Investigating Certified Community Behavioral Clinic Alternative Payment Models

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Project Team

Kyle Grazier, DrPH, MPH, MS

Amanda Mauri, MPH

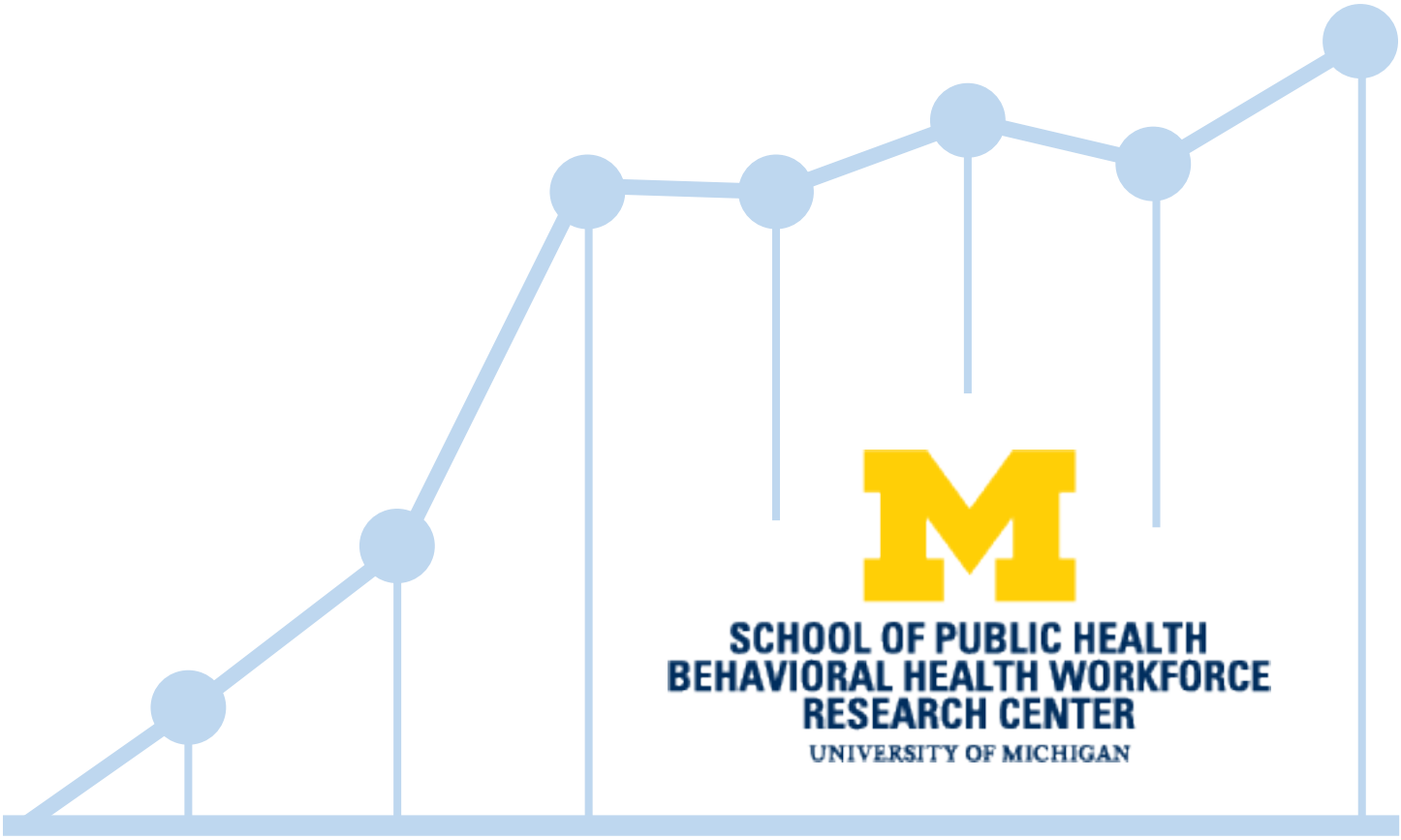

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Table of Contents

Introduction

Certified Community Behavioral Health Clinics (CCBHCs) are non-profit organizations or units of a local government's behavioral health authority that provide or contract with partner organizations to offer a comprehensive range of behavioral and physical health services. There are two federal funding programs available to CCBHCs. The Section 223 CCBHC Medicaid Demonstration grant (Medicaid Demonstration), established in 2014, mandates CCBHCs in 10 participating states receive a prospective payment for Medicaid beneficiaries.[1] The Substance Abuse and Mental Health Services Administration (SAMHSA) Expansion Grant Program (Expansion), available since 2018, awards grants that supplement reimbursement funding sources to clinics in any state.[2] These two programs are not mutually exclusive, meaning that a CCBHC can participate in the Medicaid Demonstration program and also receive an Expansion award. Congress and federal agencies continue to expand the reach of these programs, including through the 2020 Coronavirus Aid, Relief, and Economic Security Act provisions that added two states to the Medicaid Demonstration and appropriated $115 million for Expansion awards.[3]

A 2021 survey conducted by the National Council for Mental Wellbeing aligns with earlier findings that CCBHC status increases workforce capacity and decreases wait times, yet the magnitude of these effects varies by participation in the two federal funding programs.[4-8] For instance, sites participating in the Medicaid Demonstration hired a median of 42 new staff after CCBHC certification while Expansion awardees hired a median of 16. CCBHC certification was associated with a 41% increase in caseload for Medicaid Demonstration sites compared to a 10% caseload increase for sites only receiving federal CCBHC funding through an Expansion award.[9]

Disparities in workload and caseload between CCBHCs participating and not participating in the Medicaid Demonstration may result from differences in reimbursement approach. While the Medicaid Demonstration mandates sites receive a clinic-specific encounter prospective rate paid daily or monthly for Medicaid beneficiaries, the Expansion has no such Medicaid reimbursement requirement. In comparison to CCBHCs that receive a prospective payment, CCBHCs reimbursed through other approaches may be limited in their ability to project the resources available to hire new staff or take on new patients.

