Model Overview: Certified Community Behavioral Health Clinic (CCBHC)

Medicaid Medical Care Advisory Committee
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Dr. Mallory L. Malkin
Licensed Clinical Psychologist
Chief Clinical Officer
Bureau of Behavioral Health Services
Mississippi Department of Mental Health
mallory.malkin@dmh.ms.gov

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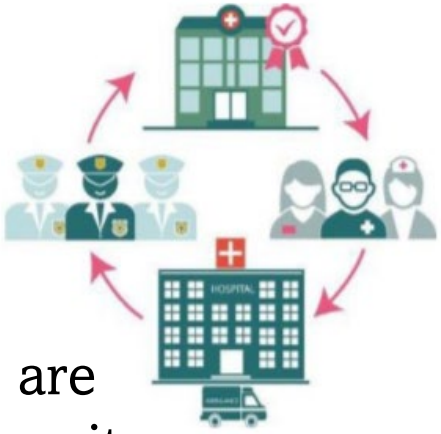
What is a CCBHC?



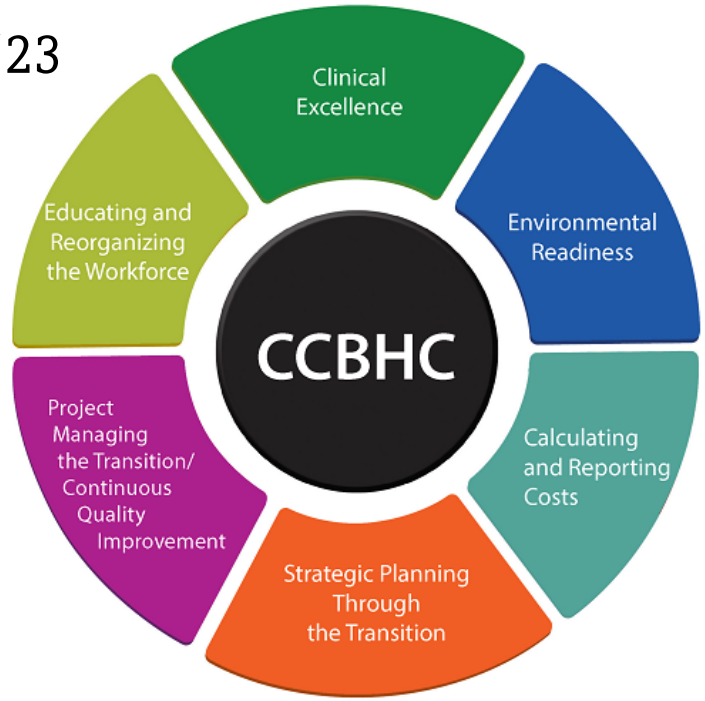
- Certified Community Behavioral Health Clinics (CCBHCs) are transformative models of comprehensive integrated community based behavioral care
- CCBHCs are non-profit organizations that meet the CMS, HHS, and SAMHSA criteria requirements
- CCBHCs serve any individual in need of care, regardless of their ability to pay
- CCBHC use a Prospective Payment System model (similar to FQHCs) versus Fee for Service reimbursement payment system

WHAT IS A CCBHC?

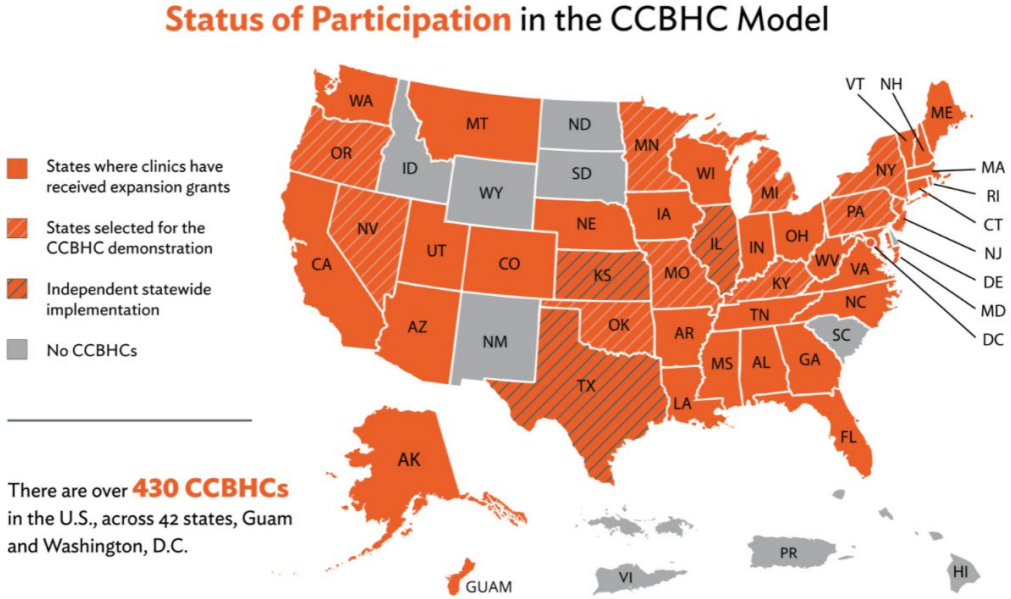
A CCBHC is a specially-designated clinic that receives flexible funding to expand the scope of mental health and substance use services available in their community. CCBHCs provide care for people with unmet needs.

