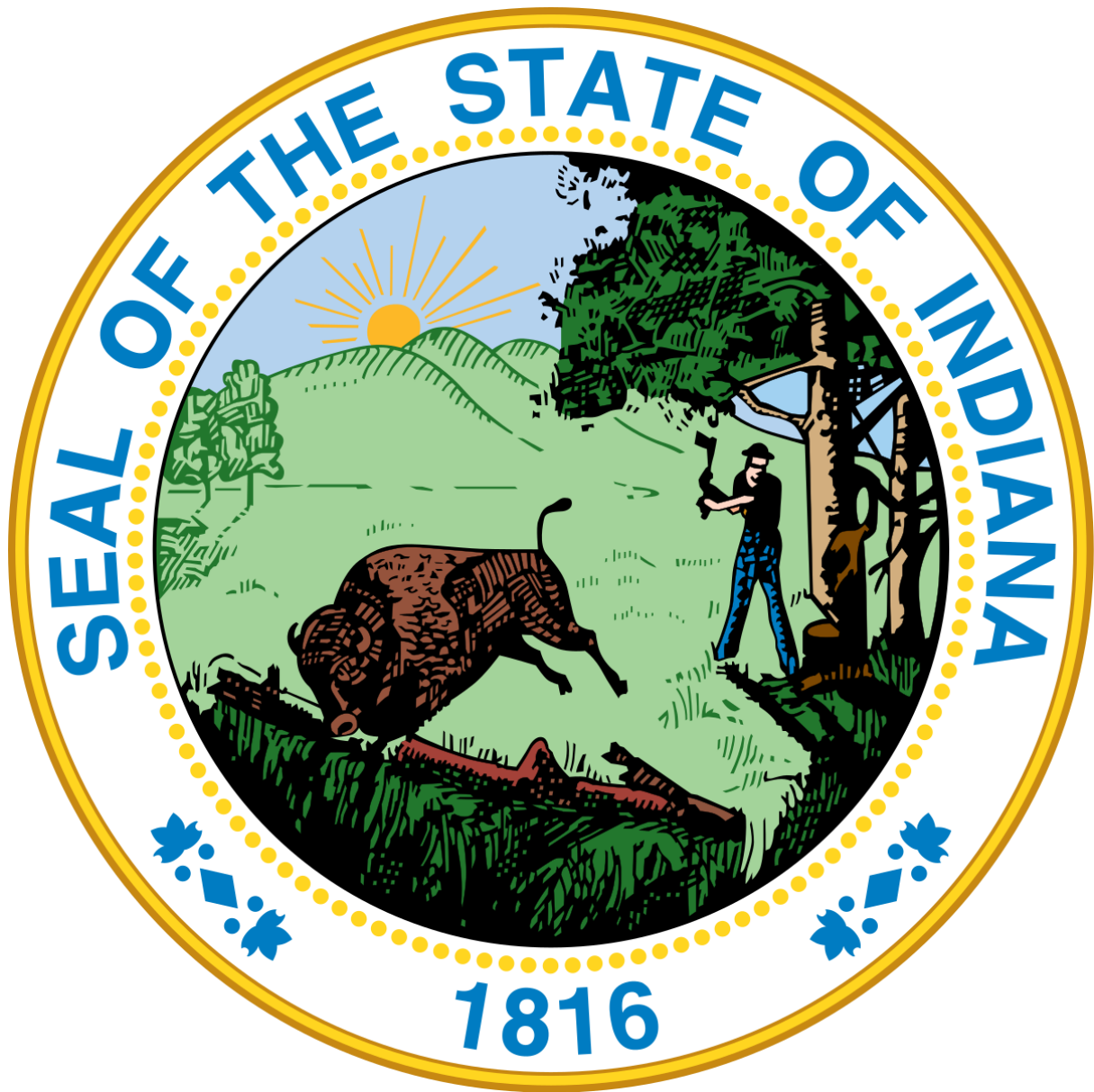


# A Plan for Indiana to Expand the Use of Certified Community Behavioral Health Clinics



Submitted to the State of Indiana Division of Mental Health and Addiction with the Support of National Council for Mental Wellbeing CCBHC Success Center

November 7, 2022

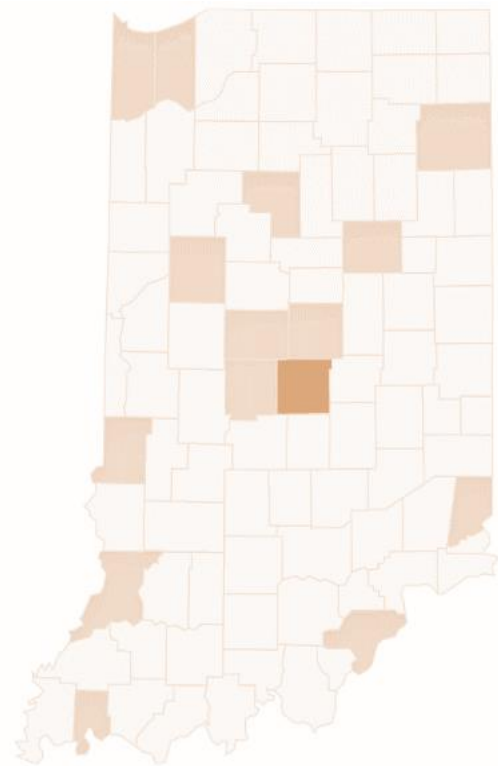
# Executive Summary

House Bill 1222 directed the Division of Mental Health and Addiction (DMHA) under the Family and Social Services Administration (FSSA) to develop a plan to expand the use of Certified Community Behavioral Health Clinics (CCBHCs) in Indiana. With the support of the National Council for Mental Wellbeing’s CCBHC Success Center,<sup>1</sup> this document outlines DMHA’s commitment and plan for adopting the CCBHC model statewide, including alignment with Indiana’s 988 hotline for suicide prevention and crisis support. The CCBHC model is an approach for providing community-based outpatient mental health and substance use care. The criteria for this model were established by the Substance Abuse and Mental Health Administration (SAMHSA) with a payment structure established by the Center for Medicare and Medicaid Services (CMS). The model has been promoted by Congress through state planning grants, enhanced Medicaid match rates, and local grants to assist community behavioral health organizations in implementing the model. House Bill 1222 made Indiana the first state to require aligning 988 with CCBHC, an innovative effort that when implemented statewide will save time, money, and lives.

State-level implementation of the CCBHC model is the key to building the comprehensive behavioral health system that Hoosiers deserve. Establishing the CCBHC model at the state level will:

1. Ensure complete transparency into the effectiveness of the behavioral health system;
2. Strengthen the whole ecosystem by linking behavioral health care with other community pillars such as education, justice, and housing systems; and
3. Build tailored treatment pathways for individuals, rather than fit complex individuals into a one-size fits all approach

Since 2018, eighteen (18) individual Indiana clinics have received federal CCBHC grants from SAMHSA. With many Indiana clinics receiving multiple grants over time, this has resulted in a total of nearly \$100 million flowing into or committed to the state’s grantees. To formalize the CCBHC model within Indiana Medicaid, the most immediate and cost-effective next step will be for the state to apply for a federal CCBHC planning grant with the intent to apply to participate in the federal CCBHC program, including receiving an enhanced Medicaid match rate. The CCBHC Medicaid Demonstration will create opportunities to ensure the CCBHC model is statewide with additional criteria to meet Indiana’s goals. This map of Indiana shows where current grantees are, many of whom may lose funding and their



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<sup>1</sup> The National Council for Mental Wellbeing (National Council) is a nonpartisan membership organization of over 3,500 mental health and substance use organizations serving over 10 million adults, children, and families in the United States. This membership includes the Indiana Council of Community Mental Health Centers. National Council also conducts the CCBHC State Learning Collaborative for all 56 states and territories Medicaid and Behavioral Health division to understand the CCBHC model and discuss areas for state-specific innovations.

