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

July 2022

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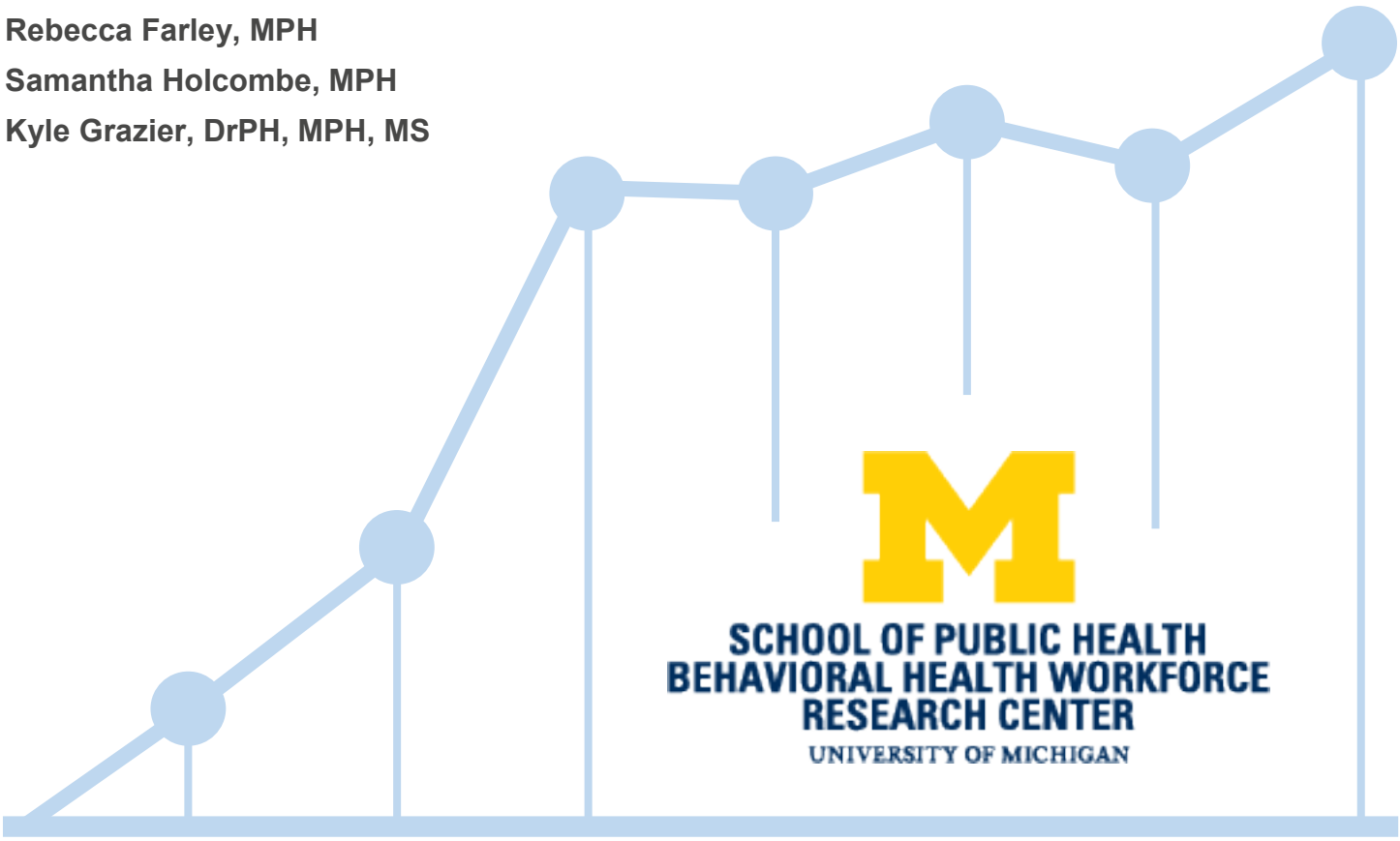

ACKNOWLEDGEMENTS

This study was 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.

SUGGESTED CITATION

University of Michigan Behavioral Health Workforce Research Center. The prevalence and structure of certified community behavioral health clinic alternative payment models: A study beyond the CCBHC demonstration grant participants. Ann Arbor, MI: UMSPH; 2022.

