NATIONAL COUNCIL *for* Mental Wellbeing

APPROACHES TO SUSTAINABILITY FOR CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS:

An Environmental Scan and Guidance for Grantees

CCBHC-E National Training & Technical Assistance Center

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

THIRD HORIZON STRATEGIES

This publication was made possible by Grant Number 1H79SM085856 from the Substance Abuse and Mental Health Services Administration (SAMHSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views, opinions, or policies of SAMHSA, or the U.S. Department of Health and Human Services (HHS).

BACKGROUND

First enacted federally under Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014 (Public Law 113-93), Certified Community Behavioral Health Clinics (CCBHCs) provide a robust range of mental health and substance use disorder (SUD) services – jointly referred to as behavioral health -- services to underserved individuals. CCBHCs can be funded and supported through the CCBHC Medicaid Demonstration, Substance Abuse Mental Health Services Administration (SAMHSA) CCBHC Expansion (CCBHC-E) grants, or independent state programs, with authorization through the Centers for Medicare and Medicaid Services (CMS) for a Medicaid 1115 waiver or State Plan Amendment (SPA). As of the publication of this resource, there were at least 500 CCBHC sites nationwide.

SAMHSA CCBHC-E grants are time limited and serve the specific purpose of assisting organizations in developing, establishing and implementing the CCBHC model to provide a comprehensive range of outreach, screening, assessment, treatment, care coordination and recovery supports. SAMHSA grantees are required to develop and implement a plan for sustaining the delivery of the CCBHC criteria and services once federal grant funding ends.

However, many grantees are challenged to achieve long-term, sustainable funding without an opportunity to move into a Prospective Payment System (PPS) as provided in the CCBHC Medicaid demonstration and promulgated by CMS. The CCBHC PPS is a special payment mechanism that sets rates informed by CCBHCs' costs of delivering care. Outside of the CCBHC PPS, community-based behavioral health providers have had limited opportunities to participate in value-based payment (VBP) or alternative payment models (APMs) that support the delivery of comprehensive services and effective interventions and models of care.[1] High levels of state interest in the CCBHC model are driving implementation efforts via SPAs and waivers, but these take time to roll out and may not be feasible in every state. Recently, legislation through the Bipartisan Safe Communities Act will allow for expansion of the CCBHC demonstration programming, adding up to 10 states every two years beginning July 2024.

The SAMHSA-funded CCBHC Expansion Grantee National Training and Technical Assistance Center, in partnership with the National Council for Mental Wellbeing (National Council) and Third Horizon Strategies (THS), conducted an environmental scan to assess the sustainability landscape for CCBHC-E grants. This paper aims to summarize the results of those efforts and identify impactful strategies being utilized by grantees to achieve sustainable funding. A key takeaway is that the most promising course of action seems to be partnerships to create a permanent CCBHC funding mechanism at the state level. A limitation of this resource, or the broader landscape, is that outside of the CCBHC demonstration states, THS could identify only a limited number of providers with access to other APMs to sustain model implementation.

1 Bailey, et al. "Behavioral Health Provider Participation in Medicaid Value-Based Payment Models: An Environmental Scan". Center for Health Care Strategies, 2019.

METHODOLOGY

To better understand the funding landscape, THS undertook two efforts: 1) Conducting a brief review of specialty community behavioral health providers' participation in APMs, and 2) Identifying and engaging nine CCBHC-E grantees (selected specifically for their work in sustainability) in interviews to learn their approaches to sustainability planning.

All interviewees were current SAMHSA CCBHC-E grantees in CCBHC demonstration and non-demonstration states. They also a) responded affirmatively that they had an APM in place or were pursuing one, or b) were recommended by SAMHSA as having a strongly written sustainability plan, or c) are in a state known to be at various stages of seeking state-based support for CCBHC.

Interviewees included:

CHRISTIE EVERETT
Director of Operations,
Clara Martin Center, Vermont

BOB SIEGMANN
Executive Director,
Centerstone Health Services, Indiana
(part of the more prominent, multi-state agency, Centerstone)

WENDY SISK
Executive Director,
Peninsula Behavioral Health, Washington

JOHN GAVINO
Associate Chief Program Officer,
Family & Children's Services, Oklahoma

CANDACE DURHAM
Project Director,
Life Springs, Indiana

JENNIFER LEOSZ
Co-chief Executive Officer,
Mental Health Partners, Colorado

MICHAEL D'AMICO
Vice President,
Oaks Integrated Care, New Jersey

MAX STEYER
Executive Vice President,
Performance Management, FCC Behavioral Health, Missouri

STEVE DENNY
Deputy Director,
Four County, Kansas

BEHAVIORAL HEALTH PARTICIPATION IN APMS

THS reviewed existing research and models of APMs relevant to behavioral health with consideration for alignment with CCBHC. There are numerous obstacles to behavioral health provider participation in APMs. Many APMs are driven by attribution methods that are tied to either a health system or primary care assignment. There are few examples of those contracting mechanisms accruing value to specialty behavioral health providers. Another obstacle is that APMs have historically utilized quality measures and/or upside or downside risk tied to impacting the total cost of care; yet behavioral health providers may lack access to the claims data necessary to demonstrate that impact.