CCBHC grantee status in the next few years. As detailed below, DMHA’s plan will include six (6) key steps by July 2024:

## Six Key Steps for CCBHC Implementation in Indiana



1. **Establish Indiana-specific Goals.** Engage stakeholders, including Indiana Medicaid, Indiana Council of Community Mental Health Centers (Indiana Council), Indiana Department of Child Service, the Indiana General Assembly, County commissioners, local service providers, Criminal Justice system stakeholders, and others in assessing and finalizing goals and objectives. CCBHC leadership and project management processes will be established by these stakeholders to ensure state staff and strategic partners are included in planning.



2. **Conduct Community Needs Assessments.** Build off the successes of local Indiana providers, (e.g., CCBHC grantees) and align with the innovations and recommendations of other Indiana-based efforts to decrease suicide and overdose. Conduct an environmental scan and surveys to identify additional needs for successful implementation of the CCBHC model to Indiana.



3. **Craft CCBHC certification criteria.** Align with the outcomes of the needs assessments and ensure Indiana’s goals will be met through strict criteria to convert a current behavioral health provider to a CCBHC. These criteria may be for both CCBHCs and any designated collaborating organization (DCO) established to strengthen Indiana’s care delivery system.



4. **Establish a CCBHC prospective payment methodology.** Reflect the anticipated costs of care delivery of mental health and substance use services by having behavioral health providers conduct a cost report based off Indiana’s criteria and their own community needs. This payment methodology allows Indiana providers to function as a competitive business to retain and recruit a workforce. The state will also create a mechanism for quality bonus payments.



5. **Develop data collection and reporting capacities.** Streamline mental health and substance use metrics at the CCBHC level to ensure state and county officials are supported in respective efforts. Identify key health information technology needs for clinics and statewide actors to expedite quality assurance, data transparency and compliance with the CCBHC model and Indiana policies.



6. **Apply for the CCBHC Planning Grant or a State Plan Amendment (SPA).** Address budgetary consideration both in and outside of Medicaid by assessing the costs of CCBHC implementation over time. The number of certifiable CCBHCs and the Indiana-specific services to be bundled into clinics’ rates will help identify a return of the investment of the CCBHC model.

While these steps are laid out sequentially, many of these actions can and should take place concurrently. In fact, the initial step should be applying for a CCBHC State Planning Grant to join the CCBHC

demonstration with applications due December 19, 2022. DMHA, the Indiana Council, and other leaders have already taken key steps to maintain momentum behind the CCBHC model. Detailed explanations of each of these six tasks are provided in the body of this report. Should Indiana receive a CCBHC state planning grant from SAMHSA, it will have the opportunity to apply to participate in the CCBHC Medicaid Demonstration in March 2024, with selection of the next cohort of demonstration sites anticipated prior to July 2024. Meanwhile, the state can continue its planning for implementation and launch of the CCBHC initiative as outlined in state law.

## CCBHC Timeline for Indiana

Flexibility may be available with both Medicaid Demonstration and SPA





passed legislation or appropriated funds to support the advancement of the CCBHC model at the state level: Alabama, Georgia, Idaho, Illinois, Kansas, Maine, Montana, New Hampshire, North Carolina, Rhode Island, Texas, Vermont, Washington, and West Virginia. Including clinic-specific SAMHSA grants, CCBHCs exist in 46 states, District of Columbia, Guam, and Puerto Rico.

With the extreme need for integrated mental health and substance use services nationwide, the CCBHC model has impressive state-level outcome data:

- Oklahoma’s CCBHC model brought in nearly 1,000 new jobs to health care with **an economic impact of \$35 million dollars and a reduction in unemployment**. The decreases in inpatient hospitalizations **saved more than \$62 million statewide**.<sup>4</sup>
- **Missouri’s CCBHC model increased access to care by 35 percent**, serving over 40,000 more Missourians. The state **doubled its behavioral health provider workforce** with positions such as peer specialists and prescribers (e.g., physician assistants). In a 5-year review of the general budget, **the state identified \$15.4 million in savings** due to the CCBHC model, including a per-person savings of \$484.<sup>5</sup>
- In New York, **Medicaid clients served increased by 21 percent** in the first year. One out of four of those Medicaid-enrolled clients had not received a behavioral health service in the prior three years – an indication of CCBHCs’ role in meeting previously unmet needs. New York also saw a **61 percent decrease in the number of clients using general hospital inpatient services** and a **54 percent decrease in all-cause readmissions**.<sup>6</sup>

Given the momentum at the state level and the impressive outcomes of the current demonstration states, Congress passed the Bipartisan Safer Communities Act which expands the CCBHC program to allow any state the opportunity to apply to participate in the CCBHC Medicaid demonstration, while allocating additional planning grant monies for states to develop proposals to participate. Specifically, starting in July 2024, and every 2 two years thereafter, 10 additional states will be selected by Department of Health and Human Services (HHS) to join the demonstration. While states have the option to pursue an independent path for CCBHC, the state would forgo the enhanced Medicaid match (equivalent to the state’s CHIP rate) that has supported current demonstration states in their successes. With Indiana required by state law to implement the CCBHC model, participating in the CCBHC Medicaid demonstration would offer a federal matching rate that is 8.44 percentage points higher than the state’s standard FMAP, providing more funds to its Medicaid budget without any additional state costs other than those that would be incurred regardless for the CCBHC implementation. The CCBHC Demonstration provides the State of Indiana with the opportunity to see savings to the state Medicaid budget through reduction in high cost service utilization such as emergency department visits, inpatient hospital services, and readmissions.<sup>7</sup> States similar to Indiana have been savings in their justice, education, and housing sectors as well creating a return on investment in general revenue statewide.

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<sup>4</sup> Commissioner Carrie Slatton-Hodges, Oklahoma Department of Mental Health and Substance Abuse Services. Cited <https://allianceok.com/2021/11/29/ccbhc-oklahoma/>

<sup>5</sup> Missouri Behavioral Health Council (2022). CCBHC: Missouri’s Impact Report - Year 5. <https://www.mobhc.org/uploads/Missouri-CCBHC-Infograph-Year-5-Impact-2022.pdf>

<sup>6</sup> National Council (2021). CCBHC State Impact Report: Transforming State Behavioral Health Systems. <https://www.thenationalcouncil.org/wp-content/uploads/2022/02/Transforming-State-Behavioral-Health-Systems.pdf>

<sup>7</sup> Data gathered from Kaiser Family Foundation on CHIP rate (<https://www.kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>) and Medicaid FMAP rates (<https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>)

This following plan outlines key state activities that are central to a successful planning and implementation process, based on the experiences of states that have been through the CCBHC planning process, have obtained CMS approval for CCBHC Medicaid demonstration or SPA, and have a strong knowledge of the model from working with their CCBHC grantees and associations. This document does not constitute official SAMHSA or CMS guidance and should not be interpreted as a guaranteed mechanism to secure the CCBHC Medicaid Demonstration, SPA or waiver approval. States are encouraged to consult with SAMHSA and CMS with any programmatic or process questions. The purpose of this document is a plan is to lay a foundational roadmap for Indiana leadership to support their decisions relating to the CCBHC model.

# A Plan for Indiana to Expand the Use of CCBHCs

Following is a summary of key activities for Indiana to increase access to sustainably-financed, integrated behavioral health care through CCBHCs. These recommendations are built to support the 18-month training and education sessions to be conducted by National Council with Indiana CCBHCs, the Indiana Council, key stakeholders, and state agency officials. This work will focus on Indiana-specific opportunities and goals within the framework established by SAMHSA, CMS, and Indiana leaders. This framework includes criteria across six domains:<sup>8</sup> 1) Staffing, 2) Availability and accessibility of services, 3) Care coordination, 4) Scope of services, 5) Quality and other reporting, and 6) Organizational authority, governance, and accreditation, along with a prospective payment system established within Medicaid for CCBHCs.

These criteria and other baseline requirements from SAMHSA and CMS are embedded throughout this report with recommendations on how Indiana may build off this foundation to tailor the model to the state's mental health, substance use, and overall public health needs.<sup>9</sup>



## Establish Indiana-specific CCBHC goals

The Indiana Governor's Public Health Commission released a report<sup>10</sup> with statewide goals across the public health spectrum. In October 2022, the legislatively-created Indiana Behavioral Health Commission released its own report<sup>11</sup> with recommendations and goal for the state to achieve through the implementation of a series of efforts, including establishing the CCBHC model. Transitioning to the CCBHC model will help Indiana meet the goals of both of these reports.