History of CCBHCs

- Protecting Access to Medicare Act (PAMA) (2014) established the CCBHCs and initiated demonstration programs
- Original SAMHSA demonstration program cohort:
  - Section 223 demonstration programs for CCBHCs
    - Originally 6/30/17-6/30/19 but *extended* to 9/30/23
      - Minnesota
      - Missouri
      - New York
      - New Jersey
      - Nevada
      - Oklahoma
      - Oregon
      - Pennsylvania



CCBHCs



- Currently >430 CCBHCs across 42 states funded as Section 223 demonstration programs, through SAMHSA expansion grants, or independent state amendment implementation
- CCBHC expansion grants are for those not yet certified but meet certification criteria and can be certified within 4 months of award
  - Up to 2 million dollar (≤ 2 years)
- Expansion grants were not developed to provide a mechanism of sustainability → infrastructure and MCO must support
- 1.5 million people served nationwide by 224 CCBHCs (January 2021)
- CCBHCs are serving, on average, 17% more people than prior to CCBHC implementation
- Nationwide average wait time for care (time btw outreach/referral & 1st appointment) is 48 days
  - SAMHSA criteria require CCBHCs to schedule the 1st appointment within 10 days of a patient's outreach/referral

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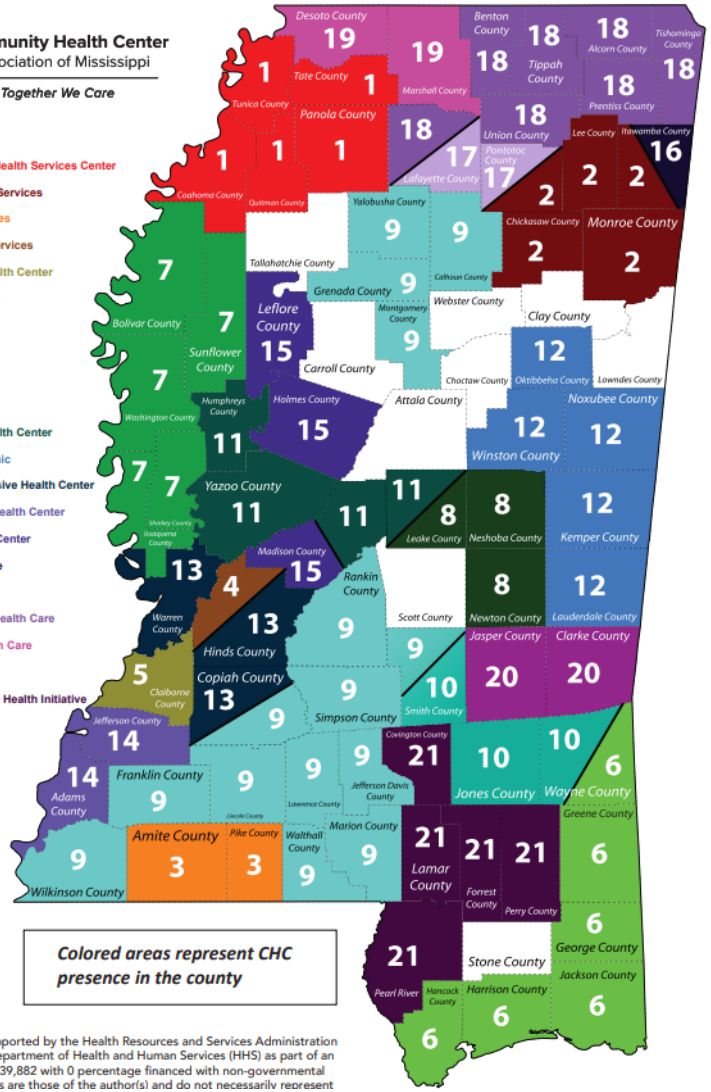
Federally Qualified Health Centers (FQHCs)

Community Health Center Association of Mississippi
Together We Care

1. Aaron E. Henry Community Health Services Center
2. ACCESS Community Health Services
3. Amite County Medical Services
4. Central Mississippi Health Services
5. Claiborne County Family Health Center
6. Coastal Family Health Center
7. Delta Health Center
8. East Central MS Health Care
9. Family Health Care Clinic
10. Family Health Center
11 .G.A. Carmichael Family Health Center
12. Greater Meridian Health Clinic
13. Jackson-Hinds Comprehensive Health Center
14. Jefferson Comprehensive Health Center
15. Mallory Community Health Center
16. Mantachie Rural Health Care
17. MississippiCare
18. North Mississippi Primary Health Care
19. Northeast Mississippi Health Care
20. Outreach Health Services
21. Southeast Mississippi Rural Health Initiative