In a 2019 environmental scan, the Center for Health Care Strategies described that despite the increasing adoption of APMs, the extent to which APM policies in state Medicaid programs are inclusive of specialty behavioral health varies significantly across states. Further, the scan found that "while VBP provides an opportunity to improve quality and access to behavioral health care, significant structural and policy barriers to VBP adoption exist for behavioral health providers." These barriers include a lack of state interest in targeting specialty behavioral health providers for APMs, primary care focused attribution models, technological and regulatory challenges to participation in health information exchanges and other barriers. The scan cited the PPS in CCBHC demonstration states as one of the primary behavioral health focused value-based payment models currently in use.

The Addiction Recovery Medical Home Alternative Payment Model (ARMH-APM) is a multi-faceted payment model that uses a bundled approach for addiction treatment and recovery services. Some specific state Medicaid programs have shown interest in the model and a few integrated systems and commercial markets have launched promising pilots such as AmeriHealth Caritas District of Columbia. The ARMH-APM is based on a total cost of care and is not designed to support the full array of services built into the CCBHC model. Elements of the CCBHC service requirements that could align with and potentially be sustained by the ARMH-APM include outpatient SUD treatment and recovery supports, as well as care coordination, particularly pre- and post-hospitalization.

The National Academy of State Health Policy (NASHP) described three VBP strategies some states use to improve SUD treatment for Medicaid beneficiaries: Incentives for managed care plans to improve performance on SUD quality metrics, requirements for plans to increase the use of VBP models that include SUD providers and services and requirements for plans to pay providers of SUD services via a model that was uniform across all projects. The paper did not examine the ability of these payment models to sustain the CCBHC model, though again, the SUD treatment and recovery supports required within CCBHC align with these models.

The Centers for Medicare & Medicaid Services (CMS) outlined its behavioral health strategy in 2022; however, as of the publication of this paper, they have not released any new APM models for specialty behavioral health providers. CCBHCs are a supporting activity under Goal 4: Improve access and quality of mental health care and services.

The University of Michigan Behavioral Health Workforce Research Center conducted a survey to assess the success of CCBHCs in obtaining APM arrangements beyond the PPS. The survey received a limited response, with nine sites completing the survey. Only one of the nine, Oaks Integrated Care (Oaks) in New Jersey, indicated they currently have an APM with a commercial payer. THS interviewed Oaks for this paper.

KEY FINDINGS AND RECOMMENDATIONS

THS interviewed nine CCBHC-E grantees to solicit information about their sustainability plans, including strategies for sustainability, what data and metrics they were collecting to demonstrate the impact and value of their work as a CCBHC and what recommendations they had for other grantees. THS also reviewed websites and materials provided by the interviewed organizations. Interviews revealed six common themes:

1. Focus on sustainability planning efforts that help achieve internal efficiencies, maximize billing and understand costs.

Interviewees described basic steps grantees should undertake that reflect sound business practices. Recommendations included crosswalking CCBHC services with allowable CPT codes within the state and assessing current billing practices to maximize billable costs. It is vital to the sustainability of behavioral health services generally and for CCBHCs specifically to manage claims properly, minimize coding errors and promptly handle rejected claims. Interviewees discussed the importance of ensuring the right person with the required credentials is in the role for billing for services.

Several interviewees, such as Family and Children's Services (Oklahoma) and Four County (Kansas), have been preparing to move from CCBHC-E grant funding into the CCBHC demonstration or state-led certification process tied to a Medicaid SPA. They started to capture all costs related to CCBHC to inform PPS or APM negotiations and to assess rate adequacy. They advise other grantees to walk through the CCBHC cost report early, with a technical expert if possible.

SUGGESTED STRATEGIES AND TACTICS:

- **Identify CCBHC billable services.** Crosswalk CCBHC services with allowable CPT codes within your state to identify any services or billing opportunities you may not currently be utilizing. Be sure to identify all CPT procedure codes that you are directly providing under each CCBHC core service category, as well as all types of licensed or unlicensed provider types that you may be using to provide each service. Based on the services provided and licensure level of provider(s) used, identify whether these services are reimbursable under your state Medicaid plan, by Medicare or under your various other third-party, private payer contracts. See Exhibit 1 for a sample framework to assess and identify billable CCBHC services.

