



The Certified Community Behavioral Health Clinic (CCBHC) Model & Possibilities for Montana

January 2022

CCBHC SUCCESS CENTER

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 to ensure health equity and high-quality care for underserved populations.

Standard definition  Raises the bar for service delivery

Evidence-based care  Guarantees the most effective clinical care for consumers and families

Quality reporting  Ensures accountability

Prospective payment system  Covers anticipated CCBHC costs

CCBHC Criteria

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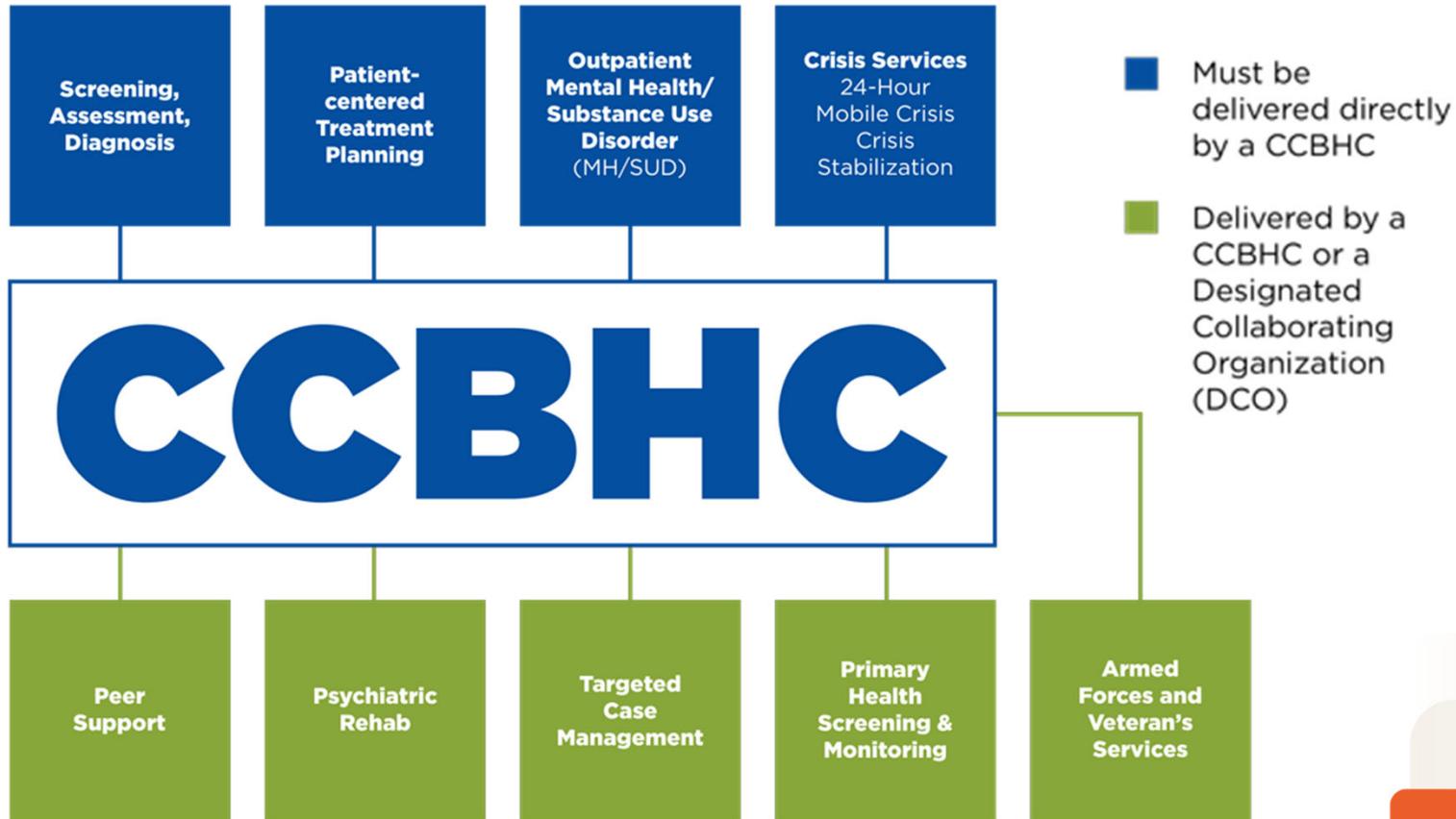
1. Staffing
2. Availability and Accessibility of Services
3. Care Coordination
4. Scope of Services
5. Quality and Other Reporting
6. Organizational Authority, Governance and Accreditation

