Washington State Health Care Authority

Report to the Legislature

Funding Certified Community Behavioral Health Clinics in Washington State

Exploration of the Design and Implementation of a Statewide CCBHC Initiative

Engrossed Substitute Senate Bill 5693; Section 215(106); Chapter 297; Laws of 2022

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Division of Behavioral Health and Recovery
P.O. Box 45503
Olympia, WA 98504-5503
Phone: (360) 725-9408
www.hca.wa.gov

MILLIMAN REPORT

Funding Certified Community Behavioral Health Clinics in Washington State

Exploration of the Design and Implementation of a Statewide CCBHC Initiative

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Jeremy Cunningham, FSA, MAAA
Barbara Culley, MPA, NHA
Libby Bunzli, MPH
Ryan Melson, JD
David Applegate, MPP
Joseph Whitley, MPP
Jacob Epperly, FSA, MAAA

Milliman

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1. Executive Summary

The Washington State Health Care Authority (HCA) has engaged Milliman, Inc. (Milliman) to support the work directed in Engrossed Substitute Senate Bill (ESSB) 5693, Section 215 (Proviso 106),[i] which provided funding for the exploration of a sustainable, alternative payment model for comprehensive community behavioral health services, including the certified community behavioral health clinic (CCBHC) model. This report meets the legislative requirements of Proviso 106 and begins the work to prepare Washington for future federal CCBHC planning and demonstration opportunities.

A CCBHC is a community-based clinic that provides a comprehensive range of mental health and substance use services to any person who seeks care. CCBHCs are also responsible for ensuring integration of primary and behavioral health care, developing formal partnerships with primary care providers, and engaging in whole-person care coordination to ensure a person's healthcare, behavioral health, and social needs are identified and addressed in a holistic manner. The Protecting Access to Medicare Act of 2014 (PAMA) established the concept of CCBHCs and identified a set of initial criteria, which were further developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) to set forth rigorous standards that a behavioral health provider must meet to become a CCBHC.[iiiii] Early findings published by the National Council for Mental Wellbeing suggest that CCBHCs present an opportunity to improve access to behavioral healthcare, improve quality outcomes, and alleviate behavioral health workforce shortages.[iv]

The project team responsible for fulfilling this legislative requirement consisted of HCA and Milliman staff. The team members met throughout the Spring, Summer, and Fall of 2022 to explore and discuss key considerations for designing a CCBHC model in Washington. In this process, the project team engaged the National Council for Mental Wellbeing for expertise in the implementation of the CCBHC model across the country and interested parties, including but not limited to state Behavioral Health Council representatives, current and aspiring CCBHC and other behavioral health providers, Medicaid Managed Care Organizations, and Behavioral Health Administrative Services Organizations to inform the development of this report.

The scope of this work included primary research on national data and CCBHC models as implemented in other states to identify leading practices and to inform the development of implementation and rate recommendations to the legislature. The exploration of CCBHC model implementation in Washington State has also been heavily informed by a series of interested party workgroups, interviews, and data gathered through a provider survey process. Milliman has included the perspectives and preferences of interested parties throughout this report as we outline considerations for a CCBHC care model and payment model, estimate budgetary and delivery system impacts of implementation, and articulate HCA's recommendations for both short-term and long-term opportunities to leverage the CCBHC model in Washington State with the primary goals of improved quality and expanded access to behavioral health services.

This work included actuarial expertise to analyze potential payment models and related expense implications for various rate models. The actuarial analysis included within the report should be considered preliminary as information was not provided by all prospective CCBHCs, and the information that was provided was given with the caveat that there are still many unknowns regarding state requirements and providers' future staffing needs.

Based on the data and discussions captured through this project and after accounting for potential cost increases under the existing care model and CCBHC billable staff, the estimated incremental cost of implementing the CCBHC care model is approximately a 10% to 15% increase to state and federal Apple Health expenditures, reflecting increases to CCBHC provider non-billable staff and other non-personnel costs. It is important to note that if Washington is selected to participate in the federal demonstration, expenditures on CCBHC services would receive an enhanced Federal Medical Assistance Percentage (FMAP) over a four-year period.

Structure of this report:

- This report first summarizes the national opportunities to fund CCBHC activities and the local behavioral health context, demonstrating that Washington is well positioned to pursue a CCBHC initiative.

- We then highlight the state's vision and goals for the behavioral health delivery system, which grounded the preliminary decisions, recommendations, and analysis. Key themes from interested party engagement are summarized. Among the stakeholders engaged for this project, there is resounding support for a statewide CCBHC initiative.
- The report then introduces a framework for the CCBHC model which addresses both the care model design and the payment model development. The care model addresses the CCBHC program and service requirements, challenges, and opportunities for customization in Washington, while the payment model provides options for short- and long-term consideration and confronts the trade-offs of each potential payment approach. Within this section, we highlight HCA's initial care model and payment model design preferences.
- The assessment of impact section of this report describes the quantitative methodology applied and initial findings in evaluating the budget impact of a statewide CCBHC implementation. We also explore anticipated impacts on the delivery system, exploring operational demands and workforce issues likely to be experienced by participating providers and anticipated impacts on quality of and access to comprehensive, community-based behavioral healthcare, drawing from provider experiences, national expertise, and early evaluation findings.
- The final section of the report offers additional considerations for implementation, specifically related to state and federal policy actions needed to move forward, operationalizing a CCBHC program through integrated managed care, and state operational impacts.
- Additionally, appendices are provided for additional, relevant information, specifically:

I. Proviso 106 of Engrossed Substitute Senate Bill (ESSB) 5693, Section 215 – Appendix I provides the Washington State legislative mandate to explore the development and implementation of a sustainable, alternative payment model for comprehensive community behavioral health services, including the certified community behavioral health clinic (CCBHC) model.

II. Interested party engagement participants – Appendix II provides a list of the invited participants in the interested party activities, e.g., surveys and workgroups.

III. Behavioral health services – Appendix III provides a list of service delivery codes that were reported by providers responding to the CCBHC data request with the total units delivered by procedure code for each of the services listed to assist in understanding current utilization.

IV. Non-personnel costs – Appendix IV provides a list of typical non-personnel costs incurred by CCBHC clinics with an indication of high-level one time and ongoing costs with suggested cost basis for each cost.

While this report discusses potential pathways for implementing a statewide CCBHC initiative, which can be done independent of the federal demonstration, HCA has expressed a commitment and strong interest in pursuing the federal opportunities to support CCBHC planning, implementation, and financing. The considerations, analysis, and recommendations included in this report presume that Washington will pursue the federal demonstration as the state's selected path to implementation. Furthermore, HCA intends to submit an application for the federal planning grant opportunity as the requisite first step toward participation in the federal CCBHC demonstration.

2. Introduction

Legislative Requirements in Proviso 106 and the Bipartisan Safer Communities Act

The Governor signed Engrossed Substitute Senate Bill (ESSB) 5693[v] into law on March 31, 2022. Section 215(106) directed the Washington State Health Care Authority (HCA) to explore, develop, and implement a sustainable, alternative payment model for comprehensive community behavioral health clinics (CCBHCs).[vi] In compliance with Proviso 106, HCA has contracted with Milliman to leverage our actuarial and policy expertise, research national data and other state models, work with the National Council, and engage interested parties, including current CCBHCs, potential CCBHCs, managed care organizations (MCOs), and behavioral health administrative service organizations (BH-ASOs). CCBHC services are part of and complementary to the broader behavioral health system.

The legislative requirements set forth in Proviso 106 include the following:

1. An overview of alternative payment models, options, and considerations for implementing the CCBHC model in Washington State;
2. An analysis of the impact of expanding alternative payment models on the state's behavioral health systems;
3. Relevant federal regulations and options to implement alternative payment models;
4. Options for payment rate designs;
5. An analysis of the benefits and potential challenges in integrating the CCBHC reimbursement model within an integrated managed care environment;
6. Actuarial analysis on the costs for implementing alternative payment model options, including opportunities for leveraging federal funding; and
7. Recommendations to the legislature on a pathway for statewide implementation.[vii]

After ESSB 5693 was signed into law, the United States Congress passed the Bipartisan Safer Communities Act[viii], which became law on June 25, 2022. Section 11001 of the Bipartisan Safer Communities Act expanded the community mental health services demonstration program, which enables states to receive enhanced federal funding to certify CCBHCs and reimburse them through a Prospective Payment System (PPS) methodology.[ix] Additionally, Section 11001 requires the Centers for Medicare and Medicaid Services (CMS) to award new planning grants to States to develop proposals to design and begin implementation of statewide CCBHC initiatives, which is a required precursor to participation in the demonstration.[x] Beginning on July 1, 2024, up to ten additional States may be selected to operate a CCBHC demonstration program.[xi] Every two years thereafter, up to ten additional States could be selected for a four-year demonstration program.[xii]

This report has been developed to meet the legislative mandate set forth in Proviso 106 while also supporting preliminary strategic planning and interested party engagement efforts that can position the state to be competitive in pursuing future federal CCBHC planning and demonstration opportunities, which aligns with the stated interests and intent of the state. The HCA is pursuing the planning grant application, which were due Dec. 19, 2022, with an eye towards applying for a July 2024 demonstration if Governor Inslee and the State Legislature approve that request.

National Context for CCBHCs

What is a CCBHC?

A CCBHC is an outpatient, community-based clinic that provides a comprehensive range of mental health and substance use services to any person who seeks care. CCBHCs are also responsible for ensuring integration of primary care and behavioral health care, developing formal partnerships with primary care providers, and engaging in whole-person care coordination to ensure a person's healthcare, behavioral health, and social needs are identified and addressed in a holistic manner. The Protecting Access to Medicare Act of 2014 (PAMA) established the concept

of CCBHCs and identified a set of initial criteria, which were further developed by SAMHSA to set forth rigorous standards that a behavioral health provider must meet in order to become a CCBHC.[xiii,xiv] To be qualified for consideration to implement the CCBHC model, providers must be non-profit organization, part of a local government behavioral health authority, or a tribal health entity under the authority of Indian Health Services, an Indian tribe or a tribal organization under agreement with Indian Health Services (IHS) under the Indian Self-Determination Act. Only providers meeting these criteria are eligible to become a CCBHC provider.

The stated aims of the model are to provide community-based mental health and substance use disorder (SUD) services, advance integration of behavioral health with physical health care, increase consistent use of evidence-based practices, and improve access to high-quality care.[xv]

Section 223 of the Protecting Access to Medicare Act of 2014 specifies six criteria that CCBHCs must meet.

1. Staffing;
2. Availability and accessibility of services;
3. Care coordination;
4. Scope of services;
5. Quality and other reporting; and
6. Organizational authority.[xvi]

It is important to note that while the CCBHC is meant to establish a safety net for community-based behavioral healthcare, and while CCBHCs are required to coordinate their patient's holistic care needs, the CCBHC scope of services does not include the full continuum of behavioral health services or the full network of behavioral health providers. Institutional and residential levels of care are not included in the CCBHC model, although CCBHCs are expected to establish formal care coordination relationships with these types of providers to support transitions of care and effective care management across levels of care.

Funding Pathways for CCBHC

There are currently two pathways that support CCBHC implementation with federal funds. A Medicaid demonstration program has been made available to enable statewide initiatives and a grant program has provided funds directly to clinics to enable implementation at the provider level. Through these opportunities nationally, over 500 CCBHCs have been developed in more than 46 states.[xvii]

Medicaid Demonstration Program: Section 223 of the Protecting Access to Medicare Act of 2014 created a Medicaid demonstration opportunity for participating states to certify CCBHCs and implement the prescribed Prospective Payment System (PPS) payment methodology to support the model.[xviii] The original demonstration program began with a planning grant process whereby twenty-four states were awarded planning grants to design their programs and begin to certify clinics. Eight states were selected to participate in the demonstration in 2016, which included Minnesota, Missouri, New Jersey, Nevada, New York, Oklahoma, Oregon, and Pennsylvania. These states received an enhanced Federal Medical Assistance Percentage (FMAP) such that CCBHC expenditures are matched at the state's CHIP rate.[xix] Expenditures for CCBHC services provided to newly eligible Medicaid beneficiaries enrolled in the New Adult Eligibility Group matched at that group's normal (90%) FMAP rate.[xx] Indian Health Service or tribal facilities providing CCBHC services to American Indians and Alaskan Natives, the expenditures are matched at 100 percent.[xxi] The CARES Act expanded authorization for two additional states in 2020, and Kentucky and Michigan were selected to participate in the CCBHC demonstration. As noted above, the Bipartisan Safer Communities Act recently authorized an expansion of the demonstration program, which will enable up to ten states to be added to the participants every two years, starting in 2024.[xxii] This opportunity will provide states with four years of enhanced federal funding to test and evaluate their CCBHC program.[xxiii]

Provider Grant Program: In addition to the state demonstration program, the Substance Abuse and Mental Health Services Administration (SAMHSA) has made grant funding directly available to community providers through the expansion grant program, which began in 2018. Participating providers are held to the same criteria as those established by PAMA but receive grant funds from SAMHSA to support implementation of the model rather than

receiving reimbursement for services through the PPS payment methodology as implemented in demonstration states. In Washington, seventeen providers have been awarded CCBHC expansion grants from SAMHSA as of November 2022.[xxiv]

The CCBHC expansion grant program provided funding to providers for up to two years. Beginning in March of 2022, SAMHSA extended the grant term to 4 years and implemented two eligibility categories for the expansion grants: one for established CCBHCs or grantees to continue and expand their work, and the other for organizations implementing the CCBHC model for the first time. Total grant funding remained the same at $4 million per grant."[xxv] [xxvi]

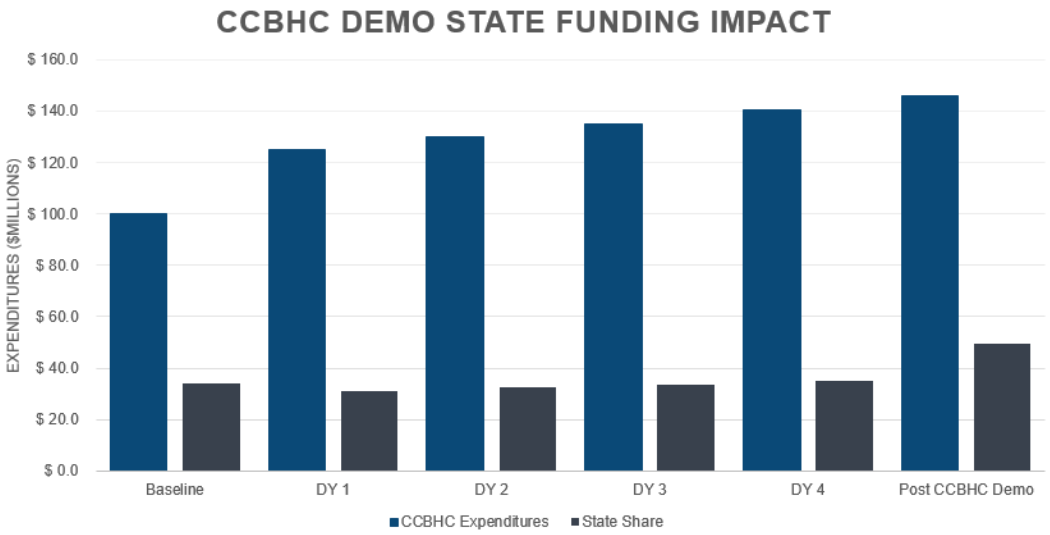
Sustaining CCBHCs

Given that the federal funding opportunities at the state level and provider level offer time-limited support for CCBHC implementation, states have the option to pursue longer term regulatory actions to sustain the CCBHC model. States that do not participate in the demonstration or whose demonstration is expiring can implement CCBHCs by submitting a state plan amendment (SPA) or a Medicaid section 1115 demonstration waiver to the Centers for Medicare & Medicaid Services (CMS) for review and approval to provide a long-term solution to implementing CCBHCs. Once a SPA is approved, it is permanent and does not expire, but a state can change that approved SPA through a subsequent SPA.[xxvii] An 1115 demonstration can be approved for an initial five-year period and can be extended in additional five-year extensions.[xxviii] To date, Texas has pursued an 1115 waiver to sustain its demonstration program, while Kansas, Minnesota, Missouri, Nevada, and Oklahoma have had CCBHC SPAs approved by CMS. Other states, e.g., Indiana, and West Virginia, have enacted laws or measures to continue or expand CCBHC efforts.[xxixxxx]

While pursuing a SPA or 1115 waiver may present Washington with the opportunity to implement a CCBHC program along a longer time horizon, these authorities would authorize federal funding at the normal Medicaid FMAP rate. Therefore, if the state is awarded the demonstration and associated enhanced FMAP, and then decides to sustain CCBHCs post-demonstration, they may face a federal funding cliff. The structure needed to support long-term sustainability of the model is an area for careful consideration as the state develops the CCBHC implementation strategy.