CONTINUE →

EXHIBIT 1

CCBHC CPT CROSSWALK						
CCBHC Category	*List CPT Code Service Provided*	*Provider Type Used in Service Delivery*	*Medicaid Reimbursable in your State*	*Medicare Reimbursable*	*Commercial Payer Reimbursable*	*Reimbursable by local managed care organizations*
Crisis Behavioral Health Services						
Screening, Assessment and Diagnosis						
Outpatient Mental Health and Substance Use Disorder Services						
Outpatient Primary Care Screening						
Targeted Care Management						
Psychiatric Rehabilitation Services						
Peer Support and Counselor Services and Family Supports						
Targeted, comprehensive outpatient veterans services						

CONTINUE →

- **Assess and establish processes to optimize billing.** Run an assessment of your current billing practices including clinical and coding documentation. Consider working with financial experts and your internal team to refine processes that can minimize billing and coding errors and optimize reimbursement.
- **Capture your costs as a CCBHC.** Familiarize your organization with the CCBHC cost report and establish a process for capturing and assessing all costs related to CCBHC implementation. CCBHCs need to understand their total cost of operation, allocated between direct CCBHC services, non-CCBHC services and overhead. The accounting system established must be able to adequately account for costs between these three cost centers to allow for proper reporting of costs in a cost reporting exercise. In addition, billing systems may need to be improved to accurately account and report on billable visits in a future CCBHC PPS rate environment. As you identify a process for assessing the total cost of CCBHC program implementation, key questions to ask include:
  - **Staffing costs:** How are you tracking staff time and effort related to the CCBHC program and how are you capturing this in your systems to easily identify the full cost of the program?
  - **Other direct costs:** Are you updating your accounting systems to assign codes to direct CCBHC costs for future capturing and monitoring? Do you have an allocation methodology in place to capture and assess other direct costs that may be shared across several programs, including the CCHBC program, such as telehealth infrastructure?
  - **Indirect and administrative costs:** Do you have an allocation methodology in place to identify the proportion of occupancy costs, maintenance, depreciation, etc., attributable to the CCBHC program? Does your allocation methodology accurately include administrative costs such as office supplies, insurance or other overhead expenses?

Tip: *Remember to identify a means to assess both incurred costs as well as anticipated costs as you develop the full cost of your CCBHC program*

2. Capture and share compelling data to demonstrate the value proposition of CCBHCs and promote sustainability.

As discussed in this guide from National Council, a value proposition is a positioning statement that explains what benefits your organization provides, for whom they are provided and why your organization is uniquely positioned to offer them. Having a clear understanding and articulation of the value that you bring as a CCBHC is essential to positioning your organization for future sustainability – whether that be to demonstrate CCBHC's impact and promote future state implementation of the model or engage with payers to explore opportunities for alternative payment models.

Data points help enhance a value proposition. CCBHC-E grantees can use their value proposition to bolster community support for the CCBHC model by applying the following tactics:

- Integrate data points into fact sheets and white papers.
- Share outcomes in community forums.
- Host clinic tours and invite clients to share their success stories.
- Write op-eds or letters to the editor and issue public service announcements for local media.
- Provide data to state agencies, legislators and key decision makers to demonstrate the value of the CCBHC model and considerations for state adoption.

As different messages will resonate with diverse audiences, interviewees described the need for CCBHC-E grantees to tailor their messages.

By far, grantees pointed to increased access to care as the data domain that resonated most with decision makers to support the value proposition of CCBHCs. Interviewees described that some of the services required in the CCBHC scope were not previously available in the community, such as mobile crisis, targeted assistance to veterans and care coordination. Expanded workforce capacity, requirements around serving everyone regardless of ability to pay and quality metrics mandating that clients be seen within 10 days have also increased access to care.

Some interviewees stressed the importance of sharing SAMHSA's National Outcomes Measurement System (NOMS) data, such as those showing improvements in symptom severity, housing stability and perception of care. They have incorporated NOMS data into communications, such as other grant proposals, annual reports or issue briefs.

Although CCBHC-E grantees through 2022 were not required to report on the nine clinic-led measures, some interviewees implemented processes to collect and analyze this data as if a requirement. They view this as critical to readiness for participation in the CCBHC Medicaid demonstration or other state-led initiatives.

SUGGESTED STRATEGIES AND TACTICS:

- Develop a value proposition using your CCBHC-E grantee data. These examples (CCBHC Impact Report, Transforming State Behavioral Health Systems) of how CCBHC data has been used at a national level to showcase impact may be of use to guide thinking about what data points are relevant and compelling to various audiences.
- Identify opportunities to share the value proposition using a variety of tactics and communication strategies.
- Tailor messages to the interests of specific audiences.
- Prepare to collect and report on additional data elements required under the CCBHC Medicaid demonstration.

3. Build or expand community partnerships that can help champion the value of CCBHCs to state policymakers.

There was consensus among the interviewees around the importance of building partnerships and champions of CCBHCs in the community within and outside of health care, such as law enforcement, schools, human service organizations, etc. Some interviewees used data to help develop new relationships in their local community, such as identifying shared clients with FQHCs, other primary care providers and hospitals. Others were able to enhance existing partnerships and benefit from data sharing that demonstrated the return on investment across the community. Interviewees often cited law enforcement and first responders as likely proponents of CCBHCs once grantees can demonstrate the impact of crisis services and other model components that reduce criminal involvement or unnecessary emergency department and hospital utilization. Several interviewees had dedicated staff capacity to build these partnerships through community health workers, program staff or people in leadership positions.

