Florida Behavioral Health Association
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Certified Community Behavioral Health Clinics
(Updated December 2023)

Background:

The Certified Community Behavioral Health Clinic (CCBHC) model was created through the Protecting Access to Medicare Act of 2014 as a Medicaid demonstration program. The law establishes a federal definition and minimum criteria for CCBHCs, giving states the opportunity to develop innovative behavioral health delivery models and use a cost based Prospective Payment System (PPS) to reimburse for services provided. CCBHCs are a new provider type in Medicaid designed to provide timely access to a comprehensive range of mental health and substance use disorder services to vulnerable individuals. In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of complex populations.[1] In 2017, 8 states were funded to implement demonstration projects and two states were added in 2020. Due to the improved outcomes realized, Congress has appropriated funds annually for CCBHC expansion grants through the Substance Abuse and Mental Health Services Administration (SAMHSA) since 2018 to further these organization's reach. Furthermore, in 2022 the Bipartisan Safer Communities Act expanded the Medicaid Demonstration to ten additional states every two years starting in 2024.[2]

The Model:

The CCBHC model is not another siloed program, rather a transformational shift throughout provider organizations to improve how community-based behavioral healthcare is delivered and reimbursed. CCBHCs must provide services to anyone seeking help for a mental health or substance use condition, regardless of their place of residence, ability to pay, or age. SAMHSA has established a comprehensive set of criteria in six domains that an organization must achieve in order to attain certification as a CCBHC. The state is responsible for developing and maintaining the certification process based on these minimum standards. Once an organization becomes certified, they are eligible to be reimbursed at higher rates through a Prospective Payment System. The CCBHC must meet established thresholds and performance outcomes as well as maintain fidelity to the standards to maintain certification. The six domains are:

- Staffing
- Availability and Accessibility of Services
- Care Coordination
- Scope of Services
- Quality and Other Reporting
- Organizational authority and Governance

[1] See, https://www.thenationalcouncil.org/wp-content/uploads/2015/11/Fact-Sheet_Excellence-in-mental-health-act-an-introduction-FINAL.pdf?daf=375ateTbd56, retrieved September 28, 2020

[2] National Council for Mental Wellbeing. (2022). *2022 CCBHC Impact Report: Expanding Access to Comprehensive, Integrated Mental Health & Substance Use Care.* https://www.thenationalcouncil.org/wp-content/uploads/2022/10/2022-CCBHC-Impact-Report.pdf

The expected impact of CCBHCs is to substantially improve care coordination and integrated care for patients, with special focus on individuals with serious mental illness (SMI), serious emotional disturbance (SED), and chronic substance use disorders (SUD). Providers must demonstrate expansion of person-centered, family-centered, and recovery-oriented care that integrates physical and behavioral healthcare to serve the "whole person". Additionally, expanded, and improved data collection is expected. Beyond the floor set by SAMHSA, the state may define additional requirements and may require CCBHCs to prioritize specific difficult-to-serve populations.

Staffing

A CCBHC must minimally have a chief executive officer and psychiatrist serving as a medical director on their management team. Other required staff members include:

- Medical staff able to prescribe and manage medications to treat SMI, SED, and SUDs.
- Credentialed substance abuse specialists.
- Individuals with trauma expertise who are able to promote recovery.

Required competency-based staff trainings completed at orientation and annually thereafter include:

- Evidence-based practices.
- Cultural competency aligned with the National Standards for Culturally and Linguistically
- Appropriate Services (CLAS).
- Person-centered and family-centered, recovery-oriented planning and services.
- Trauma-informed care.
- The clinic's policy and procedures for continuity of operations/disasters.
- The clinic's policy and procedures for integration and coordination with primary care.
- Care for co-occurring mental health and substance use disorders.
- Other trainings required by the state.

Accessibility

CCBHCs must offer services in a manner accessible and available to individuals in their community. Access is required at times and places convenient for those served, including expanded hours on evenings and weekends. Prompt intake and engagement in services is expected. CCBHCs must provide access regardless of ability to pay and place of residence using sliding scale fees. Crisis management services must be available 24 hours per day, 7 days per week. CCBHCs must have clearly established relationships with local emergency departments to facilitate care coordination, discharge, and follow-up, as well as relationships with other sources of crisis care. Accessibility must be promoted via peer, recovery, and clinical supports in the community and CCBHCs must provide increased access through use of telehealth/telemedicine, online treatment services, and mobile in-home supports. Transportation support must be provided to the extent possible.