Figure 1 illustrates a hypothetical example of a CCBHC program with $100M worth of expenditures during the baseline period and an enhanced CCBHC FMAP of 65%, compared to a state FMAP of 50%, which leads to an initial decrease in state expenditures. A one-time 20% increase in baseline provider expenses is assumed in the first demonstration year due to becoming a CCBHC, and an annual cost trend of 4% is also assumed. Note that each year there is an increase in overall CCBHC expenditures, but these increases are not reflected by the state share until after federal funding cliff reveals itself as the CCBHC demonstration concludes. As such, it is important for Washington State to monitor cost growth over time and consider programmatic guardrails, such as a rigorous cost report review process, to control cost growth and cost variation that it deems unnecessary.

FIGURE 1: HYPOTHETICAL FUNDING IMPACT FOR PARTICIPATION IN A CCBHC DEMONSTRATION



The assumptions used to develop the illustration shown in this diagram are as follows:

Expansion Population FMAP	90.0%
Expansion Population Share of Service Mix	40.0%
Standard State FMAP[1]	50.0%
Enhanced CCBHC FMAP	65.0%
Effective State FMAP[2] (w/out CCBHC enhancement)	66.0%
Effective FMAP (w/CCBHC enhancement)	75.0%
Increase in Provider Expenses due to becoming a CCBHC	20.0%
Annual Cost Trend	4.0%

[1] Excluded 6.2pp enhancement due to the Public Health Emergency (PHE).

[2] Estimated effective FMAP based on service mix. Assumes a service mix of 40% expansion and 60% standard federal match.

While this report and the fiscal analyses that follow focus on the cost impact in terms of spending on behavioral health services, it should be noted that the CCBHC model has the potential to lead to offsets in cost increases through reduced utilization in other segments of the healthcare system. Preliminary data identified a reduction in hospitalizations and emergency department utilization in states participating in the CCBHC demonstration.[xxxi]

Local Behavioral Health Context

In exploring the implementation of a payment model for a statewide CCBHC initiative, it is important to consider the model within the context of the current behavioral health landscape and other HCA initiatives that are currently underway in Washington.

Washington's Behavioral Health Delivery System

Washington's Medicaid program, Apple Health, covers comprehensive mental health and SUD services through its integrated managed care program, with managed care organizations (MCOs) operating in all regions. MCOs coordinate physical health, mental health, and substance use disorder treatment services to provide whole-person care under one health plan.[xxxii] Apple Health also includes the Behavioral Health Services Only (BHSO) program, administered by the same health plans as integrated managed care, to clients who received their physical health services through fee for services but maintain MCO enrollment for their behavioral health benefit. The majority of

BHSO clients are dual eligible (those eligible for both Medicaid and Medicare). Clients in the BHSO program have access to the same behavioral health provider networks as clients in integrated managed care.[xxxiii] Community-based behavioral health services are provided throughout the state by licensed behavioral health agencies, many of whom are dually licensed as mental health and SUD providers.

Another key feature of the Washington behavioral health delivery system is the role of the Behavioral Health Administrative Service Organizations (BH-ASO). BH-ASOs operate regionally and contract with local providers to administer services to anyone in the region experiencing a mental health or SUD crisis. This includes the administration of regional crisis hotlines, mobile crisis teams, short term SUD crisis, involuntary commitment, and coordination of care with MCOs, behavioral health providers, hospitals, and law enforcement agencies.[xxxiv] The BH-ASO also administers certain mental health services and SUD services to people not enrolled in or eligible for Apple Health, serving as a critical safety net.[xxxv]

Implementing a statewide CCBHC initiative in Washington will require thoughtful planning and updates to contracts with MCOs and BH-ASOs to clarify roles and establish protocols for effective coordination between providers, payers, and benefit administrators. Considerations for implementation through managed care are discussed further in later sections of this report.

Concurrent HCA Initiatives

1. Recent Funding Increases

Washington State has committed significant resources to behavioral health treatment agencies and the Health Care Authority (HCA) will distribute $100 million for a workforce provider relief fund.[xxxvi] The funds are lump sum payments to eligible community behavioral health treatment providers contracted and receiving payments through a managed care organization or behavioral health administrative service organization.[xxxvii] This includes Indian health care providers who have received payments by MCOs or BH-ASOs with or without a contract.[xxxviii] The Workforce Stabilization Provider Relief Fund payments are non-grant based payments that can be used for:

- Immediate workforce retention and recruitment.
- Costs incurred due to the COVID-19 public health emergency.
- Childcare stipends.
- Student loan repayment, tuition assistance, relocation expenses, or other recruitment efforts.[xxxix]

The Legislature also funded a 7% rate increase for all services covered under the behavioral health benefit, with the exception of opioid treatment program (OTP) services[xl] and a 32% rate increase for OTP services. Both of these increases are incorporated into the managed care rates effective January 1, 2023.

2. CCBHC Bridge Funding

In fiscal year 2023, ESSB 5693, Proviso 123 authorized $5 million in bridge funding grants to community behavioral health agencies participating in the federally certified CCBHC expansion grant programs[xli]. These funds are meant to help providers sustain the continued level of operations as federal grant dollars expire and while a longer-term, statewide implementation of the CCBHC model is planned.

3. Behavioral Health Comparison Rates

Milliman is conducting a behavioral health comparison rate study to develop transparent payment rate benchmarks for Medicaid funded behavioral health services. The benchmarks are intended to capture an efficient provider's cost of delivering a specific service. The study uses an independent rate model approach incorporating assumptions around provider wages, costs, and staffing patterns to develop a rate at the services level. Phase one was completed in June 2022 and focused on mental health outpatient, SUD outpatient, SUD residential, Wraparound with Intensive Services (WISe) and Program of Assertive Community Treatment (PACT) services.[xlii] Phase two focuses on refining the rates developed during phase one through the use of a provider wage and cost survey. The survey will collect both general information and specific information related to productivity, staffing patterns, staff compensation, and administrative and

program costs. This work will be used to support the development of the CCBHC rate options. More information can be found under the "Behavioral Health Comparison Rates Project" section here https://www.hca.wa.gov/billers-providers-partners/program-information-providers/contractor-and-provider-resources#bh-comparison-rates.

4. Health Home Program

The Health Home program in Washington offers a comprehensive set of services and care management activities to support eligible clients with complex healthcare needs.[xliii] Health Home clients are able develop a person-centered health action plan, improve self-management of chronic conditions, and ensure care coordination and care transitions.[xliv] A health home in Washington provides comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, referral to community and social support services.[xlv] HCA contracts with health home lead organizations, such as an MCO or Qualified community-based organizations.[xlvi] The lead organizations contract with care coordination organizations (CCOs), such as community health centers, mental health clinics, substance use disorder (SUD) specialists, etc.[xlvii]

5. Integrated Primary Care

Integrated primary care allows medical and behavioral health clinicians to work together as a team to address a patient's concerns.[xlviii] Through integrated primary care, there is better coordination and communication, while working to one set of overall health goals.[xlix] Beginning in 2016, Washington State worked on integrating physical and behavioral health care within the Apple Health program.[l] As a result, services are coordinated through a single health plan, including physical health, mental health, and substance use disorder treatment.[li] Currently, the State continues to focus on clinical integration to support whole-person care by creating one system for physical and behavioral health care, rather than having two separate systems.[lii] Washington is currently working on the Washington Integrated Care Assessment (WA-ICA).[liii] The WA-ICA is meant to develop an improvement roadmap for clinical practices to advance integration and whole-person care and understand the level of, and progress toward, clinical integration with behavioral health and primary care outpatient practices.[liv]

6. Accountable Communities of Health (ACHs)

ACHs are independent, regional organizations who work with their communities on specific health care and social needs-related projects and activities.[lv] ACHs play an integral role in Washington's Medicaid Transformation Project (MTP) efforts.[lvi] ACHs promote health equity, address, and coordinate around social determinants of health.[lvii] ACHs partner with health care providers, local health jurisdictions, community-based organizations, and many others seeking to improve whole-person health, improve the Medicaid delivery system, integrate physical and behavioral health, coordinate care, address the opioid crisis, and invest in a community infrastructure.[lviii]

7. Mental Health Crisis Line and 988 Implementation:

In July 2022, the new 988 dialing code rolled out nationwide connecting people via call, text, or chat to the National Suicide Prevention Lifeline (NSPL).[lix] Washington State has taken a proactive approach with regards to 988 implementation. In 2021, the Washington State Department of Health was awarded a $190,000 planning grant to prepare for 988 implementation.[lx] Additionally, the Washington State Legislature passed HB 1477 in the spring of 2021 to support 988 implementation across the state.[lxi,lxii] HB 1477 established the Crisis Response Improvement Strategy (CRIS) committee with the charge of developing recommendations around 988 implementation and enhancing the state's behavioral health crisis response and suicide prevention services more generally.[lxiii] The CRIS committee and its seven subcommittees have met regularly since 2021 released its first report on January 1, 2022, with two more reports due in January 2023 and 2024.[lxiv] Given crisis services being one of the nine core services, CCBHC implementation represents an opportunity to increase coordination, improve the state's behavioral health crisis response services, and bolster prevention and post-crisis stabilization.

3. State Vision and Goals

An important first step in planning a health system delivery system transformation effort is to articulate a set of strategic goals to guide and inform planning and decision making. At the outset of this CCBHC planning effort, HCA defined five strategic goals for the behavioral health delivery system:

1. Improve the quality of care and population health outcomes for the behavioral health population across the lifespan with a focus on health equity and addressing disparities
2. Promote integrated, person-centered care coordination to holistically address mental health, substance use disorder, physical health, and social needs
3. Promote behavioral health workforce stability and efficiency through appropriate and sustainable financing
4. Increase access to the full continuum of care, from outreach to recovery
5. Improve system efficiency and simplify administrative functions to facilitate a seamless member experience

The CCBHC model holds promise for advancing these strategic goals, given the rigorous standards and alignment with evidence-based practices, the alignment of quality goals with financial incentives, and resource flexibility to support hiring and retention of staff, among other key aspects of the CCBHC model. As the state has considered options for the design of its CCBHC care model and payment model, which are discussed throughout this report, these goals have informed and guided the preliminary decision-making process.

4. Framework for the CCBHC Model

In exploring the design and implementation of a statewide CCBHC initiative, this report adopts a framework for behavioral health delivery reform that features the clinical care model and the payment model as two sides of the same coin. The care model includes key aspects of the delivery model, including provider requirements, scope of services offered, and key activities required of CCBHCs. For the purposes of this report, the care model aligns closely with SAMHSA defined CCBHC criteria, highlighting areas for state customization and weighing considerations for the state. The payment model defines the payment methodology and rate setting approach that will effectively reimburse providers for delivering care as a CCBHC. This report outlines payment model options that the state may adopt in order to finance CCBHC activities. Importantly, decisions made with regard to the care model will have an impact on the payment model. For example, if the state opts to require CCBHCs to provide a robust scope of care coordination activities, the payment model should be developed in a way to cover the costs of that function and afford flexibility to providers to deploy care coordination resources in a way that meets the unique needs of the population served.

CCBHC Care Model

After the passage of the Protecting Access to Medicare Act of 2014, SAMSHA published a set of criteria to guide the implementation of the Section 223 demonstration program. These criteria establish the standards that providers must meet in order to participate in a state demonstration, and include requirements for clinic staffing, availability and accessibility of services, care coordination, scope of services, quality and reporting, and organizational authority, governance, and accreditation.[lxv] In order to take advantage of future opportunities to participate in the expansion of the federal demonstration, and to align with the growing evidence basis supporting the CCBHC model, the care model explored in this report aligns with the SAMHSA criteria. Within these parameters, Washington has the ability to customize certain aspects of the model. For these areas, we present options and considerations, and where applicable, assumptive decisions made for the purposes of modeling program impacts.

Provider Organizational Requirements

Per Section 223 (a)(2)(F) of PAMA, in order to participate as a CCBHC, a provider must be nonprofit entity, part of a local government behavioral health authority, or under the authority the Indian Health Service, an Indian Tribe, or a Tribal organization.[lxvi] Participation in the federal CCBHC demonstration enables the state to certify CCBHC providers. Under the demonstration, the number of CCBHCs that states certified ranged from three in Nevada and

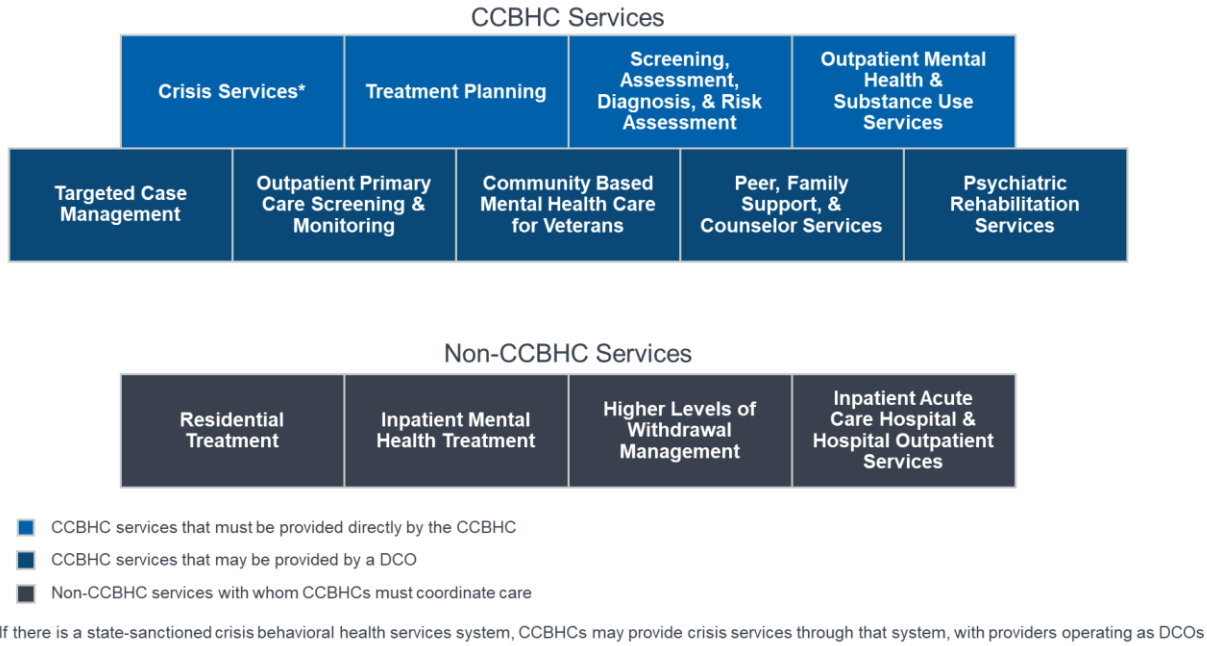
Oklahoma to fifteen in Missouri.[lxvii] Given this state flexibility to structure the certification process as a limited or expansive opportunity, states can approach the initiative as a smaller scale pilot or a broader, statewide transformation.