By building a groundswell of supporters of the CCBHC model, clinics may be more likely to create sustainable funding streams such as through local government contracts and have advocates beyond providers who can advocate with state legislators and state agencies to pursue a statewide CCBHC funding mechanism.

Grantees also highlighted partnerships with Federally Qualified Health Centers (FQHCs) or other primary care providers, hospitals and human service organizations to improve client outcomes, enhance care coordination and build relationships that can outlive grant funding if those partners recognize the value of CCBHCs and work collaboratively to identify long-term funding.

SUGGESTED STRATEGIES AND TACTICS:

- Identify who will be responsible for building or nurturing specific partnerships and collaborations.
- Share the clinic's vision for CCBHC and available data on the impact of CCBHC with likely partners.
- Create a partnership of supporters, who can help inform and educate key state and local partners and funders about the value of CCBHCs.

4. Work alongside other grantees and state associations to educate and communicate the value of CCBHCs and explore pathways for statewide implementation.

Without exception, each CCBHC-E grantee interviewed described access to a PPS or other permanent funding stream built into the state Medicaid program as necessary to sustain their CCBHC programming. Interviewees were at various stages of working with their state associations and state officials to implement support for CCBHCs.

Note: *Federal law prohibits the use of appropriated funds for publicity or propaganda purposes or for the preparation, distribution or use of the information designed to support or defeat legislation pending before Congress or state legislatures. It is important that grantees do not use any federal funding to support advocacy or lobbying efforts.*

Efforts adopted by some CCBHCs include:

- **Clara Martin Center** worked with the National Council, its state association, elected officials and regulatory agencies' leadership in Vermont to institute a "CCBHC Policy Academy," which served as a forum to convene and educate key stakeholders, including but not limited to government officials and current or prospective CCBHCs, about the CCBHC model, implementation pathways and lessons learned from other states and consider alignment of CCBHC implementation with state Medicaid and behavioral health goals.
- **Centerstone and Life Springs** in Indiana both advocated for the state's legislative and administrative branches to ensure the passage of legislation that formalizes a plan of action to establish CCBHC in alignment with federal criteria, including the payment structure, and connects the effort with 9-8-8 (the national suicide and crisis prevention lifeline), by November 1, 2022.
- **Peninsula Behavioral Health** worked with the Washington state behavioral health association and state officials to secure bridge funding for CCBHC-E grantees whose grant terms are ending and to enact a budget provision that requires the state to conduct a study on launching a statewide CCBHC program.
- **Mental Health Partners** in Colorado is using its NOMS data and common data points across CCBHC grantees in Colorado and working with its state association to educate state leaders about the impact and value of the CCBHC program.
- **Four County** in Kansas conducted extensive outreach to legislators and key stakeholders, shared its data and worked with its state association to pass legislation requiring Kansas to implement a SPA. Four County is one of the first CCBHCs to be certified by Kansas.

SUGGESTED STRATEGIES AND TACTICS:

- Let government agencies and policymakers know you are doing this work. When you receive a CCBHC grant, issue a press release and send communication to state policymakers and other stakeholders introducing them to the work you will be doing and the community impact you aim to achieve as a CCBHC. Ask government officials about the problems they are trying to solve within the mental health and substance use spaces and track how your CCBHC efforts may provide a solution for their needs.
- Identify and connect with your state behavioral health association and other CCBHC grantees within your state to understand the current landscape and consider opportunities for collaborative education and/or sharing of data and impact. Pilot programs that are run through a state often monitor progress and successes. As the CCBHC grant goes directly to the clinics and not the state, collaborative efforts from clinics to align data, metrics and outcomes is key to educating policymakers.
- Communicate frequently. Keep key stakeholders updated on your progress – consider sharing data and progress as well as patient or community success stories periodically throughout the year. Many different community programs – both within and outside of health care – will be positively affected by the CCBHC model. In communicating with partners such as law enforcement, schools or shelters, see how their outcomes have been affected by the CCBHC grant.

5. National CCBHC Expansion is a pathway to sustainability.

In July 2022, Congress passed the Bipartisan Safe Communities Act, legislation to dramatically increase funding for mental health programs and reduce the threat and incidence of violence in America. Included in the act's provisions is an expansion of opportunity to apply for the CCBHC demonstration program to states that are not currently participating in the program and a provision of planning grant funds for states to develop proposals to join the program. The CCBHC provisions of the bill include:

- Expanding the CCBHC demonstration program to allow any state not currently in the demonstration program or the District of Columbia the opportunity to apply to participate in the demonstration while allocating additional planning grant monies for states to develop proposals to participate.
- Starting in July 2024, and every two years after that, up to 10 additional states will be selected by the Department of Health and Human Services (HHS) to join the demonstration.
- Seven of the original eight demonstration program states are extended to September 2025, and the two newer demonstration states (Kentucky and Michigan) are extended to six years after their program launch.