CCBHC Payment

- **The CCBHC model:** Cost-related Medicaid reimbursement rate through:
 - The CCBHC Demonstration
 - CMS-approved SPA or waiver
- **The CCBHC-E grant:** Up-to \$2 million/year for up-to 2 years through SAMHSA

Note: This presentation contains a summary of selected CCBHC certification criteria. To view the full criteria: https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

CCBHC Scope of Services



NATIONAL
COUNCIL
for Mental
Wellbeing

Designated Collaborating Organization

Activities & Requirements

- Augment or fill gaps in CCBHCs' service array
- Coordinate care with CCBHC
- Provide access to all CCBHC clients (regardless of ability to pay)

Relationship with CCBHC

- Formal contract = "purchase of services"
- DCO reports patient visits to CCBHC; CCBHC bills for visits and pays DCO the agreed-upon rate

Advantages to the DCO

- Negotiate favorable (i.e., cost-related) payment with CCBHC
- Improved access to full continuum of care for clients and/or families through CCBHC/DCO network



The CCBHC Landscape

Three implementation options:

1. Federal grant funding for clinics
 - 400+ grantees in 44 states and territories
2. Medicaid demonstration
 - 10 states approved for the Medicaid enhanced match
 - Possibly more states with Congressional action
3. Independent state implementation via Medicaid SPA or waiver

CCBHC Medicaid Demonstration

Authorized through **Sept. 30, 2023**

8 states entering 5th year of demo in 2021

Michigan's demo began October 1, 2021

Kentucky's demo began January 1, 2022

SAMHSA CCBHC Expansion Grants

Yearly funds appropriated since 2018

Grantees in 42 states, DC & Guam

Latest grant cycle closed March 1, 2021

FOA to be released in early 2022

NATIONAL
COUNCIL
for Mental
Wellbeing



CCBHC National Impacts with Grantees and States

Mental Health & Substance Use Workforce

- Estimated in hiring over 9,000 new staff positions, average of 41 new jobs per clinics
- Increased retention and job satisfaction
- Redesigning care teams to meet community needs

Access to care

- 1.5 million people receive care at a CCBHC with 17% increase in number of clients served
- 89% of CCBHCs provide medication-assisted treatment (MAT) with 60% of CCBHCs adding this service due to CCBHC funds and requirements
- 50% of CCBHC provide same-day access with 93% providing access within 10 days.

Innovations in care

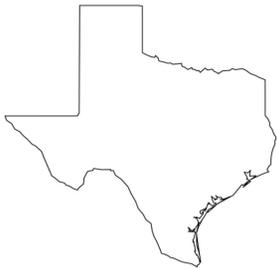
- 75% of CCBHCs reported increasing screening for unmet social needs that affect health, like housing, income, insurance status, transportation and more
- 79% coordinate with hospital systems, including 91% with crisis response to deflect admissions when appropriate
- Funded an unfunded partnerships with criminal justice, education, homelessness, and hotline (e.g., 988) services

CCBHCs' State Impact Over Time



Missouri (A CCBHC Demonstration State)

- Hospitalizations **dropped 20%** after 3 years, ED visits **dropped 36%**
- Overall access to BH services **increased 23% in 3 years**, with veteran services **increasing 19%**
- **In 1 year, 20% decrease** in cholesterol; **1.48-point Hgb A1c decrease**
- Justice involvement with BH populations **decreased 55%** in 1 year