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Background

Certified Community Behavioral Health Centers (CCBHCs) are clinics that receive enhanced funding to offer a comprehensive range of mental and substance use services to patients regardless of ability to pay. Originally implemented as an eight-state Medicaid Demonstration, the Demonstration expanded to an additional two states in 2020. The 2022 Bipartisan Safer Communities Act further expanded the Demonstration to include 10 new states every 2 years, beginning in 2024. CCBHCs participating in the Demonstration receive a daily or monthly prospective payment for qualifying visits.[1] In addition, a growing number of states are using Medicaid state plan amendments (SPAs) and Section 1115 waivers to implement the model and associated alternative payment in their states. As of September 2022, states with state-certified clinics were Kansas, Kentucky, Michigan, Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, Pennsylvania, and Texas.[1] Separately from the Demonstration program and SPA or waiver, the Substance Abuse and Mental Health Services Administration (SAMHSA) has funded clinics through the Expansion Grant Program in 38 states. These grants are in the form of lump sum payments and are not meant to supplant existing funding, including Medicaid payments. Indeed, expansion recipients are expected to bill payers per usual.

The combination of these funding programs has produced over 500 CCBHCs operating in 46 states, as well as Puerto Rico, Washington D.C., and Guam, that can be organized into five CCBHC types (Table 1). The Demonstration/SPA/waiver and expansion grants are not mutually exclusive. As is illustrated in Table 1, CCBHCs participating in the Demonstration or otherwise certified by their state can also receive an expansion award.

Table 1: CCBHC Types Based on Participation in CCBHC Programs

	Medicaid Demonstration	State plan amend-ment or waiver	SAMHSA Expansion Grant
Demonstration only	X		
Grantee only			X
SPA or waiver only		X	
Demonstration and grantee	X		X
SPA or waiver and grantee		X	X

Early research reveals differences between demonstration/SPA/waiver CCBHCs and CCBHCs participating only in the SAMHSA Expansion Grant program. The National Council for Mental Wellbeing (formerly National Council for Behavioral Health) has surveyed CCBHCs, starting in 2017, on CCBHC activities and outcomes. Since 2021, they have examined their findings by CCBHC type. This survey revealed that demonstration CCBHCs hired a median of 42 new staff after CCBHC certification as compared to grantees who reporting hiring a median of 16 new staff. Becoming a CCBHC was also associated with a 41% increase in caseload for demonstration sites compared with a 10% caseload increase for CCBHCs only receiving funding through the Expansion grant program.[2] Unfortunately, the existing peer-reviewed literature has not explored differences by CCBHC type. Our review identified five peer-reviewed publications on the CCBHC model.[3-7] While these articles investigate the impact of the CCBHC model on service offerings, emergency department visits, and hospitalizations, none of these articles consider the impact of variation in funding by CCBHC type.

Differences in activities and outcomes by CCBHC type may depend on reimbursement. One of the main differences between CCBHC types is eligibility for the special Medicaid payment methodology. Clinics participating in either the demonstration or state-certified through a SPA or waiver receive a standardized Medicaid payment for all qualifying visits regardless of the services delivered or the providers involved,

whereas grantees rely on expansion awards to cover non-reimbursable costs of the CCBHC model.[a] In comparison to CCBHCs receiving the special Medicaid payment, grantee-only clinics may be limited in their ability to project the resources available to hire new staff or take on new patients.

CCBHCs may also contract with payers to form other alternative payment models (APMs) outside of the Medicaid demonstration and SPA or waiver. Expansion grantees 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. We hope that the findings from this report can be used both by CCBHCs and federal and state agencies involved in the CCBHC program. It will provide insights on the types of APM structures currently negotiated or contracted between CCBHCs and Medicaid and commercial payers. It will also highlight facilitators and barriers to negotiating APMs from CCBHCs who previously negotiated or are currently negotiating an APM.

Methods

Survey

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 in Table 1: grantee only, SPA or waiver only, demonstration only, demonstration and grantee, and SPA or waiver and grantee.

The survey included five questions related to APMs:

1. Does your organization have an APM in place with one or more payers (e.g., private insurer, Medicaid, etc.) to provide reimbursement for some or all CCBHC services and activities? If you have more than one APM in place, please answer all questions in this section for your most established APM. As a reminder, if you are a demonstration site, please exclude your Medicaid prospective payment system (PPS) when answering.
2. Which type of payer is the contracted APM with? If you have more than one APM in place, please answer all questions in this section for your most established APM. Please select only one response.
3. Which of the following nine required CCBHC service categories are included in the APM? As a reminder, if you are a demonstration site, please exclude your Medicaid PPS when answering. Please select all that apply.
4. Which kind of payment methodology is used for the alternative payment model (APM)? Please only select one. If you have more than one APM in place, please answer all questions in this section for your most established APM.
5. How was the payment rate for the alternative payment model (APM) calculated?