There remains minimal scholarship on how Medicaid and commercial payors reimburse CCBHCs not participating in the Medicaid Demonstration program. The research on CCBHC payment models tends to focus on rate setting involved in the prospective payment arrangements required by the Medicaid Demonstration. For instance, several HHS reports submitted to Congress, as mandated by Section 223 of the Protecting Access to Medicare Act, highlight variation in rates within and across Medicaid Demonstration sites; these reports also highlight challenges associated with initial rate setting before year 1 of the Medicaid Demonstration and re-calculating rates based on year 1 costs.[10,11]

These reports do not speak to the payment arrangements between CCBHCs not participating in the Medicaid Demonstration and Medicaid, nor the arrangements between any site and other payor types. To address this gap, we conducted the first round of primary data collection in partnership with the National Council for Mental Wellbeing to capture the types and designs of two types of alternative payment models: prospective payment systems (PPS) and quality bonus payments (QBPs) between CCBHCs and Medicaid managed care organizations (MCOs) and commercial payors.

Methods

The National Council for Mental Wellbeing annually fields a survey to CCBHCs asking a diverse range of questions about their staffing, service, patient, and payment characteristics.[6,12] The 2021 survey asked, "Has your CCBHC entered conversations with managed care plans or commercial payors about establishing a PPS or alternative payment model (APM) for your CCBHC services?"[9] Forty-five sites answered this question affirmatively. Our survey builds upon this question by asking a series of follow-up

questions regarding payment models to these 45 sites.

The survey is divided into two modules: PPS and QBP. The QBP module asks about the measures tied to quality bonus payments. The section on PPS asks questions regarding the structure of the prospective arrangements, including the following:

- Is the rate daily or monthly?
- Does the rate vary by clinical conditions?
- Does the rate vary by patient age?
- Were anticipated and/or historic costs used in rate-setting?