Of the states publicly assessing the CCBHC model, Indiana has been one of the most proactive in convening key stakeholders to begin discussions on how to establish a CCBHC program that meets the required criteria while aligning with the specific needs of Hoosiers. To continue that momentum, National Council with the support of DMHA, recommends the following steps:

- **Establish a shared understanding of state agency roles and responsibilities**
- **Form an internal planning team**
- **Form a stakeholder advisory committee**
- **Articulate CCBHC goals and timelines**

**Establish a Shared Understanding of State Agency Roles and Responsibilities:** Within the CCBHC framework set forward by SAMHSA and CMS, states have significant leeway to tailor the model to their own needs and aims. State implementation of CCBHCs requires collaboration across state Medicaid and behavioral health agencies, with each playing complementary important roles. One early decision for Indiana will be to

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<sup>8</sup> Substance Abuse and Mental Health Services Administration (SAMHSA). (2016). Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics. Retrieved from [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/ccbhc-criteria.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf)

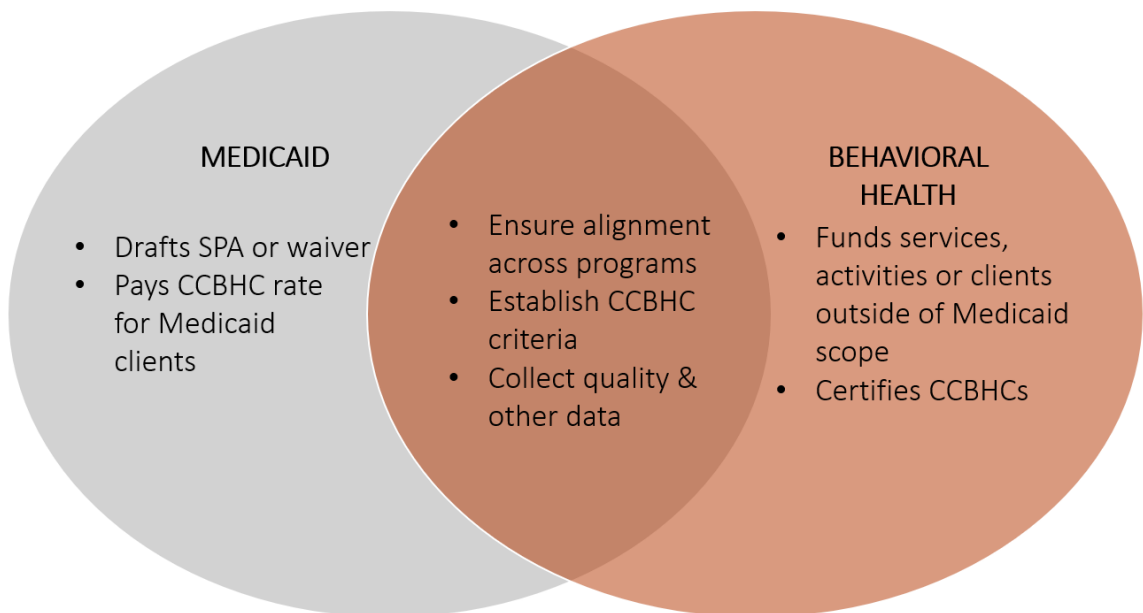
<sup>9</sup> SAMHSA. (2015). Planning Grants for Certified Community Behavioral Health Clinics. Retrieved from <https://www.samhsa.gov/sites/default/files/grants/pdf/sm-16-001.pdf#page=94>

<sup>10</sup> Indiana Governor's Public Health Commission. (2022). Report to the Governor in fulfillment of Executive Order 21-21. <https://www.in.gov/health/files/GPHC-Report-FINAL-2022-08-01.pdf>

<sup>11</sup> Indiana Behavioral Health Commission. (2022). Final Report. <https://www.in.gov/fssa/dmha/files/INBHC-Report.pdf>



delineate areas of individual and joint responsibility between DMHA and Indiana Medicaid as part of FSSA. While these decisions may be different in each state based on its own unique structures, areas of responsibility in Medicaid demonstration, areas of responsibility in other states have generally fallen as described in the following diagram. Indiana’s collaborative activities and structure may align with what has proven successful in other states or may be amended based off state-specific needs.



**Form an Internal Planning Team:** To ensure that CCBHC stakeholders are supported with a shared vision and strategic partners are included in planning within government and in the community, Indiana should **identify an internal planning team** to establish clear expectations, goals, and leadership. Individuals on the team will be tasked with leading the planning and implementation of the CCBHC initiative. This team may be primarily, if not entirely, government officials as key component to the success of the CCBHC model is integrated efforts within government as well as within community care delivery. **At a minimum, this team include staff representatives from the Indiana Division of Mental Health and Addiction (DMHA), Indiana Medicaid (OMPP), Indiana Department of Children Services (DCS), and the Indiana Department of Health (IDOH) among others.** The team may also consider including representatives from other relevant agencies, such as the departments reflecting justice sectors, education, housing, and others. We recommend the inclusion of both policy and fiscal or budget staff to ensure alignment between programmatic operations and financing within the internal planning team or other appropriate agency representatives may wish to establish a clear process for maintaining regular contact with key state legislative committees with oversight over health care and appropriations to coordinate around needed funding or any state statutory changes that may arise from CCBHC implementation.

**Form a Stakeholder Advisory Committee:** The National Council recommends that the internal planning team establish formal mechanisms for participation and input by an **advisory or steering committee** made up of external stakeholders, to build buy-in and ensure the program design will work as intended for CCBHCs, individuals they serve, and their partner organizations. **Members of the Behavioral Health Commission may be ideal leaders within this stakeholder advisory committee.** Recommended participants

may include (but are not limited to) prospective CCBHCs, state associations of behavioral health services, service recipients (i.e., consumers, families), CCBHC partner organizations (e.g. children’s service providers, FQHCs, and non-health partners such as schools, shelters, and courts), tribal organizations, advocacy organizations (e.g., peer, provider, and family support groups) and other key stakeholders to guide and provide input throughout the planning and implementation process. Indiana’s leadership is specifically invested in the lived experience of clients and their families, such as the members of the Indiana chapters of the National Alliance for Mental Illness and the Indiana Recovery Network. At a minimum, advisory group activities should begin with a process of establishing clarity on participants’ roles, responsibilities, and expectations. To ensure equity and inclusion in the formation of the advisory group, the National Council strongly recommends that states prioritize underserved populations as well as breadth of stakeholder groups from across the spectrum of health needs intended to be addressed by the CCBHC initiative.

**DMHA Proposed Governance Structure:** Based on the recommendations from the National Council, DMHA is developing a governance structure to manage the CCBHC initiative as preparations are made to apply for the CCBHC State Planning Grant. The current structure proposes a CCBHC Internal Planning Team to drive the initiative and manage the project through at least five workgroups, while supported by a Stakeholder Advisory Committee and a State Steering Committee. The Stakeholder Advisory Committee will guide at least two advisory groups of external stakeholders from across the 92 counties of the state to provide report outs based on stakeholder’s input and guide the initiative. The State Steering Committee is proposed to be made up of key State leadership executives from FSSA, IDOH, DCS, Court Services, and the Governor’s office. The State Steering Committee will receive report outs from the CCBHC Internal Planning Team, provide guidance on the initiative, and strategic support as needed. DMHA’s proposed governance structure is visualized on Appendix E.

**Articulate CCBHC Goals and Timelines:** The National Council recommends that the early phases of the internal planning team’s and advisory committee’s work include a clear articulation of goals and timelines for the CCBHC initiative in Indiana. These goals may be informed by the results of the community needs assessment and input from the advisory committee. This process may also include identification of any targeted underserved populations whose needs will be spotlighted in CCBHC program design and quality reporting activities. This process will support subsequent conversations on what CCBHC service requirements, payment structures and data collection activities will be needed to incentivize, support and track progress toward these goals.