[a]Texas is an exception. Clinics certified by the Texas Health and Human Services Commission, known as T-CCBHCs, must meet the requirements of the federal CCBHC model but do not receive a Medicaid PPS. Instead, depending on the provider type, they participate in a Medicaid Directed Payment Program for Behavioral Health Services, a Public Health Provider Charity Care Pool, or both.

Interviews

We contacted the 4 CCBHCs that responded to last year's survey that they had negotiated or contracted a PPS or quality-based payments with a Medicaid MCO or commercial payer.[8] 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

Survey

Table 2 presents statistics illustrating the number and percentage of respondents that have APMs, are in the process of establishing APMs, or do not have APMs in place. The data demonstrated that 47% of CCBHC 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%). Entities that have had their CCBHC designation longer were more likely to have contracted APMs than organizations with a shorter length of time as a CCBHC (54% of CCBHCs older than ≥3 years, 20% of CCBHCs between 2 years and ≤3 years, and 28% of CCBHCs that are ≤1 year). We also observed that larger CCBHCs in terms of clients (≥5,000: 44%; 1,000–4,999: 34%; <1,000: 24%) and employees (≥500: 46%; 100–499: 39%; <100: 27%) were more likely to have contracted APMS than their smaller peers. We observed no difference by rurality.

Tables 3 and 4 contain the results describing the types of APMs between CCBHCs and different payers. Overall and regardless of CCBHC type, CCBHC respondents 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%). Given that more than two-thirds of APMs were arrangements with Medicaid MCOs, we focus the narrative on these APMs. Grantee respondents (55%) were more likely to have APMs with Medicaid MCOs than other CCBHC groups, though this was likely because there were more grantees than any other CCBHC type. The proportion of organizations with an APM with a Medicaid MCO was similar for entities that have been CCBHCs for ≤1 year (40%) or ≥3 years (40%). These arrangements were more common in the midwest (33%) and south (31%) compared with the northeast (21%) and west (16%), as well as non-rural (74%) compared with rural (22%). We also observed that organizations with more clients were more likely to have Medicaid MCO APMs, with 52% of arrangements involving a CCBHC with ≥5,000 clients compared with 26% involving a CCBHC with 1,000–4,999 clients and 22% with <1,000 clients.

Each of the nine required CCBHC services were included by >50% of respondent APMs (Table 5). 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. Table 6 illustrates the proportion of CCBHCs with APMs that cover the nine services by rurality. APMs involving rural CCBHCs were more likely to include all services except for outpatient clinic primary care screening and monitoring of key health indicators and health risks.

Table 7 displays the proportion of APMs by payment methodology. A PPS or bundled payment structure, in which a single payment rate is set for all services provided in an encounter, was the most

Table 2: Number and Percentage of CCBHCs with APMs

Question: Does your organization have an APM in place with one or more payers (e.g., private insurer, Medicaid, etc.) to provide reimbursement for some or all CCBHC services and activities?