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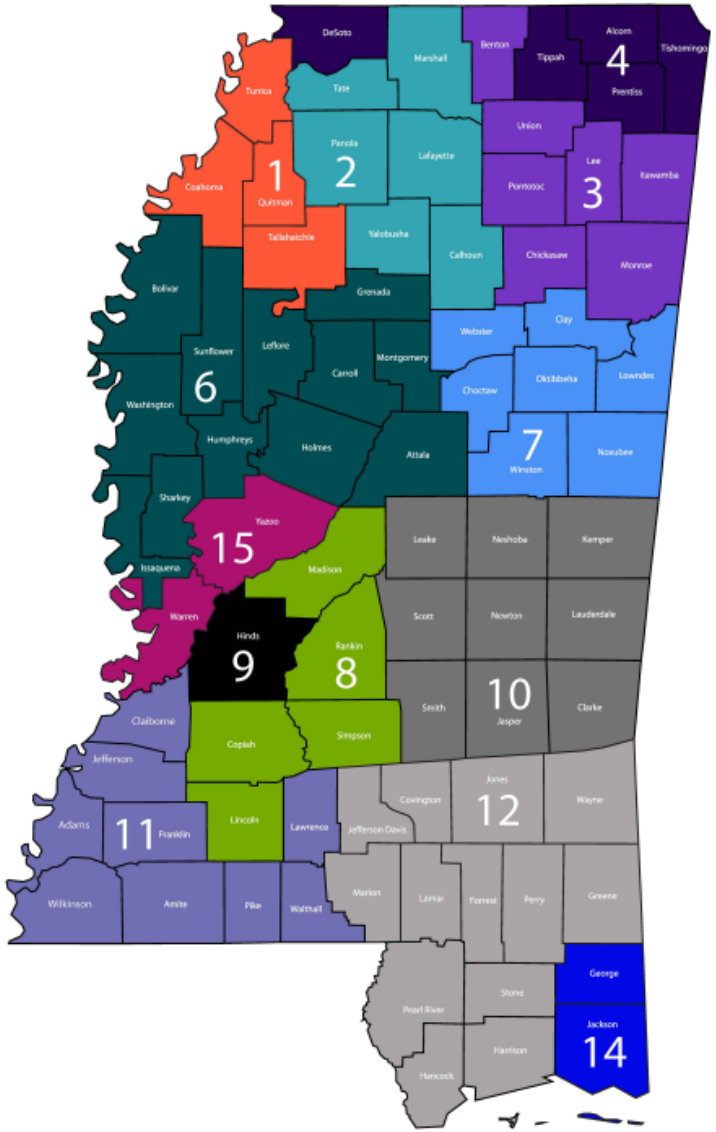
Mississippi Regional Community Mental Health Centers



CCBHCs in MS & Current Efforts

- Current SAMHSA CCBHC Expansion Grantees in MS:
  - Communicare (Oxford, MS)
  - Singing River Services (Gautier, MS)
  - Southwest Community Mental Health (McComb, MS)
- MS Department of Mental Health and Life Help (Region 6) represented MS during recent Technical Assistance:
  - Southeast Mental Health Technology Transfer Center CCBHC Learning Collaborative
    - 12 weeks, weekly call (9/23/21-12/16/21)
- Upcoming Technical Assistance:
  - National Council for Mental Wellbeing CCBHC Technical Assistance and Learning Collaborative
    - 10 monthly learning sessions

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9 Required CCBHC Services

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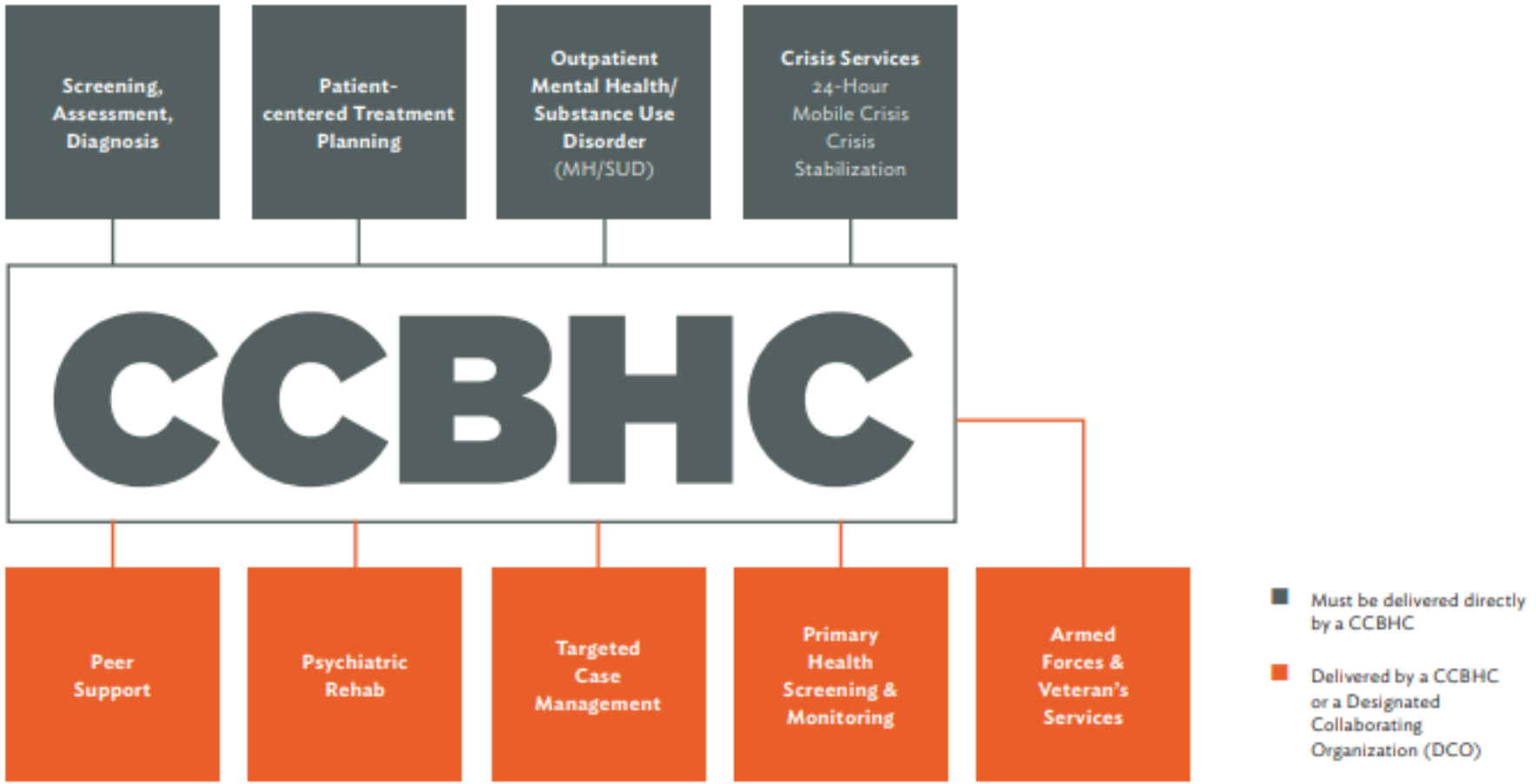

