, access to adequate crisis services, and consumer choice in treatment planning and services.</td>
</tr>
<tr>
<td><strong>Care Coordination</strong></td>
<td>CCBHCs must provide integrated and coordinated care to address all aspects of a person’s health; care coordination is described as the “linchpin” of the model.</td>
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</tbody>
</table>
| **Service Scope**   | CCBHCs are required to provide directly, or through referral or formal relationships, a broad array of person-centered and family-centered services. Although they must meet minimum requirements, states can shape the scope of services to align with their state Medicaid Plans and other state regulations. At a minimum, the following services must be provided, directly or via formal relationships with other providers (* indicates services where occupational therapists can especially contribute):  
  - Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.  
  - 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.*  
  - Peer support and counselor services and family supports.*  
  - Intensive, community-based mental health care for members of the armed forces and veterans* |
| **Quality/Reporting** | States must collect and report on encounter, clinical outcomes, and quality improvement data, and provide annual reports on their achievements. A comparison group of Medicaid beneficiaries will be identified by each state to measure the overall impact of the model.                          |
| **Organizational Authority** | CCBHCs must be nonprofit organizations, local government organizations, or operated under the authority of an Indian Tribe. Each CCBHC must ensure a minimum level of consumer participation on the Board of Directors. |

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Prospective Payment System (PPS) Options

PAMA requires states participating in the CCBHC demonstration program to develop a PPS to reimburse clinics for CCBHC services. The PPS is a method in which clinics (or providers) are reimbursed prospectively at a pre-determined fixed rate for services rendered, regardless of the type or intensity of the service(s) provided. In terms of public insurance programs, Medicare implemented a PPS in the early 1980s to attempt to reign in growing costs of inpatient care, and in 2000, Congress established a prospective payment rate based on a daily fixed rate for Medicaid to reimburse Federally Qualified Health Centers (FQHCs) (including FQHC look-alikes, Indian Health Services, and Rural Health Centers). In October of 2014, Medicare payment to FQHCs also began transitioning to a PPS.

PAMA provides guidance to states on the development of the PPS. The PPS must cover all services included in the Demonstration’s criteria by CCBHCs, as well as by Qualified Satellite Facilities established prior to April 1, 2014, and Designated Collaborating Organizations. Generally, PPS rates are built on a complex formula based on what it would cost to provide services efficiently and in a cost effective manner. The Secretary of the Department of Health and Human Services (HHS) established two options for PPS rate methodologies states participating in the CCBHC pilot could choose from: Certified Clinic PPS-1 (CC PPS-1) and Certified Clinic PPS Alternative (CC PPS-2). Whichever option is selected must be applied demonstration-wide and must be used to develop CCBHC-specific rates.

<table>
<thead>
<tr>
<th>Rate Elements of CC PPS-1 and CC PPS-2</th>
<th>CC PPS-1</th>
<th>CC PPS-2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Rate</strong></td>
<td>Daily</td>
<td>Monthly</td>
</tr>
<tr>
<td>Payments for services provided to clinic users with certain conditions</td>
<td>NA</td>
<td>Separate monthly PPS rate to reimburse CCBHCs for the higher costs associated with providing all services necessary to meet the needs of special populations</td>
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<tr>
<td><strong>Update Factor</strong></td>
<td>MEI or rebasing</td>
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</tr>
<tr>
<td><strong>Outlier Payments</strong></td>
<td>NA</td>
<td>Reimbursement for portion of participant costs in excess of a state-defined threshold made on an annual or monthly basis</td>
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<tr>
<td><strong>QBPs</strong></td>
<td>Optional bonus payment for CCBHCs that meet quality measures</td>
<td>Mandatory bonus payment for CCBHCs that meet quality measures</td>
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*SAMSHA RFA, Appendix III, 2015.

The first option, CC PPS-1, more closely mirrors the FQHC PPS in that the base payment is a pre-determined, fixed daily rate for services performed. A quality bonus payment (QBP) may also be made to CCBHCs that achieve specified measures at the state’s option; however, the bonus payments are not factored into the PPS rate.
The CC PPS-2, is a cost-based per-clinic monthly rate, which must include QBPs as part of the payment and also includes outlier payments for the portion of costs that exceed the state-defined threshold amount. States may also choose to vary rates under CC PPS-2 to account for the higher intensity of services required by particular populations served (such as the seriously mentally ill or children with serious emotional disturbances) by the CCBHC.