	Total		Yes		In Process		No but Interested		No and No Plans		Not Sure	
	N	%	N	%	N	%	N	%	N	%	N	%
CCBHC program												
Grantee only	176	100%	44	25%	23	13%	69	39%	17	10%	23	13%
SPA or waiver	13	100%	8	62%	0	0%	3	23%	1	8%	1	8%
Demo only	18	100%	9	50%	3	17%	3	17%	1	6%	2	11%
Demo and grantee	31	100%	16	52%	4	13%	5	16%	4	13%	2	6%
SPA or waiver and grantee	11	100%	9	82%	0	0%	1	9%	1	9%	0	0%
Total	*249*	*100%*	*86*	*35%*	*30*	*12%*	*81*	*33%*	*24*	*10%*	*28*	*11%*
Length of time as CCBHC												
≤1 year	102	100%	29	28%	8	8%	40	39%	11	11%	14	14%
2 years to <3 years	65	100%	13	20%	13	20%	25	38%	6	9%	8	12%
≥3 years	71	100%	38	54%	9	13%	13	18%	6	8%	5	7%
Total	*238*	*100%*	*80*	*34%*	*30*	*13%*	*78*	*33%*	*23*	*10%*	*27*	*11%*
Regional location of CCBHC												
Northeast	65	100%	19	29%	10	15%	21	32%	4	6%	11	17%
Midwest	79	100%	27	34%	7	9%	27	34%	12	15%	6	8%
South	69	100%	28	41%	9	13%	21	30%	5	7%	6	9%
West	36	100%	12	33%	4	11%	12	33%	3	8%	5	14%
Total	*249*	*100%*	*86*	*35%*	*30*	*12%*	*81*	*33%*	*24*	*10%*	*28*	*11%*
Located in rural setting												
Yes	57	100%	22	39%	7	12%	18	32%	4	7%	6	11%
No	192	100%	64	33%	23	12%	63	33%	20	10%	22	11%
Total	*249*	*100%*	*86*	*35%*	*30*	*12%*	*81*	*33%*	*24*	*10%*	*0.22*	*0%*
Number of clients CCBHC services each year												
<1,000	76	100%	18	24%	6	8%	35	46%	8	11%	9	12%
1,000–4,999	87	100%	30	34%	11	13%	22	25%	8	9%	16	18%
≥5,000	86	100%	38	44%	13	15%	24	28%	8	9%	3	3%
Total	*249*	*100%*	*86*	*35%*	*30*	*12%*	*81*	*33%*	*24*	*10%*	*28*	*11%*
Number of employees at CCBHC												
<100	108	100%	29	27%	12	11%	40	37%	10	9%	17	16%
100–499	115	100%	45	39%	15	13%	34	30%	11	10%	10	9%
≥500	26	100%	12	46%	3	12%	7	27%	3	12%	1	4%
Total	*249*	*100%*	*86*	*35%*	*30*	*12%*	*81*	*33%*	*24*	*10%*	*28*	*11%*

Table 3: Number and Percentage of APMs by Payer
Question: Which type of payer is the contracted APM with?

	Total		Medicaid MCO		Commercial payer		Non-MCO Medicaid		Other	
	N	%	N	%	N	%	N	%	N	%
Grantee only	44	100%	32	73%	2	5%	4	9%	6	14%
SPA or waiver only	8	100%	7	88%	1	13%	0	0%	0	0%
Demo only	9	100%	3	33%	2	22%	2	22%	2	22%
Demo and Grantee	16	100%	10	63%	4	25%	0	0%	2	13%
SPA or waiver and grantee	9	100%	6	67%	0	0%	3	33%	0	0%
Total	*86*	*100%*	*58*	*67%*	*9*	*10%*	*9*	*10%*	*10*	*12%*

Table 4: Number and Percentage of APMs by Payer
Question: Which type of payer is the contracted APM with?

	Total		Medicaid MCO		Commercial payer		Non-MCO Medicaid		Other	
	N	%	N	%	N	%	N	%	N	%
CCBHC program										
Grantee only	44	51%	32	55%	2	22%	4	44%	6	60%
SPA or waiver only	8	9%	7	12%	1	11%	0	0%	0	0%
Demo only	9	10%	3	5%	2	22%	2	22%	2	20%
Demo and Grantee	16	19%	10	17%	4	44%	0	0%	2	20%
SPA or waiver and grantee	9	10%	6	10%	0	0%	3	33%	0	0%
Total	*86*	*100%*	*58*	*100%*	*9*	*100%*	*9*	*100%*	*10*	*100%*
Length of time as CCBHC										
≤1 year	29	36%	21	40%	1	11%	3	33%	4	40%
2 years to <3 years	13	16%	10	19%	1	11%	1	11%	1	10%
≥3 years	38	48%	21	40%	7	78%	5	56%	5	50%
Total	*80*	*100%*	*52*	*100%*	*9*	*100%*	*9*	*100%*	*10*	*100%*
Regional location of CCBHC										
Northeast	19	22%	12	21%	4	44%	4	44%	1	10%
Midwest	27	31%	19	33%	2	22%	2	22%	4	40%
South	28	33%	18	31%	1	11%	1	11%	5	50%
West	12	14%	9	16%	2	22%	2	22%	0	0%
Total	*86*	*100%*	*58*	*100%*	*9*	*100%*	*9*	*100%*	*10*	*100%*
Located in rural setting										
Yes	22	26%	15	26%	2	22%	2	22%	3	30%
No	64	74%	43	74%	7	78%	7	78%	7	70%
Total	*86*	*100%*	*58*	*100%*	*9*	*100%*	*9*	*100%*	*10*	*100%*
Number of clients CCBHC services each year										
<1,000	18	21%	13	22%	1	11%	1	11%	3	30%
1,000–4,999	30	35%	15	26%	7	78%	7	78%	3	30%
≥5,000	38	44%	30	52%	1	11%	1	11%	4	40%
Total	*86*	*100%*	*58*	*100%*	*9*	*100%*	*9*	*100%*	*10*	*100%*
Number of employees at CCBHC										
<100	29	34%	20	34%	2	22%	2	22%	5	50%
100–499	45	52%	29	50%	6	67%	6	67%	4	40%
≥500	12	14%	9	16%	1	11%	1	11%	1	10%
Total	*86*	*100%*	*58*	*100%*	*9*	*100%*	*9*	*100%*	*10*	*100%*