CCBHC: Care Coordination

- Care coordination is the “linchpin” of the CCBHC program
  - Creation of seamless transitions between service settings

- Care coordination is required of CCBHCs
  - CCBHCs must coordinate care across “safety-net” services (e.g., inpatient care, primary care, housing access)

- Designating Collaborating Organizations (DCOs)
  - Contractual agreements under which the CCBHC purchases the services of another provider, the DCO
  - CCBHC is clinically and financially responsible for services provided by DCOs

- CCBHC and/or formal relationships (aka DCOs) must provide all required services
  - DCOs are not required under the CCBHC demonstration

Role of Medicaid

- To implement CCBHCs in MS using Medicaid funding, MS will need to seek either the 1115 waiver or state plan amendment
  - State plan amendment defines CCBHCs as a Medicaid Service and Prospective Payment System methodology
  - Non-expansion states and states not participating in the demonstration programs are eligible for Federal Medical Assistance Percentage (FMAP) for CCBHC services
  - Approximately 18-month process

- CCBHC is a new provider type through Medicaid
  - Does not increase eligibility

- Centers for Medicare and Medicaid Services (CMS) provided guidance for Prospective Payment System Methodology

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CCBHC FUNDING STREAMS

	CCBHC Demonstration Planning Grant	CCBHC Medicaid Demonstration	CCBHC Expansion Grants
Amount of funding	$24 million	Not capped	Funds have been available yearly through SAMHSA since FY2018. Grants are awarded for up to $2 million per year for 2 years.
Source & type of funds	SAMHSA grant to states	Medicaid	SAMHSA grant to clinics
Timeframe	2015-2016; no additional funds expected to become available	2017-present (demo currently authorized through Nov. 30, 2020 with further extension anticipated. In August 2020, 2 states were added for a 2-year demonstration period.)	2018-present
Role of state Medicaid/ BH agencies	Applied for grants; led planning process	Administer and oversee state's CCBHC demonstration program, including clinic certification, payment, compliance and more	None; grants are given directly to clinics with self-attestation that they meet CCBHC criteria
Eligibility for funds	All states were eligible to apply; 28 submitted applications and 24 received grants	24 states that received planning grants were eligible to apply; 19 submitted applications and 8 were selected in 2016. The CARES Act of 2020 expanded the demo to 2 additional states.	Clinics from all states are eligible to apply if they are capable of meeting the CCBHC criteria within four months of the date of award. States do not need to have a certification process in place for a clinic from that state to apply.
Activities	Provided funds to states to plan their participation in the CCBHC Medicaid demonstration and conduct required readiness activities (e.g. needs assessment, certification of clinics, etc.). Only states that received a planning grant were eligible to apply for the CCBHC Medicaid demonstration.	Clinics provide all CCBHC services and conduct all activities of a CCBHC as required and overseen by their state. States supplemented the core SAMHSA criteria by including particular services and requirements to meet state-specific needs and goals and to adapt the program to their own state environment. CCBHCs conduct federal- and state-required data reporting. Clinics serve all individuals regardless of ability to pay.	Clinics provide all CCBHC services and conduct all activities of a CCBHC as required by SAMHSA, including basic reporting requirements. Clinics serve all individuals regardless of ability to pay.
How services are paid for	N/A	Medicaid prospective payment rate for qualifying encounters provided to Medicaid enrollees; payment as usual for Medicare, commercially insured, and uninsured	Grant funds supplement but do not supplant other coverage sources; grantees continue to bill Medicaid and other payers as usual

The Prospective Payment System (PPS)

- The Prospective Payment System (PPS) currently used by Federally Qualified Health Centers (FQHCs) and other types of health care organizations

- Current Fee for Service (FFS) system is a reimbursement of service only, not financially stable

- PPS is an average payment based on the actual costs incurred for the clinic providing services to all patients in a year:
  - Includes only Medicaid allowable costs in cost reports
  - Each CCBHC would have their own rate based on analysis of their cost reports
  - The total costs of providing care (the numerator) are then divided by the total number of designated encounters during a year (the denominator) to arrive at a per-encounter payment rate.