HCA expressed a preference in exploring a statewide implementation of the CCBHC model, enabling providers across the state to become certified if they demonstrate compliance with program requirements, rather than limiting participation. As such, this report presumes that Washington will pursue a statewide initiative, broadening the opportunity to providers within any geographical region to participate. Given regional differences in consumer needs, delivery systems, and availability of other service providers, the care model will have to allow for enough flexibility to allow both urban and rural providers to succeed under the model.

Scope of Services

The CCBHC Criteria outlines a comprehensive set of nine service categories, as shown in Figure 2 that the CCBHC is responsible to provide to clients. These services are meant to provide a full continuum of outpatient and community based mental health, SUD, and primary care services. CCBHCs are required to provide a core subset of services directly (those shown in the lighter blue) and may provide the other service categories either directly or through a contract with an external provider, known as a "Designated Collaborating Organization" (DCO). If a CCBHC contracts with a DCO to provide care under the model, the CCBHC maintains clinical responsibility for services rendered, and retains responsibility for care coordination. While CCBHCs cannot be private, for-profit organizations, they are permitted to contract with DCOs who are. The criteria also specify that in states with an existing state-sanctioned crisis system, like Washington, CCBHCs may engage in DCO relationships with that system.

FIGURE 2: CCBHC SCOPE OF SERVICES



Within the service requirements outlined in the CCBHC criteria, there are a few key areas where Washington has the ability to customize the model to meet the state's unique needs.

1. ***Primary care integration***: CCBHCs are required to provide primary care screening and monitoring to improve integration of behavioral health and primary care and to help individuals with behavioral health needs manage medical conditions. In reviewing implementation of the CCBHC model in other states, we have observed some variation in practice. Most states align with the CCBHC criteria by simply requiring screening of health indicators like BMI and tobacco use and monitoring chronic conditions like high blood pressure and diabetes.[lxviii,lxix] Oregon adopts a more comprehensive approach to primary care integration,

requiring a broader set of primary care services to be made available by CCBHCs, including acute care for minor illnesses, office-based procedures and diagnostic testing, chronic disease management, and education, prevention, and wellness services.[lxx] CCBHCs in Oregon must provide these services onsite at least 20 hours a week, either by the CCBHC directly or through a co-located DCO partner, although primary care services beyond screening and monitoring are not built into the CCBHC's rate.

Washington has a history of promoting the integration of behavioral and physical health in the Medicaid program. In 2014, Senate Bill 6312 directed the state to implement an integrated managed care program statewide; currently, Apple Health managed care plans administer and coordinate all physical, mental health, and SUD care for enrollees.[lxxi] In 2017, Senate Bill 5779 called upon the HCA to review billing codes and update policies to better support bi-directional integration of behavioral health and primary care.[lxxii] Effective January 1, 2018, HCA implemented a Collaborative Care Model (CoCM) for furnishing behavioral health integration (BHI) services through enhanced primary care services for patients receiving behavioral health treatment. HCA continues to evaluate opportunities to advance care integration and has collaborated with Accountable Communities of Health (ACHs) and Managed Care Organizations (MCOs) to identify and implement a standard assessment of clinical integration in outpatient physical health and behavioral health settings.[lxxiii]

Throughout internal planning sessions with HCA and external discussions with interested parties, there is consensus among state staff, behavioral health providers, and payers that the CCBHC model offers an opportunity to advance bi-directional clinical integration, both by enabling providers to build primary care capacity in behavioral health settings as well as enhancing coordination between behavioral health and primary care. This bi-directional aspect is a critical aspect, as CCBHCs can customize clinical care and care coordination to meet individuals' needs while preserving choice and existing clinical relationships. This opportunity is particularly salient for individuals with more complex behavioral health needs, who may not regularly see a primary care provider. Providers participating in the CCBHC expansion grant program shared early successes in integrating primary care, both through developing capacity in-house and through partnership with local Federally Qualified Health Centers (FQHC) providers. As such, HCA leadership expressed a preference for requiring CCBHCs in Washington to provide a broader scope of primary care services, either directly or through DCO providers, similar to Oregon's model.

2. ***Crisis services***: While the majority of Medicaid covered physical health, mental health, and SUD services are administered through integrated managed care, Washington's behavioral health delivery system also features a statewide system of Behavioral Health Administrative Service Organizations (BH-ASOs) who are responsible for administering mental health crisis services to all individuals within a given community.[lxxiv] Because this state-sanctioned crisis services delivery system is in effect, Washington's CCBHC model may leverage this infrastructure, rather than requiring CCBHC providers to duplicate a set of services that exists in the community.

   As HCA and the Milliman team engaged with interested parties, providers, MCOs, and BH-ASOs identified current challenges in coordinating care within the existing crisis services continuum, including the recent implementation of the 988 hotline, and noted that a CCBHC initiative presents an opportunity to improve coordination and build capacity in community-based behavioral health to promote prevention and post-crisis stabilization. Interested parties also noted geographical differences in the implementation of crisis care, with variation by region in terms of provider roles, level of community need, and availability of workforce to support crisis care. Feedback also identified the potential for one CCBHC to utilize the crisis system as it exists today, while another CCBHC in the same area may choose to provide crisis services directly, creating potential confusion for clients. HCA does not necessarily envision the CCBHC model replacing or substantively changing the existing crisis delivery system, but rather sees the CCBHC model as enhancing the current landscape and addressing challenges noted by interested parties. CCBHC requirements will have to contain clear requirements for care coordination and communication between CCBHCs and other providers along the crisis continuum and clarify post-discharge processes to ensure effective stabilization in the community following a crisis event. The CCBHC model in Washington will require flexibility in scope given the regional differences.

3. ***Use of Designated Collaborating Organizations (DCO)***: As noted previously, the SAMHSA CCBHC criteria enables CCBHCs to provide a subset of services through formal relationships with DCOs. Most demonstration states have aligned with the CCBHC criteria in terms of the services that may be provided through a DCO, although Michigan has been afforded flexibility in implementation, and allows DCOs to provide any CCBHC service.[lxxv] Establishing DCO relationships allows CCBHCs to leverage the expertise and capacity of external providers in the community, leveraging existing resources rather than having to recreate similar capacities. However, as DCOs provide services to CCBHC clients, they bill the CCBHC for reimbursement, which can lead to a loss of transparency on administrative costs and an increase in provider cost variation. Additionally, having a higher proportion of CCBHC services provided by a CCBHC directly can improve a provider's ability to integrate an individual's whole-person care.

   HCA is interested in exploring the concept of DCOs more deeply in the planning grant process. While HCA recognizes the potential opportunities presented by leveraging existing expertise and infrastructure in the delivery system, HCA is also cognizant of potential loss of transparency in utilization absent effective monitoring, and duplicative administrative costs that may result from an over-reliance on DCOs. Additionally, HCA recognizes the need for some degree of flexibility given geographical variation in the availability of service providers, such as FQHCs or veteran's service agencies that may already be serving CCBHC patients and uniquely positioned to provide a subset of CCBHC services in coordination with a CCBHC.

4. ***Inclusion of high intensity, team-based services***: Within the CCBHC scope of services, states have the flexibility to identify the evidence-based outpatient mental health and SUD services that CCBHCs are required to provide. This set of services constitutes a minimum standard of outpatient care that can be built upon depending on the needs of a CCBHC's population served. A key consideration in the selection of evidence-based outpatient services is whether to require CCBHCs to offer high intensity, team-based models that already have been implemented in Washington, such as WISe, PACT, and New Journeys. In looking at other states' CCBHC models, Missouri, Michigan, Minnesota, and Oregon require CCBHCs to provide team-based treatment modalities like Assertive Community Treatment (ACT) and Children's Therapeutic Services and Supports, whereas New York recommends but does not require CCBHCs to offer ACT and community wrap-around services.[lxxvi,lxxvii,lxxviii,lxxix,lxxx]

   These types of services already have monthly rates established in Washington based on defined staffing ratios and building these services into CCBHC payment may make the model more sensitive to service mix changes. Additionally, for providers that have not already established these services, it may be a heavy lift to build staffing capacity and clinical expertise to implement these models with fidelity. That said, it is critical to establish a consistent, evidence-based standard for high-intensity treatment across the state for individuals with more acute behavioral health needs. In engaging with interested parties, providers expressed support for including high intensity team-based treatment models in the CCBHC care model, as a fundamental standard of care as part of the continuum of services. Providers acknowledged the need for capacity building and highlighted the need for some flexibility based on geographical differences and community needs. For instance, in rural geographies, there may not be enough of a demand for services to warrant a full PACT team. Rather, it may be more efficient for a CCBHC to enter into a DCO arrangement with an existing team. HCA envisions the inclusion of high intensity team-based services in Washington's set of evidence-based services as a mechanism to improve quality of and access to these critical services. HCA will also explore programmatic mechanisms to account for regional differences while ensuring accountability for access and quality. As such, these services have been included in the actuarial analysis.

Care Coordination

SAMHSA describes care coordination as the "linchpin of the CCBHC program."[lxxxi] The CCBHC criteria include requirements for CCBHCs to provide person-centered care, coordinating care across medical, behavioral health, and social services. CCBHCs must have interdisciplinary care teams which include the consumer and family/caregivers as appropriate and elevate consumer choice in the development and execution of a care plan. CCBHCs are required to establish formal care coordination agreements with other healthcare and social service providers to enable communication and coordination to meet consumers' holistic needs and establish health information technology (HIT)

solutions to enable such provider-to-provider collaboration. While the criteria for care coordination are comprehensive, states can add specificity or new requirements to customize their programs. For example, Oregon has developed enhanced requirements on communication and record sharing processes during transitions of care and Minnesota specifies the type of notification and follow up protocols that must be included in care coordination agreements.[lxxxii]

Throughout discussions with interested parties, providers indicated that care coordination for individuals with behavioral health needs is already within the scope of practice of many community-based providers, although workforce shortages have become a barrier to hiring and retaining staff to carry out care coordination functions under current reimbursement structures. It is widely perceived by interested parties that the CCBHC model presents an opportunity to better resource care coordination activities and systematically establish standards for coordination between behavioral health providers and other key provider entities such as hospitals, residential SUD programs, and veteran's service agencies. There may also be an opportunity for the state to act as a convener to bring together CCBHCs, payers, and other providers such as hospitals, SUD inpatient facilities, or veteran's services providers to work collaboratively through barriers to effective information sharing and coordination.

HCA envisions a robust care coordination function for CCBHCs and anticipates developing standards above and beyond the CCBHC criteria, specifically around protocols for communication and information sharing with other providers and identifying the provider types with whom CCBHCs must have formal care coordination agreements.

Figure 3 shows the provider types with whom CCBHCs are required to establish formal care coordination agreements, per the SAMHSA criteria, alongside additional provider types for whom Washington may consider requiring CCBHC care coordination.

FIGURE 3: REQUIREMENTS FOR FORMAL CCBHC CARE COORDINATION

Requirements for Formal CCBHC Care Coordination	
Provider entities for formal CCBHC care coordination, as required by SAMHSA	**Additional provider entities for formal CCBHC care coordination under consideration in WA**
▪ FQHCs and Rural Health Clinics (RCHs) as applicable ▪ Programs that can provide inpatient psychiatric treatment, with ambulatory and medical detoxification, post-detoxification step-down, and residential programs ▪ Community or regional services, such as schools, child welfare agencies, Indian Health Services, juvenile and criminal justice agencies ▪ Departments of Veteran's Affairs	▪ Health Home organizations ▪ BH-ASOs ▪ Managed Care Organizations (MCOs) ▪ Housing service agencies ▪ Intellectual and Developmental Disability (I/DD) service providers ▪ Accountable Communities of Health (ACHs) and locally relevant entities, including HUBs and state and local public health agencies

Additionally, HCA recognizes that CCBHCs are not the only providers in the delivery system who are accountable for care coordination. Health Home organizations and Accountable Communities for Health (ACH) also offer care coordination for their populations, and significant work is underway to clarify roles and standards for care coordination under these initiatives. It is important to be cognizant of the risk of duplication of effort and expense that can result without thoughtful planning and alignment. In designing CCBHC standards for Washington, HCA intends to develop concrete guidance to define a lead coordinating entity and care coordination protocols for individuals who receive care from more than one care coordinating entity (e.g., a health home and a CCBHC). Additionally, HCA will explore standards for the adoption and use of health information technology that can facilitate coordination and communication between providers, such as OneHealthPort or the Community Information Exchange. For the

purposes of this report and actuarial analysis, a robust care coordination function is assumed to be included within the CCBHC payment model. In the future, HCA may consider an attribution methodology that operationalizes a hierarchy for care coordination in instances where an individual receives services from multiple care coordinating entities and additional requirements of the lead entity in coordinating care.

Populations Served

A key aspect of the CCBHC model is the requirement to provide care to any person, regardless of insurance status, ability to pay, or place of residence.[lxxxiii] This notion of providing care for any person is woven throughout the SAMHSA criteria, as CCBHCs must have clinical staff with expertise in caring for children and adolescents with serious emotional disturbance (SED), adults with serious mental illness (SMI), and those with SUD, and the care coordination and service requirements span across age groups, levels of acuity, and diagnoses. The SAMHSA criteria have specific access, service, and coordination requirements centered around enhancing care for American Indian/Alaska Native populations and veterans. Collectively, these requirements are meant to expand access to populations that may have experienced barriers to care or health disparities in the past. They also improve the CCBHC's ability to coordinate care for individuals with multiple diagnoses, complex needs, or those transitioning between levels of care. While a CCBHC's needs assessment will help to clarify the unique needs within the region served, providers may expand their practice to serve sub-populations they may not have served previously, or experience service-mix changes upon becoming a CCBHC. For instance, a provider that has traditionally served an adult population will have to expand capacity to care for children, adolescents, and families, and a provider that has focused their care on mental illness will have to become licensed to provide SUD services. CCBHCs must also care for members with varying degrees of acuity, ranging from mild-to-moderate to severe and persistent, and may identify certain sub-populations with that would benefit from specialized programming or community partnerships, such as veterans, tribal communities, criminal or juvenile justice involved individuals, or persons experiencing homelessness. Interested party feedback indicated that these changes in populations served can be a challenge in recruiting and hiring needed expertise and developing programs to meet the range of required services for CCBHC populations, e.g., primary care and transportation.

Some providers that have participated as CCBHC Expansion sites indicated that their populations did not change substantially upon meeting CCBHC requirements since they already served a broad population, while others shared experiences in broadening their practice to serve different age groups, expanding their service array, and engaging with community partners to better coordinate care. Providers recognized that the state's implementation of the CCBHC demonstration would support further opportunities to develop expertise in serving special populations. In pursuing a CCBHC planning grant, HCA will have the ability to highlight particular sub-populations of interest and customize the CCBHC care model to include requirements or interventions designed to improve care for those sub-populations. The project team indicated a preliminary interest in further exploring how a CCBHC initiative can be tailored in Washington to address the unique needs of tribal populations and criminal justice system involved populations.