Table 5: Required CCBHC Service Categories Included in APM

Question: Which of the following nine required CCBHC service categories are included in the APM?

	Total		Grantee only		SPA or waiver only		Demo only		Demo and Grantee		Grantee and SPA or waiver	
	N	%	N	%	N	%	N	%	N	%	N	%
Outpatient mental health and substance use services	72	84%	34	77%	8	100%	8	89%	14	88%	8	89%
Screening, assessment, and diagnosis, including risk assessment	61	71%	26	59%	6	75%	8	89%	13	81%	8	89%
Targeted case management	60	70%	26	59%	8	100%	5	56%	13	81%	8	89%
Crisis mental health services	58	67%	20	45%	7	88%	8	89%	14	88%	9	100%
Psychiatric rehabilitation services	58	67%	27	61%	7	88%	7	78%	10	63%	7	78%
Patient-centered treatment planning or similar processes	57	66%	25	57%	5	63%	8	89%	11	69%	8	89%
Peer support, counselor services, and family support	57	66%	25	57%	6	75%	5	56%	12	75%	9	100%
Outpatient clinic primary care screening and monitoring of key health indicators and health	52	60%	21	48%	6	75%	4	44%	13	81%	8	89%
Intensive, community-based mental health care for members of the armed forces and veter-	47	55%	17	39%	6	75%	7	78%	10	63%	7	78%
Not at all sure	4	5%	3	7%	0	0%	0	0%	1	6%	0	0%
Total	*86*	*100%*	*44*	*100%*	*8*	*100%*	*9*	*100%*	*16*	*100%*	*9*	*100%*

Table 6: Required CCBHC Service Categories Included in APM by Rurality

Question: Which of the following nine required CCBHC service categories are included in the APM?

	Rural		Not Rural	
	N	%	N	%
Outpatient mental health and substance use services	19	86%	53	83%
Screening, assessment, and diagnosis, including risk assessment	19	86%	42	66%
Targeted case management	18	82%	42	66%
Crisis mental health services	18	82%	40	63%
Psychiatric rehabilitation services	18	82%	40	63%
Patient-centered treatment planning or similar processes	18	82%	39	61%
Peer support, counselor services, and family support	17	77%	40	63%
Outpatient clinic primary care screening and monitoring of key health indicators and health risks	13	59%	39	61%
Intensive, community-based mental health care for members of the armed forces and veterans	16	73%	31	48%
Not at all sure	1	5%	3	5%
Total	*22*	*100%*	*64*	*100%*

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 respondents. 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. Indeed, only 3% of all APMs involved a shared savings model, in which the clinic receives a portion of any savings attained as a result of its services, and only 1 APM used downside risk where providers must refund the payer if costs exceed the set financial benchmark.

Table 7: Structure of APM by CCBHC Type
Question: Which kind of payment methodology is used for the alternative payment model (APM)?