Both the Governor’s Public Health Commission (GPHC) and the Indiana Behavioral Health Commission (IBHC) identified a series of recommended focus areas, which the CCBHC model will be able to support when implemented to fidelity. Here is a truncated, combined look at these reports’ recommendations and where the CCBHC model can support achieving these goals:

Snapshot: Governor’s Report & IBHC Combined Recommendations	CCBHC Requirements and Proven Successes to Achieve the Recommendations
Build a sustainable infrastructure, including crisis response with 988 hotlines ( <i>IBHC recommendation and HB 1222 legislation requirement</i> ), with baseline local-level standards for quality care ( <i>GPHC recommendation</i> )	CCBHCs have a national standard definition, including quality metrics, that is built upon by state- and local-level needs. CCBHC is required to provide 24/7 mobile crisis response and the CCBHC may include 988 alignment costs and services where Medicaid allows

Improve overall Hoosier Mental Wellbeing, particularly children and adolescents ( <i>as identified by GPHC</i> ) and those currently, previously, or potentially involved with the justice systems ( <i>IBHC recommendation</i> )	CCBHCs must partner with school and justice settings as well as other pillars in the community for care coordination. Data tracking of care delivery helps to show the effects of population health improvements
Strengthen Indiana’s workforce by streamlining licensure requirements for facilities and providers ( <i>IBHC recommendation</i> ) and leveraging technology and data to alleviate workforce burdens ( <i>GPHC recommendation</i> )	CCBHCs’ site-specific reimbursement rates allow them to function more like a proper business, including ways to support recruitment and staff retention, ensuring technology supports what the state needs and provides timely access and information
Maximize federal public health dollars to ensure retention and recruitment of high-performing staff and other key community needs so appropriated state funds can strengthen and improve where necessary, similar to Missouri’s CCBHC efforts ( <i>GPHC/IBHC</i> )	CCBHC grantees provide a steppingstone for local and state government to understand impacts of the CCBHC model as they develop the CCBHC PPS rate. Where Medicaid dollars may not be used, state funds can support implementation and delivery of services and programs

**At a high level, Indiana’s primary goal is to increase access to care across the state. The CCBHC model requires access within 10 days of need, with more immediate access in moments of crisis or urgent care.** The state may also determine a timeline for the activities outlined in this roadmap document, including those that will be completed prior to the CCBHC Medicaid demonstration, SPA, or waiver submission. Timelines for the CCBHC Medicaid demonstration are already established, but additional state-specific benchmarks and milestones should be established with a mind toward state budget cycles and the need for any appropriated funding from the Indiana state legislature. Identifying individuals or offices responsible for carrying out the activities ensures buy-in and establishes accountability as well. The CCBHC Medicaid Demonstration has specific timelines in place to establish the model at the state level.

Improving access to high-quality mental health and substance use care across the State of Indiana is the north star for the CCBHC model in the state. Additional goals can and should be considered, after robust stakeholder engagement efforts, by the Indiana CCBHC advisory committee and internal state agency planning team. These goals could include:

- Improve high-quality mental health and substance use services for children and youth and embed those services in areas where other youth-focused programs are working; improve integration and coordination of services across behavioral health providers and other child-serving systems.
- Ensure services for individuals with co-occurring intellectual developmental disabilities (IDD) and mental health or substance use conditions are coordinated or co-located.
- Strengthen care for people with any substance use disorder (e.g., tobacco, alcohol, opioids, and stimulants) with services to treat the condition(s) such as medication-assisted treatment (MAT) and to reduce the risk of overdose and death.
- Ensure services are coordinated and integrated across delivery sites and systems (e.g., Behavioral Health Homes, FQHCs, and other SAMHSA- or state-funded grants) by establishing CCBHC partnership requirements, service delivery requirements, quality reporting metrics, and/or incentive payments around key areas where system gaps or fragmentation currently exist.

- Deflect and divert justice-involved persons with mental health and substance use conditions to treatment and other social services in lieu of an arrest, charge, or incarceration, where appropriate.
- Align the CCBHC model with federally-mandated efforts to establish 988 as a crisis hotline for mental health and substance use emergencies and with other telehealth services.
- Create community-based partnerships through the designated collaborating organization (DCO) component of the CCBHC model with state-funded Medicaid providers as well as other partnership types with non-Medicaid entities (e.g., schools, shelters, recovery centers).
- Produce Medicaid and non-Medicaid savings by adopting a CCBHC Prospective Payment System (PPS) reimbursement system that enables CCBHCs help the state recoup the cost of diverting individuals from more expensive levels of care with same-day access, outreach and engagement of individuals with behavioral health issues inappropriately accessing emergency room services, and individuals tying up law enforcement resources

Increased access to care, along with the other identified goals, will help realize Indiana’s vision for a system that will:

1. Ensure complete transparency into the effectiveness of the behavioral health system;
2. Strengthen the whole ecosystem by linking behavioral health care with other community pillars such as education, justice, and housing systems; and
3. Build tailored treatment pathways for individuals, rather than fit complex individuals into a one-size fits all approach

The following are examples from other CCBHC Medicaid demonstration states where this aspect of the model has fully connected mental health and substance use care delivery systems and the culture of care around them.

- **Ensure Complete Transparency:** Quality Bonus Payments (QBP) can not only provide assurance to the state that high-quality care is being delivered, but it can also provide a baseline of understanding to establish what that bonus should look like for future years. In Nevada, the QBP was provided when clinic submitted all data on state-identified metrics. Those data were then used to create a benchmark for progress in the second year.<sup>12</sup> (Note that Indiana has the benefit of pre-existing CCBHC grantees that could help in providing that benchmark for quality should the state convert to a CCBHC model statewide.) Nevada stakeholders shared that the quality metrics identified that children and youth were a population that substantially increased in access to treatment.<sup>13</sup>

The costs of strengthening data tracking can be built into the model. Minnesota used CMS-optional measure Screening for Clinical Depression and Follow-Up Plan (CDF-A) in determining QBPs, and New York added two state-specific measures based on state data regarding suicide attempts and deaths from suicide. Additional measure that are unique to Indiana’s population needs may be added to ensure the financial investments from the state achieve their appropriate return in health outcomes and potentially costs.<sup>14</sup>

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<sup>12</sup> Department of Health and Human Services, Assistant Secretary for Planning and Evaluation. (2020). Preliminary Cost and Quality Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration. Retrieved from <https://aspe.hhs.gov/system/files/pdf/263976/CCBHCPreCost.pdf>

<sup>13</sup> National Council for Mental Wellbeing. (2020). Behavioral Health Commissioners’ Summit.

<sup>14</sup> Ibid.

- **Strengthen the Whole Ecosystem:** Criminal justice systems involve multiple divisions from police to sheriffs to judges that are too often disconnected, especially with the mental health and substance use sector. The State of Missouri linked several behavioral health focused efforts within its criminal justice system (from crisis care to mental health court liaisons) into its CCBHCs. In doing so, they were able to decrease justice involvement for CCBHC clients by 55% in first year of the model.<sup>15</sup>

Half (51%) of CCBHCs added crisis behavioral health services within the first year of the demonstration, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.<sup>16</sup> Prior to CCBHC, a clinic may be unaware of a client’s contact with crisis systems. **With the CCBHC’s connection to emergency medical records (EMRs) and ties to 988,<sup>17</sup> the new national mental health and substance use hotline, these tracking systems will be in place to better support the client and track outcomes for the CCBHC.** According to the Group for the Advancement of Psychiatry, an ideal crisis system should have providers notified of a client’s crisis at least 90 percent of the time.<sup>18</sup> This goal can be achieved with the CCBHC model.