Staffing and Infrastructure

The CCBHC criteria include some specific requirements for staffing, including basic leadership positions, licensure requirements, and cultural and linguistic competency standards, as well as general requirements for CCBHC staff to have the expertise and disciplinary backgrounds to care for the clinic's unique populations.[lxxxiv] Beyond these basic requirements, there is broad discretion for states to create minimum staffing standards for CCBHCs.[lxxxv]

In discussions with interested parties, providers described workforce shortages and persistent challenges in hiring and retaining staff to carry out clinical and non-clinical functions. While these workforce issues may make it challenging for providers to fully implement the CCBHC model, interested parties expressed that an adequate and flexible payment model for CCBHC services offers providers the tools to attract and retain staff more effectively than under current reimbursement methods.

Staffing reflects the largest cost for implementing the CCBHC model, both in terms of direct service staff and administrative staff, and staff time should account for the billable and non-billable activities completed by CCBHCs. In addition to providing the scope of services outlined above, CCBHCs carry out activities that are typically not reimbursed under fee-for-service arrangements, including interdisciplinary care planning, care coordination, outreach

and engagement, and population health management. Preliminary estimates from the federal demonstration found that staffing costs accounted for 60 to 70 percent of the total CCBHC costs.[lxxxvi]

HCA recognizes that the minimum staffing standards should afford some degree of flexibility to CCBHCs, in acknowledgement of underlying workforce constraints and differences in population needs by region. Additionally, the payment model will have to be developed in a way that supports direct service, administrative, and non-billable staffing activities while enabling CCBHCs to innovate in their programming.

Interested party feedback also indicated the need for significant and ongoing training to ensure staff understand the Evidence Based Practices and CCBHC model. Training is part of a group of required activities that are non-encounterable, e.g., clinical supervision, paperwork, phone messaging for care coordination, internal care coordination, reaching clients in the community, and assisting clients with daily tasks. It was noted that the CCBHC funding model provides flexibility to cover these costs.

In addition to staffing needs, providers have identified investments in infrastructure that are necessary to fully implement the model, such as health information technology platforms. The CCBHC criteria require the adoption of Electronic Health Records (EHR) at a minimum,[lxxxvii] and providers have highlighted the potential of these technologies to improve efficiency, alleviate administrative burden, facilitate data exchange, and prevent duplication of effort between providers. Robust systems will be essential to support the timely, complete, and accurate submission of all CCBHC encounters and required reporting. Encounter data is required to understand the utilization of services and encounter data serves as a key input on rate development.

Quality Measurement

A framework for continuous quality improvement is an important feature of the CCBHC model and alternative payment methodologies more broadly. The establishing legislation for the CCBHC demonstration requires the reporting of clinical outcomes and quality data,[lxxxviii] and SAMHSA and CMS subsequently identified a set of clinic-reported measures and published technical guidance to support measurement and reporting.[lxxxix] CCBHC criteria also outline standards for CCBHCs to adopt best practices in clinical quality improvement.[xc] The CCBHC quality measures focus on timely access, identification of behavioral health and chronic conditions, and management of such conditions. The full set of CCBHC reported quality measures that are currently in use are provided below in Figure 4.

FIGURE 4: CURRENT SET OF CCBHC REPORTED QUALITY MEASURES

Figure 4: Current Set of CCBHC Reported Quality Measures[xci]
Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients
Adult Body Mass Index (BMI) Screening and Follow-Up
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
Tobacco Use: Screening & Cessation Intervention
Unhealthy Alcohol Use: Screening and Brief Counseling
Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment
Adult major depressive disorder (MDD): Suicide Risk Assessment
Screening for Clinical Depression and Follow-Up Plan
Depression Remission at 12 months

If Washington is selected to participate in the federal demonstration opportunity, the state will have the ability to adopt additional quality measures and define the parameters for CCBHCs to demonstrate adequate quality improvement.

This represents a structured opportunity for the state to identify the clinical and population health outcomes that it wishes CCBHCs to improve upon, tie a clear financial incentive to quantitative improvement, and establish the processes and systems to support reporting and monitoring over time. HCA is committed to using the planning grant process to further define quality goals for its CCBHC program. Additionally, SAMHSA has announced an opportunity for public input into the criteria and standards; HCA is interested in providing feedback to SAMHSA on CCBHC quality standards.

In addition to the key CCBHC care model design considerations discussed above, there are other areas for state discretion that will allow Washington to further customize its model. SAMHSA has published a summary of the aspects of the CCBHC model that allow for state discretion.[xcii]

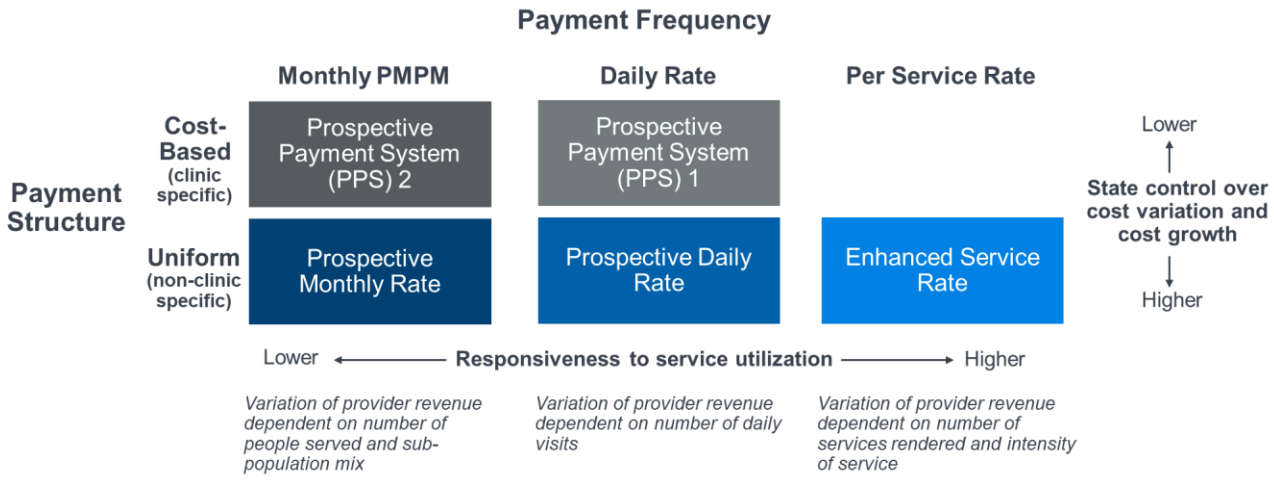
CCBHC Payment Model

The CCBHC payment model should be structured to effectively reimburse CCBHCs for the service and non-service activities carried out by clinics and incentivize high quality care and population health outcomes. We have identified five payment model options for consideration which are described in this section, along with an assessment of advantages and disadvantages. Importantly, the federal demonstration requires states to implement a Prospective Payment System (PPS) methodology, similar to FQHC cost-based reimbursement, giving two options for implementation.[xciii,xciv] If Washington is selected for the demonstration opportunity, one of these options will have to be implemented in order to receive the enhanced FMAP for the four-year demonstration period. That said, the three non-PPS options are also included in this report for consideration to be responsive to the legislative charge of Proviso 106 and to assess additional options for sustaining the CCBHC model after participating in the four-year demonstration.

Upon reviewing payment model options and considering the availability of federal enhanced funding and interested party feedback, HCA's preference is to move toward initial implementation of a PPS-1 daily rate coinciding with participation in the Section 223 demonstration. Over the course of the demonstration, HCA is willing to explore transitioning to a PPS-2 monthly rate during the demonstration period once experience is gained under the model. The demonstration experience will enable HCA to evaluate a payment model that can be used to sustain the CCBHC model once the demonstration concludes.

Figure 5 below provides a summary of the payment model options, highlighting each model's responsiveness to changes in service utilization:

FIGURE 5: SUMMARY OF CCBHC PAYMENT MODEL OPTIONS



Payment Model Options

1. PPS-1

The PPS-1 methodology establishes a cost-based and clinic-specific rate for all CCBHC services delivered on a given day, including services delivered at a DCO. Additionally, there is an option to include a quality bonus payment on top of the daily rate. The PPS-1 rate is calculated separately for each clinic using one year of cost and visit data (including anticipated costs in year one), using the following formula:

$$\frac{Total\ Annual\ Allowable\ Clinic\ Specific\ CCBHC\ Costs}{Total\ Number\ of\ CCBHC\ Daily\ Visits\ Per\ Year}$$

PPS-1 rates can be updated over time using an inflation index or rebased using more recent CCBHC cost report data. Regularly rebasing to reflect emerging cost report data would generally increase risk to the state without processes to rigorously review and evaluate provider reported costs before approving and operationalizing a clinic's PPS rate. Additionally, non-Medicaid population costs and visits are included in the numerator and denominator.

***Advantages*:** The PPS-1 methodology is one of two options that state programs must follow in order to receive the enhanced FMAP through the Section 223 demonstration. Provider revenue is more predictable under this methodology when compared to fee-for-service (FFS) payments.

***Disadvantages*:** The PPS-1 rate methodology allows for substantial variation in costs among providers due to the rate being clinic-specific. The methodology also lacks measures of controlling cost growth and risks a loss of transparency in payments. Lastly, it doesn't consider service mix changes between the base period used to develop the PPS-1 rate and the experience period, which can lead to provider gains or losses that may be outside of a provider's control.

2. PPS-2

The PPS-2 methodology establishes a cost-based and clinic-specific rate for all CCBHC services delivered in a given month, triggered by the delivery of a single CCBHC service. Separate rates are developed for condition-based subpopulations, such as adults with SMI, and *a quality bonus payment is required.* The PPS-2 rate is calculated separately for each clinic using one year of cost and visit data, using the following formula:

$$\frac{Total\ Annual\ Allowable\ Clinic\ Specific\ CCBHC\ Costs}{Total\ Number\ of\ Unduplicated\ CCBHC\ Monthly\ Visits\ Per\ Year}$$

PPS-2 rates can be updated over time using an inflation index or rebased using more recent CCBHC cost report data. Consistent with the PPS-1 calculation, non-Medicaid population costs and visits are included in the numerator and denominator.

***Advantages*:** The PPS-2 methodology is one of two options that state programs must follow in order to receive the enhanced FMAP through the federal demonstration. Also, provider revenue is more predictable under this methodology when compared to either FFS payments or PPS-1. This methodology includes a mechanism for adjusting outliers beyond a defined threshold.

***Disadvantages*:** The PPS-2 rate methodology allows for substantial variation in costs across providers due to the rate being clinic-specific. The methodology also lacks measures of controlling cost growth and risks a loss of transparency in payments. PPS-2 is also more complex to administer from both a state and provider perspective relative to PPS-1 if rates are developed for multiple sub-populations.

3. Prospective Monthly Rate

The Prospective Monthly Rate methodology establishes a uniform (not clinic specific) per member per month case rate using the Enhanced Service Rate, which is described in more detail under option 5 below, using the following formula:

$$\frac{Enhanced\ Service\ Rate\ \times\ Historical\ CCBHC\ Utilization}{Total\ Number\ of\ Unduplicated\ CCBHC\ Monthly\ Visits\ Per\ Year}$$

Separate rates can be developed for sub-populations, or an acuity adjustment can be applied to reflect provider-specific populations served. This methodology can be tied to outcomes and quality measures through use of the Enhanced Service Rate. The monthly rate can also be calculated using behavioral health comparison rates and historical utilization.

***Advantages*:** Relative to using the Enhanced Service Rate (option 5 below) or standard FFS alone, the Prospective Daily Rate increases the predictability of provider revenue and rewards cost efficiency. State budget predictability is improved through the usage of monthly rates. The optional acuity adjustments allow for the ability to better reflect provider-specific populations served.

***Disadvantages*:** The Prospective Monthly Rate methodology does not align with the federal demonstration, thus restricting the state from receiving the enhanced FMAP should it be selected for the federal demonstration. The methodology relies on risk and acuity adjustments to appropriately account for the population served rather than through more innate means.

4. Prospective Daily Rate

The Prospective Daily Rate methodology establishes a uniform (not clinic-specific) daily rate using the Enhanced Service Rate explained above, using the following formula:

$$\frac{Enhanced\ Service\ Rate\ \times\ Historical\ CCBHC\ Utilization}{Total\ Number\ of\ CCBHC\ Daily\ Visits\ Per\ Year}$$

This methodology can be tied to outcomes and quality measures through use of the Enhanced Service Rate. The daily rate can also be calculated using behavioral health comparison rates and historical utilization. One consideration for improving this approach (relative to PPS-1) is the inclusion of an adjustment to the per day rate at the end of the reporting period to account for service mix changes between the baseline period and emerging experience period.

***Advantages*:** Relative to using the Enhanced Service Rate or standard FFS payments alone, the Prospective Daily Rate increases the predictability of provider revenue, increases provider flexibility, and rewards cost efficiency. Unsustainable cost growth is contained by tying to behavioral health comparison rates.

***Disadvantages*:** The Prospective Daily Rate methodology does not align with the federal demonstration, thus restricting the state from receiving the enhanced FMAP should it be selected for the federal demonstration. When compared to PPS-1, there is a decrease in the ability to account for differences in provider costs.

5. Enhanced Service Rate

The Enhanced Service Rate methodology utilizes the behavioral health comparison rates coupled with an additional administrative increase (compared to non-CCBHCs) to establish a uniform rate enhancement to support providers with the increased costs and demands that come with becoming a CCBHC. For example, additional administrative costs could arise during the process of becoming a CCBHC through developing enhanced care coordination processes. Under this approach, enhanced administrative costs would be identified based on CCBHC care model requirements on a statewide or regional basis. This enhanced rate can also be tied to outcomes and quality measures, as demonstrated in its formula below:

$$BH\ Comparison\ Rate\ With\ CCBHC\ Enhanced\ Administrative\ \%\ +\ Quality\ Bonus\ \%$$

***Advantages*:** The Enhanced Service Rate methodology would not be a significant administrative change for the state or MCOs. It would also reward cost efficiency of providers, which would give more control to the state regarding long-term funding sustainability.

***Disadvantages*:** The Enhanced Service Rate methodology does not align with the federal demonstration, thus restricting the state from receiving the enhanced FMAP should it be selected for the federal demonstration. This methodology also comes with the drawbacks that come with a fee-for-service billing

framework, such as rewarding visit volume over outcomes. Lastly, this approach affords less flexibility to providers in implementing the CCBHC care model.

Key Considerations for a CCBHC Payment Model

Several considerations should be contemplated when determining the most suitable CCBHC payment model as suggested in the section above. The purpose of this section is to describe key considerations and their potential effects on the CCBHC program.

Payment structure: Cost-based payment structures reimburse at provider-specific rates based on allowable incurred costs while uniform structures pay a standardized rate for a given service. A uniform payment structure can ease state and MCO administrative burden and requires the provider to assume the risk of increasing costs. A uniform payment structure may prompt provider improvements in cost effectiveness, but there is the potential for this payment structure to not adequately account for differences in provider risk pools. This structure may also provide a perverse incentive to not provide the necessary level of service for given individuals when compared to a cost-based reimbursement structure.

While a cost-based, provider specific payment structure inherently allows for more cost variation across providers, states may establish processes to rigorously review and evaluate provider reported costs before approving and operationalizing a clinic's PPS rate. This can allow the state to understand sources of variation that it deems appropriate, while working with providers to eliminate sources of variation that it deems inappropriate.