In interviews conducted after the passage of the legislation, interviewees expressed optimism that this landmark federal law will help spread CCBHC to additional states and they view this as their most significant opportunity for permanent, sustainable funding. They recommend that CCBHC-E grantees work with their state associations to educate state leaders about the CCBHC model and encourage them to take advantage of these new opportunities.

SUGGESTED STRATEGIES AND TACTICS:

- Work with your state association to educate state leaders about the CCBHC model, leveraging any impact data from individual and collective CCBHCs and connections to state priorities and needs.
- Closely track policy process, such as the timeline of activities and funding authorized by the Bipartisan Safer Communities Act, and communicate with state policymakers about opportunities, such as SAMHSA's notice of funding opportunity for CCBHC state planning grants.
- Engage in state planning processes – share data and experience as a CCBHC, participate in workgroups or other planning activities to shape state programming.

6. CCBHC can help prepare providers for APMs. However, these do not replace the need for a permanent state-led CCBHC model.

Three interviewees had experience participating in an APM outside of the CCBHC PPS including:

- **Mental Health Partners** has a subcapitation arrangement or per-member-per-month with their Regional Accountable Entity (Colorado's name for a Medicaid managed care organization). The arrangement predates their CCBHC-E grant and does not cover the costs of all of the outreach and engagement strategies they have implemented through the grant, such as community health workers, which are not currently reimbursable.
- **Oaks** has an APM in place with a commercial payer, consisting of a bundled case rate for covered beneficiaries with a qualifying condition.
- **Centerstone** has held various APM contracts in different states in recent years, including with Anthem for commercially insured clients, though none was specifically for the full range of CCBHC services.
- In each case, the arrangements either are separate from the Medicaid PPS (Oaks) or were viewed as insufficient to sustain CCBHC without a permanent funding mechanism within the state Medicaid plan. FCC attempted to secure a commercial APM until the payer unexpectedly ended the negotiations.

SUGGESTED STRATEGIES AND TACTICS:

- As you are investing in health information technology as a CCBHC, consider infrastructure that could be beneficial to managing to an APM, such as EHR and financial management system enhancements.
- Develop your system's ability to capture all meaningful touches with clients and all associated costs. The ability to describe all the services/contacts that CCBHCs are having with their clients can help drive the return on investment and make the value case to payers. This will assist with developing a VBP rate and selling it to payers.

CASE STUDIES

CLARA MARTIN CENTER (CLARA MARTIN):
Educating state leaders through a CCBHC Policy Academy

Clara Martin is a community-based, nonprofit organization with five locations, and in February 2021 became the first CCBHC-E grantee in Vermont. Clara Martin's mission is to provide acute and long-term behavioral health care services. The organization strives to be consumer-sensitive, cost-effective and outcome based.

Clara Martin's sustainability planning focused on working collaboratively to pursue a permanent state-based funding mechanism. The organization has a highly collaborative relationship with the state of Vermont and is active in its state association. Soon after the implementation of CCBHC, Clara Martin partnered with the National Council to bring a "CCBHC Policy Academy" to the state. The academy was designed to establish a foundation for policymakers and clinics to assess if and how the state, its CCBHC grantee clinics and other provider organizations in the behavioral health care delivery system could evolve to be a statewide, sustainably funded model.

The steering committee includes providers, people with lived experience, the Medicaid office, state legislators and representatives from the Department of Public Health, the Department of Mental Health and the Department of Aging and Independent Living.

Simultaneously, Clara Martin works with the state association to educate other community behavioral health providers about CCBHC and sharing outcomes. Collectively, it is working to align outcomes and screening tools, looking at evidence-based practices (EBPs) that they could all adopt as a unified system and preparing to demonstrate to state officials that there is already a system set up that will make it easier for the state to move forward with a state plan amendment.

According to Christie Everett, director of operations, it is essential that grantees work collaboratively to engage with and educate state officials and "consider how to reduce their burden and give them fewer reasons to say no." Christie indicated that once the mental health department realized all nine other mental health centers were interested in CCBHC, the department took it much more seriously.

CENTERSTONE:
Leveraging alignment as a FQHC look-alike

Centerstone operates 170 locations in Florida, Indiana, Illinois and Tennessee and has multiple CCBHC-E grants. Centerstone's mission is to deliver care that changes people's lives. In Indiana, the organization opened Centerstone Heath Services in April 2019, a FQHC look-alike. Bob Siegmann is the first executive director of Centerstone Health Services.

