STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Certified Community Behavioral Health Clinic (CCBHC) Stakeholder Committee

Meeting #2

June 22, 2023

Agenda

- Welcome and Updates – 5 minutes
- Prospective Payment System (PPS) Overview and Options –20 minutes
- Approach to CCBHC Services & Partnerships – 50 minutes
- CCBHC Focus Group Planning – 15 minutes
- Public Comment – 20 minutes
- Next Steps/Questions – 10 minutes

Welcome and Updates

Updates

- CCBHC Planning Grant Website
- CCBHC Planning Grant FAQ
- *CCBHC Preliminary Interest Survey*

PPS Overview and Options

What is PPS?

- PPS is a Medicaid per-encounter rate set based on a cost report that documents a CCBHC's **allowable costs** and **qualifying patient encounters** (either on a monthly or daily basis) over a year.
  - CCBHCs complete a cost report including both current costs and anticipated future costs associated with becoming a CCBHC.
- The costs are divided by the number of qualifying encounters to arrive at a **clinic-specific rate**, which is paid to the CCBHC each time a monthly or daily encounter occurs, regardless of the number or intensity of services provided.

FMAP/Opportunity

Federal Medical Assistance Percentages (FMAP) is used to determine the amount of Federal matching funds a State receives for its expenditures on Medicaid. Participation in the federal demonstration program enables Iowa to access enhanced FMAPs for CCBHC services:

63.13% standard FMAP becomes 74.19% FMAP

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What is PPS? (cont.)

- In places with managed Medicaid, states may either make up the difference between managed care payments and PPS through a periodic reconciliation process or require managed care organizations to pay the full PPS rate.
- Rates are clinic-specific, but through the process of documenting anticipated costs, state Medicaid agencies have an opportunity to benchmark clinics against one another and ensure services are being provided at comparable cost.
- CCBHCs receive one PPS payment for each daily (or monthly, at state option) encounter. They cannot bill multiple PPS encounters for the same day/month.
- Quality bonus payments are mandatory under the monthly PPS and have been voluntarily adopted by nearly all states using the daily PPS.

CCBHCs participating in the Expansion Grant program can receive both grant funding from SAMHSA and a PPS rate from their State Medicaid program.

Starting Point

PPS-1

- Daily "threshold" encounter rate
  - Annual cost of operations is the numerator
  - Total number of daily encounters is the denominator
- Optional quality bonus payment option

PPS-2

- Monthly rate paid in any month with an encounter
- Costs reported by population: rate cell per population
- Quality bonus payments are required

PPS-1 vs. PPS-2

PPS-1

PROs	CONs
• PPS-1 is **comparatively simpler** to administer than PPS-2 • Providers are incented to generate multiple visits • Simpler cost reporting for providers • More states have implemented PPS-1 (8 out of 10) so better base of implementation experience	• **Harder to incorporate accountability & value** – via reporting, performance standards, certification • Clinics are not able to access variable rates based on the specific or specialized needs of the patient

PPS-2

PROs	CONs

• **Incentivizes higher level of customer service and accountability**
• Allows clinics to access variable rates based on the needs of the patient
• Disincentivizes only serving individuals with less intense needs.
	• **Administratively more complex**
	  • Requires attribution methodology, more sophisticated cost reporting from providers, and outlier payments
	  • Requires process of re-assigning people based on acuity with some periodicity
	  • State needs to define and designate special populations
	  • State must define an indirect cost methodology for special populations

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Proposed Changes to Payment Rule

- Special population rates are now optional under PPS-2
- Establishes a three-year standard rebasing pace
- Permits tiered/sliding quality bonus payments (QBP)
- Prohibits QBPs for reporting
- Prohibits claiming 988 costs within the PPS
- Adds requirement that payments are "consistent with efficiency, economy, and quality of care" and create service availability "at least to the extent that such care and services are available to the **general population"**
- Updates telehealth language
- Permits directing managed care organizations to make full PPS payments without prior approval because the PPS payment is statutory

PPS-3 & PPS-4

- Creates two new PPS options for States: PPS-3 and PPS-4
  - PPS 3 is a daily rate like PPS 1 and PPS 4 is a monthly rate like PPS 2
- Adds at least one Special Crisis Services (CSC) rate
  - Section 9813 compliant mobile crisis – 85% FMAP
  - CCBHC Demo (but not 9813) compliant mobile crisis – 74.9% FMAP
  - On-site crisis stabilization – 74.9% FMAP
- All other crisis services outside of the three crisis rate options will be included in the base PPS rate

Section 9813 Compliant Mobile Crisis Services

- Available 24 hours a day, 365 days a year
- Provide all required components
  - Screening and assessment
  - Stabilization and de-escalation
  - Coordination and referrals to health, social and other services, as needed
- Provided to individuals who reside in the community and outside of a hospital or other facility setting
- Provided by a multi-disciplinary team with appropriate expertise
  - At a minimum, one behavioral health care professional who is qualified to provide an assessment within scope of practice requirements under state law
- All members of the multi-disciplinary team are trained in trauma informed care, de-escalation strategies and harm reduction
- Respond to crises "in a timely manner"
- Maintain relationships with relevant community partners
- Maintain the privacy and confidentiality of beneficiary information consistent with federal and state requirements.