Payment frequency: Payment models can vary in how frequently providers are paid in terms of services rendered; there are options for a service rate, a daily rate, and a monthly rate. Less frequent rates of payment, such as monthly rates, create more stability in provider revenue while more frequent rates are more responsive to increases in utilization or service intensity.

CCBHC services: Selection of services to include in the CCBHC program can have material impacts on provider financials in either direction, depending on which model is selected. Behavioral health programs cover a wide array of services, some of which can be very intensive (e.g., WISe) while others can be more limited and supportive of individuals in the community (e.g., H2015 community living supports). Providers that see a change in service frequency (for either high-intensity or low-intensity services) compared to their cost report period will realize a greater impact to financials more so under daily and monthly rates because revenue is less responsive to service intensity changes.

Sub-population considerations for monthly rates: A program with a monthly rating structure may reimburse at different rates for varying subpopulations, which provides a mechanism to account for differences in provider risk pools. It is important to correctly identify different subpopulations and accurately account for their differences in costs when implementing this sort of payment system. The PPS-2 option requires cost reports to separately develop costs for sub-populations, which increases the administrative burden of implementing this option. The payment model workgroup agreed that diagnosis-based sub-populations may be easier to implement, but do not appropriately reflect for treatment plan differences of individuals who have similar diagnoses, and thus recommended sub-populations to be developed considering assessment data.

Risk considerations for monthly rates: Most traditional monthly sub-capitated rates cede risk to the sub-capitated entity, who takes responsibility for providing or paying for all services covered in the arrangement. Under the PPS-2 option, a monthly rate is paid to the CCBHC provider based on assumed staffing costs and the historical unique number of individuals receiving services in a month. CCBHC providers would not be required to pay for CCBHC services delivered by other non-DCO providers.

Primary Care: Depending on the scope of primary care services that CCBHCs are required to provide, the payment may be constructed to include primary care services as eligible encounters or carve out primary care services and allow for reimbursement outside of the CCBHC payment. The inclusion of primary care services impacts each rate option differently. Under a per service rate, primary care services rendered would result in additional provider revenue on a per unit basis. However, it was noted by stakeholders that under a

per service rate, reimbursement needs to be higher to serve the behavioral health population because it takes longer to perform the same level of service. It is unclear how the inclusion of primary care would impact daily rates; rate impacts would depend on the intensity mix of primary care services provided relative to the intensity mix of behavioral health services as well as how often primary care services occurred on the same day as behavioral health services. The inclusion of primary care would increase monthly rates based on incremental staffing increases.

Inclusion of a Quality Incentive: Under all PPS or non-PPS options, a quality incentive payment can be built into the payment model. In the federal demonstration program, a quality bonus payment (QBP) is optional under PPS-1 and mandatory under PPS-2, and seven of the eight original demonstration states implemented QBPs.[xcv] The state will have the flexibility to determine the size of an incentive payment, which can be constructed as a percentage of payments received by the provider, and the quality benchmarks and methodology for determining success. Seven of the eight original demonstration states implemented a QBP with varying incentive amounts.[xcvi] As examples, Pennsylvania, Minnesota, and Nevada implemented QBP incentive opportunities of 3%, 5%, and 15%, respectively.[xcvii,xcviii,xcix]

Rebasing and Indexing: In order for the payment to sustainably cover the cost of operating as a CCBHC over time, the state will have to determine a methodology and frequency for rebasing rates and/or applying an inflation index. The demonstration program required states to update rates in the second year of the program using either the Medicare Economic Index (MEI) or collecting new cost report data with the first years' experience and rebasing the PPS rates.[c] Rebasing the PPS rate recognizes the fluctuations in costs associated with standing up a new program and can help to right-size the payment to align with costs as program operations stabilize.

Anticipated Costs: In the demonstration program, CCBHCs are able to include anticipated costs in the first year of the CCBHC cost report. This can allow providers to reflect costs of standing up new services or reflecting expected increases to costs that would not be captured in the reporting period, such as staff personnel that they expect to hire or start-up infrastructure they plan to acquire as they implement their programs. In subsequent years, CCBHCs will not be able to report anticipated costs, and rebasing processes will right-size PPS rates to reflect true provider costs.

5. Interested Party Engagement

Process

HCA is interested in understanding perspectives on the CCBHC model from the delivery systems involved, including providers who are currently operating as CCBHCs, providers considering or currently applying to become a CCBHC, the MCOs, and the BH-ASOs. The development of the CCBHC model in Washington will be informed by the feedback shared through this interested party engagement process, which includes interested party interviews, payment model and care model workgroups, written submissions, and data submission through a survey process. Additionally, this work is informed by the participation and input from subject matter experts representing the National Council for Mental Wellbeing.

Feedback from interested parties has been incorporated throughout this report as a source of key stakeholder input into the program and cost framework in response to the Proviso.

Interested party interviews and written input revealed recurring themes, potential opportunities flowing from model adoption, potential barriers and concerns, and payment related issues. Each of these topics are detailed in the following sections.

Themes

General

- The provider community is seeking HCA leadership to set standards and expectations to guide implementation of the model for consistency and to convene providers and related entities for input on design.
- The providers expressed a general concern about the adequacy of funding to cover the model costs, including non-billable activities, and a desire to use the model to support the ability to pay staff competitive wages.
- Overall, providers are concerned about the ability to recruit and retain qualified staff to do the work, citing current and ongoing recruitment and retention challenges that may impact the ability to provide the required CCBHC services.
- Interviews noted variability in CCBHC implementations, e.g., no two CCBHCs are the same, with the expectation that the model provides the ability to be creative and flexible to meet the unique needs of each location within the standard framework.
- Providers vocalized the need for ongoing technical support in the implementation of a CCBHC initiative, particularly to support their ability to produce accurate CCBHC cost reports.

Care Model

- There is broad provider support for, and positive perception of, the CCBHC model. Providers believe the CCBHC model will achieve improved outcomes, quality of patient care, and care integration through flexibility in the model for organizations to creatively solve problems and provide services.
- Providers noted that the model requires investment in significant and ongoing training on Evidence Based Practices, e.g., trauma-informed care, motivational interviewing, and other topics.
- Multiple participants raised concerns about coordination of crisis services across the BH-ASO, MCO, CCBHC, and provider responsibilities, which has the potential for duplication of services. Clarity on how the current crisis system will interact with the CCBHC and state crisis services will be needed in designating responsibilities. Additionally, there may be confusion if one CCBHC maintains existing state crisis services, and another CCBHC in the same service area provides the services directly.

Payment Model

- The PPS-1 rate model is generally viewed as the preferred payment model by various interested parties.
- Provider feedback was supportive of a cost-based reimbursement model, which can allow for provider flexibility in programming, can account for variation in costs across providers, and can help providers to overcome some barriers to hiring and retaining staff. Other interested parties noted that provider specific rates have less incentive to be efficient and would likely increase in costs over time.
- Providers noted they are struggling with behavioral and physical health integration as the two currently have distinct funding streams. Additionally, feedback noted that the primary care reimbursement rate does not cover the more complicated care for behavioral health clients who may not be well served in traditional primary care.
- From the MCO perspective, it was noted that a statewide rate would be easier to administer and that region specific rates are problematic, however a state rate loses nuances of the region, e.g., urban vs. rural, and population specific services.
- MCO participants noted a preference for a set fee schedule due to challenges when moving to integrated care with fluctuation in rates.

- The BH-ASO participants noted that it is easier to provide care, budget, and recruit staff with consistent funding. Care integration could be part of the funding model, if designed as capitated whole person care.
- Interested parties discussed using an Alternative Payment Model for increasing care coordination, with more capitation arrangements.

Opportunities

- Providers cited significant care gaps due to silos between providers, e.g., follow up for crisis services, especially in Eastern Washington. The CCBHC model is seen as the potential means to address and close these care gaps.
- The model is seen as a means to propel integration, e.g., enhanced care management coordination between the MCO and CCBHC with designation of the care coordination lead entity based on who has the primary relationship with the client.
- The CCBHC model supports working with MCOs on systemic issues, e.g., focus on quality and total cost of care, not just HEDIS measures or other required reporting.
- Providers view this model as an opportunity for financial stability as behavioral health services are viewed as historically underfunded.
- Providers noted there are clients impacted by crisis, but who are not eligible for standard Medicaid or are underfunded to receive services. The CCBHC model provides an opportunity to serve these individuals.

Barriers/Concerns

- The interviewed parties noted there have been other new service models, however, there is not always sustainable funding to support the model from the onset.
- Participants raised the issue of delegation oversight requirements, noting that some CCBHCs may have limited oversight capacity and infrastructure to ensure model fidelity.
- Concerns were raised about the provision and integration of physical health, e.g., the mechanics of the process, relationships, contracts, attribution/assignment, and data exchange.
- The complex contracting regulatory environment and subcontracting requirements were noted as needing thoughtful and careful direction for clarity on roles, responsibilities, and reporting.
- Providers noted that care coordination is a current challenge with multiple providers (e.g., physical health, behavioral health, BH-ASO, crisis services, and others), all with a coordination role. Clarity on the roles is critical and may be especially challenging if the CCBHC subcontracts care coordination or for clients who are not actively being treated.
- The model will require robust data sharing agreements to eliminate barriers to coordinated care.
- Providers will need the systems and interfaces necessary to generate required state and federal reporting, encounter submission, clean claims, and operational capacity to grow into another type of model.
- Coordination with the 988 system with the CCBHC providers will need to be designed to ensure coherent crisis care coordination and appropriate client hand-off for response. There are four crisis providers (e.g., 988, the BH-ASO, the CCBHC, and 911 emergency services) each with different responsibilities, oversight, and funding.
- Providers need clarification on the CCBHC role for housing and working with homeless as related to the BH-ASO housing options.
- Providers' feedback noted that each region typically has a big agency that provides all services, and that agency will likely become a CCBHC. This may restrict client choice if there is only one CCBHC serving each area.

- Feedback noted that some of the smaller providers are trying to discern their role, e.g., are frontier providers permitted to be in subcontractor agreements with larger CCBHC organizations.

In addition to the themes noted above, providers vocalized an appreciation for the opportunity to provide input into the state's planning processes and expressed a strong desire for continued opportunities for engagement as planning continues.

6. Impact Assessment

Budget Impact Results

Per the legislative requirements set forth in Proviso 106, an actuarial analysis has been conducted to determine preliminary cost estimates surrounding the implementation of the CCBHC model. Detailed cost information is not robustly available from all potential CCBHC providers reflecting what is currently paid by the MCOs at a service level. Additionally, actual provider costs incurred to provide care in the existing program is not available at an individual service level. To support this analysis, a CCBHC Data Request was performed to capture the following information from potential CCBHC providers:

- Qualitative information to inform how implementing a CCBHC care model impacts providers
- Units performed by service code for behavioral health and primary care services
- Overall provider expenses, and the percentage attributable to behavioral health CCBHC providers
- Anticipated staffing increases for both billable and non-billable staff related to CCBHC care model implementation

Providers expressed concern over the reliability of the information submitted in the CCBHC Data Request, stating it was preliminary in nature given there are still many unknowns regarding how the state will implement their CCBHC program. Given the lack of robust data, the actuarial analysis was limited.

We estimated costs under the following three scenarios to isolate the estimated incremental cost of the CCBHC care model implementation under a uniform payment model compared to the estimated potential costs under the existing care model. Cost-based clinic specific PPS payment models were not able to be quantitatively evaluated without CCBHC cost reports.

FIGURE 6: STEPS FOR ESTIMATING INCREMENTAL COST OF THE CCBHC CARE MODEL

A. ***Current reimbursement***: the estimated unit cost currently paid by the MCOs to providers in Washington's Medicaid program multiplied by existing utilization of proposed CCBHC services by current CCBHC Expansion Grant providers

B. ***Potential cost under existing care model***: estimated reimbursement to provide services under the existing care model based on the behavioral health comparison rates[ci] and the CCBHC service utilization underlying scenario 1. Adjustments using the behavioral health comparison rates offer a cost basis that is more reflective of underlying costs of providing services under the current care model (e.g., reflecting higher wages for existing staff).

C. ***Potential cost under CCBHC care model***: estimated reimbursement to provide services under the CCBHC care model based on estimated personnel and non-personnel cost increases and the CCBHC service utilization underlying scenario 1.

Figure 7 illustrates the cost estimates under each scenario by CCBHC service category leveraging a uniform statewide payment structure. Estimates reflect a potential future CCBHC program with current CCBHC's comprising one-third of program expenditures. The estimated aggregate cumulative cost increase of the modeled potential future CCBHC program is approximately a 33% to 39% increase in state and federal Medicaid funding. However, it is important to consider the different steps outlined below and illustrated in Figure 7.

- Current reimbursement reflects CY 2021 unit cost reported via the managed care encounter data for CCBHC providers. Service utilization from the five survey responses were given a scale factor to reflect all current CCBHCs and the entities that are interested in becoming a CCBHC under the demonstration.
- The potential cost under the existing care model, which is based on the behavioral health comparison rates, reflects approximately a 12% increase above the average reimbursement reported in managed care encounter data for CCBHC providers. Please note that CY 2021 reimbursement, and therefore this comparison, does not consider other state initiatives which have increased provider funding during CY 2022 through rate increases, CCBHC bridge funding, and provider relief funds.
- Implementing a CCBHC care model is anticipated to increase billable staff in order to provide the full array of CCBHC services, but these increases are identified separately given these staff would result in increased utilization of services.
- After accounting for potential cost increases under the existing care model and CCBHC billable staff, ***the incremental cost of implementing the CCBHC care model is approximately a 10% to 15% increase*** based on estimated increases to non-billable staff and other non-personnel cost increases. Please note non-personnel estimates exclude one-time costs of becoming a CCBHC, which are assumed to be covered by other funding sources such as a CCBHC Expansion Grant.

FIGURE 7: CCBHC COST ESTIMATES BY CCBHC SERVICE CATEGORY (VALUES IN $MILLIONS)

				POTENTIAL COST UNDER CCBHC CARE MODEL (C)	
CCBHC SERVICE CATEGORY	CURRENT 2021 REIMBURSEMENT (A)	POTENTIAL COST UNDER EXISTING CARE MODEL (B)	CCBHC BILLABLE STAFF ONLY	LOW ESTIMATE	HIGH ESTIMATE
Crisis Services	$ 2.9	$ 3.2	$ 3.4	$ 3.8	$ 3.9
Screening, Assessment, Diagnosis, & Risk Assessment	8.9	11.7	12.7	13.9	14.5
Outpatient Mental Health & Substance Use Services	98.7	110.6	119.5	131.0	137.0
Targeted Case Management	4.8	4.0	4.4	4.8	5.0
Peer, Family Support, & Counselor Services	7.2	7.6	8.3	9.1	9.5
Psychiatric Rehabilitation Services	5.7	6.3	6.8	7.5	7.8
Total	$ 128.2	$ 143.4	$ 155.1	$ 169.9	$ 177.7
Cumulative Increase		12%	21%	33%	39%
Increase by Step		12%	8%	10%	15%

Incremental cost estimate of cost-based provider-specific reimbursement

One of the primary payment model decisions described above is to decide between cost-based provider-specific reimbursement versus leveraging a statewide uniform payment structure. As noted above, provider expense information is largely not available for the behavioral health provider network.

Our CCBHC Data Request initially asked for actual provider cost at the service code level to support the comparison of current cost to the statewide payment rates found in the behavioral health comparison rate report. However,

providers indicated they would not be able to report this information in time to support this analysis. Several providers indicated they have started communication with external vendors to support cost reporting, and the Payment Model Workgroup discussed that credible cost information would be available via the CCBHC Cost Report if HCA was awarded the planning grant.