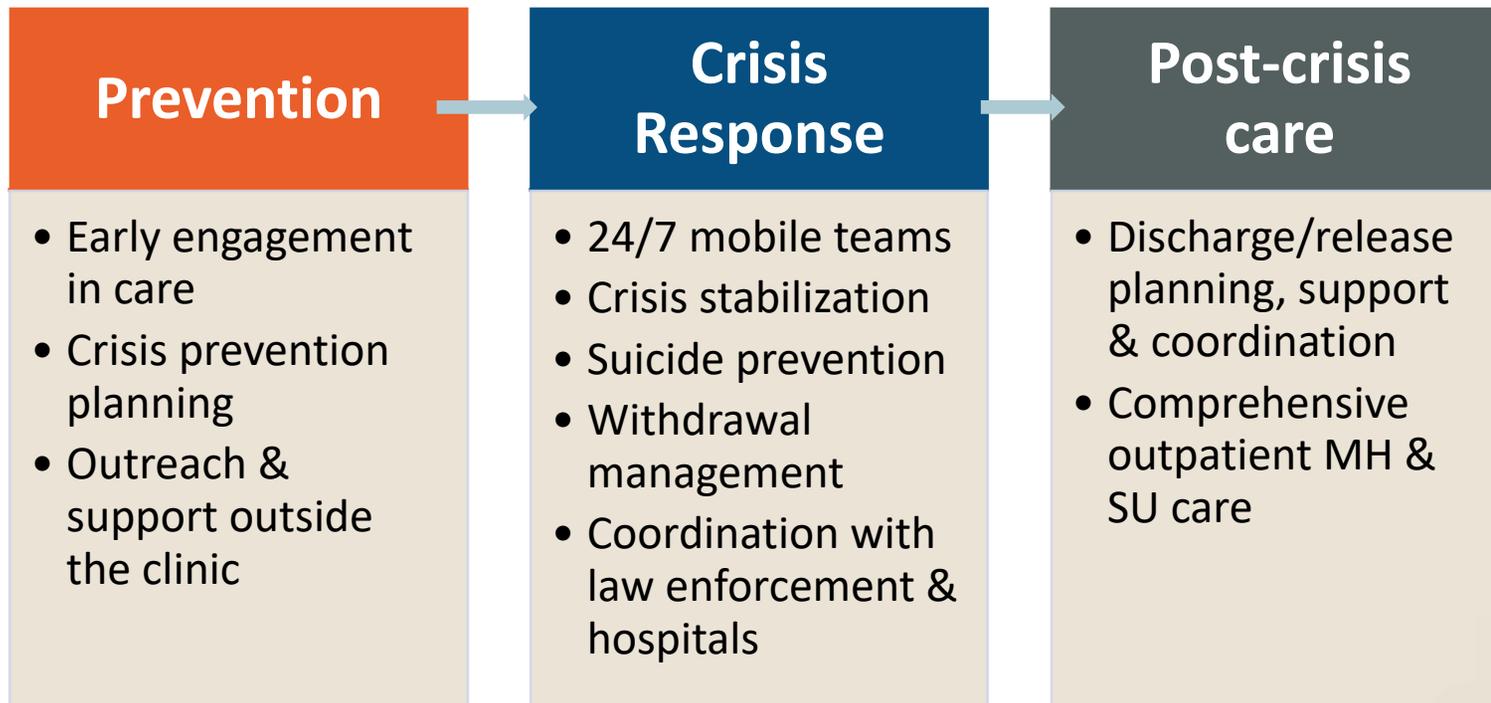


Texas (A State Using an Independent Approach)

- The CCBHC model in Texas is projected to save **\$10 billion by 2030**
- In 2 years, there were **no wait lists** at any CCBHC clinic
- **40% of clients** treated for cooccurring SUD and SMI needs, compared to 25% of other clinics