Proposed New Required QBP Measures

Required CCBHC Report?	Measure	Collector	Current	Proposed
Y	Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD-AD)	State	N/A	New measure
Y	Depression Remission at Six Months (DEP-REM-6)	Clinic	Optional QBP (12 month version)	Required for QBP
Y	Time to Services (I-SERV)	Clinic	N/A	New measure
Y	Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)	State	Required for QBP	Unchanged
Y	Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)	State	Required for QBP	Unchanged
Y	Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	State	Required for QBP	Unchanged

Proposed New Optional QBP Measures

Required CCBHC Report?	Measure	Collector	Current	Proposed
Y	Follow-Up After Emergency Department Visit for Substance Use (FUA-CH and FUA-AD)	State	N/A	New measure
Y	Plan All-Cause Readmissions Rate (PCR-AD)	State	Optional for QBP	Unchanged
Y	Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)	State	Optional for QBP	Unchanged
Y	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	Clinic	N/A	New measure
Y	Screening for Depression and Follow-Up Plan (CDFCH and CDF-AD)	Clinic	Optional for QBP	Child measure added as optional for QBP
N	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA) (SRA-C)	Clinic	Required for QBP	Optional for QBP
N	Adult Major Depressive Disorder: Suicide Risk Assessment (SRA) (SRA-A)	Clinic	Required for QBP	Optional for QBP
N	Controlling High Blood Pressure (CBP-AD)	Clinic	N/A	New measure
N	Weight Assessment and Counseling for Nutrition and Physical Activity for children/Adolescents (WCC-CH)	Clinic	N/A	New measure

PPS-3 Considerations

PPS-3 benefits

- Mobile crisis development incentive
- Cleaner PPS rates
- Enhanced FMAP for three years
- Demonstration appeal

PPS-3 costs

- Added complexity
- Abrupt pivot
- Timeline

PPS Discussion Questions

- As Iowa considers PPS options, are there any significant drawbacks or advantages to any of the payment models we discussed?
- What type of technical assistance would be of most help to providers that are new to CCBHC cost reporting?
- Are there any optional QBP measures that stood out that would be particularly meaningful for assessing the performance of the CCBHC program?

Approach to CCBHC Scope of Services & Partnerships

Reminder - Nine Required Services

1. Screening, Assessment and Diagnosis
2. Comprehensive Outpatient BH Service Across the Entire Life Cycle
3. Patient-Centered Care Planning
4. Case Management
5. Peer and Family Support
6. Psychiatric Rehabilitation
7. Medical Screening and Monitoring
8. Services for Armed Forces and Veterans
9. Mobile Crisis

- A CCBHC can use a Designated Collaborative Organization (DCO) to provide up to 49% of the (non-crisis) required service encounters

CCBHC Service Requirements

- SAMHSA establishes minimum standards for all CCBHC services, which must serve as a "floor" for all CCBHC service requirements
- States are permitted to add more stringent or additional service requirements and are prompted to establish state-specific definitions to ensure the CCBHC demonstration meets statewide and local behavioral health needs
- Iowa HHS has proposed a preliminary, general approach to establishing service requirements for CCBHCs that ensure services are available throughout the catchment area, meet licensure/accreditation standards, and do not unintentionally create redundant/duplicative services

HHS' Proposed Approach to CCBHC Service Requirements

- Demonstration CCBHCs will be expected to meet all SAMHSA service requirements and relevant Iowa requirements
- Demonstration CCBHCs must be licensed and accredited as a MH and SUD provider in Iowa, under Chapter 24 and Chapter 155 of Iowa State Code
  - A provider applying who does not possess both licenses/accreditations at time of application must be in the process of applying for any missing licensure/accreditation.
- Demonstration CCBHCs must be capable and must demonstrate ability to provide all required services to all populations either directly or through a DCO