- **Tailored Treatment Pathways:** In addressing needs for children and youth, the CCBHC model provides the opportunity to embed staff within schools to coordinate care through the education system (with parental consent). The State of New York not only found success here for mental health and substance use service for youth by increasing access by 24 percent statewide, but with their children receiving care at the CCBHC, parents and caregivers began treatment too.<sup>19</sup>

In Missouri, the CCBHC model was built into the pre-existing Health Home infrastructure as a whole person (i.e., patient-centered) care. Within one year of CCBHC model, the state saw 10 percent decrease in cholesterol equating to a 10 percent decrease in cardiovascular disease; a 6 mm/Hg reduction in blood pressure aligning with a 42 percent decrease in stroke; and a 1-point reduction in HgbA1c, which connect to a 21 percent reduction in diabetes deaths, 14 percent reduction in heart attacks, and a 37 percent reduction in microvascular complications.<sup>20</sup>

Examples of the CCBHC model working toward these goals exist throughout the Medicaid demonstration. Part of the model’s success arises from CCBHCs’ ability to provide care outside of the clinics’ walls. Data from the Department of Health and Human Services (see chart below) shows how CCBHCs have embedded services into multiple settings to deliver care and meet people where they are.<sup>21</sup> The availability of

<sup>15</sup> Missouri Coalition for Community Behavioral Healthcare (2019) CCBHC. Retrieved from [https://41e56e24-d282-42b5-b0f1-f16abf1bc04b.filesusr.com/ugd/6dadf9\\_540312935fa045658f3271e488ca8ee4.pdf](https://41e56e24-d282-42b5-b0f1-f16abf1bc04b.filesusr.com/ugd/6dadf9_540312935fa045658f3271e488ca8ee4.pdf)

<sup>16</sup> US Department of Health and Human Services. 2020. Preliminary Cost and Quality Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration. Available online at: <https://aspe.hhs.gov/system/files/pdf/263976/CCBHCPreCost.pdf>

<sup>17</sup> Federal legislation (National Suicide Prevention Hotline Improvement Act) passed in the Summer of 2020 has led to the initiation of implementation of a national suicide prevention and behavioral health crisis line number – 988 – that is intended to go live in every state by July 2022. This major initiative provides an opportunity for the creation of high-quality community crisis response systems that approximate the level of response that we have grown to expect from medical, fire and public safety emergency response since the implementation of 911 several decades ago.

<sup>18</sup> Group for the Advancement of Psychiatry (2021). Roadmap to the Ideal Crisis System. [https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121\\_GAP\\_Crisis-Report\\_Final.pdf?daf=375ateTbd56](https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56)

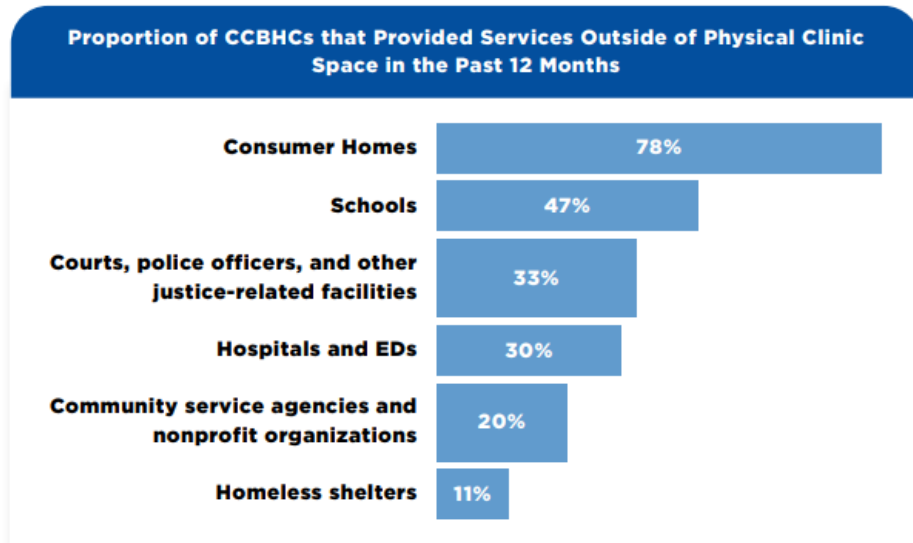
<sup>19</sup> National Council for Mental Wellbeing. (2020). Behavioral Health Commissioners’ Summit.

<sup>20</sup> Missouri Coalition for Community Behavioral Healthcare (2015). Missouri Community Behavioral Health Clinics – Integrated Care Model. [https://knowledgecenter.csg.org/kc/system/files/McGinty\\_June29%20PDF.pdf](https://knowledgecenter.csg.org/kc/system/files/McGinty_June29%20PDF.pdf)

<sup>21</sup> RAND Corporation. (2016). Evaluation Design Recommendations for the Certified Community Behavioral Health Clinic Demonstration Program. Retrieved from [https://www.rand.org/pubs/research\\_reports/RR1439.html](https://www.rand.org/pubs/research_reports/RR1439.html)

community-based services is a major component of the CCBHC model that ensures there is “no wrong door” to care.

From its standards and ability to provide care where necessary to the payment structure that supports innovation and coordination in care delivery, CCBHC can support states in achieving their goals in mental health, substance use, and primary care as well as the co-occurring social issues such as housing supports that are needed within communities nationwide.





## Conduct a community needs assessment

To identify ways in which the CCBHC model can align with and advance other state-driven efforts to address behavioral health needs and gaps, the National Council recommends that Indiana:

- **Conduct a community needs assessment, or utilize the findings from current work**
- **Conduct clinic-level readiness assessments, or utilize the findings from current work**
- **Align planning activities with existing state efforts across relevant agencies**

**Conduct a Community Needs Assessment:** A statewide population needs assessment for Indiana is the first step to identifying geographic and population gaps in service that the CCBHC model would seek to fill. This needs assessment will inform final decisions about service area coverage goals, certification criteria and a staffing plan for CCBHCs across the state. The process may include outreach, recruitment, and engagement of the population of focus including adults with serious mental illness and children with serious emotional disturbances and their families, and those with long term and serious substance use disorders, as well as others with dual mental illness and substance use disorders in the solicitation of input. Direct conversations with stakeholders are important, but public and private data analyses may also assist with this task. SAMHSA has provided resources<sup>22</sup> for states on conducting a community needs assessment.

**Conduct Clinic-level Readiness Assessments informed by the CMHC Assessment Project:** DMHA is currently conducting a broad and deep assessment of the CMHC system. This assessment will yield valuable information on the degree to which Indiana clinics are ready to expand services or activities and potentially acquire state certifications or licenses; how prepared the clinic is to integrate care; how prepared they are to develop a cost report; the degree to which their electronic health record (EHR) and other information technology (IT) systems are equipped to accommodate CCBHC billing, data collection, integration and care coordination; and other important readiness factors. The readiness assessment can also inform the state as to what types of technical assistance and training activities it will need to conduct with prospective CCBHCs and to plan for any state staff resources or external support needs in providing this technical assistance.

DMHA should also maximize use of the information that the CCBHC expansion grantees are required to track, including an attestation that the awardees are able to comply with CCBHC criteria. The CMHC Assessment Project and Expansion Grantee data will provide a significant springboard to launch a comprehensive, clinic-level readiness assessment.

**Align Planning Activities with Existing State Efforts Across Relevant Agencies:** The National Council recommends that Indiana also conduct an environmental scan of current policies and activities (e.g., grants, waivers, legislation) to determine where the CCBHC initiative can build on, supplement, or coordinate with existing efforts. A high-level review of the state's Medicaid plan, facility licensure for safety-net providers, and current waivers indicates that many of the CCBHC criteria are addressed in various parts of the state plan or licensure requirements. Further analysis will be required to determine where there are any gaps and determine the best structure and processes for ascertaining clinics' compliance with all criteria.

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<sup>22</sup> SAMHSA. (2020). How States Can Conduct a Needs Assessment. Retrieved from <https://www.samhsa.gov/section-223/certification-resource-guides/conduct-needs-assessment>

Moreover, the CCBHC Medicaid demonstration may allow for more flexibilities with the state’s current policies to support implementation.