EX: $\frac{\$4,000,000}{15,000 \text{ encounters}} = \$266.67$

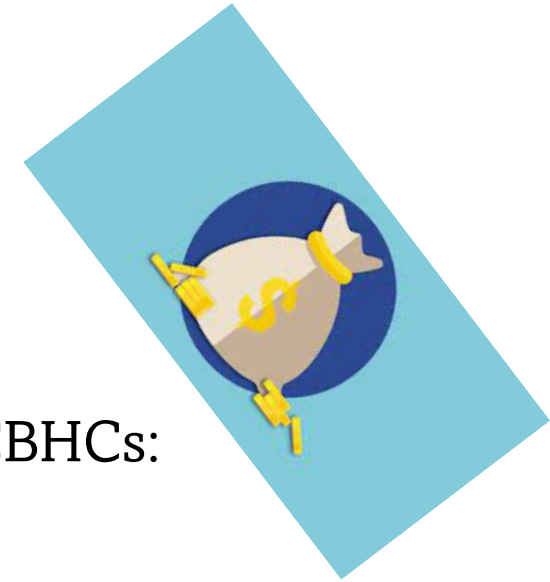
PPS

- Each time a designated encounter occurs, the clinic receives a payment. The payment is the same regardless of the intensity of services the patient receives.

- **<u>CMS PPS Methodologies:</u>**
  - **PPS-1 : Daily Rate**
    - Fixed amount for daily payment for each day a beneficiary receives a CCBHC service
    - State option to provide quality bonus payments to CCBHCs that meet metrics threshold

  - **PPS-2: Unduplicated Monthly Encounter**
    - Incorporate quality bonus payments as part of the payment
    - Fixed amount paid when at least 1 CCBHC service is delivered during the month
    - Preferable for clinics whose rates may vary depending on the populations served by the clinic (e.g., SMI, SUD)

PPS



- CCBHC demonstration program 1st year rates across 56 CCBHCs:
  - Daily rate ranged from $151-$667
  - Monthly rate ranged from $558-$902

- PPS is a value-based payment system that incentivizes high-quality and cost-effective care

Current MS PPS Medicaid Rates

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MISSISSIPPI DIVISION OF MEDICAID
RURAL HEALTH CLINIC PER VISIT RATES
Current Rates

Provider Name	PPS Rate
ABERDEEN HEALTH CLINIC INC	93.14
AFTER HOURS CLINIC	109.21
AIRPARK FAMILY MEDICAL CLINIC	221.03
ANDERSON CHILDRENS MEDICAL CLINIC	173.58
ANDREW GEORGE MD	97.79
ARRINGTON MEDICAL CLINIC	150.96
ARTHUR E WOOD MEDICAL CLINIC	87.92
BAPTIST CALHOUN RURAL HEA	
BEACHAM RURAL HEALTH CLIN	
BELMONT FAMILY MEDICAL CLI	
BMC ATTALA KOSCIUSKO PRIM	
BMC LEAKE CARTHAGE PRIMAI	
BMC LEAKE MADDEN PRIMARY	
BMC LEAKE WALNUT GROVE PI	
BMC YAZOO PRIMARY CARE	

MISSISSIPPI DIVISION OF MEDICAID
LONG TERM CARE PROVIDERS AND RATES
Current Rates

Provider Name	PPS Rate
2ND GENERATION HEALTH CARE LLC	239.41
ADAMS COUNTY NURSING CENTER	209.72
	260.00
	234.37
	268.77
	231.76
	209.71
	220.20
	228.63
	245.39
BAPTIST NURSING HOME CALHOUN INC	224.33
BEDFORD ALZHEIMERS CARE CENTERLLC	260.53
BEDFORD CARE CENTER OF HATTIESBURG	230.55
BEDFORD CARE CENTER OF MARION LLC	227.88
BEDFORD CARE CENTER OF MENDENHALL	210.57
BEDFORD CARE CENTER OF NEWTON LLC	208.76
BEDFORD CARE CENTER OF PETAL LLC	255.35
BEDFORD CARE CENTER OF PICAYUNE	248.04

MISSISSIPPI DIVISION OF MEDICAID
STATE DEPARTMENT OF HEALTH
Current Rates

Provider Name	PPS Rate
S B H EPSDT	440.33
S B H FAM PLAN CL	477.15
S B H GEN MED CL	539.69
S B H PHRM	525.28
SBH FIRST STEPS PROGRAM	447.15