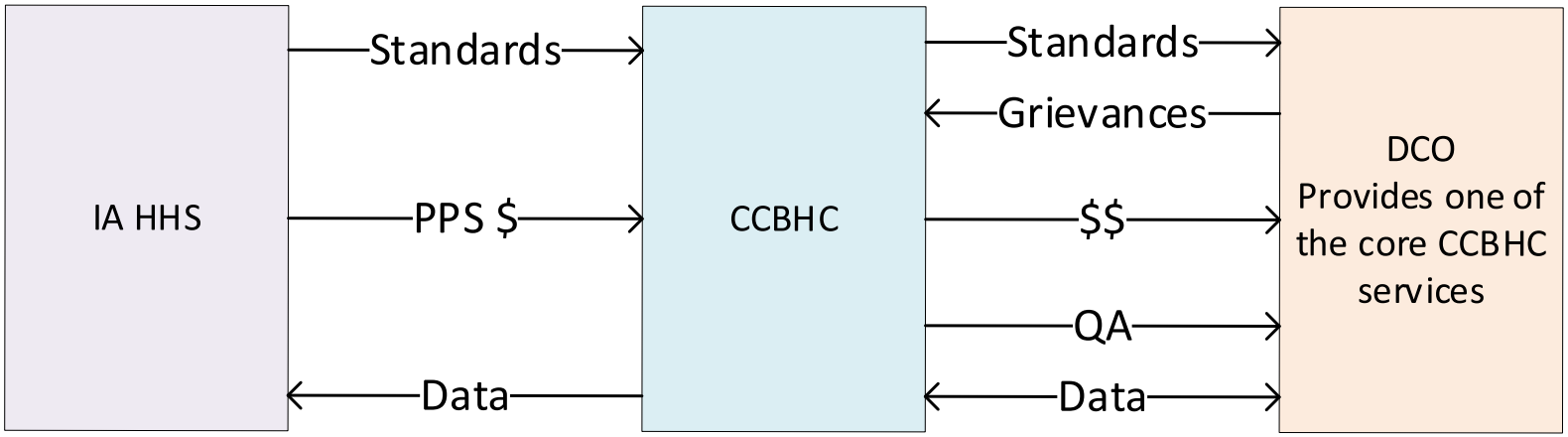
HHS' Proposed Approach to CCBHC Service Requirements

- The CCBHC must ensure all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, consistent with the freedom of the person receiving services to choose providers within the CCBHC and its DCOs. This requirement does not preclude the use of referrals outside the CCBHC or DCO if a needed specialty service is unavailable through the CCBHC or DCO entities.

CCBHC DCOs vs. Care Coordination Partners

DCO	Care Coordination Partners
• **Provides one of the 9 required services** • A formal relationship where CCBHC retains clinical responsibility for all care provided, whether those services are direct or provided by the DCO. • Formal relationship means "contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal arrangements describing parties' mutual expectations and establishing accountability for services to provided and funding to be sough and utilized." • CCBHCs have responsibility for ensuring the DCO complies with all CCBHC criteria, including staffing, data collection, reporting and care coordination. • DCO encounters are included for applicable services in the CCBHC cost report.	• **Provides non-CCBHC services** • Care Coordination partnerships should be supported by a formal, signed agreement detailing the roles of each party. • If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. • At a minimum, the CCBHC has written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed.

CCBHC DCOs Structure



HHS' Proposed Approach to CCBHC Service Requirements

- **If a service does not exist in the catchment area,** the CCBHC is expected to establish that service and directly (or through a DCO) provide access to it for the entirety of the area. (*Network adequacy standards for such services will be discussed at a future meeting.*)
- **If a service exists but is insufficient to serve the full range of need in a catchment area,** the CCBHC will be expected to supplement the service and provide access to the CCBHC service in areas of need.
- **If a service exists in the catchment area**, the CCBHC must partner with existing service providers to facilitate access to CCBHC services.
  - Demonstration CCBHCs must have referral/care coordination arrangements in place (in addition to DCO arrangements, if applicable) with all required provider types to facilitate connection to appropriate treatment and services.

SAMHSA CCBHC Partnership Requirements

Service Type	Providers
Primary Care	Primary Care Providers, including Federally Qualified Health Centers, Rural Health Clinics, or Community Health Centers
SUD	Inpatient psychiatric treatment, OTP services, medical withdrawal management facilities and ambulatory medical withdrawal management providers for substance use disorders, and residential substance use disorder treatment programs
Tribal Services	Tribally operated mental health and substance use services including crisis services that are in the service area
Veterans	Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department
Hospitals	Inpatient acute-care hospitals and their associated services/facilities, including emergency departments, hospital outpatient clinics, urgent care centers, and residential crisis settings
Step Down/Follow Up	Ability to transition individuals from EDs, inpatient psychiatric programs, medically monitored withdrawal management services, and residential or inpatient facilities that serve children and youth such as Psychiatric Residential Treatment Facilities and other residential treatment facilities, to a safe community setting. Includes procedures and services, such as peer recovery specialist/coaches, to help individuals successfully transition from ED or hospital to CCBHC and community care to ensure continuity of services and to minimize the time between discharge and follow up