**Alignment with 988, Mobile Crisis Response, and CCBHC:** Perhaps the single biggest area to ensure alignment with is Indiana’s 988/Crisis response planning efforts. CCBHCs can be a crucial partner in a comprehensive crisis response system. In states with a CCBHC PPS in place, if the CCBHC provides crisis services directly or contracts with another organization (e.g., a state-sanctioned crisis division) to provide 24/7/365 mobile crisis team services, states can work with CMS to understand how to properly segregate and claim eligible expenditures to secure the appropriate enhanced match for CCBHCs’ mobile crisis services (including relevant technologies, overhead, and staffing per CMS guidelines). Clinics can embed staff into law enforcement settings,

911 call centers and in spaces where 988 hotlines happen. The infographic above outlines the aligned common goal of both 988 and 911 efforts for persons with mental health or substance use needs.

States can use the CCBHC cost reporting process—in which CCBHCs clearly delineate their direct and indirect expenditures, with state review and approval—to ensure transparency around CCBHCs’ anticipated costs associated with crisis response services, crisis stabilization services, and referral coordination. The State of Michigan’s CCBHC handbook<sup>23</sup> identifies the Michigan Crisis Action Line (MiCAL) as a required evidence-based program as well as component of other criteria. This hotline was established prior to the creation of 988, but may prove to be a good reference for Indiana as it begins implementation. DMHA’s CCBHC and 988 teams have collaborated to align the initiatives and identified that CCBHCs will be required to link with the 988 center software for centralized mobile crisis dispatch, scheduling outpatient appointments, and helping develop a crisis receiving and stabilization services bed/chair registry. In establishing CCBHC and 988 partnerships, there are two roles that the CCBHC can complement the 988 initiatives:

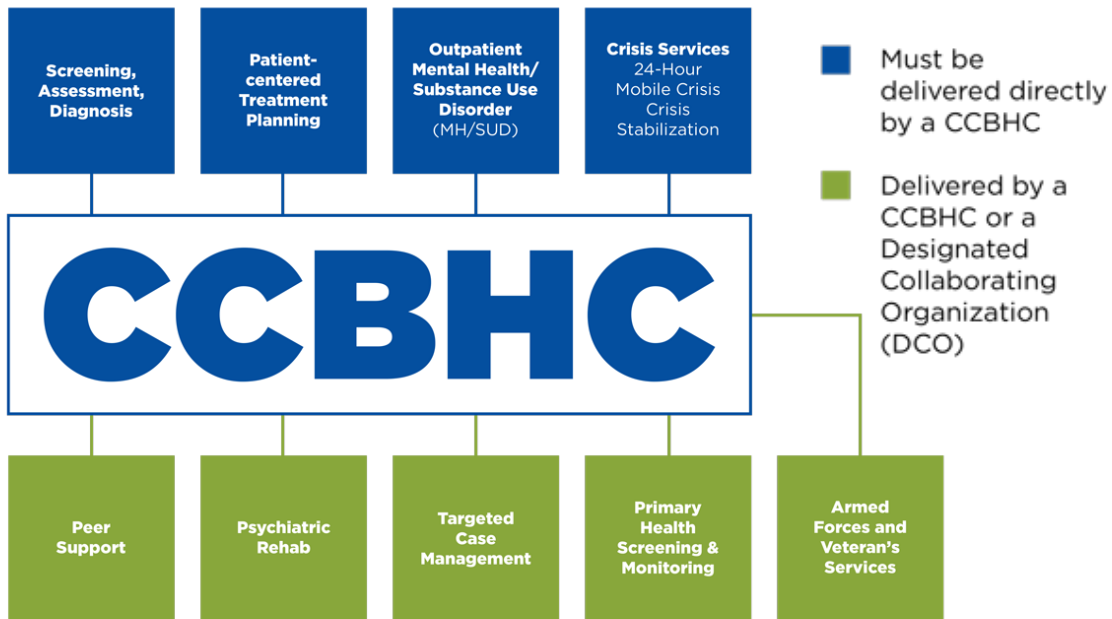
- **CCBHCs as Immediate Care Providers:** CCBHCs can serve as partners to 988 call centers for direct services the call centers don’t directly provide (mobile crisis response, crisis stabilization, etc.)
- **CCBHCs as Referral Partners:** For post-crisis and/or non-urgent needs: CCBHCs can serve as referral partners to 988 call centers and other crisis responders.

**Designated collaborating organizations:** A potential opportunity for Indiana in producing a greater level of integration and coordination across systems is the “Designated Collaborating Organization” (DCO) construct in the CCBHC model. DCOs deliver required services that are not directly provided by the CCBHC, while meeting the same requirements as a CCBHC in terms of cultural competency, non-refusal of services due to inability to pay, and criteria set both by the federal government and by Indiana. These relationships are different from care coordination or other agreements in that the DCO operates essentially as an arm of the CCBHC, has a financial relationship in place with the CCBHC, and must take part in a higher level of information-sharing and collaborative care delivery than might be done under a simple care coordination agreement. When implemented well, the structure of the DCO has the potential to benefit all parties.

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<sup>23</sup> MI Certified Community Behavioral Health Clinic (CCBHC) Handbook Version 1.4. [https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder4/Folder43/Folder3/Folder143/Folder2/Folder243/Folder1/Folder343/CCBHC\\_Demonstration\\_Handbook.pdf?rev=7691cc9d92f2414e97bf727d5a950d67](https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder4/Folder43/Folder3/Folder143/Folder2/Folder243/Folder1/Folder343/CCBHC_Demonstration_Handbook.pdf?rev=7691cc9d92f2414e97bf727d5a950d67)





Planning teams and steering committees for the CCBHC model in Indiana may consider where any existing state programs and expenditures may be incorporated into the CCBHC initiative, either as DCOs or care coordination partners (and thus included in the CCBHC payment model), where requirements for partnership between CCBHCs and other entities will be put in place, and what kind of data collection might be needed to demonstrate CCBHC impact across multiple fields (e.g., criminal justice, school, and broader welfare systems). In Fall 2022, Rhode Island provided an opportunity for funding for DCOs to support their planning and partnerships with CCBHCs. Processes may be put in place to ensure coordination with Indiana leaders to ensure that services are accessible, available, and aligned with any existing efforts. When goals and needs are identified broadly, similar governmental supports could prove beneficial to the DCO-CCBHC partnerships. Any policies that may present a barrier to CCBHC implementation, including those DCO partnerships, may also be identified at this time and the planning group may develop recommendations for any needed policy changes.



## Craft CCBHC certification criteria for Indiana

Using the federal criteria as a foundation, Indiana leaders will want to establish CCBHC certification criteria that are tailored to their communities’ needs. Steps to create CCBHC certification include:

- Review and identify areas of state discretion
- Finalize state-specific CCBHC certification criteria
- Certify clinics

**Review and Identify Areas of State Discretion:** Within the federal CCBHC framework, SAMHSA has outlined multiple areas of discretion for states to tailor the CCBHC criteria to their own needs.<sup>24</sup> States implementing CCBHCs outside of the Medicaid CCBHC demonstration have even greater flexibility to customize the model; however, the National Council advises states to adhere relatively closely to the federal framework to reap the benefits of this proven model. States whose programs depart from the federal criteria would not be able to participate in the Medicaid demonstration. Areas of state discretion identified by SAMHSA are listed in Appendix A.

**Finalize State-specific CCBHC Certification Criteria:** Based on the results of the community needs assessment and with input from the advisory committee, Indiana may finalize its CCBHC certification criteria. The final certification requirements may articulate required state-defined evidence-based practices, staffing plans, cultural competency requirements, and other elements indicated by SAMHSA.

The Indiana Behavioral Health Commission recommended CCBHC implementation be similar to the implementation of Missouri’s CCBHC model. With the six CCBHC criteria, here are examples of where Missouri was innovative in its efforts establish the CCBHC model to its state’s needs.

CCBHC Criteria	CCBHC Implementation in Missouri
Staffing	Prior to CCBHC implementation, the state funded Community Mental Health Liaisons who support coordinated care with justice sectors. With CCBHC, the state built in the costs of those staff and their technology needs into CCBHC PPS which generated a federal Medicaid match, creating cost savings for the state and allowing for statewide expansion. In the first year of the CCBHC demonstration, Missouri law enforcement had a 55 percent decrease in engagement with persons with a behavioral health condition. <sup>25</sup> Recent data show a year over year impact with 2022 showing a 41 percent increase in deflection and diversion. <sup>26</sup>
Availability and Accessibility of Services	The CCBHC model in Missouri increased access to care by 35 percent, <sup>27</sup> which is more than the national average of CCBHCs with a PPS. The state accomplished this work by both ensuring crisis care was part of the CCBHC bundled payment as well as embedding staff in care settings for urgent or crisis needs such as emergency departments.