MISSISSIPPI DIVISION OF MEDICAID
FEDERALLY QUALIFIED HEALTH CENTER PER VISIT RATES
Current Rates

Provider Name	PPS Rate
AARON E HENRY COMMUNITY HEALTH SER	150.16
ACCESS FAMILY HLTH SERVSMITHVILLE	139.61
AMITE COUNTY MEDICAL SERVICES INC	134.18
BENTON MEDICAL CENTER	117.80
BYHALIA FAMILY HEALTH CENTER	99.00
CENTRAL MISSISSIPPI HEALTH SERVICES	109.82
CLAIBORNE COUNTY FAMILY HC	120.25
COASTAL FAMILY HEALTH CENTER	114.14
DELTA HEALTH CENTER INC	126.77
FAMILY HEALTH CARE CLINIC	153.34
FAMILY HEALTH CENTER INC	124.99
G A CARMICHAEL FAMILY HEALTH CENTER	114.14
GREATER MERIDIAN HEALTH CLINIC	116.86
JACKSON HINDS COMPREHENSIVE HEALTH	159.94
JEFFERSON COMPREHENSIVE HEALTH CTR	98.00
MALLORY COMMUNITY HEALTH CENTER	140.11
MANTACHIE CLINIC	96.79
OUTREACH HEALTH SERVICES INC	130.26
SEBASTOPOL CLINIC	110.05
SEMINARY FAMILY HEALTH CENTER	156.79

Benefits of CCBHC model

- Reduced inpatient admissions
- Increased state hospital diversion rates
- Reduction in ER admissions for psychiatric symptoms
- Increased # of individuals served by clinic
- Increased access to mental health & addiction treatment
- Expanded capacity to address opioid crisis
- Establish partnerships with LEO and hospitals to reduce recidivism and readmissions
- Investment in workforce (on avg 41 new jobs per clinic)
- Expanding access to Medication Assisted Treatment (MAT)

(37k nationwide engaged in MAT across all 224 active CCBHCS)

- Expansion and greater utilization of crisis services

(33% operate a crisis drop-in center/23-hour observation style)

- Reduction of health disparities in their communities

Required State & CCBHC Quality Measures

- <u>CCBHC Measures:</u>
  - #/% of new clients with initial evaluation provided within 10 business days & mean # of days until initial evaluation for new clients
  - Preventive care and screening: adult BMI screening and f/u
  - Weight assessment & counseling for nutrition & physical activity for children/adolescents
  - Preventive care & screening: tobacco use- screening & cessation intervention
  - Preventive care & screening: unhealthy alcohol use- screening & brief counseling
  - Child & adolescent major depressive disorder: suicide risk assessment
  - Screening for clinical depression & f/u plan
  - Depression remission at 12 months

Required State & CCBHC Quality Measures

- State Measures:
  - Housing status (residential status at admission or start of the reporting period)
  - F/U after ER for mental health
  - F/U after ER for alcohol or other dependence
  - Plan all-cause readmission rate
  - Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications
  - Adherence to antipsychotic medications for individuals with schizophrenia
  - F/U after hospitalization for mental illness (Adult)
  - F/U after hospitalization for mental illness (Child/Adolescent)
  - F/U care for children prescribed ADHD medication
  - Antidepressant medication management
  - Initiation & engagement of alcohol and drug dependence treatment
  - Client experience of care survey and family experience of care survey

Next Steps

- Outline infrastructure strengths and deficiencies to support CCBHC, PPS model of integrated community-based behavioral care

- Partnership with Medicaid and SAMHSA in the development of pilot sites to develop cost reports

- Standardization of data collection and health information systems

- Conduct needs assessment throughout state related to access to care difficulties, care coordination, DCOs, and financial viability FFS model vs PPS model

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CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS (CCBHCS)

MEDICAID MEDICAL CARE ADVISORY COMMITTEE

DECEMBER 10, 2021

OFFICE OF THE COORDINATOR OF MENTAL HEALTH ACCESSIBILITY (OCMHA)

BILL ROSAMOND, JD, OCMHA COORDINATOR

JERRI AVERY, PHD, LPC, OCMHA CONSULTANT

CCBHCS ARE DESIGNED TO

Increase quality of care

Reduce

- Suicides
- Overdose deaths
- Barriers to timely access to addiction and mental health treatment
- Delayed care
- Inadequate care for veterans
- Use of overburdened jails and emergency departments

Are over 430 CCBHCs operating in 42 states, DC and Guam

Mississippi has three funded (federally) by SAMHSA Expansion Grants

- Regions 2, 11, and 14

SUSTAINABLE PAYMENT MODEL

FINANCIAL SUPPORT

+

PRESCRIBES SPECIFIC PROGRAMMATIC REQUIREMENTS

INCREASED RATES RESULT IN …

Enhanced workforce through paying competitive wages and increasing training in care coordination and evidence-based practices (EBPs)

Mitigation of the addiction crisis including the required provision of **medication assisted treatment for opioid and alcohol** use disorders

Increased **outreach, education, and engagement**

Services offered in **alternate locations** such as homes, emergency rooms, and jails

Improved exchange of **electronic information, data collection**, and **quality reporting**

TWO MECHANISMS FOR THE CREATION OF AN ENHANCED MEDICAID RATE THAT UTILIZES PPS

1115 Waiver (Texas)

State Plan Amendment (SPA): (Oklahoma, Minnesota, Missouri, Nevada)