Each module is applied to both Medicaid MCOs and commercial payors, leading to a total of four survey sections. Only sites not participating in the Medicaid Demonstration program received the PPS and QBP sections for arrangements between CCBHCs and Medicaid MCOs. The PPS and QBP sections for arrangements between CCBHCs and commercial payors were fielded to all 45 participants.

The survey also asked questions regarding CCBHC characteristics, including state location, counties served, number of employees, number of patients, and total CCBHC budgets. We also asked sites when they received their CCBHC certification, if they participated in the Medicaid Demonstration and/or SAMHSA Expansion Grant Program, and if so, what dates they received the relevant awards.

Results

Nine of the 45 contacted CCBHCs responded to the survey, resulting in a response rate of 20%. The respondents were distributed equally across the following three groups based on federal funding program participation: 1) Medicaid Demonstration participant and Expansion awardee, 2) Medicaid Demonstration participant only, and 3) Expansion awardee only. While respondents varied by geographic location with representation from seven states, they were geographically concentrated within federal funding groups. For instance, respondents representing CCBHCs who were Expansion awardees and participated in the Medicaid Demonstration were based in the Northeast, whereas CCBHCs only participating in the Medicaid Demonstration resided in mountain states. CCBHCs vary by employee size, patient population size, and annual budget. Table 1 contains a breakdown of these characteristics by CCBHC.

Table 1: Overview of CCBHC Patient, Employee, and Budget Characteristics by Federal Funding Program Participation

Ref. No.	Medicaid Demonstration Participation	SAMHSA Expansion Awardee	State	Employee Size	Patient Size	Annual Budget
1	Yes	Yes	NY	80	1,000+	$20,000,000
2	Yes	Yes	NJ	250	751-1000	$125,000,000
3	Yes	Yes	NY	80	251-500	$31,500,000
4	Yes	No	MO	564	1,000+	$50,000,000
5	Yes	No	NV	65	751-1000	$4,200,000
6	Yes	No	MO	155	1,000+	$25,000,000
7	No	Yes	AR	Not reported	1,000+	Not reported
8	No	Yes	IA	26	251-500	Not reported
9	No	Yes	WA	Not reported	751-1000	$15,000,000

See Table 2 for an overview of PPS and QBP arrangements between respondents and Medicaid MCOs or commercial payors. Of the 9 respondents, under half (4) responded that they have contracted or are negotiating a PPS or QBP with either an MCO or a commercial payor. Of these 4, only 1 had any relationship currently in place.

The most common arrangement (4/9 respondents) contracted or under negotiation was a QBP with a commercial payor. Two of these 4 respondents are Medicaid Demonstration program participants and Expansion awardees, 1 is a Medicaid Demonstration participant only, and 1 is an Expansion awardee only. The one contracted QBP was implemented in January 2021 with payments tied to the following measures: follow-up after hospitalization for mental illness (adult age groups), initiation and engagement of alcohol and other drug dependence treatment, and all-cause readmission rate.

Table 2: PPS and QBP Arrangements between CCBHCs and MCOs and Commercial Payors

Ref. No.	Medicaid Demonstration Participation	SAMHSA Expansion Awardee	Medicaid PPS	Medicaid QBP	Commercial PPS	Commercial QBP
1	Yes	Yes	-	-	No	No
2	Yes	Yes	-	-	Yes	Yes
3	Yes	Yes	-	-	No	Under negotiation
4	Yes	No	-	-	Under negotiation	Under negotiation
5	Yes	No	-	-	No	No
6	Yes	No	-	-	No	No
7	No	Yes	No	No	No	No
8	No	Yes	No	Under negotiation	No	Under negotiation
9	No	Yes	No	No	No	No

Two of the 9 respondents have contracted or were negotiating a PPS with a commercial payor. Both are Medicaid Demonstration sites but differ by Expansion awardee status. The contracted PPS was implemented in January 2021. It is a monthly payment incorporating both anticipated and historic direct service costs. Patients with a serious mental illness or a co-occurring substance use disorder qualify for a different PPS than the standard rate.