<sup>24</sup> SAMHSA. (n.d.) Areas of State Discretion in the CCBHC Criteria. Retrieved from <https://www.samhsa.gov/sites/default/files/state-discretion-ccbhc-criteria.pdf>

<sup>25</sup> National Council. (2021). Certified Community Behavioral Health Clinics and the Justice Systems. <https://www.thenationalcouncil.org/wp-content/uploads/2022/02/2021-CCBHC-and-Justice-Systems-Report.pdf>

<sup>26</sup> Missouri Behavioral Health Council. (2022). Missouri’s Impact Report – Year 5. [https://www.mobhc.org/uploads/Missouri-CCBHC-Infograph\\_Year-5-Impact\\_2022.pdf](https://www.mobhc.org/uploads/Missouri-CCBHC-Infograph_Year-5-Impact_2022.pdf)

<sup>27</sup> Ibid.

<p style="text-align: center;"><b>Care Coordination</b></p>	<p>Many Missouri CCBHCs embed both staff and technology in the child welfare systems such as the foster care system as well as in schools – from elementary to community colleges – to provide timely services as well as coordinate care when clinically appropriate. These efforts decreased the cost of “Medicaid for Children Poverty” a category the state identified by 56 percent and for Independent Foster Care for Children Ages 18 to 21 by 47 percent.<sup>28</sup></p>
<p style="text-align: center;"><b>Scope of Services</b></p>	<p>The state conducted a crosswalk of its CCBHC required services with its children, adult, and other service areas and identified what may constitute a reimbursable visit to help control cost and support quality care delivery. Moreover, the state supported partnerships where formal agreements may be more complex. An example may be veterans’ services, which over a 5-year timeframe, have increased 26 percent.</p>
<p style="text-align: center;"><b>Quality and Other Reporting</b></p>	<p>Behavioral Health Home, another integrated care model, used a state platform called <i>CareManager</i>, a product of Netsmart. In building the CCBHC model, the state used this same platform to expand its data and metric track capacities. To date, Missouri has some of the most robust, timely data of any CCBHC Medicaid Demonstration state.</p>
<p style="text-align: center;"><b>Organizational Authority, Accreditation, and Governance</b></p>	<p>The CCBHC model was built atop the Behavioral Health Home model in Missouri and managed through a state partnership with the Missouri Behavioral Health Council, the statewide outpatient behavioral health provider association. The association supports both clinics and the state in ensuring quality performance and information sharing, particularly as needs arise.</p>

**Certify CCBHCs:** The National Council recommends certifying no fewer than two CCBHCs that represent diverse geographic areas, including rural and underserved areas. States choosing to certify greater numbers of clinics will reap greater benefits from the initiative. Indiana may wish to provisionally certify clinics that do not yet meet all CCBHC criteria while making final certification contingent upon successful completion of any training or readiness activities described below. Given the timeline for grants to expire, Indiana may choose to prioritize current CCBHC grantees in their certification. Two items may take place concurrently in supporting the clinics and the state in this certification process:

1. **Establish a certification process and monitoring and compliance plan:** With input from prospective CCBHCs and the advisory committee, Indiana may establish procedures and necessary infrastructure to certify CCBHCs and ensure clinic compliance with certification criteria over time. States must provide guidance on which types of entities will be eligible to apply for CCBHC certification. The certification process may clarify what level of review state officials will exercise over DCO arrangements to ensure the full scope of CCBHC services are provided by the CCBHC and its DCOs and that DCOs meet applicable requirements.
2. **Provide technical assistance and training to clinics:** Indiana may assist clinics with meeting certification standards by facilitating access to training and technical assistance on topics such as:
  - Assessing gaps in staffing and services, building partnerships and formal relationships, implementing evidence-based practices with fidelity, care coordination, performance measurement and reporting, continuous quality improvement processes, and

<sup>28</sup> 2022. CCBHC State Learning Collaborative – Care Coordination toward Person- and Family-centered Care. National Council. August 15, 2022.

implementing and optimizing health information technology (HIT) infrastructure (e.g., telehealth, registries, or electronic health record functionality).

- Facilitating cultural, procedural, and organizational changes to CCBHCs that will result in the delivery of high quality, comprehensive, person-centered, and evidence-based services that are accessible to the target population.
- Assisting CCBHCs with improving the cultural diversity and competence of their workforces.
- Recruiting and training the workforce necessary to provide high quality services through CCBHCs.



## Establish a CCBHC prospective payment methodology

The PPS rate is the foundational element of the CCBHC model that differentiates it from other community mental health and substance use financing structures, primarily fee-for-service. To establish a PPS rate for Indiana CCBHCs:

- **Develop a PPS methodology, definitions, and quality bonus payments**
- **Work with CCBHCs to set first-year payment rates**
- **Establish new billing processes and provide technical assistance to CCBHCs**
- **Estimate costs and savings to the state and request the necessary state appropriations**

**Develop a PPS Methodology, Definitions, and Quality Bonus Payments:** The CCBHC PPS guidance outlined by CMS provides a sustainable, cost-related payment mechanism with opportunities for states to build in additional value-based payment elements such as quality bonus payments. DMHA also endorses this approach as the PPS rate would provide a mechanism to alleviate the current barriers with the current behavioral health and addiction payment methodology in place today, by addressing the costs involved with providing services required by the CCBHC certification developed by Indiana. DMHA also endorses the PPS payment methodology due to the CCBHC criteria requirement for each CCBHC to update their needs assessment and staffing plan no less frequently than every three years. In establishing its PPS, Indiana may solicit input from prospective CCBHCs and the advisory committee. PPS decisions the state must make include:

- Selecting either the PPS-1 (daily) or PPS-2 (monthly) methodology. In National Council-facilitated workgroup meetings, stakeholders expressed that a daily rate would likely be preferred. This also aligns with the current rate structure for Health Homes in Indiana. The internal planning team and advisory committee may discuss this approach and reach a final decision about which PPS approach will be used.
- Exploring whether and how to adapt Indiana's chosen PPS methodology in alignment with the state's goals for quality, outcomes, or value-based payment, including current efforts on the overdose crisis in the state and efforts to improve care for children and youth.
- Deciding how key elements of the Indiana PPS (e.g., what constitutes an encounter) will be defined. If Indiana were to select PPS-2, it must define the special population groups that will be used for rate determination.
- Establishing a process for cost reporting and rate setting, including developing a cost report format in accordance with CMS guidance<sup>29</sup> and instituting a review process for ensuring rates are actuarially sound.
- Selecting a methodology for making PPS payments when clinics are operating under Medicaid managed care. States have typically selected one of two options: requiring MCOs to pay the PPS rate to CCBHCs or allowing MCOs to contract with CCBHCs under usual rate methodologies and providing a periodic wraparound payment from the state to make up any difference between total payments and what the payments would have been under a PPS.

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<sup>29</sup> Medicaid.gov. (n.d.). Section 223 Demonstration Program to Improve Community Mental Health Services. Retrieved from <https://www.medicaid.gov/medicaid/financial-management/section-223-demonstration-program-improve-community-mental-health-services/index.html>

- Choosing whether to implement a quality bonus payment system (required for PPS-2, optional for PPS-1), what quality metrics and performance thresholds will be required for bonus payments to occur, the frequency with which bonus payments will be made, and the magnitude of those payments.
- Determining how rates will be updated from year to year, whether and with what frequency rebasing will occur, and a process by which CCBHCs that wish to modify their scope of work may file for a scope of service change and a new rate.