	Total		Grantee only		SPA or waiver only		Demo only		Demo and Grantee		Grantee and SPA or waiver	
	N	%	N	%	N	%	N	%	N	%	N	%
Single payment rate is set for all services provided in an encounter (e.g., PPS, bundled payment)	28	33%	2	5%	4	50%	4	44%	9	56%	9	100%
Quality bonus or pay-for-performance payment	13	15%	12	27%	0	0%	0	0%	1	6%	0	0%
Monthly payment is received for clients attributed to your organization (e.g., per member per month [PMPM])	8	9%	3	7%	0	0%	2	22%	3	19%	0	0%
Single payment is received for an entire care episode (e.g., episode of care)	7	8%	5	11%	1	13%	1	11%	0	0%	0	0%
Clinic receives a portion of any savings attained as a result of its services (e.g., shared savings)	3	3%	2	5%	1	13%	0	0%	0	0%	0	0%
Providers must refund the payer if costs exceed the set financial benchmark (e.g., downside risk)	1	1%	0	0%	0	0%	0	0%	1	6%	0	0%
Other	15	17%[b]	11	25%	1	13%	1	11%	2	13%	0	0%
Not at all sure	11	13%	9	20%	1	13%	1	11%	0	0%	0	0%
Total	*86*	*100%*	*44*	*100%*	*8*	*100%*	*9*	*100%*	*16*	*100%*	*9*	*100%*

For the 43 respondents that answered that their APM involved a prospective payment system, bundled payment, episode of care model, or per member per month (PMPM) capitation structure, we asked a follow-up question: How was the payment rate for the alternative payment model (APM) calculated? The answers to this question are presented in Table 8. Fifty-three percent of all respondent APMs used the CCBHC cost report to calculate the rate. One hundred percent of respondent APMs involving an SPA or

[b]We caution readers in assuming that 17.0% of grantee respondents are in another form of APM arrangement. We suspect that it is more likely that most grantee respondents who answered "other," or "not sure," to this question are likely not in an APM arrangement, or they are in some sort of payment situation for some subsidiary of services.

waiver-only CCBHC used the CCBHC cost report for the rate calculation, and approximately 50% of demonstration CCBHCs used the CCBHC cost report. By contrast, no grantee-only APMs used the CCBHC cost report; the payment was based either on the non-CCBHC cost report (50%) or a different methodology (50%).

Table 8: Rate Calculation for APMs
Question: How was the payment rate for the alternative payment model (APM) calculated?

	Total		Grantee only		SPA or waiver only		Demo only		Demo and Grantee		Grantee and SPA or waiver	
	N	%	N	%	N	%	N	%	N	%	N	%
Single payment rate is set for all services provided in an encounter (e.g., PPS, bundled payment)	28	33%	2	5%	4	50%	4	44%	9	56%	9	100%
Quality bonus or pay-for-performance payment	13	15%	12	27%	0	0%	0	0%	1	6%	0	0%
Monthly payment is received for clients attributed to your organization (e.g., per member per month [PMPM])	8	9%	3	7%	0	0%	2	22%	3	19%	0	0%
Single payment is received for an entire care episode (e.g., episode of care)	7	8%	5	11%	1	13%	1	11%	0	0%	0	0%
Clinic receives a portion of any savings attained as a result of its services (e.g., shared savings)	3	3%	2	5%	1	13%	0	0%	0	0%	0	0%
Providers must refund the payer if costs exceed the set financial benchmark (e.g., downside risk)	1	1%	0	0%	0	0%	0	0%	1	6%	0	0%
Other	15	17%[b]	11	25%	1	13%	1	11%	2	13%	0	0%
Not at all sure	11	13%	9	20%	1	13%	1	11%	0	0%	0	0%
Total	*86*	*100%*	*44*	*100%*	*8*	*100%*	*9*	*100%*	*16*	*100%*	*9*	*100%*

Case Study 1: CCBHC Awarded Two Expansion Grants but Not Participating in the Demonstration

A CCBHC established a sub-capitated model with their regional Medicaid MCO. The arrangement takes the form of a PMPM rate that is annually adjusted and reconciled. To receive the PMPM, they must have seen the attributed client at least once in the last year. Attribution occurs through the physician health provider. At the time of the interview, the PMPM penetration rate was 45% of the Medicaid population within their region. In addition to the PMPM, the arrangement included bonus payments tied to six metrics set by the Medicaid MCO. The interviewee recommended that other CCBHCs interested in similar arrangements understand how to optimize the contract in terms of claims and codes. Specifically, they recommend making sure that organizations "pull down on what you can from the contract," for instance, by making sure that they are appropriately shadow billing for covered encounters.

The CCBHC found that the sub-capitation model provides immense flexibility useful in providing all CCBHC required services. However, they still rely on the expansion grant funds to support programs, including the community health worker program, outreach and engagement services, and care referrals to substance use disorder (SUD) treatment providers. An opportunity for improvement includes facilitating payments for hospital liaisons. The sub-capitated model does not support hospital liaisons, nor does the CCBHC model require entities to hire hospital liaisons. Interviewees believe that adding hospital liaison requirements to the model or adding this as eligible under the sub-capitation would further facilitate diversions from hospitalization.

