POLICY BRIEF

The prevalence and structure of certified community behavioral health clinic alternative payment models: A study beyond the CCBHC demonstration grant participants

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Project Team

Amanda Mauri, MPH, PhD(c)
Jackson Bensley, MPH
Adam Flood, MHSA
Rebecca Farley, MPH
Samantha Holcombe, MPH
Kyle Grazier, DrPH, MPH, MS

Background

Certified Community Behavioral Health Clinics (CCBHCs) receive enhanced funding to offer a comprehensive range of mental and substance use services to patients regardless of ability to pay. The combination of federal and state initiatives to expand the CCBHC model has produced over 500 CCBHCs operating in 46 states, including a Medicaid Demonstration, state plan amendments (SPAs), and Section 1115 waivers that offer participating CCBHCs a daily or monthly prospective payment for qualifying Medicaid visits. CCBHCs may also contract with payers to form other alternative payment models (APMs) outside of the Medicaid demonstration and SPA or waiver. Expansion grantees who do not receive the Medicaid prospective payment may form arrangements with Medicaid managed care organizations (MCOs), and all CCBHCs may contract APMs with commercial payers. Clinics may use these arrangements to support the comprehensive access, service, and coordination requirements of the CCBHC model. This study examined the prevalence and design of these arrangements through a mixed methods approach. Specifically, the Behavioral Health Workforce Research Center (BHWRC) partnered with the National Council for Mental Wellbeing to embed questions on the structure and form of CCBHC APMs in their 2022 Impact Survey. In addition, we conducted two case studies of CCBHC APMs.

Methods

The BHWRC collaborated with the National Council for Mental Wellbeing to embed several questions related to APMs in their annual impact survey of CCBHCs. The Harris Poll contacted 449 CCBHCs, of which 249 participated, resulting in a response rate of 55.5%. The survey was fielded between July 14 and August 26, 2022. All survey responses were stratified into the five CCBHC types displayed: grantee only, SPA or waiver only, demonstration only, demonstration and grantee, and SPA or waiver and grantee.

We contacted the four CCBHCs that responded to a survey last year that they had negotiated or contracted a prospective payment system (PPS) or quality-based payments with a Medicaid MCO or commercial payer. From February to August 2022, we conducted 1-hour, semi-structured interviews with CCBHC administrative leadership from the two CCBHCs that responded to our interview request. All interviews were conducted in and recorded using Zoom (Version, 5.11.3. [9065], Zoom Video Communications, Inc.). The University of Michigan's Institutional Review Board approved this study.

Findings

The data demonstrated that 47% of respondents have established APMs or are in the process of establishing one. Specifically, 86 CCBHCs, or 35% of all respondents, reported that they have an APM contract with a payer and are receiving the payment. An additional 30 CCBHCs, or 12% of respondents,

selected that they did not yet have an APM but are working on it. The grantee-only group had the lowest proportion of CCBHCs (25%) with an APM in place in comparison with SPA or waiver only (62%), demonstration only (50%), demonstration and grantee (52%), and grantee and SPA or waiver (82%). Overall and regardless of CCBHC type, CCBHCs were far more likely to have APMs with Medicaid MCOs (67.0%) than commercial payers (10.0%), non-managed care Medicaid (10.0%), and other payers (12.0%).

Each of the nine required CCBHC services were included by >50% of APMs (Table 4). The percentage including each service ranged from 84% of APMs including outpatient mental health and substance use services to 55% of APMs including intensive, community-based mental health care for members of the armed services and veterans. A lower proportion of grantee-only APMs included outpatient clinic primary care screening and monitoring of key health indictors and health risks (48%), crisis mental health services (45%), and services for members of the armed forces and veterans (39%) in comparison with other CCBHC groups.

A PPS or bundled payment structure, in which a single payment rate is set for all services provided in an encounter, was the most common payment methodology at one-third of all APMs. When we stratified APMs by CCBHC type, a PPS or bundled payment remained the most common for all CCBHC groups except grantee. Only 5% of grantee-only APMs used this methodology; 15% of all APMs used quality bonus or pay-for-performance payments. Very few APMs involved risk sharing or downside risk.

Our two interviews revealed two APMs with differing structures. The first included a sub-capitated model with their regional Medicaid MCO, taking the form of a per member per month rate that is annually adjusted and reconciled. The second was an arrangement with a commercial payor involving a monthly, bundled care rate with two diagnostic categories, serious mental illness and substance use disorder, and three levels based on time and intensity of services. The latter communicated that their existing experience with the CCBHC Demonstration, specifically the PPS and outcome reporting, prepared them to implement the APM with the commercial payer.

Conclusion

Recent activities by federal and state policymakers signal that expanding the CCBHC model is a policy priority. These activities include legislative and administrative initiatives to grow the number of states and clinics that receive a Medicaid alternative payment for CCBHC services through the CCBHC Demonstration, SPA, or Medicaid waiver. Yet, no other research has explored other CCBHC APM activities outside of these initiatives. In this report, we analyze both survey and interview data to describe the prevalence and structure of these arrangements.

Our analysis reveals that approximately one-third of survey respondents were receiving payment through an APM. Grantee-only CCBHCs were the least likely of all respondents to have established arrangements. This may signal that receiving the Medicaid special payment through the Demonstration, SPA, or waiver may provide CCBHCs critical experience in implementing APMs. The data also provide a correlation between CCBHC size and APMs. The largest CCBHCs—both measured as the number of clients and employees—were the most likely to have CCBHCs in comparison with small- and medium-sized clinics. It is possible that larger organizations have more administrative capacity and/or experience in designing and implementing APMs than their peers in smaller organizations.

While more than two-thirds of APMS cover the required crisis mental health services, only 45% of grantee-only CCBHCs include these required CCBHC services. Policymakers and advocates alike have discussed relying on CCBHCs to support 988 implementation. In light of the likely projected increase in call volume associated with 988, grantee-only CCBHCs may consider prioritizing inclusion of crisis intervention services when negotiating APMs to support their delivery of crisis services.

Finally, the analysis reveals that very few APMs involve risk sharing. Indeed, <5% of APMS include shared savings or downside risk. Future research should examine the factors contributing to organizational

and payer decisions to contract these advanced APMs, as well as factors that facilitate success in these arrangements.

Acknowledgements

This research is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1.4 million. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.