SUSTAINABILITY

Requires implementation of a Medicaid 1115 Waiver or State Plan Amendment (SPA)

CMS recommends 18 months to draft the waiver and obtain approval

OCMHA proposed state funding for two years for three CMHCs ($12 million)

TWO STEPS

First Step

Department of Mental Health creates CCBHC certification process using the standardized criteria set forth by the Substance Abuse Mental Health Services Administration (SAMHSA) and state regulations

STEP TWO: DIVISION OF MEDICAID DEVELOPS AND IMPLEMENTS A PROSPECTIVE PAYMENT SYSTEM (PPS) THAT PROVIDES ADEQUATE FINANCIAL SUPPORT

Rates are clinic-specific and include the sum total of a clinic's costs

(not just the costs of persons with Medicaid)

Payment is the same regardless of intensity or quantity of services received

Does not prioritize higher-margin services over services that may be a better fit

Does not offer a financial incentive to provide lots of units of service when fewer services would be as effective

Does not require that all services be translated into units and therefore supports nonbillable activities (care coordination, outreach and engagement, services at other site locations) (Parks, 2021).

PPS

- Reimbursement based on anticipated costs
- Establishes an average daily or monthly encounter rate that is inclusive of :
  - all current and anticipated costs of care,
  - new service lines,
  - staff salaries,
  - technology costs, and
  - services delivered outside the four walls of the clinic,…
- More comprehensive reimbursement model than Fee for Services
- Provides a sound, predictable, and sustainable footing for CCBHC operations now and into the future.

COST REPORTS

ALL costs incurred by the clinic for providing services to ALL patients. *(Note that only allowable costs are included; for example, the cost report for a Medicaid PPS does not include the costs of providing residential treatment in facilities of more than 16 beds because those costs are unallowable in Medicaid.)*

The total costs of providing care (the numerator) are then divided by the total number of designated encounters during a year (the denominator) to arrive at a per-encounter payment rate.

Each time a designated encounter occurs, the clinic receives a payment. The payment is the same regardless of the intensity of services the patient receives.

OUTCOMES REPORTED

- Other states report the following **outcomes**
  - Improved workforce retention and recruitment
  - Reduced hospitalization
  - Increased access to services
  - Elimination of wait lists
  - Reduced health issues
  - Increase in veterans' services

SUPPORT FOR THE CREATION OF CCBHCS CAN HAPPEN IN ONE OF THREE WAYS:

Federal Medicaid state **demonstration** grants offering enhanced rates

SAMHSA **expansion** grants awarded directly from SAMHSA to individual CMHCs

- Two-year grants
- No funding mechanism at the end of the two-year period
- Sustaining the services created under these grant awards would require Medicaid or state funding

Independent state Medicaid initiatives utilizing the 1115 or SPA

OCMHA ARPA FUNDING RECOMMENDATION

- **State-legislation initiative allowing a financial bridge while states pursue the feasibility of or transition to implementation of a Medicaid 1115 Waiver or SPA**

- **Three state-funded clinics offering the start-up funds needed to create three additional CCBHC clinics**

AND

- **DMH and DOM simultaneously work to establish the PPS and criteria for certification**

SUGGESTIONS FOR THE THREE CMHCS

- CMHCs that illustrate the most need and are at most financial risk
- **Estimated Cost: $12,000,000**
  - (2,000,000/year for two years at three CMHCs)

FUNDING RECOMMENDATION 2:

Consulting partnerships with *The National Council of Mental Wellbeing* and other subject matter experts to:

- (1) assist DMH with the creation of the CCBHC certification process;
- (2) research available revenue enhancements, in particular the use of state source funds to leverage federal dollars;
- (3) facilitate PPS planning and cost rate development by CCBHCs and the DOM;
- (4) determine whether the use of a Medicaid 1115 Waiver or a State Plan Amendment (SPA) is the best avenue for financing;
- (5) examine the budgetary impact on the chosen future funding methodology (Medicaid 1115 Waiver or SPA budget); and
- (6) identify the most effective data platform for data analysis and sharing and development of pay for performance models.

Estimated Cost: $750,000

FUNDING RECOMMENDATION 3

Three FTEs at DMH to establish a certification system for CCBHCs

Three FTEs at DOM to

- Establish cost rate procedures
- Assist CCBHCs in submission of cost reports and to draft
- Submit and gain approval of CMS to implement the funding mechanism for PPS (1115 Waiver or SPA)

Estimated Cost: $450,000

Certified Community Behavioral Health Clinics Moving Beyond "Business as Usual" to Fill the Addiction and Mental Health Treatment Gap

Only 43.1 percent of all people living with serious mental illnesses like schizophrenia, bipolar disorders and major clinical depression receive behavioral health care,[i] and only one in 10 Americans with a substance use disorder receives treatment in any given year.[ii] In 2014, Congress enacted the bipartisan Certified Community Behavioral Health Clinic (CCBHC) demonstration program to test a model to improve the quality of addiction and mental health care and fill the gap in the unmet need for care.