Case Study 2: CCBHC Participating in the Demonstration and Expansion Grant Program

The APM originated with an expansion of a pilot between a commercial payer and another CCBHC. The commercial payer expressed interest in establishing an APM. Not only were they impressed by initial CCBHC outcomes, but new leadership with experience in community mental health declared that behavioral health physician health integration was an organizational strategic priority. Following a series of workshops between CCBHCs, the commercial payer, and consultants, the payer presented the APM informed by the CCBHC Demonstration PPS model.

The APM takes the form of a monthly, bundled care rate with two diagnostic categories, serious mental illness (SMI) and SUD, and three levels based on time and intensity of services. While the qualifying diagnoses were initially restrictive, they have since been revised to include a more expansive list of diagnoses. The rates do not differ between SMI and SUD, so there is no incentive to bill one over another for patients with co-occurring disorders. The APM was awarded to the interviewee's organization in 2020 and implemented in January 2021 with a 3–4-month phase in. The APM also included value-based payments using claims-based measures very similar to those under the CCBHC Demonstration. The bonus payments do not take on a gap to goal design, which involves a progressive structure where you work up to the "goal" over a defined period.

At the time of the interview, the interviewee's organization has 250 unduplicated patients attributed to the model each year. Since the organization had a minimal relationship with commercial payers prior to establishing the APM, attribution occurred through several mechanisms. The primary strategy was through a partner organization, contracted by the commercial payers to connect primary care offices with behavioral health providers. In addition, the interviewee's organization received patients through community-facing programs with more patients with commercial insurance, including urgent care and crisis screening centers. A small number of patients were also existing members already served by the interviewee's organization.

The interviewee expressed that their existing experience with the CCBHC Demonstration, specifically the PPS and outcome reporting, prepared them to implement this APM with the commercial payer. Indeed, the interviewee shared that he did not believe that the expansion grant alone would have prepared his organization for negotiating, contracting, and implementing this bundled rate. Even with the Demonstration experience, the interviewee shared that their organization experienced a significant learning curve with implementing the technical aspects of the APM. For instance, the commercial payer uses a different claim form than their usual form and that they had to reconfigure that electronic health record to ensure billing was correctly using the proper Healthcare Common Procedure Coding System codes and modifiers.

Discussion

Recent activities by federal and state policymakers demonstrate that expanding the CCBHC model is a policy priority. These activities include legislative and administrative initiatives to grow the number of states and clinics who 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. Indeed, one of our interviewees expressed that their experience with the Demonstration, specifically the PPS and outcome reporting, prepared them to negotiate and implement a bundled rate with value-based payments with a commercial payer. 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.

The most common payer CCBHCs contract APMs with was Medicaid MCOs, with other payers making up less than 25% of arrangements. The larger the client population, the more likely entities were to have an arrangement with a Medicaid MCO. Indeed, CCBHCs with ≥5,000 employees made up 52% of these arrangements. Interestingly, we do not observe the same pattern by employee number, with organizations with 100–499 employees making up the largest proportion of arrangements with a Medicaid MCO APM (50.0%) followed by <100 employees (34%) and ≥500 employees (16.0%). This suggests that the potential attributed population, not organizational size, may provide both organizations and MCOs an incentive to establish APMs.

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.9-11 In light of the likely projected increase in call volume associated with 988,12-14 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.

This report is not without limitations. All survey data are vulnerable to errors due to nonresponse bias, question wording or response options, and post-survey weighting. We also acknowledge that some respondents may have answered the APM survey questions with information about the CCBHC PPS – the specialized Medicaid payment CCBHCs receive if they participate in the Section 223 Medicaid Demonstration or are state-certified through a SPA or waiver (except Texas). While we reminded respondents and clarified that we were only interested in other APMs, some respondents may still have incorporated information about the CCBHC PPS. If this is the case, our data would overrepresent certain clinic types, specifically SPA or waiver only, Demo only, Demo and grantee only, and Grantee and SPA or waiver. It also would overrepresent PPS forms of payment arrangements. We caution readers in generalizing findings derived from the case studies. The purpose of the interviews was to provide an in-depth description of the design of CCBHC APMs and the processes leading to and embedded within their negotiation and implementation. Our findings may or may not reflect the designs and processes of other CCBHC APMs.

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