Limited information collected at an aggregate level within the CCBHC Data Request as well as discussions with HCA point towards provider costs being generally aligned with current reimbursement because Medicaid is the primary payer for the community behavioral health providers. *However, it is important to note that the current difference between cost-based reimbursement and uniform payment rates should not inform the future payment structure. Instead, the previous section outlining each payment options' advantages and disadvantages should be used along with the additional considerations impacting potential costs outlined in the next section to support understanding of cost differences under each scenario.*

Additional considerations impacting potential cost increases

Given HCA is in the preliminary stages of creating a CCBHC program and limited availability of data for this analysis, we wanted to outline several additional areas to consider that will impact the ultimate cost increase associated with a CCBHC program. Things such as wage levels and more non-billable staffing than anticipated to deliver the CCBHC model result in "per unit" increases while utilization increases and the extent to which primary care is included may result in increases in overall funding associated with the CCBHC program but may come with offsetting reductions to other providers if individuals shift where they receive care. While considerations of potential cost savings were beyond the scope of this analysis, it is important to note that the CCBHC model has the potential to offset cost increases through reductions in emergency department utilization and inpatient hospitalizations, as indicated by early experiences in other states.[cii]

- **Wage levels** – interested party engagement for this project as well as feedback from the behavioral health comparison rate development has indicated that current wage levels are not sufficient to retain quality staff. The behavioral health comparison rates included more competitive wage levels; however, there may still be a gap between the wage levels included within the behavioral health comparison rates and wages paid by competing employers. Under a provider-specific cost-based system for CCBHC services, providers would have more flexibility to pay the wages they believe are necessary while HCA would have more control over expected wages under a state uniform payment structure. Further analysis would be required to estimate the impact of increased wage levels.
- **Higher than expected non-billable personnel and non-personnel costs** – the CCBHC Data Request included capturing estimated increased costs due to moving from a non-CCBHC entity to a CCBHC, including billable staff, non-billable staff, and other qualitative data. The Payment Model Workgroup discussed that although many providers have implemented the CCBHC care model outlined by SAMHSA via an Expansion Grant, there could be additional cost increases associated with HCA's CCBHC care model relative to the model implemented as part of the Expansion Grant. Providers were requested to estimate the increases associated with HCA's CCBHC care model, but given all information is not known, the providers indicated that estimates included in Figure 6 should be viewed as preliminary.
- **Utilization increases** – utilization of services is likely to increase overall expenditures for potential CCBHCs relative to what is included in this analysis due to the following:
    - Providers being required to provide care to individuals with mild-to-moderate behavioral health diagnoses, which is not a requirement of behavioral health agencies currently.
    - Providers increasing capacity in order to deliver all CCBHC services to both children and adults. Potential CCBHCs vary in terms of the service array provided. Some of this increased utilization could be shifted from non-CCBHC providers, resulting in increased costs for the CCBHC program, but with offsets when considering the broader behavioral health program.
    - Preliminary information reported by providers suggests an approximately 8% increase in provider costs attributable to more services being provided by additional billable staff.

- **Primary Care** – Based on the CCBHC data request information, there are few primary care services currently provided directly by potential CCBHCs. However, there was significant discussion in the workgroups and interest in primary care services being included to provide whole-person care. Provider's implementation of primary care services will vary, with some adding staff to their organization and others establishing relationships with FQHCs. Future CCBHC program expenditures related to primary care will vary depending on HCA decisions regarding the extent to which primary care is included in the CCBHC model. The more expansive primary care services are within the CCBHC program, the higher the increase in funding will be attributable to the CCBHC program.
- **Funding of non-Medicaid individuals –** CCBHC providers are required to serve the non-Medicaid population as part of the program. This report is focused on the cost impact associated with the Medicaid enrolled population. Under PPS-1 and PPS-2, costs and utilization (e.g., daily/monthly visits) associated with serving the non-Medicaid population are included in the rate development. *However, without identification of non-Medicaid funding sources, CCBHCs would have a shortfall in revenue to cover their costs included in the CCBHC Cost Report.*

As noted previously, it is important to note that this analysis is focused on the incremental cost impact of implementing a CCBHC model, in terms of behavioral health service spending. While not considered in this analysis, implementation of a CCBHC model may lead to offsets to overall spending, as reductions in hospital and emergency department utilization have been reported by states participating in the demonstration.[ciii]

Long-term funding considerations

It is HCA's intent to use the demonstration to test CCBHC care delivery under a PPS model and to use the demonstration to determine a sustainable long-term approach to payment for safety net CCBHC providers. During the demonstration period, HCA plans to leverage the behavioral health comparison rates as benchmarks for monitoring provider efficiency and evaluating provider cost variation. In particular, provider-reported utilization and the enhanced comparison rate payment approach outlined in this report will be compared against provider-specific costs. These analyses will support HCA's spending oversight and give HCA a clearer understanding of provider cost variation across the state. The results of these analyses, coupled with measures of quality, access, and member outcomes gathered through the demonstration, will enable HCA to evaluate the effectiveness of the CCBHC model, how that may vary by CCBHC provider, and to determine a sustainable long-term approach to payment. HCA's long-term approach might include, for example, a continuation of PPS or a transition to a uniform payment methodology that can leverage the enhanced comparison rates, which would build in the added costs of operating as a CCBHC. A key consideration will be the payment model's ability to constrain long term cost growth and to incentivize provider efficiency.

Budget Impact Methodology and Data Sources

The fundamental formula used for obtaining cost estimates for the high-level budget impact estimates presented in this report is shown below:

$$Service\ Units \times Unit\ Cost = Service\ Expenditures$$

This formula is applied separately for each procedure code and the sum of service expenditures across all proposed CCBHC procedure codes develops an overall cost estimate.

***Service Units*:** Service Units are defined as a metric of how often a service is performed. The current Medicaid behavioral health program reflects different unit types for each covered service (e.g., per 15 minutes, per encounter, per day, etc.). Under PPS-1 for example, an alternative approach would be taken to determine reimbursement, with units measured as on a per day basis regardless of how many services are provided.

Service units were obtained from the CCBHC Data Request for each proposed CCBHC procedure code. This listing of CCBHC procedure codes can be found in Appendix III. Our financial analysis included fixed service units for each of the three scenarios. For purposes of this analysis, we have leveraged the service utilization information reported by potential CCBHCs in the CCBHC Data Request to serve as a proxy for the service mix of a future statewide CCBHC program. We used reported service utilization from five of the current CCBHC Expansion Grantees who submitted survey responses as a proxy for the potential future CCBHC program. In the above section, *Additional considerations*

impacting potential cost increases, we've provided observations regarding how increased utilization would impact overall CCBHC program cost estimates.

***Unit Cost*:** Unit cost is defined as the cost to provide a unit of service. Unit cost increases resulting from implementing a CCBHC Care Model are the focal point of this analysis. We leveraged information from the CCBHC Data Request, Managed Care Encounter Data, and behavioral health comparison rates to estimate increases. The following provides additional information regarding how unit cost varies under each of the three scenarios.

Current Reimbursement (A): Current reimbursement reflects the fees paid to providers under Washington's Medicaid managed care program.

- *Approach*: Identify average reimbursement for each CCBHC provider service based on available encounter data for potential CCBHCs.
- *Data Source for Unit Cost*: Calendar Year (CY) 2021 Medicaid managed care encounter data
- *Caveats*: Medicaid managed care encounter data is incomplete for some providers and may have other data quality concerns for other providers

Potential Cost Under Existing Care Model (B): Estimated reimbursement to provide services under the existing care model using the behavioral health comparison rates

- *Approach*: Leverage the comparison rates developed for the major behavioral health services. For services without a comparison rate, we assumed percentage increases were equal to other services in that service category with a comparison rate or we leveraged the composite average increase across all services with a comparison rate.
- *Data Source for Unit Cost*: Milliman Behavioral Health Comparison Rate Report[civ]
- *Caveats*: Only five CCBHC Data Request responses were received that included service utilization information. The behavioral health comparison rate report did not have comparison rates for every procedure code, and assumptions were needed for services without a rate.[cv]

Potential Cost Under CCBHC Care Model (C): Estimated reimbursement to provide services under the CCBHC care model.

- *Approach*: Incremental costs associated with the CCBHC care model were added to the *Potential Cost Under Existing Care Model* cost estimates. These incremental costs were estimated using different approaches for personnel and non-personnel costs, and the methodology is explained in the following section. Note that the "CCBHC BILLABLE STAFF ONLY" column in Figure 6 only adds the billable personnel costs onto the Potential Cost Under Existing Care Model amounts. A low estimate and a high estimate were included for this scenario due to the uncertainty present with determining non-billable personnel and non-personnel costs. The high estimate reflects an additional 5% added above the data driven low estimate percentage to account for the future unknown requirements of HCA's implementation of their CCBHC program.
- *Data Source for Additional Costs Under CCBHC Care Model*: CCBHC Data Request
- *Caveats*: Only five CCBHC Data Request responses were received, which raised concerns about whether or not the billable and non-billable staffing needs information reflects the staffing needs of all entities participating in the demonstration. Reported pre-CCBHC personnel resulted in materially higher expenditures using benchmark staffing costs relative to the costs identified for these providers in Scenario A. Staffing may have been reflective of broader provider operations and/or benchmark wages used may be different than actual incurred provider expenses.

Determining Additional Costs Under CCBHC Care Model:

Additional costs associated with operating a CCBHC Care Model were categorized as personnel or non-personnel costs and were estimated separately.

- **Personnel Costs:** Providers are expected to hire more staff in order to fulfill the additional requirements arising from becoming a CCBHC. These added personnel costs were estimated using the CCBHC Data

Request responses, specifically from the Billable Staffing Needs and Non-Billable Staffing Needs tabs, where pre-CCBHC and post-CCBHC staffing levels were reported.

Cost increases attributable to additional billable staff were estimated by multiplying the Potential Cost Under Existing Care Model cost by the percentage increase in billable staff reported. The percentage increase in billable staff was calculated as the ratio of reported pre-CCBHC billable staffing costs and reported post-CCBHC billable staffing costs. Wages and employee related expenses were determined for each staff group by reviewing May 2021 State Occupational Employment and Wage Estimates for the state of Washington from the Bureau of Labor Statistics (https://www.bls.gov/oes/current/oes_wa.htm#00-0000) and applying employee related expense loadings in a manner similar to what was done in the behavioral health comparison rate report.[cvi] It was assumed that reported utilization by the current CCBHCs already reflected the post-CCBHC billable staffing and, therefore, adjustments were not made for these providers (reflecting one-third of the potential future CCBHC program).

Non-billable staffing cost increases were calculated and included in a similar manner to billable staffing. However, the percentage increase attributable to non-billable staffing was applied to both CCBHC and non-CCBHC entities given the reimbursement for current CCBHCs does not reflect a CCBHC care model.

- **Non-Personnel Costs:** Non-personnel costs associated with operating as a CCBHC reflect all other costs incurred by providers outside of staff wages and benefits. Examples include increases in additional facility costs, contract management, and software costs. We developed a listing of all assumed material non-personnel costs that were likely to be impacted either on a one-time basis or ongoing basis. Cost estimates for each component were based on responses to the CCBHC Data Request Questionnaire, interested party engagement, and other industry experience. Appendix IV provides each non-personnel item anticipated to result in material cost increases when implementing the CCBHC care model. Each non-personnel cost component reflects a range of potential increases given this will vary by entity based on their current operations and practices.

Behavioral Health System Impact

Washington can learn from the experience of states and clinics that have participated in the CCBHC demonstration program thus far and through these lessons can anticipate potential challenges, needs, and impacts on Washington's behavioral health system.

Operational Demands and Workforce Issues

Providers have expressed a willingness and enthusiasm to undertake the operational lift to become CCBHCs. However, to ensure they can effectively do so, there are multiple considerations relating to operational and workforce demands and requirements.

- **Workforce:** As discussed previously in this report, the CCBHC model requires that clinics meet certain staffing requirements. However, according to the U.S. Department of Health and Human Services, 157 million Americans live in an area with a shortage of mental health providers.[cvii] Washington is not an exception. Throughout engagement with interested parties, providers consistently highlighted staff recruitment and retention as a central challenge, and it is reasonable to anticipate that this will continue to be significant challenge for clinics moving forward.

  A 2018 report to Congress, which evaluated the early phases of the CCBHC demonstration, reported that three-quarters of CCBHCs struggled to fill staff positions, with the most common vacancies being psychiatrists, peer support staff, SUD treatment providers, and licensed clinical social workers.[cviii] Demonstration states cited offering more competitive salaries and advertising vacancies with professional networks as strategies to recruit and retain staff.[cix] Interested parties also noted the extensive training required for the model to bolster staff satisfaction through professional development, as well as the flexibility of the model to accomplish care goals creatively as methods to retain staff.

  While the pervasive shortage of behavioral health workers is a national challenge that remains unresolved, and one that will make it difficult for providers to build out the model, the CCBHC model offers promise in

ameliorating workforce shortages, particularly under a cost-based reimbursement framework, since they would not face the same financial constraints that they face under current reimbursement. Additionally, interested party input included the suggestion to work collaboratively with the state to identify those tasks that may be appropriate for less than master's level staff and work with state licensing to broaden the pool of qualified staff.

- **DCOs and provider relationships**: As discussed above, an important part of the CCBHC model is allowing clinics to leverage formal relationships with other providers/DCOs for the delivery of certain services. These relationships are critical to promoting increased care coordination and ensuring that patients have access to the full spectrum of services.

  Generally, CCBHCs in the demonstration have reported a reticence towards providing services through DCOs and preference for providing the entire array of services directly.[cx] Some of the reasons CCBHCs cited as reasoning for this preference were:[cxi]

  - Complex and administratively burdensome legal requirements for DCO agreements
  - Challenges related to information sharing
  - Lack of experience with PPS

  Regardless, particularly in areas with more acute provider shortages or in situations where a clinic lacks current capacity to provide a particular service, DCOs provide an opportunity to bolster clinics' ability to guarantee service delivery and mitigate the impact of provider shortages. Interested party feedback also noted for smaller behavioral health providers, they are more likely to enter into a DCO relationship rather than becoming a CCBHC themselves. Establishing DCO relationships with small providers is particularly important in rural and frontier areas to support access.

- **Technology and Data Exchange**: During conversations with providers, a consistent concern was the logistics and infrastructure needed for data exchange across provider organizations. Small providers in particular do not necessarily have the needed technological foundation that allows them to share data across different providers. This is important because it is to be expected that clients will move across providers. This includes DCOs with which the CCBHCs establish formal relationships. In order to successfully carry out key activities like creating a service plan while avoiding duplication, providers will need to be able to share data across organizations. Demonstration states made investments in technical assistance and other supports both prior to and after launch of the demonstration to ensure clinics had the necessary technological infrastructure and capabilities to facilitate data exchange.[cxii]

- **Cost Reporting**: All CCBHCs that have participated in the demonstration program have been required to submit annual cost reports that were approved by their state governments. Submission of accurate cost reports is critical to the setting of the PPS rates, which are a core requirement of the CCBHC demonstration program, and development of a general understanding of the costs clinics incur during operations.

  However, there is a learning-curve inherent to the cost-reporting process. Most states that have participated in the demonstration did not have a pre-established cost-reporting system or process.[cxiii] As a result, state staff and clinics in demonstration states reported challenges early in the demonstration with the cost-reporting process.[cxiv] In an effort to support clinic staff with the cost-reporting process, states offered extensive technical assistance, including hiring consultants to directly support clinics and, in one state, having clinics conduct a "dry-run" six months into the demonstration to identify challenges prior to the annual cost report.[cxv]

  Washington can learn from other states' experiences and anticipate the need for technical support around cost-reporting by preparing upfront to offer clinics with technical assistance and support with completing the annual cost reports.