Proposed Iowa-Specific Services and Evidence Based Practices (EBPs)

- Assertive Community Treatment (ACT)
- Individual Placement Support
- At Least One Intensive EBP for Families/Children (i.e., Functional Family Therapy, Multi-Systemic Therapy, Multi-Dimensional Therapy)

- CCBHCs will also be permitted to identify and offer additional EBPs based on the needs of their catchment area

Iowa's Population of Focus:

- Serious Mental Illness (SMI)
- Serious Emotional Disturbance (SED)
- Substance Use Disorder
- Pregnant women
- Veterans
- Adolescents: Depression and Substance Use
- BIPOC and Underrepresented Populations
- Native American & Tribal Populations
- LGBTQ+

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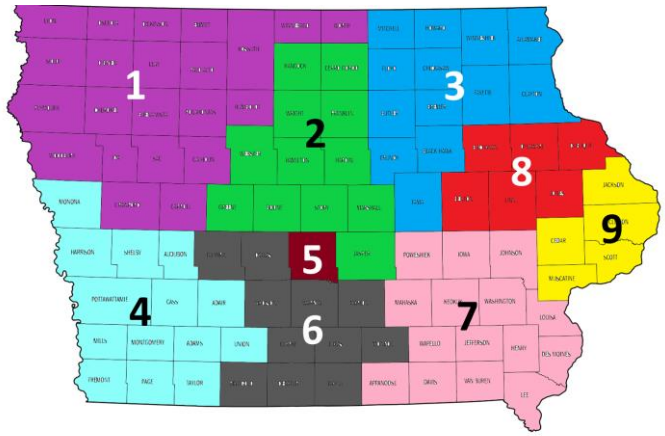
CCBHC Service and Partnership Discussion Questions

- How can we structure partnerships to ensure sufficient access to CCBHC services, particularly for larger catchment areas?
- Are there additional services/supports HHS should consider including in the CCBHC demonstration as either **required** or **optional** services?
- Are there additional EBPs HHS should consider including in the CCBHC demonstration?
- What type of technical assistance would be of most help to providers that are exploring DCO or Care Coordination arrangements?

CCBHC Focus Group Planning

CCBHC Focus Groups

- **Thank you for your feedback!**
- Iowa HHS is planning 11 in-person focus groups
  - At least one in each of the CCBHC catchment areas and a dedicated tribal focus group
- Two additional virtual focus groups will be held for any interested party not able to attend in person
- In-person focus groups will be held **July 17 – July 21**
- Goal is to gather local perspectives and feedback on CCBHC program design to ensure catchment area needs are addressed with particular attention on recipients of services



Stakeholder committee members are asked to attend at least one focus group that occurs in their catchment area.

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Upcoming Focus Group Meetings

July 17th-21st 2023

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Indianola	Davenport	Waterloo	Mason City	Sioux City
Afternoon	Fairfield	Cedar Rapids	Urbandale	Storm Lake	Council Bluffs

Focus Group Facilitation Questions

What questions should we prioritize to ensure the focus groups provide the feedback needed to help inform our CCBHC demonstration design?

- What are the biggest behavioral health needs in your catchment area?
- What is your experience accessing behavioral health services?
- Are you and your community able to receive timely behavioral health services?
- What is missing from your current behavioral health system that you or your community need?
- Are services accessible to all communities in your catchment area?
- Does the behavioral health service adequately address the needs of children and families?
- Are there enough clinicians, professionals, and staff available to ensure a sufficient behavioral health workforce? What would help build additional behavioral health workforce in this community?
- What is your experience with telehealth vs. in-person behavioral health services? For rural communities, has telehealth improved access to services? Are there other strategies you would recommend?
- What parts of the health system in your catchment area feel well connected? Where is better coordination needed to ensure individuals with BH conditions don't fall through the cracks?
- If we could design a clinic that best serves the BH needs in your catchment area, what features, services, or supports would it offer?
- How are crisis services accessed in your area? Do you feel there are adequate crisis services in your area?

Public Comment

IowaCCBHC@dhs.state.ia.us

Upcoming Stakeholder Meetings

Date	Time	Location
Thurs. July 27th 2023	2pm-4pm	Lucas State Office Building 321 E. 12th Des Moines, Iowa 50319
Thurs. August 24th 2023	2pm-4pm	Lucas State Office Building 321 E. 12th Des Moines, Iowa 50319
Thur. September 28th 2023	2pm-4pm	TBD
Thurs. October 26th 2023	2pm-4pm	TBD