Although the prospective payment system (PPS) available to FQHCs and look-alikes may not fully sustain CCBHC services (Ex: the CCBHC-required crisis services, such as mobile crisis, are not built into the FQHC PPS), Centerstone has leveraged their look-alike status to support specific aspects of CCBHC, such as primary care monitoring and screening. They can provide a higher level of integrated care services as a result.

Centerstone has built on its experience with CCBHCs, as well as Health Homes, to attempt to negotiate value-based payment arrangements with commercial payers.

PENINSULA BEHAVIORAL HEALTH (PENINSULA):
Promoting CCBHC exploration at the state level

Peninsula operates clinics in four locations in Washington, with the mission to provide excellent psychiatric treatment focusing on a collaborative approach to patient care using up-to-date standard practices of medicine in a welcoming, safe environment. Peninsula was awarded a CCBHC-E grant in April 2020, and is now one of 13 grantees in the state.

According to CEO Wendy Sisk, its adoption of the CCBHC model led to a record number of people accessing behavioral health care and improved employee recruitment and retention efforts based on salary increases afforded to the organization because of CCBHC-E funding. The most dramatic outcomes measured are in primary care screening and monitoring. Peninsula went beyond the CCBHC requirements for scope of services and fully integrated behavioral health and primary care services by hiring a primary care provider and nurse practitioner. She shared a success story about one client who had previously been going to the emergency department more than 10 a month. Integrated services under CCBHC reduced this to three or four ED visits in three months.

Peninsula improved its capacity for population health management to demonstrate strong outcomes to managed care organizations, the state and other key partners. The organization hired a data analyst that built a dashboard and disease registry that augments and is linked to its electronic health record (EHR). The dashboard provides a mechanism to monitor all patients with hypertension, asthma, diabetes and other diagnoses, illustrating significant changes in their health status.

Peninsula also worked with managed care partners to contract for new services it had not provided before becoming a CCBHC, such as SUD Level II services. This is an example of how a grantee used its funding to expand on its service array and secure more sustainable funding for certain portions of the CCBHC scope of services.

Peninsula partnered with its state association to educate other stakeholders about CCBHC. As a result of the state association's efforts, the state secured "bridge funding" for CCBHC-E grantees whose grants were ending as the state plans for CCBHC. The state authorized the ESSB 5693 Sec. 215 (123) – CCBHC Bridge Funding Budget Proviso that reads:

"$5,000,000 of the general fund—state appropriation for the fiscal year 2023 is provided solely for bridge funding grants to community behavioral health agencies participating in federal certified community behavioral health clinic expansion grant programs to sustain their continued level of operations following [the]expiration of federal grant funding during the planning process for adoption of the certified community behavioral health clinic model statewide."

Washington State also invested $300,000 for a study on launching the CCBHC model, which will include a focus on crisis response and potential avenues for a state-supported funding mechanism.

FAMILY AND CHILDREN'S SERVICES (FCS):

Leveraging CCBHC Expansion grant funding to establish foundations for participating in the demonstration

FCS has 11 locations in Oklahoma, with the mission to promote, support and strengthen the wellbeing and behavioral health of adults, children and families. FCS has received CCBHC-E grants since 2018. Oklahoma is a CCBHC Medicaid demonstration state, and FCS is now working on transitioning from grant funds to being a state-certified CCBHC.

The Oklahoma Department of Mental Health and Substance Abuse Services granted Family & Children's Services a permit for temporary operation certification to operate as a CCBHC in January 2021. FCS strategically pursued agency-wide CCBHC designation in concert with Oklahoma's Medicaid expansion under the Affordable Care Act, which went into effect July 1, 2021.

Operating in a demonstration state, FCS's eye was on sustainability through state certification since it received the grant. According to John Gavino, associate chief program officer, FCS worked hard to understand and maintain high fidelity to the requirements of the demonstration, including state-specific elements, even while initially funded as a grantee. FCS has staff designated to track and remain updated on policy changes and future opportunities. FCS continues to develop data analysis and visualization tools to measure its impact in anticipation of state certification as a CCBHC. Key metrics include time to initial evaluation and several primary care measures. FCS is working to develop the capabilities to report on all of the quality measures required in the CCBHC demonstration.

FCS's goals are to improve outcomes and reduce long-term costs, focusing on providing services that engage clients in primary care and reduce unnecessary emergency department utilization. FCS determined that it was essential to the sustainability of CCBHC to put a robust risk stratification system in place. "Knowing where clients fall within the tiered risk pyramid helps us to manage grant money and allocate resources appropriately," John explained. FCS uses the client assessment record, LOCUS/CALOCUS, history of hospitalization and factors such as suicide risk to inform this stratification.

John described a philosophical shift within the organization as a necessary precursor to sustainability. Both staff and clients needed to understand the value of integrated, whole-person care. In addition to mental health and SUD treatment, FCS is now screening and assessing for physical health concerns like weight, diabetes and nicotine usage. It works to break down internal and external siloes and better coordinate as a team.