- **Accurate and Complete Encounter Data**: In order to implement PPS with fidelity, providers and MCOs will need to be able to report accurate, timely, and complete encounter data into HCA's ProviderOne system. This is an essential input for the implementation of a successful PPS model, as the encounter data is used

for many purposes, including rate development, enhanced federal match claiming, and program evaluation. More information is provided below:

- **Rate development:** CCBHC encounter data will be used to support identification of the number of daily visits in the CCBHC cost report (i.e., the denominator of the PPS-1 calculation) for each provider. CCBHC encounter data will also be the primary source of information to identify the base experience used to develop the existing managed care capitation rates. Accurate, timely, and complete encounter data is required to ensure that these payments are sound and representative of the services delivered by the providers and health plans for Medicaid services.
- **CCBHC PPS-1 encounter rates:** CCBHC providers are entitled to their PPS-1 encounter rate under a Section 223 CCBHC demonstration for each daily visit rendered. Often times, this requires an enhancement payment to be paid on top of the contracted service rates to ensure the provider specific PPS-1 rate is paid to the provider. The preferred CCBHC payment model would leverage the payment process currently used for Rural Health Center (RHC) reimbursement, which uses encounter data to initiate an enhancement payment, which is paid to the MCOs/providers through HCA's ProviderOne system. Under this model of reimbursement, the CCBHC would be paid the full encounter rate at the time of service. The full encounter rate would be initiated when the CCBHC submits a claim to the MCO. The MCO would be required to pay the CCBHC for each contracted service on the claim. MCOs would be at full risk for these contracts as this experience would be included in the MCO's monthly capitation payment from the HCA. Additionally, the MCO would be required to calculate and pay a claim line enhancement payment, which is the difference between the CCBHCS's PPS encounter rate and the MCO's contracted rate for each service rendered. MCOs would not be at risk for this enhancement payment and would be reimbursed by HCA using a service-based enhancement (SBE) once the encounter is submitted into ProviderOne. Accurate, timely, and complete encounter data is required to ensure that CCBHC providers are paid their correct PPS rate at the time of service.
- **Federal match claiming:** Following the end of the managed care contract period, encounter data will also be used by the state and its contracted actuaries to perform calculations to claim enhanced match for eligible CCBHC services. Accurate, timely, and complete encounter data is required to ensure that the state is able to claim the correct enhanced match amounts in a timely manner, as required by CMS.
- **Program evaluation:** Provide encounter data that will also be used by HCA to ensure transparency, quality, access, and value in the CCBHC demonstration. Accurate, timely, and complete encounter data is required to ensure that HCA is able to evaluate the program, maximize quality and access, and ensure that all required reporting to stakeholders can be performed.

Anticipated Impact on Quality of Care

The quality reporting requirements and incentive structures included in the CCBHC model enable monitoring of quality improvement at the clinic level and state level with respect to access to care and patient outcomes.

- **Reporting:** Like the processes around cost-reporting and technology and data exchange, clinics will need support as they undertake reporting on the required quality measures. Many clinics do not have experience reporting on the specified measures and as discussed above, might currently lack the technological infrastructure to do so. Providers also noted a challenge in clients moving across multiple providers, creating barriers to developing a full data set. Sharing of data was noted as a key factor in care coordination and holistic care planning.

  For this reason, states in the demonstration initially reported difficulties in the early phases of implementation as clinics needed assistance to better understand the actual measures, how to adequately report on them, and how to appropriately use the reporting templates.[cxvi] Additionally, clinics in the demonstration needed time and support to develop the necessary technological infrastructure to report on measures, specifically with regard to making necessary changes to their electronic health records (EHRs) and health information technology (HIT) systems.[cxvii] Additionally, providers noted the importance of

establishing data sharing agreements across the system for comprehensive understanding of client services being accessed.

To help clinics overcome these challenges, demonstration states reported providing continuous technical assistance (e.g., webinars, direct support of individual clinics).[cxviii] Washington can anticipate similar challenges as it undertakes implementation and should support clinics in the development of necessary reporting infrastructure and offer technical assistance as clinics navigate reporting on the specified measures.

- **Outcomes:** There are several quality measures that SAMHSA has required for CCBHC reporting (e.g., suicide risk assessment, depression remission) and others that are optional (e.g., controlling high blood pressure, number of suicide deaths). States also have the option to define and require additional quality reporting measures if they choose. If a quality bonus payment is included within the payment model, providers will have an added incentive to practice population health management by monitoring gaps in care and adapting clinical workflows in order to improve performance on quality measures. Currently, formal evaluations of the federal demonstration have not yet reported on quality outcomes, so it is difficult to quantify an expected impact on quality outcomes in Washington. While further insights into quality outcomes are anticipated in the forthcoming fifth report to Congress, the National Council for Mental Wellbeing has published promising indicators of quality improvement from interviews and surveys with state officials. Reduction in emergency department and inpatient hospital utilization, improvement in initiation, engagement, and follow up for mental health and SUD treatment, and improvement in the integration of primary care were among key findings in this report.[cxix]

  In terms of defining quality goals, Washington intends to continue work to define quality measurement requirements moving forward but has expressed a desire to prioritize measuring potential improvement in physical health conditions amongst behavioral health patients. As the state considers quality within the CCBHC model, it should consider if there are additional measures or goals it would like to include and recommend to CMS.

- **Care coordination**: As has been discussed throughout this report, care coordination is a fundamental component of the CCBHC model. Clinics in demonstration states highlighted making improvements to EHR and HIT systems as important to supporting their efforts to increase care coordination – specifically in the context of creating care plans, assisting clients link to other providers, and being alerted when a client transitions care.[cxx]

Anticipated Impacts on Access

The appeal of the CCBHC model is its potential to increase access to behavioral health services in Washington. As referenced previously, millions of Americans live in communities where there is a shortage of behavioral healthcare providers, resulting in a lack of access to necessary care and inability to provide the required range of CCBHC services. Through discussions with interested parties, it is clear that providers see CCBHC as an opportunity to improve their ability to offer more competitive compensation to staff, which can enable them to overcome persistent workforce challenges that lead to access barriers. Interested parties also noted that the model is agnostic to both the ability to pay and Medicaid eligibility, expanding the CCBHC's ability to provide needed services to any individual.

A forthcoming fifth report to Congress is due to be published at the end of this year and is expected to contain claims and encounter data that will provide more direct insight into access. For the moment, the analysis has focused on measures such as expanded scope of services and the hiring of additional staff that are related to access.[cxxi] To that point, most CCBHCs in the demonstration reported hiring additional staff and being able to expand and maintain their scope of services offered.[cxxii] Earlier in the demonstration period, the Department of Health and Human Services' (HHS) 2019 Report to Congress stated that clinics have varied in their ability to retain staff, which states have attributed to uncertainty around the future of the demonstration program.[cxxiii] More recent data from the National Council for Wellbeing shows that state-certified-certified clinics were able to hire 44 new positions per clinic on average.[cxxiv] The most commonly hired positions were peer support specialists, data analysts, primary care providers, substance use disorder counselors, and psychiatrists.[cxxv] CCBHCs also reported that the ability to invest in improved

salaries, benefits, and other strategies and programming aimed at improving staff satisfaction has helped with staff retention.[cxxvi]

7. Implementation Considerations and Recommendations

State and federal policy

HCA intends to move forward with participation in the federal demonstration program. In order to take advantage of the opportunities presented by the demonstration, there are actions that the state will need to take.

Federal authorities and awards: The Bipartisan Safer Communities Act authorized the expansion of the CCBHC demonstration program, whereas up to ten states may be selected every two years starting in June of 2024, and appropriated $40 million to support state planning grants. In order to participate in the demonstration, states must have received a planning grant.[cxxvii]

On October 18, 2022, SAMHSA announced a notice of funding opportunity for the planning grants made available through the Bipartisan Safe Communities Act, with an application deadline of December 19, 2022. SAMHSA anticipates selecting fifteen states to receive an award of up to $1 million.[cxxviii]

It is HCA's intention to submit an application for the federal planning grant opportunity to continue program planning, interested party engagement, and implementation activities and to prepare the state to apply for the full demonstration program.

Additionally, the federal government has signaled that it intends to update certification standards and payment guidance for the CCBHC program, communicating a forthcoming opportunity for states and interested parties to provide input to inform updates to program guidance.[cxxix] HCA is interested in providing input to SAMHSA and CMS as part of this process.

State legislative action: The Washington state legislature has authorized this thorough assessment of CCBHC programing and payment through proviso 106 of ESSB 5693. This examination of the CCBHC model and the potential impacts of implementing a CCBHC initiative in the state is what is documented in this report. It also provides great starting analysis in support of the planning grant HCA is applying for, and for a potential demonstration authority based on legislative direction.

Recommendation: HCA seeks the ongoing support of the legislature as the department prepares a planning grant application. As planning efforts continue, HCA continues to endorse the CCBHC model and tentatively recommends the eventual legislative authority to pursue the federal demonstration when the opportunity becomes available in 2024.

In the event that Washington is not selected for the federal planning grant or demonstration opportunity, HCA will consider alternative paths toward a statewide CCBHC implementation.

Managed care considerations

The goals of the CCBHC program are well aligned with the state's vision for integrated managed care, given the mutual emphasis on the integration of physical health and behavioral health and the focus on accountability and quality improvement. As such, HCA intends to implement a CCBHC initiative within the context of an integrated managed care delivery system, rather than carving CCBHC services out of the managed care contract. Additionally, it is important to leverage the MCOs' expertise in care management and population health improvement, which means that payment for CCBHCs should be included in managed care capitation rates.

Currently, HCA implements PPS payment methodologies similar to CCBHC payment methodologies for Rural Health Clinic (RHC) and FQHC providers. The processes used for these payments can be replicated and adapted for CCBHC payment. Specifically, HCA plans to implement CCBHC payment through two mechanisms that together comprise the clinic specific PPS rate: a base payment and an enhanced payment.

Base Payment: The CCBHC will be required to report all contracted Medicaid services rendered to the managed care organization. This experience should then be reported to the ProviderOne system by the managed care organization. This experience for each rendered service will be included in the managed care capitation rates and the MCO will be at full risk for these services. The state may leverage the behavioral health comparison rates and require a minimum fee schedule for CCBHC services. Under a minimum fee schedule arrangement, CCBHC providers would be paid at the behavioral health fee schedule rate once they have submitted eligible claims to the managed care organization.

Claim Enhancement: Providers are entitled to a full PPS rate for each eligible encounter submitted to the managed care organization. To ensure that the full encounter rate is paid, managed care organizations will be required to pay CCBHCS an enhancement at the time of claim submission, which is the difference between the provider's unique PPS rate and minimum fee schedule payments for each service rendered. Managed care organizations are not at risk for the claim enhancement, and it is not included in capitation rate. HCA will reimburse managed care organizations for the claim enhancement via a Service Based Enhancement (SBE) which is initiated with an encounter submission to ProviderOne. Under this proposed methodology, there is no need for an end-of-year reconciliation process, which relieves administrative burden for HCA, MCOs, and providers alike. Additionally, this approach creates an incentive for accurate, complete, and timely reporting of encounters.

State operational impacts

In order to implement a statewide CCBHC initiative, there are a number of operational impacts that HCA should prepare for, including staffing needs, contract amendments, and systems changes.

Staffing: There are several administrative processes, spanning across department function areas, that HCA staff will need to manage in order to effectively implement and sustain the CCBHC initiative. Notable activities include the development of certification standards and management of the certification process, administering and analyzing cost reports to develop unique PPS rates for each participating clinic, monitoring encounter and quality reporting, and complying with federal financial and programmatic reporting requirement. It is also imperative that the agency continue a robust interested party engagement process to allow providers, payers, members, and others to provide input into programmatic decisions and to identify pain points that can be resolved as implementation takes shape.

The planning grant opportunity will certainly support many of these staff functions in the short-term if Washington is awarded funds. In the long-term, HCA will have to monitor its internal capacity and ensure adequate staffing across the agency to implement the CCBHC initiative with rigor and fidelity. As these staffing needs are better understood, HCA anticipates putting forth thoughtful requests for additional full time equivalent (FTE) support.

Managed Care: Because HCA envisions a CCBHC program that is implemented through managed care, as opposed to a carve-out, there are a number of contractual and administrative actions that will have to occur to support implementation and ongoing operations. The integrated managed care contract, capitation rates, and oversight mechanisms will have to be updated to enable Medicaid payment for CCBHC services, as described in the section above. Throughout the interested party engagement process, MCOs expressed broad support for the CCBHC model and indicated a commitment to partner with the state in the implementation of a statewide CCBHC initiative.

Systems Changes: While a complete audit of Medicaid systems needs to implement CCBHC has not yet been conducted, it is anticipated that updates to ProviderOne, Washington's Medicaid Management Information System (MMIS), will be required in order to pay the provider specific wrap payment and any fee-for-service claims. It is likely that existing ProviderOne encounter rate payment methods for RHC and FQHC payments can be leveraged in CCBHC implementation.

HCA anticipates that systems requirements to operationalize CCBHC payment and reporting will be further explored in the planning grant process.

8. Conclusion and Next Steps

This report fulfills HCA's legislative charge to conduct a thorough exploration of the development and implementation of a statewide CCBHC payment model. Through the review of literature and best practices, actuarial analysis, policy analysis, and interested party engagement, HCA has done considerable work to understand the opportunities presented by the CCBHC model to improve the quality of behavioral healthcare, the integration of physical health, behavioral health, and social services, and access to a comprehensive array of community-based behavioral health services. This report has outlined key considerations and preliminary state preferences with regard to the CCBHC care delivery model and how it can be customized to suit the unique Washington delivery system, and the trade-offs between payment model options in how they can advance HCA's strategic goals and sustain a highly functioning system of CCBHCs in the short- and long-term. There is broad support among providers, payers, and state decision-makers for the CCBHC model and the opportunities presented by the federal CCBHC demonstration to secure financial resources and technical assistance. In particular, providers expressed strong interest in continued engagement with HCA throughout the coming planning and implementation stages.

It is HCA's intention to continue these planning efforts and work toward implementation of a statewide CCBHC initiative, pending further legislative direction. In the short-term, HCA plans to submit an application for the federal planning grant opportunity which will enable the continued program planning, interested party engagement, and implementation activities that will ultimately prepare the state to apply for the full demonstration program.

LIMITATIONS

The information contained in this document has been prepared for the State of Washington, Health Care Authority (HCA) and is subject to the terms of Milliman's contract with HCA signed on July 14, 2021. We understand that this report may be shared with related agencies, their advisors, and the other interested parties. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of this information must possess a certain level of expertise in actuarial science and health care modeling that will allow appropriate use of the information presented.

Milliman makes no representations or warranties regarding the contents of this document to third parties. Similarly, third parties are instructed that they are to place no reliance upon this information prepared for HCA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this presentation must rely upon their own experts in drawing conclusions about the information presented in this report.

Actual costs for the program will vary from our projections for many reasons. Differences between the results of our analysis and actual experience will depend on the extent to which future experience conforms to the final policy decisions made by HCA and corresponding assumptions made in the calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected.

Milliman developed certain models to estimate the values included in this report. The intent of the models was to estimate the financial impact of implementing a CCBHC program in Washington State. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs).