Three sites (Respondent 7, 8, and 9) received an Expansion Award and do not participate in the Medicaid Demonstration, implying that they do not receive one of the two PPS arrangements mandated by the Medicaid Demonstration program. However, these sites can contract their own alternative to fee-for-service arrangements with MCOs. While none of the 3 sites not participating in the Medicaid Demonstration had contracted or were negotiating a PPS, 1 was negotiating a QBP with an MCO.

The 2 Expansion-only sites with no PPS or QBP voiced that they were in the early stages of discussing establishing these alternative payment arrangements with MCOs. Several sites expressed challenges implementing PPS and QBP with commercial payors. For instance, one CCBHC wrote, “commercial payors find CCBHC rates too expensive.” Another stated that there are too few commercial payor CCBHC clients to interest the payor in moving from fee-for-service to another arrangement.

Discussion

This first round of primary data collection provides initial insights into the payment relationships between CCBHCs and commercial payors. Our results demonstrate that the far majority of CCBHCs do not

have PPS or QBP arrangements in place with MCOs or commercial payors; only 1 CCBHC had implemented any PPS or QBP. However, another 3 were negotiating these arrangements, suggesting that more CCBHCs are working with MCOs and commercial payors to establish APMs.

Three of the 4 CCBHCs implementing or negotiating PPS or QBP arrangements with commercial payors participated in the Medicaid Demonstration program. This early finding suggests that participation in the Medicaid Demonstration is correlated with interest in establishing a PPS or QBP with other payor types. This may be due to the fact that these sites already have a mandated PPS required by the Medicaid Demonstration, providing experience costing and managing a PPS rate, which may make them more equipped to and interested in negotiating a PPS with other payors.

However, it may also reflect other differences between CCBHCs participating and not participating in the Medicaid Demonstration. For instance, the organizational characteristics that made them competitive for the Medicaid Demonstration program may be the same as those that make them ready and able to negotiate and implement PPS and QBP. Future research should explore this question.

Given that only 1 CCBHC had implemented a PPS or QBP with a commercial payor at the time of this survey, there remains much to learn about these arrangements under negotiation. Future research will expand upon this survey by interviewing all four CCBHCs that responded that they either contracted or were negotiating a PPS or QBP with a commercial payor. These interviews will provide significantly more detail on the design of these arrangements, as well as the processes involved in the negotiations between CCBHCs and commercial payors in setting up APMS.

Future work should continue to survey all CCBHCs regarding the status of their APMs with Medicaid MCOs and commercial payors. Our survey was built off a prior survey that asked broadly if a CCBHC had any APM or PPS in place with an MCO or commercial payor.[6] As CCBHCs become more established, we expect that the number of CCBHCs negotiating and implementing these relationships is likely to increase.

Limitations

This project is subject to several limitations. First, while our response rate was 20%, we only contacted a total of 45 CCBHCs for a result of 9 respondents. Further, while all CCBHCs were contacted through the initial National Council for Mental Wellbeing survey, they did not have a 100% response rate The 45 CCBHCs that received this survey may or may not be reflective of all CCBHCs implementing or negotiating APMs or PPS. However, given that CCBHCs are a relatively new behavioral health provider with the first sites receiving their designations in 2017, this may actually be reflective of the total number of CCBHCs implementing and negotiating PPS and QBP.

Our survey asked follow-up questions regarding the structure of payment models to respondents with implemented PPS or QBP arrangements, including questions on variation in rates by clinical condition or age and the types of costs used in rate setting. However, we did not ask these more detailed questions about agreements under negotiation. Our future project, in which we will interview all sites that indicated interest in negotiating these relationships, will see to answer more detailed questions about agreements under negotiation.

Regarding survey questions about non-payment-related CCBHC characteristics, some respondents may have reported their employee size, patient size, and annual budget for their entire organization, rather than just the sub-set of their employees, patients, and budget involved in CCBHC care. We recommend that any future survey request clarification as to whether the researchers are interested in organizational characteristics specific to the CCBHC or to the organization overall.

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