LIFE SPRINGS:

Demonstrating the CCBHC value proposition of increasing access to care

Life Springs is a community behavioral health provider in southern Indiana with 20 locations. Life Springs' mission is "to improve and sustain the quality of life in our communities by providing comprehensive behavioral health, addiction, primary care and related services." As a CCBHC-E grantee, Life Springs offers CCBHC services in two counties.

According to Candace Durham, project director, Life Springs has used its access to care data as a CCBHC-E grantee to build community support for the CCBHC model. Stakeholders such as the Indiana Division of Mental Health and Addiction have found it compelling that Life Springs has "new ways of getting people through the door for the first time – we are serving new people" who were not previously receiving care. Life Springs offers a more robust array of services than before CCBHC. For example, one of the requirements of the CCBHC model is a 24/7 mobile crisis, and no one in the area was offering that.

Candace worked with the VP of crisis intervention and looked at the CAHOOTs model in Eugene, Oregon. Life Springs closely coordinated with the sheriff and police departments interested in seeing new approaches to dealing with mental health crises and diverting from going to the hospital or jail. Partnerships with law enforcement have strengthened Life Springs' advocacy work to show that CCBHC is needed, as they have demonstrated that crisis services can help reduce criminal justice involvement.

As Life Springs plans for sustainability, one necessary step Candace described is to map out or cross-reference CCBHC services with what Medicaid currently does and does not pay for in Indiana. Candace expressed particular concern for the mobile crisis services.

MENTAL HEALTH PARTNERS (MHP):

Using data to develop the CCBHC value proposition

MHP is a community mental health center with five locations in Boulder and Broomfield Counties in Colorado. MHP's mission statement is "Healing is our purpose. Help is our promise. Health is our passion." MHP provides immediate access to expert mental health and substance use care so people can enjoy healthy and fulfilling lives. MHP has been a CCBHC-E grantee since 2018, receiving two rounds of SAMHSA funding.

MHP has a pre-existing APM arrangement with its Medicaid managed care organization, called a Regional Accountable Entity (RAE) in Colorado. MHP receives a subcapitation rate in the form of a per-member-per-month from their RAE, which is calculated based on the percentage of Medicaid beneficiaries it serves in the region (currently 45%). MHP may also receive quality bonus payments; six metrics determine incentive payments. If the RAE meets the incentive measures, it receives an additional payment from the state that is then shared with MHP on a proportional basis.

According to Jen Leosz, co-CEO of MHP, MHP uses CCBHC-E grant funds to pay for services not covered under their subcapitation arrangement, such as extensive outreach conducted by community health workers that helps people in need who have not previously been seen by MHP get connected to services. The grants also support data collection and analytics that are more robust than MHP would otherwise have the capacity to perform.

MHP uses CCBHC data, such as NOMS outcomes, to build the value case for local funding through the counties and municipalities they serve. MHP is developing a communication plan to promote the CCBHC model and share its outcomes more broadly. It is partnering with the Colorado Behavioral Healthcare Association to encourage the adoption of CCBHC at the state level. Jen recommends that CCBHC-E grantees do some financial analysis that compares their current funding arrangements with how they would fare under a PPS payment model.

OAKS INTEGRATED CARE (OAKS):

Building on the success of CCBHC to diversify revenue and attain a commercial APM

Oaks is a behavioral health provider in New Jersey with a mission to empower and support individuals and families to achieve emotional and physical wellness by providing quality health and social services. Oaks received a CCBHC-E grant in April 2020. New Jersey is also a CCBHC demonstration state.

Oaks is one of the few CCBHC sites that identified themselves as having an APM in place with a commercial payer. Oaks receives a monthly, bundled case rate to provide an "Integrated System of Care" (ISC) for clients with serious mental illness and a similar rate for clients with SUD. They have approximately 250 attributed clients in this arrangement.

Oaks' success with CCBHC provided some leverage in negotiating the APM. The service model design and the claims-based outcomes measures in the ISC are very similar to those used in CCBHC. Oaks also had prior experience with an integrated health home model, which led to solid outcomes and helped them develop the skills and capabilities needed to manage an APM.

Michael D'Amico, vice president, says the Oaks know-how as a CCBHC was instrumental in preparing the agency for success in an APM. "We had a learning curve managing specifically the PPS and outcome reporting for CCBHC, and this prepared us well to implement the bundled payment." Michael also described that they had to reconfigure their EHR to ensure billing and coding were done correctly.

Michael indicated that one of the other factors that led to their APM was that new leadership at the payer organization came from community mental health. One lesson for grantees from Oaks' experience is to seek relationships with the right people within a payer organization and arm them with the best information and data to help them champion CCBHC-informed models.

Another learning for CCBHC-E grantees is the importance of diversifying revenue. Oaks leveraged its success with CCBHC to secure the ISC. This has enhanced their overall ability to be a sustainable organization and to provide quality care to all populations, including people with commercial insurance.