CCBHCs' Role in the Crisis Continuum



Making Crisis Services & Supports Available to All

- **100%** of CCBHCs offer crisis response services.
 - **51%** newly added crisis services as a result of certification.
- **Required crisis activities:** 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization
- **91%** are engaging in one or more research-based practices in crisis response, incl.:
 - Coordinates with hospitals/emergency departments to support diversion from EDs and inpatient (79%)
 - Behavioral health provider co-responds with police/EMS (e.g., clinician or peer embedded with first responders) (38%)
 - Operates a crisis drop-in center or similar non-hospital facility for crisis stabilization (e.g., 23-hour observation) (33%)
 - Mobile behavioral health team responds to relevant 911 calls instead of police/EMS (e.g., CAHOOTS or similar model) (19%)
 - Partners with 911 to have relevant calls routed to CCBHC (17%)



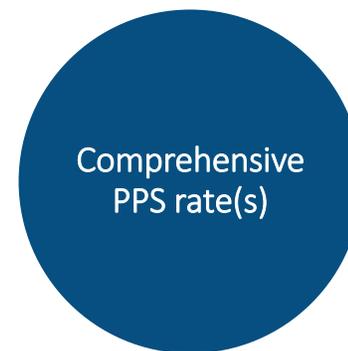
Prospective Payment System (PPS) compared to Fee-For-Service (FFS) model

Implications of a PPS compared to FFS model

- Rate is clinic-specific; accounts for varying costs in varying regions
- Payment is the same regardless of intensity or quantity of services received during encounter period (month or day)
- Does not prioritize higher-margin services over services that may better fit patient need
- No 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 (i.e., supports nonbillable activities)



CCBHCs Offer Financial Flexibility for Person-centered Service Delivery



Services are time-limited, not uniformly available, often limited to special populations/programs

All services available to all clients, regardless of ability to pay



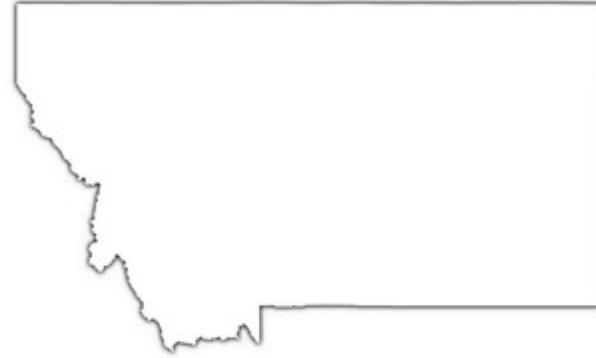
PPS Structure and Options

- **Daily rate (PPS-1):** One payment per client for any day in which the client receives at least one service
- **Monthly rate (PPS-2):** One payment per client for any month in which the client receives at least 1 service
 - Rate may be stratified by population complexity, with higher rates for higher-complexity clients and lower rates for the general population
- **Quality Bonus Payments** are optional in PPS-1 and required in PPS-2.
- CCBHCs are required to develop annual cost reports.
- The cost of DCO services is included in the CCBHC prospective payment rate, and DCO encounters are treated as CCBHC encounters for purposes of the prospective payment.

Getting Started in Montana

The National Council CCBHC team is here to help!

- Insights on SPA/waiver approach
- Lessons learned from other states
- Draft an Implementation “roadmap”
- Training for prospective CCBHCs
- Data, informational materials, and more



CCBHC SUCCESS CENTER

<https://www.thenationalcouncil.org/ccbhc-success-center/>

Email us at: ccbhc@thenationalcouncil.org

Key Reports and Links

Public links for State-level actions:

- Here are links to the CCBHC SPAs for [Minnesota](#), [Missouri](#), [Nevada](#), and [Oklahoma](#).
- Two states passed legislation recently: [Kansas](#) and [Illinois](#).
- [Maine allocated funding](#) for the State to hire staff for CCBHC

Recently released reports from National Council:

- [CCBHC National Impact Report](#)
- [CCBHC State Impact Report](#)
- [CCBHCs and the Justice Systems](#)
- [Connection between 988 and CCBHC](#)