Care Coordination

Care coordination is considered the cornerstone of CCBHCs, and CCBHCs are expected to coordinate care across the spectrum of health services and other social services. This includes deliberately organizing patient care activities and sharing information among all the participants concerned with a patient to achieve safer and more effective care. Providers must enter into formal

partnerships through memoranda of agreement or care coordination agreements with a variety of community partners, including local Federally Qualified Health Centers or Rural Health Center's for primary care provision (unless the provider directly provides comprehensive healthcare services); inpatient psychiatric and detoxification facilities/hospitals; residential programs; other behavioral health providers; other social service providers (schools, child welfare agencies, juvenile and criminal justice agencies, child placing agencies for therapeutic foster care services); and Department of Veterans Affairs facilities.

Service Scope

CCBHCs are required to provide directly or through referral or formal relationships with other providers, a broad array of services to meet the needs of the population served. For all patients, person and family-centered treatment planning and care coordination activities are required. The patient is actively involved and able to self-direct services received, having maximum choice and control over their care. The treatment team includes the patient and their family, and an interdisciplinary team composed of individuals who work together to coordinate medical, psychosocial, emotional, therapeutic, and recovery support needs of the individual served. The following comprise the service array that must be available:

- Crisis mental health services, including:
  – 24-hour mobile response teams,
  – emergency crisis intervention services, and
  – crisis stabilization (not residential or inpatient).
- Screening, assessment, and diagnosis (including risk assessment).
- Person and family-centered treatment planning.
- Outpatient mental health and substance use services.
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
- Targeted case management.
- Psychiatric rehabilitation services.
- Peer support and counselor services and family support.
- Intensive, community-based mental health care for members of the armed forces and veterans, particularly those in rural areas consistent with minimum clinical mental health guidelines established by the Veterans Health Administration.

The CCBHC must provide 51% or more of the service encounters directly. The remaining required services may be provided by designated collaborating organizations who must meet the same quality standards as those afforded by the CCBHC. Based on a comprehensive need assessment, the state must establish a minimum set of required evidence-based practices to be implemented such as:

- Motivational Interviewing
- Cognitive Behavioral individual, group, and online therapies (CBT)
- Dialectical Behavioral Therapy (DBT)
- Addiction technologies
- Recovery supports
- First episode early intervention for psychosis

- Multi-Systemic Therapy
- Assertive Community Treatment (ACT)
- Forensic Assertive Community Treatment (F-ACT)
- Evidence-based medication evaluation and management (including, but not limited to, medications for psychiatric conditions, medication assisted treatment for alcohol and opioid use disorders, long-acting injectable medications, and smoking cessation medications)
- Community Wraparound services for youth and children
- Specialty clinical interventions to treat mental and substance use disorders experienced by youth (including youth in therapeutic foster care)

Quality and Reporting

CCBHCs must establish or maintain electronic health records (EHRs). The Health IT system is used to conduct population health management, quality improvement, reduce disparities, and for research and outreach. Additionally, CCBHCs must collect data elements modeled on the FQHC Uniform Data System including:

- Encounter data
  - Consumer demographics
  - Staffing
  - Service usage
  - Service access
  - Care coordination
- Clinical outcomes data
- Quality data
- Other data as required by the state

Organizational Authority

CCBHCs must be either non-profit community organizations, part of a local government behavioral health unit, under the authority of the Indian Health Service, an Indian Tribe or a Tribal organization, or an Urban Indian organization. Governing board members must reasonably represent those served in terms of geographic areas, race, ethnicity, sex, gender identity, disability, age, and sexual orientation. This may be accomplished by at least 51% of the Board being consumers with mental illness or adults recovering from SUD, or a substantial number representing these groups. CCBHCs must implement specific methods for consumer and family input. States are encouraged to require accreditation by an appropriate nationally recognized organization (i.e., CARF, COA, or Joint Commission).

Prospective Payment Systems

Providers interested in becoming a CCBHC complete a cost report including both current costs and anticipated future costs associated with becoming a CCBHC. There are 2 payment options to implement Prospective Payment Systems (PPS). The first (Option 1) is a daily rate based on cost of services rendered by a CCBHC. This is a fixed amount for all services provided on any given day to a service recipient. The rate is based on the total annual allowable CCBHC costs divided by the total

annual number of CCBHC daily visits and results in a uniform payment amount per day, regardless of the intensity of services or individual needs of patients on that day.

The second option (Option 2) is a monthly rate that applies uniformly to all CCBHC services rendered by a certified clinic, including all qualifying sites of the certified clinic. Option 2 is paid once per month for each unduplicated patient who had one or more visits at the CCBHC in that month. Under option 2, states define "special populations" of patients based on level of complexity or need and set different rates for the general population and each special population. States must implement quality bonus payments based on state-defined metrics and include a process for addressing outlier costs. The monthly PPS option combines upside opportunity and downside risk for providers. Among the implications of this model:

- Providers experience substantially more downside risk than in a daily PPS model. Because rates are set based on anticipated monthly patient volume, clinics experience a financial loss if costs or intensity of services during a month exceed targets—for example, if a patient experiences a crisis due to a poorly controlled condition.
- Clinics are incentivized to provide care efficiently while in alignment with the patient's treatment plan. To effectively manage the financial risk associated with fixed monthly payments, clinics have an incentive to meet the goals and scope of the required patient-centered treatment plan as efficiently as possible. CCBHCs apply population health management approaches including risk stratification and utilization management to ensure each patient receives the appropriate level of care.
- States pay a rate aligned with the level of need for each population served. Rather than paying a fixed rate for all patients, including those with minimal needs, states specify targeted subpopulations with higher rates reflective of their higher complexity, while paying a lower rate for the general population. The stratified rate structure incentivizes clinics to target care to higher complexity groups resulting in decreased utilization elsewhere in the system.
- States do not pay in a month when a patient does not receive services.
- The monthly PPS includes pay-for-performance. State agencies can select specific quality measures to incentivize with bonus payments.

Outcomes

According to SAMHSA data released as part of their Fiscal Year 2023 Justification of Estimates for Appropriations Committees, CCBHC patients experienced a:

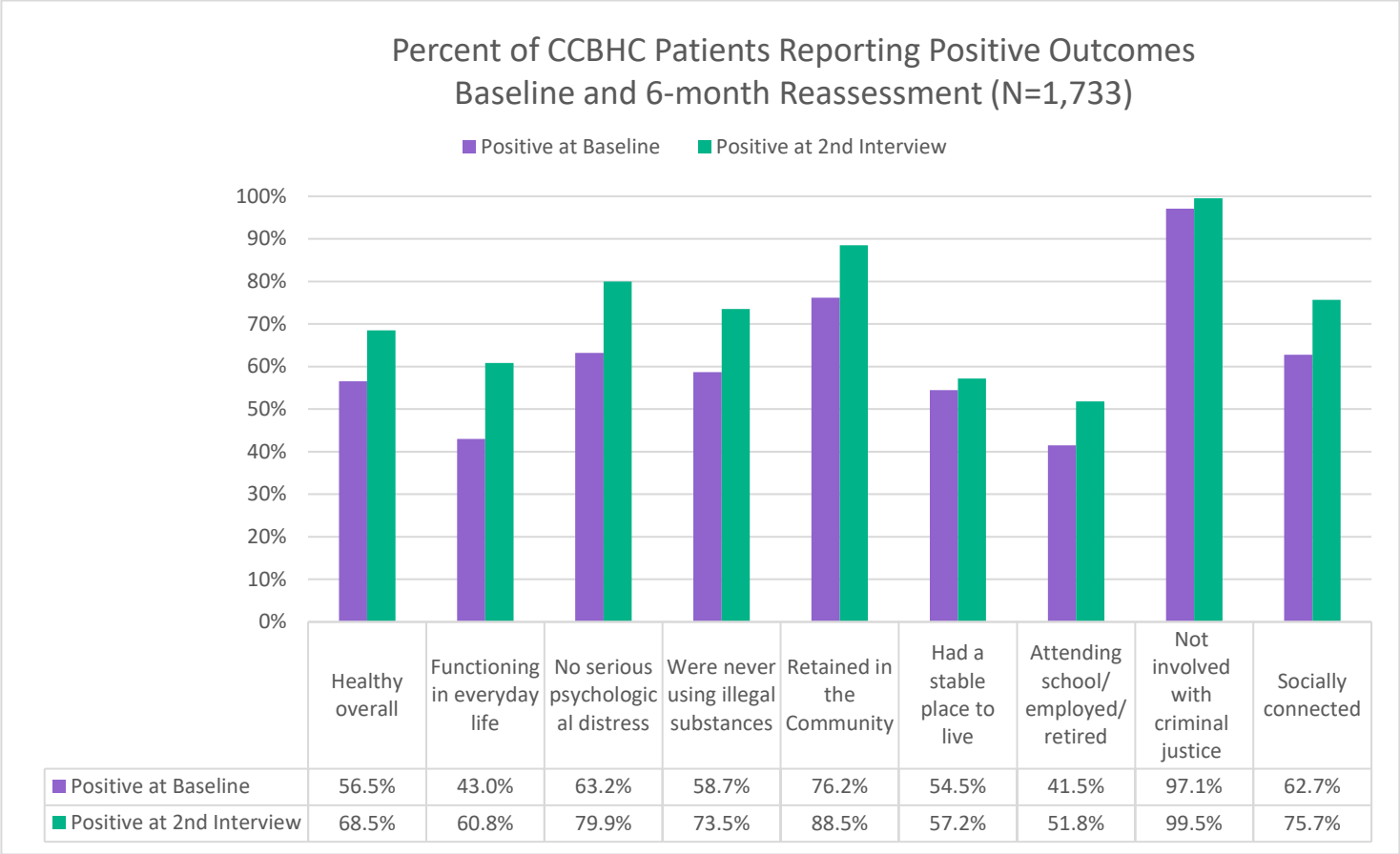
- 72% reduction in hospitalization;
- 69% reduction in ED visits;
- 12% increase in employment or started going to school; and
- 25% increase in mental health functioning in everyday life.[3]