FCC BEHAVIORAL HEALTH:

Collective collaboration to negotiate with payers

FCC Behavioral Health is a CCBHC serving 19 counties in southeast Missouri. Its core values are integrity, commitment, compassion, empowerment and excellence. FCC participates in the CCBHC demonstration in Missouri, which started in July 2017. FCC works closely with the Missouri state association, which manages the statewide care management and population health management tool on behalf of all the CCBHCs. According to Max Steyer, EVP, Performance Management, the data analytics capabilities of the association have been crucial in garnering continued support and investment for CCBHCs. FCC collaborated with several other CCBHCs to negotiate an APM with a commercial payer. Although the APM was never implemented, a valuable lesson for FCC is the importance of being tenacious. Max recommended that CCBHC-E grantees work together to identify strong outcomes and present those to key stakeholders while recognizing that building relationships with payors takes time.

FOUR COUNTY MENTAL HEALTH CENTER (FCMHC):
Successfully advocating for a Medicaid state plan amendment

FCMHC is a provider serving a rural area in Kansas with eight locations. FCMHC's mission is "dedicated to providing accessible, innovative services in partnership with individuals, families and our communities." Their vision is, "We envision healthier communities as we help individuals and families improve their lives."

According to Steve Denny, deputy director, FCMHC first pursued a CCBHC-E grant because they saw the model's success in neighboring states such as Oklahoma and Missouri and began to have workforce pressures as clinicians could earn more working for CCBHCs in those states. FCMHC engaged in extensive stakeholder engagement from the inception of their CCBHC-E funding. They hired patient navigators to build local relationships, and he and other leadership and program staff did bipartisan outreach to elected officials. For example, Steve described that one of his neighbors is a legislator who is also a veteran. Steve outreached the legislator and educated them about the provisions in CCBHC related to serving veterans and members of the armed forces. Data about populations served, NOMS data such as housing stability and other outcomes were pulled for messaging.

Steve said, "When telling our story, we tried to focus on the [data points] that would most impact our different stakeholder audiences." When at the county commissioner meeting, FCMHC talked about how it was keeping people out of jail. When talking with the FCMHC board, it spoke of the "bigger picture" of sustaining and improving services. FCMHC also created a dashboard so employees can see progress on goals and activities.

FCMHC was active with other grantees and the state association to pursue a sustainable funding model. They quickly garnered bipartisan support as they built the case that CCBHC was a way to improve outcomes and increase access to care even in rural areas of the state. Steve credited the state association for their expertise with the legislative process and knowing with whom to talk and when. He said it was important to align their efforts with what else was happening in their policy environment, such as discussions about how to enhance Medicaid benefits for people with serious mental illness without pursuing Medicaid expansion.

In April 2021, Governor Laura Kelly signed Senate Substitute for House Bill 2208, which required Kansas to adopt CCBHC statewide and pursue a Medicaid SPA. FCMHC was one of the first centers to receive provisional certification as a CCBHC by the state of Kansas in 2022. FCMHC has developed a PPS costing tool to analyze sustainability under the newly established PPS rate. Steve recommends that other CCBHC-E grantees start early "to understand the cost side of the equation" to prepare to transition to a PPS. He suggests that grantees integrate their finance and operations leadership into CCBHC implementation and sustainability planning.

CONCLUSION

CCBHC-E grants are a stepping stone to state implementation of the CCBHC model in Medicaid. The grants are intended to promote the expansion of the CCBHC model; however grant funding is time bound and it is critical for grantees to utilize the grant funding period to explore and define more sustainable pathways for implementing CCBHC services. Interviews regularly demonstrated that partnerships to explore more permanent CCBHC funding mechanisms at the state level and leveraging data to demonstrate the value proposition of CCBHC within those engagements were among the most common actions for those who have made some progress in sustaining funding beyond grants.

Although specialty behavioral health providers have had limited opportunities to participate in other APMs, the grant funding period provides opportunity to collect data on costs and outcomes that can open communication channels and negotiations with payers. As the Bipartisan Safer Communities Act provides a pathway for nationwide CCBHC program implementation, CCBHC grantees should be working alongside their peers, state associations and states to shape state programming.

ADDITIONAL RESOURCES

Integrated Care Decision Support Tool and Billing Modules: Developed by the Center of Excellence for Integrated Health Solutions, this decision support tool is designed to help provider organizations sustainably finance integrated care. The tool supports providers to estimate Medicare and Medicaid revenue across prominent integrated care services to finance these services more effectively in community mental health care, substance use treatment and primary care provider organizations. It includes a list of specific billing codes, service types, professional discipline coverage, documentation and time requirements. A set of companion integrated care billing modules offers guidance for optimizing financing strategies across four integrated care service types: Medication for opioid use disorder (MOUD), screening, care coordination and metabolic monitoring.