These models relied on data and other information as inputs to the models. This data was provided by HCA and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and did not find material defects in the data. If there are material defects in the data, it is possible they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable, or for relationships that are materially inconsistent. Such a review was beyond the scope of our engagement.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Jeremy Cunningham and Jacob Epperly are members of the American Academy of Actuaries and meets the qualification standards for performing the analyses in this report.

APPENDICES

I. Proviso 106 of Engrossed Substitute Senate Bill (ESSB) 5693, Section 215

II. Interested party engagement participants

III. Behavioral health services

IV. Non-personnel costs

APPENDIX I: PROVISO 106

Engrossed Substitute Senate Bill (ESSB) 5693, Section 215 (106):

$300,000 of the general fund—state appropriation for fiscal year 2023 and $300,000 of the general fund—federal appropriation are provided on a one-time basis solely for the authority to explore the development and implementation of a sustainable, alternative payment model for comprehensive community behavioral health services, including the certified community behavioral health clinic (CCBHC) model. Funding must be used to secure actuarial expertise; conduct research into national data and other state models, including obtaining resources and expertise from the national council for mental well-being CCBHC success center; and engage stakeholders, including representatives of licensed community behavioral health agencies and Medicaid managed care organizations, in the process. The authority must provide a preliminary report to the office of financial management and the appropriate committees of the legislature with findings, recommendations, and preliminary cost estimates by December 31, 2022. The study must include:

(a) Overviews of alternate payment models and options and considerations for implementing the certified community behavioral health clinic model within Washington state;

(b) An analysis of the impact of expanding alternate payment models on the state's behavioral health systems;

(c) Relevant federal regulations and options to implement alternate payment models under those regulations;

(d) Options for payment rate designs;

(e) An analysis of the benefits and potential challenges in integrating the CCBHC reimbursement model within an integrated managed care environment;

(f) Actuarial analysis on the costs for implementing alternative payment model options, including opportunities for leveraging federal funding; and

(g) Recommendations to the legislature on a pathway for statewide implementation.

APPENDIX II: INTERESTED PARTY ENGAGEMENT PARTICIPANTS

HCA identified key interested parties to invite to participate in provider surveys and workgroups designed to gather provider perspectives from current CCBHCs and providers interested in becoming a CCBHC. Additionally, the national and state councils were included in the discussions to understand larger context lessons learned. HCA is appreciative of the time and commitment to provide valuable insights to inform the development of the program.

Interview Participants
Behavioral Health Providers
Peninsula Behavioral Health
Sound Health
Valley Cities Behavioral Health Care
Managed Care Organizations
Community Health Plan of Washington
UnitedHealthcare
Behavioral Health Administrative Services Organizations
Thurston-Mason Behavioral Health

CCBHC Data Request Respondents
Cascade Mental Health
Columbia Wellness
Columbia River Mental Health Services
Comprehensive Life Resources
Excelsior Wellness
Sound Health

Workgroup Invited Participants	
Care Model Workgroup	**Payment Model Workgroup**
Sound Health	Sound Health
Excelsior Wellness	Excelsior Wellness
Cascade Mental Health	Cascade Mental Health
Olalla Recovery Centers	Olalla Recovery Centers
Seattle YMCA	Seattle YMCA
Okanogan Behavioral Healthcare	Okanogan Behavioral Healthcare
Lydia Place	Lydia Place
MultiCare	MultiCare
King County	King County
Lake Whatcom Residential Treatment Center	Lake Whatcom Residential Treatment Center
Comprehensive Life Resources	Comprehensive Life Resources
American Indian Community Center Inc	American Indian Community Center Inc
Lifeline Connections	Lifeline Connections
Catholic Community Services of Western WA	Catholic Community Services of Western WA
CHAS Behavioral Health Center	CHAS Behavioral Health Center

Workgroup Invited Participants	
Care Model Workgroup	**Payment Model Workgroup**
Comprehensive Healthcare	Comprehensive Healthcare
Catholic Charities Eastern WA	Catholic Charities Eastern WA
Renton Counseling Center	Passages Spokane Family Support
Valley Cities	Valley Cities
Columbia River Mental Health Services	Columbia River Mental Health Services
Prosperity Wellness Center	Prosperity Wellness Center
Peninsula Behavioral Health	Peninsula Behavioral Health
National Council for Mental Wellbeing	National Council for Mental Wellbeing
Washington Council for Behavioral Health	Washington Council for Behavioral Health
	Kitsap Mental Health Services

APPENDIX III: BEHAVIORAL HEALTH SERVICES

Providers responding to the CCBHC data request were instructed to provide the total units delivered by procedure code for each of the services listed.

The demonstration service category refers to the nine categories of CCBHC services, as defined in the key below.

Demo Service Category	Service Description
CRISIS	Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization
SADRA	Screening, assessment, and diagnosis, including risk assessment
PCTP	Patient-centered treatment planning or similar processes, including risk assessment and crisis planning
OMHSUS	Outpatient mental health and substance use services
PCSM	Outpatient clinic primary care screening and monitoring of key health indicators and health risk
TCM	Targeted case management
PRS	Psychiatric rehabilitation services
PEER	Peer support and counselor services and family supports
VETS	Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration

CCBHC Services Included in Data Collection Tool

Index	Procedure Code (CPT/HCPCS)	Demonstration Service Category	Service Description
1	90785	OMHSUS	Psytx complex interactive
2	90791	SADRA	Psych diagnostic evaluation
3	90792	SADRA	Psych diag eval w/med srvcs
4	90832	OMHSUS	Psytx w pt 30 minutes
5	90833	OMHSUS	Psytx w pt w e/m 30 min
6	90834	OMHSUS	Psytx w pt 45 minutes
7	90836	OMHSUS	Psytx w pt w e/m 45 min
8	90837	OMHSUS	Psytx w pt 60 minutes
9	90838	OMHSUS	Psytx w pt w e/m 60 min
10	90846	OMHSUS	Family psytx w/o pt 50 min
11	90847	OMHSUS	Family psytx w/pt 50 min
12	90849	OMHSUS	Multiple family group psytx
13	90853	OMHSUS	Group psychotherapy
14	96101	SADRA	Psycho testing by psych/phys
15	96102	SADRA	Psycho testing by technician
16	96110	SADRA	Developmental screen w/score
17	96116	SADRA	Nubhvl xm phys/qhp 1st hr
18	96119	SADRA	Neuropsych testing by tec
19	96121	SADRA	Nubhvl Xm Phy/Qhp Ea Addl Hr

Index	Procedure Code (CPT/HCPCS)	Demonstration Service Category	Service Description
20	96130	SADRA	Psycl Tst Eval Phys/Qhp 1St
21	96131	SADRA	Psycl Tst Eval Phys/Qhp Ea
22	96132	SADRA	Nrpsyc Tst Eval Phys/Qhp 1St
23	96133	SADRA	Nrpsyc Tst Eval Phys/Qhp Ea
24	96136	SADRA	Psycl/Nrpsyc Tst Phy/Qhp 1St
25	96137	SADRA	Psycl/Nrpsyc Tst Phy/Qhp Ea
26	96138	SADRA	Psycl/Nrpsyc Tech 1St
27	96139	SADRA	Psycl/Nrpsyc Tst Tech Ea
28	96153	OMHSUS	Intervene hlth/behave group
29	96154	OMHSUS	Interv hlth/behav fam w/pt
30	96155	OMHSUS	Interv hlth/behav fam no pt
31	96164	OMHSUS	Hlth bhv ivntj grp 1st 30
32	96165	OMHSUS	Hlth bhv ivntj grp ea addl
33	96167	OMHSUS	Hlth bhv ivntj fam 1st 30
34	96168	OMHSUS	Hlth bhv ivntj fam ea addl
35	96170	OMHSUS	Hlth bhv ivntj fam wo pt 1st
36	96171	OMHSUS	Hlth bhv ivntj fam w/o pt ea
37	96372	OMHSUS	Ther/proph/diag inj sc/im
38	99050	OMHSUS	Medical services after hrs
39	99051	OMHSUS	Med serv eve/wkend/holiday
40	99201	SADRA	Office/outpatient visit new
41	99202	SADRA	Office O/P New Sf 15-29 Min
42	99203	SADRA	Office O/P New Low 30-44 Min
43	99204	SADRA	Office O/P New Mod 45-59 Min
44	99205	SADRA	Office O/P New Hi 60-74 Min
45	99211	OMHSUS	Office O/P Est Minimal Prob
46	99211	OMHSUS	Office O/P Est Minimal Prob
47	99212	OMHSUS	Office O/P Est Sf 10-19 Min
48	99212	OMHSUS	Office O/P Est Sf 10-19 Min
49	99213	OMHSUS	Office O/P Est Low 20-29 Min
50	99213	OMHSUS	Office O/P Est Low 20-29 Min
51	99214	OMHSUS	Office O/P Est Mod 30-39 Min
52	99214	OMHSUS	Office O/P Est Mod 30-39 Min
53	99215	OMHSUS	Office O/P Est Hi 40-54 Min
54	99215	OMHSUS	Office O/P Est Hi 40-54 Min
55	99304	SADRA	Nursing facility care init
56	99305	SADRA	Nursing facility care init
57	99306	SADRA	Nursing facility care init
58	99307	OMHSUS	Nursing fac care subseq
59	99308	OMHSUS	Nursing fac care subseq
60	99309	OMHSUS	Nursing fac care subseq
61	99310	OMHSUS	Nursing fac care subseq
62	99324	SADRA	Domicil/r-home visit new pat
63	99325	SADRA	Domicil/r-home visit new pat
64	99326	SADRA	Domicil/r-home visit new pat
65	99327	SADRA	Domicil/r-home visit new pat

Index	Procedure Code (CPT/HCPCS)	Demonstration Service Category	Service Description
66	99328	SADRA	Domicil/r-home visit new pat
67	99334	OMHSUS	Domicil/r-home visit est pat
68	99335	OMHSUS	Domicil/r-home visit est pat
69	99336	OMHSUS	Domicil/r-home visit est pat
70	99337	OMHSUS	Domicil/r-home visit est pat
71	99341	SADRA	Home visit new patient
72	99342	SADRA	Home visit new patient
73	99343	SADRA	Home visit new patient CPT® (Current Procedural Terminology) | CPT® Codes | AMA (ama-assn.org)
74	99344	SADRA	Home visit new patient
75	99345	SADRA	Home visit new patient
76	99347	OMHSUS	Home visit est patient
77	99348	OMHSUS	Home visit est patient
78	99349	OMHSUS	Home visit est patient
79	99350	OMHSUS	Home visit est patient
80	99354	OMHSUS	Prolng Svc O/P 1St Hour
81	99355	OMHSUS	Prolng Svc O/P Ea Addl 30
82	99356	OMHSUS	Prolng Svc I/P/Obs 1St Hour
83	99357	OMHSUS	Prolng svc i/p/obs ea addl
84	99421	OMHSUS	Ol dig e/m svc 5-10 min
85	99422	OMHSUS	Ol dig e/m svc 11-20 min
86	99423	OMHSUS	Ol dig e/m svc 21+ min
87	99441	OMHSUS	Phone e/m phys/qhp 5-10 min
88	99442	OMHSUS	Phone e/m phys/qhp 11-20 min
89	99443	OMHSUS	Phone e/m phys/qhp 21-30 min
90	G2212	SADRA	Prolong outpt/office vis
91	H0001	SADRA	Alcohol and/or drug assess
92	H0004	OMHSUS	Behavioral health counseling and therapy, per 15 minutes
93	H0004	OMHSUS	Behavioral health counseling and therapy, per 15 minutes
94	H0023	PRS	Behavioral health outreach service (planned approach to reach a targeted population)
95	H0025	PRS	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
96	H0027	PRS	Psycho-ed srvc, per 15 mins
97	H0031	SADRA	Mh health assess by non-md
98	H0033	OMHSUS	Oral med adm direct observe
99	H0034	OMHSUS	Med trng & support per 15min
100	H0035	OMHSUS	Mh partial hosp tx under 24h
101	H0036	PRS	Comm psy face-face per 15min
102	H0038	PEER	Self-help/peer svc per 15min
103	H0038	PEER	Self-help/peer svc per 15min
104	H0040	OMHSUS	Assert comm tx pgm per diem
105	H0046	PRS	Mental health srvcs, NOS
106	H0047	TCM	Alcohol/drug abuse svc nos
107	H0050	OMHSUS	Alcohol and/or drug services, brief intervention, per 15 min
108	H2011	CRISIS	Crisis interven svc, 15 min

Index	Procedure Code (CPT/HCPCS)	Demonstration Service Category	Service Description
109	H2012	OMHSUS	Behav hlth day treat, per hr
110	H2014	OMHSUS	Skills train and dev, 15 min
111	H2015	OMHSUS	Comp comm supp svc, 15 min
112	H2017	PRS	Psysoc rehab svc, per 15 min
113	H2022	OMHSUS	Com wrap-around sv, per diem
114	H2027	PRS	Psychoed svc, per 15 min
115	H2033	OMHSUS	Multisys ther/juvenile 15min
116	S9446	PRS	PT education noc group
117	S9480	OMHSUS	Intensive outpatient psychia
118	S9484	CRISIS	Crisis intervention per hour
119	T1001	OMHSUS	Nursing assessment/evaluatn
120	T1016	TCM	Case management
121	T1017	TCM	Targeted case management
122	T1023	SADRA	Program intake assessment

APPENDIX IV: NON-PERSONNEL COSTS

	One Time	Ongoing	Suggested Cost Basis
HIT			
Electronic Health Records (EHR)	Modifications for required reporting and capture of added data elements and development of workflows **Range: $50K - $150K**	Keeping current with any program design change requirements. Assume costs are not material for planning purposes.	Per clinic/practice group
Software (e.g., care coordination, population health management)	Assume software updates to existing applications **Range: $15K - $50K**	Keeping current with any program design change requirements. Assume not all systems every year **Range: $5K - $50K**	Per software application, per clinic/practice group
Claims system	Update to incorporate new billing codes, e.g., primary care; system configuration for processing **Range: $20K - $100K**	Keeping current with any changing codes, e.g., adds/deletes Assume costs are not material for planning purposes.	Per clinic/practice group
Hardware	Laptops/desktops, phones for new employees to meet added specialty/volume requirements **Range: $1,500 - $3,000**	Depreciation, if any Assume costs are not material for planning purposes.	Per FTE added Range based on Pre/Post CCBHC FTEs reported: 7, 32, 36, 44, 54,76
Delegation/Oversight			
Reporting/quality	Assume DCO system can send reporting files/data as automated process but requires building an interface. **Range: $15K - $50K**	Assume costs are not material for planning purposes.	Per DCO
Contract management	Cost of vendor for legal review of contracts **Range: $500 - $1K**	Assume costs are not material for renewing contracts.	Per DCO

Claims processing	Assume claim system can adjudicate claims after software update (above) as automated process but requires building an interface. **Range: $25K - $50K**	Assume costs are not material for planning purposes.	Per DCO
Facilities			
Space for new staff/ programs	Initial acquisition or remodeling. Assume mostly office type space. **Range: $15K - $30K**	Ongoing facilities/space cost allocation. Assume costs are not material for planning purposes.	Square footage added or modified for CCBHC use.
Equipment (e.g., primary care)	Initial development of clinical treatment space, assume 3 exam rooms, one office, and reception. **Range: $50K - $75K** Added offices (furniture, technology, phones, etc.) **Range: $15K - $20K**	Depreciation, if any Assume costs are not material for planning purposes.	Per clinic
Recruitment			
Bonuses/incentives	Assumes that not all positions will require a bonus for recruitment. **Range: $3,000 - $5,000**	Assumes ongoing recruitment challenge **Range: $3,000 - $5,000**	50% of added average FTE

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