States using a managed care delivery system must also identify the PPS methodology being used and apply it demonstration-wide. They have the option of incorporating the payment into the managed care organizations’ (MCO) capitation rate or to employ a wrap-around payment. States must ensure duplicative payments are not made for CCBHC demonstration services that the MCO may offer and adjust payments accordingly.

**Baseline Data**

Regardless of method chosen, baseline rates are established using cost and visit data from the planning grant year, adjusted for inflation by the Medicare Economic Index (MEI) annually. In Demonstration Year 2, states may re-baseline the rates or simply adjust by MEI.

**Quality Bonus Payments**

CCBHCs that achieve six specified quality measures may receive a QBP under CC PPS-1 and must receive a QBP under CC PPS-2. In both methods states determine the QBP amount, but must develop a methodology outlining how payment is triggered, the payment amount, and how the payment will be made.

The six quality measures are:
1. FUH-AD, Follow-up After Hospitalization for Mental Illness (adult age groups)
2. FUH-CH, Follow-up After Hospitalization for Mental Illness (child/adolescents)
3. SAA-AD, Adherence to Antipsychotics for Individuals with Schizophrenia
4. IET-AD, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
5. NQF-01014, Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
6. SRA-CH, Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

If the CCBHC achieves the measures laid out above, the state may also make QBPs using additional CMS specified measures:
1. ADD-CH, Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication
2. CDF-AD, Screening for Clinical Depression and Follow-up Plan
3. AMM-AD, Antidepressant Medication Management
4. PCR-AD, Plan All-Cause Readmission Rate
5. NQF-0710, Depression Remission at Twelve-Months-Adults

Any additional measures states wish to use but are not included in the guidance require CMS approval.
Federal Matching Assistance Percentage (FMAP)

States participating in the demonstration will receive an enhanced federal match rate for CCBHC services equivalent to either the enhanced Federal Matching Assistance Percentage (e-FMAP) for the Children’s Health Insurance Program or the e-FMAP for the newly eligible, now set at 100% but set to ramp down to 90 percent by 2020.

CMS issued an opportunity for public comment on CMS cost reporting, including information to be used in determining each participating clinic’s PPS rate, for states participating in the pilot on September 9, 2015 with comments due by October 14, 2015.
How to Act Now

AOTA Chapters within states awarded a CCBHC Planning grant can begin to engage in the following ways:

1. Connect with/join your state’s Planning Grant Steering Committee so that OT interests are well represented in the CCBHC planning process.
2. Participate in your state’s stakeholder engagement process, through which they are required to engage a diverse array of providers, advocates, and consumers.
3. Connect with the community mental health centers in your state/region which are likely to be certified as CCBHCs to explore how OT can best be incorporated into their services in alignment with the CCBHC model.
4. Watch/participate in the CCBHC webinar provided by AOTA to learn more about the Demonstration and sign up to receive OT advocacy material developed for CCBHC planners.

Who to Contact to Get Involved in Your State

Planning Grant Contacts for each CCBHC Planning Grant recipient state can be found at http://www.samhsa.gov/grants/awards/2015/SM-16-001.

Individuals involved in various aspects of state level CCBHC planning include the following:

- Executive Officer, Department of Human Services, Division of Mental Health and Disability Services
- Director of Policy Implementation & the Administrator of Research, Data Evaluation, and Compliance
  - Both at the Dept. of Behavioral Healthcare, Developmental Disabilities, and Hospitals
- Deputy Director of Behavioral Health and Development Disabilities, Department of Health and Human Services
- Assistant Division Director of Planning, Research, Evaluation, & Prevention at the Division of Mental Health and Addiction Services within the Dept. of Human Services.

More Information

- The Substance Abuse and Mental Health Services Administration recently posted materials to support the state planning grant process including CCBHC criteria, Certification Resources and Guides, and other resources at: http://www.samhsa.gov/section-223.
- The Center for Medicare and Medicaid Services (CMS) has posted resources, specific to Financing and Reimbursement here: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/223-demonstration-for-ccbhc.html
- The National Council for Behavioral Health published a Toolkit for State Planning grant Applicants that includes further detail http://www.thenationalcouncil.org/topics-a-z/state-planning-grant-toolkit/.