Florida did not participate in the Medicaid Demonstration; however, 26 non-profit behavioral health organizations in the state are implementing the CCBHC model through SAMHSA grants. As part of the grant requirements, these organizations must report National Outcome Measures (NOMs) to SAMHSA. Patients are interviewed at intake to gather a baseline and then every 6 months and at

[3] See, https://www.samhsa.gov/sites/default/files/samhsa-fy-2023-cj.pdf, retrieved November 10, 2022

discharge to measure changes. Nine organizations had reassessment data to share, and impact is displayed in Graph 1 below.

Graph 1: Florida CCBHC Outcomes



	Healthy overall	Functioning in everyday life	No serious psychological distress	Were never using illegal substances	Retained in the Community	Had a stable place to live	Attending school/ employed/ retired	Not involved with criminal justice	Socially connected
Positive at Baseline	56.5%	43.0%	63.2%	58.7%	76.2%	54.5%	41.5%	97.1%	62.7%
Positive at 2nd Interview	68.5%	60.8%	79.9%	73.5%	88.5%	57.2%	51.8%	99.5%	75.7%

The National Council for Mental Wellbeing recently published the 2022 *CCBHC Impact Report: Expanding Access to Comprehensive, Integrated Mental Health & Substance Use Care*. This report highlights accomplishments of 249 CCBHCs serving over 1.2 million patients that responded to a survey administered online by The Harris Poll on behalf of the National Council for Mental Wellbeing conducted July 14th – August 26th, 2022. Florida's CCBHCs had a 100% response rate to the survey. Here are the impact CCBHCs demonstrated:

- Expanded Access to Care
    - On average CCBHCs serve more than 900 more people per clinic than prior to CCBHC implementation, representing a 23% increase.
        - State-certified CCBHCs experienced a 30% increase.
        - SAMHSA-funded grantees experienced a 18% increase
    - 87% see patients for routine needs within 10 days of the initial call or referral (compared to national average of 48 days)
        - 71% within 1 week or less
        - 32% same-day access
    - 79% deliver services on site at schools

    - 82% use one or more forms of MAT for opioid use disorder, compared to only 56% of substance use clinics nationwide that provide any MAT services
- Alleviated Workforce Shortages
    - On average CCBHCs hired 27 new staff
        - State-certified CCBHCs hired an average of 44 positions
        - SAMHSA-funded grantees hired an average of 20 positions
    - 92% were able to raise salaries and offer bonuses and reported increased recruitment and retention
- Improving Care Coordination and Integration
    - 81% increased referrals to primary care
    - 98% are engaged in collaborative activities with hospitals and EDs
    - 96% are engaged in activities in partnership with criminal justice agencies
    - 73% directly provide primary care screening and monitoring

In conclusion, the National Council report noted that *CCBHCs have proven to be successful in expanding access to comprehensive mental health and substance use treatment services. The model's ability to increase access while supporting and expanding the workforce is a blueprint for the future of the behavioral health system.*[4]

Florida Proposal

The FBHA continues to advocate for implementation of the CCBHC model in Florida to improve quality of care through a more flexible, cost-based payment system. Behavioral health providers would have more opportunity to pay competitive salaries for credentialed staff, implement evidence-based practices, and expand service and support options for special populations. The PPS incentivizes providers to treat the most complex patients who are more likely to require crisis interventions. As noted earlier, there are 26 community behavioral health providers in Florida that have received federal SAMHSA grants to transform their organizations into CCBHCs. The FBHA is actively working with relevant state agencies to:

- Develop the certification process
- Develop the Prospective Payment System
- Negotiate daily or monthly population-based rates specific to each participating provider
- Set thresholds and quality metrics for participating provider performance

The Department of Children and Families' Office of Substance Abuse and Mental Health, as the state's mental health and substance use authority, is currently working on rules to implement the certification process. The Agency for Health Care Administration is working on Federal authority to define CCBHCs as a Medicaid service, a Medicaid provider type, and describe the CCBHC prospective payment methodology. Once provider organizations are certified, they would be able to enroll in Medicaid as provider type CCBHC and be paid a per diem or monthly rate. Ideally, the same payment methodology would be applied to the managing entity contracts.

[4] National Council for Mental Wellbeing. (2022). *2022 CCBHC Impact Report: Expanding Access to Comprehensive, Integrated Mental Health & Substance Use Care*. https://www.thenationalcouncil.org/wp-content/uploads/2022/10/2022-CCBHC-Impact-Report.pdf