In order to qualify for the CCBHC demonstration, all participating clinics had to make changes to expand their service array in required categories such as crisis services and care coordination, developing sliding fee schedules and implementing same-day access. Since launching in 2017, CCBHCs have dramatically increased access to mental health and addiction treatment,[iii] expanded capacity to address the opioid crisis[iv] and established innovative partnerships with jail diversion and hospitalization-reduction programs to improve care and reduce recidivism.[v] These entities differ from business as usual in that they are required, by statute, to provide a comprehensive range of addiction and mental health services regardless of an individual's ability to pay and are supported by a restructured payment system.

How Services are Different

Unlike traditional service organizations that operate differently in each state or community, CCBHCs are required to meet established criteria related to

care coordination, crisis response and service delivery, and be evaluated by a common set of quality measures. Furthermore, CCBHCs establish a sustainable payment model that differs from the traditional system funded by time-limited grants that only support pockets of innovation for specific populations. Early experiences demonstrate that CCBHCs have shown tremendous progress in building a comprehensive, robust behavioral health system that can meet the treatment demand.

Key Differences in CCBHC Service Delivery vs. Business as Usual

	Traditional Delivery Models	CCBHC Service Delivery
Access to Care	Low reimbursement rates result in workforce shortages, inability to recruit and retain qualified staff and limited capacity to meet the demand for treatment resulting in clinics turning away patients or placing them on long waiting lists.	CCBHCs are required to serve everyone, regardless of geographic location or ability to pay. Nationally, 100% of CCBHCs have hired new staff including 72 psychiatrists and 212 staff with addiction specialty focus expanding their capacity to meet the demand for treatment. As a result, CCBHCs report an aggregate increase of 25% in patient caseload.
Wait Times	Wait times from referral to first appointment average 48 days nationally at community-based behavioral health clinics.	For routine needs, 46% of CCBHCs offer same-day access to services and 94% offer access within 10 days or less.
Evidence- based Practices (EBPs)	No standard definition of services that requires evidence-based practices. Services vary widely between clinics with little guarantee that clients will have access to high quality, comprehensive care. Array of services and staff training is dependent upon grant funds.	CCBHCs are required to provide a comprehensive array of services including 24/7 crisis services, integrated health care, care coordination, medication-assisted treatment (MAT), peer and family support and care coordination. Across CCBHCs, 75% have expanded capacity to provide crisis care, 73% have adopted innovative technologies to support care, 57% have implemented same-day access protocols and 64% have expanded services to veterans.
Quality Measures	Quality measures are inconsistent across states, communities and grant programs.	Clinics are required to report on standardized quality metrics, while states report on additional quality and cost measures. Nationally, 79% of CCBHCs reported using quality measures to change clinical practice.
Crisis Services	Crisis services provide necessary assessment, screening, triage, counseling and referral services to individuals in need but vary nationally due to limited reimbursement.	All CCBHCs offer 24/7 access to crisis care, including mobile crisis teams, ensuring individuals of all ages receive the care they need and avoid unnecessary hospitalizations. A CCBHC in Oklahoma reported a 64% reduction in psychiatric hospitalizations as a result of its crisis response activities and improved care transitions with the hospital.

Care Coordination	Care coordination and integration of physical and behavioral health care services result in improved health outcomes and reduced costs. Traditional reimbursement does not cover care coordination services; therefore, physical and behavioral health conditions are seldom diagnosed and treated simultaneously.	CCBHCs are required to coordinate care with hospitals, schools, criminal justice agencies and other providers to improve health outcomes and reduce use of emergency room and inpatient facilities. Estimated savings of guiding one high-resource-user to care coordination is estimated to be $39,000 per year. These activities are incorporated into the reimbursement rate.
MAT Access	Nationally, only 36% of substance use treatment facilities offer access to one or more types of MAT, due in part to funding shortfalls that prevent hiring prescribers.	92% of CCBHCs offer MAT due to state-driven requirements and a reimbursement rate that supports prescriber hiring and training.
Payment	Services are supported by grant funding that is limited in scope and not sustainable.	CCBHCs establish a sustainable payment model that ends reliance on time-limited grants.

CCBHCs are leveraging their status and payment to expand treatment capacity and serve more individuals in their communities with a comprehensive array of evidence-based services. The model moves the treatment system beyond "business as usual" to fill the treatment gap and hold clinics accountable for high-quality outcomes.

Preparing the Next Generation

Since Fiscal Year 2018, Congress has appropriated annual grant monies to help organizations build readiness to become CCBHCs. There are now organizations across 33 states operating or preparing to operate as CCBHCs. While these grantees do not receive the same sustainable payment as those in the original demonstration, they are building the infrastructure and capacity to perform as a CCBHC should the program be expanded.

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[i] Park-Lee, E., Lipari, R. N., Hedden, S. L., Kroutil, L. A., & Porter, J. D. (2017, September). Receipt of Services for Substance Use and Mental Health Issues among Adults: Results from the 2016 National Survey on Drug Use and Health. NSDUH Data Review. Retrieved from https://www.samhsa.gov/data/report/receipt-services-substance-use-and-mental-health-issues-among-adults-results-2016-national

[ii] Ibid.

[iii] National Council for Mental Wellbeing. (2017, November 28). CCBHC Demonstration. Early results show expanded access to care, increased scope of services [fact sheet]. Retrieved from https://www.thenationalcouncil.org/wp-content/uploads/2017/11/National-CCBHC-survey-write-up-FINAL-11-28-17.pdf

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