***Discussion of Upside and Downside Risk with CCBHC Payment Rates:*** The monthly PPS option combines upside opportunity and downside risk for providers, making it ideal for states wishing to incorporate both approaches into their value-based payment efforts. However, the monthly PPS option also introduces greater levels of complexity for both clinics and the state, especially in terms of clinical and fiscal reporting, and payment systems. Among the implications of this model:

- Providers experience substantially more downside risk than in a daily PPS model. Because rates are set based on anticipated monthly client volume, clinics experience a financial loss if costs or intensity of services during a month exceed targets—for example, if a patient experiences a crisis due to a poorly controlled condition.
- Clinics are incentivized to provide care efficiently while in alignment with the patient’s treatment plan. To effectively manage the financial risk associated with fixed monthly payments, clinics have an incentive to meet the goals and scope of the required patient-centered treatment plan as efficiently as possible. CCBHCs apply population health management approaches including risk stratification and utilization management to ensure each client receives appropriate care.
- States pay a rate aligned with the level of need for each population served. Rather than paying a fixed rate for all patients, states specify targeted subpopulations with higher rates reflecting their higher complexity, while paying a lower rate for the general population. States do not pay in a month when a client does not receive services.
- States can use differentiated rates to target services to specific difficult-to-serve populations. The stratified rate structure allows states to create higher rates for subpopulations with higher costs, incentivizing clinics to target care to those groups and resulting in decreased utilization elsewhere in the system.
- The monthly PPS requires quality bonus payments; however, states may also adopt quality bonus payments while using the daily PPS approach. State Medicaid agencies can select specific quality measures to incentivize with bonus payments.<sup>30</sup>
- Both provider and state information systems will likely require significant upgrades. For example, providers must be able to track and report changes in level of need to trigger appropriate invoicing, and both provider and state systems will require modification to be able to appropriately invoice for or pay distinct reimbursement rates for individuals in several target populations each month.

**Establish New Billing Processes and Provide Technical Assistance to CCBHCs:** Indiana must assess existing technologies and systems and make any upgrades needed to accommodate PPS billing by CCBHCs and

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<sup>30</sup> The National Council for Mental Wellbeing (2020). Certified Community Behavioral Health Clinics: A new type of prospective payment system. <https://www.thenationalcouncil.org/wp-content/uploads/2020/07/CCBHCs-A-New-Type-of-PPS-3-2-20.pdf?dof=375ateTbd56>

submission of claims to CMS. Clinics and managed care organizations (MCOs) may need support and technical assistance in updating their systems to support submission of claims to the state and collection of any information needed for oversight and monitoring purposes.

**Work with CCBHCs to Set first-year PPS Rates:** Once the PPS methodology has been set, CCBHCs will go through their first process of completing a cost report and working with their state to establish their first-year rates. After extended time in the CCBHC Demonstration (if selected), Indiana may wish to complete this process after approval of the SPA or waiver to ensure clinics are working within an approved methodology for setting first-year rates. Experience in CCBHC demonstration states suggests that CCBHCs that are unfamiliar with the practice of cost reporting may need significant technical assistance in understanding how to accurately complete the cost report.<sup>31</sup> The National Council encourages states to work collaboratively with CCBHCs to review the cost reports for reasonableness and establish clarity on assumptions going into the first-year rate (e.g., how quickly do clinics expect to hire up? How significantly are caseloads/encounters expected to increase and what is the expected complexity or severity of need among individuals who will be newly served?) Cost reports and proposed rates typically may go through actuarial review to ensure soundness.

**Estimate Costs and Savings to the State and Request the Necessary State Appropriations:** The interim cost and quality findings from the national evaluation of the CCBHC demonstration was released in December 2021 by ASPE indicating that while, in the first year of the demonstration (DY1) rates were higher than costs due to lack of historical data, this was corrected in year two with the gaps between rates and costs smaller in DY2 than they were in DY1<sup>32</sup>. Additionally, Missouri released recent findings of CCBHC pre and post period hospital costs finding a total of \$15.4 million in total savings, or \$483.67/person with more information detailed in the following chart.<sup>33</sup>

CCBHO client hospitalization costs by Medicaid eligibility code						
ME Code	CCBHO pre period hospital cost	CCBHO post period hospital cost	% change pre-post	cost per person pre	cost per person post	
13 - Medical Assistance - PTD	\$ 55,744,212.50	\$ 49,971,085.22	-10%	\$ 7,342.49	\$ 6,582.07	
<b>40 - Medicaid for Children Poverty</b>	<b>\$ 5,493,468.78</b>	<b>\$ 2,417,148.52</b>	<b>-56%</b>	<b>\$ 1,002.27</b>	<b>\$ 441.01</b>	
06 - Medical Assistance for Families (MAF)						
Child	\$ 2,235,670.04	\$ 1,375,147.46	-38%	\$ 633.87	\$ 389.89	
55 - QMB Only	\$ 4,826,718.94	\$ 2,420,778.08	-50%	\$ 1,846.49	\$ 926.08	
05 - Medical Assistance for Families (MAF)						
Adult	\$ 1,827,467.42	\$ 1,049,051.45	-43%	\$ 967.94	\$ 555.64	
11 - Medical Assistance - Old Age Assistance	\$ 4,933,752.54	\$ 4,521,261.98	-8%	\$ 3,181.01	\$ 2,915.06	
16 - Supplemental Nursing Care - PTD	\$ 6,198,612.29	\$ 5,200,642.89	-16%	\$ 6,636.63	\$ 5,568.14	
37 - HDN FS/Title XIX	\$ 6,089,557.94	\$ 8,399,780.10	38%	\$ 6,604.73	\$ 9,110.39	
56 - Title IV-E - Adoption Subsidy	\$ 2,971,496.32	\$ 4,031,430.92	36%	\$ 4,502.27	\$ 6,108.23	
<b>38 - Independent Foster Care Children Ages 18-21</b>	<b>\$ 3,841,908.43</b>	<b>\$ 2,047,821.04</b>	<b>-47%</b>	<b>\$ 11,008.33</b>	<b>\$ 5,867.68</b>	
All other codes	\$ 7,934,074	\$ 6,585,322	-17%	\$ 2,488.73	\$ 2,065.66	
	\$ 110,031,013.58	\$ 94,604,792.00	<b>-14%</b>	\$ 3,449.90	\$ 2,966.23	
		<b>\$ 15,426,221.58</b>			<b>\$ 483.67</b>	

<sup>31</sup> Department of Health and Human Services, Assistant Secretary for Planning and Evaluation. (2020). Preliminary Cost and Quality Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration. Retrieved from <https://aspe.hhs.gov/system/files/pdf/263976/CCBHCPreCost.pdf>

<sup>32</sup> Office of the Assistant Secretary for Planning and Evaluation and Office of Behavioral Health, Disability, and Aging Policy, Siegarth, A. W., Miller, R., Little, J., Brown, J., Case, C., Breslau, J., Dunbar, M., & Mathematica Policy Research. (2020). Implementation findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration. Washington, D.C.: U.S. Department of Health and Human Services. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm>

<sup>33</sup> Missouri Behavioral Health Council (2022). CCBHC: Missouri's Impact Report - Year 5. [https://www.mobhc.org/uploads/Missouri-CCBHC-Infograph\\_Year-5-Impact\\_2022.pdf](https://www.mobhc.org/uploads/Missouri-CCBHC-Infograph_Year-5-Impact_2022.pdf)

Indiana should build off the Missouri experience by measuring returns on CCBHC investment through a reduction in utilization of high-cost services such as emergency room services and inpatient hospitalization services. An estimate of these savings cannot be made at this time because it depends on two key factors that have not been determined: (1) the number of CCBHC clinics, and (2) what services and staffing will be provided at the CCBHCs. Indiana must first utilize the Needs Assessment to identify what is needed by the community, then define the services required to be provided by a CCBHC according to new state certification requirements. Each prospective CCBHC will develop a cost report based upon the developed Indiana certification requirements to propose staffing and other costs required to meet the service needs of their defined service area. DMHA should then engage with actuaries to thoroughly review the cost reports proposed by the CCBHCs until they meet approval by the State. Next, the State would engage with actuaries to review the State approved cost reports to estimate associated costs and savings to the State.

Appendix B includes considerations for states wishing to understand how CCBHC implementation could affect state Medicaid (and other) expenditures. **States have many options to customize the design of their CCBHC program to bring estimated costs and savings in line with targets.**



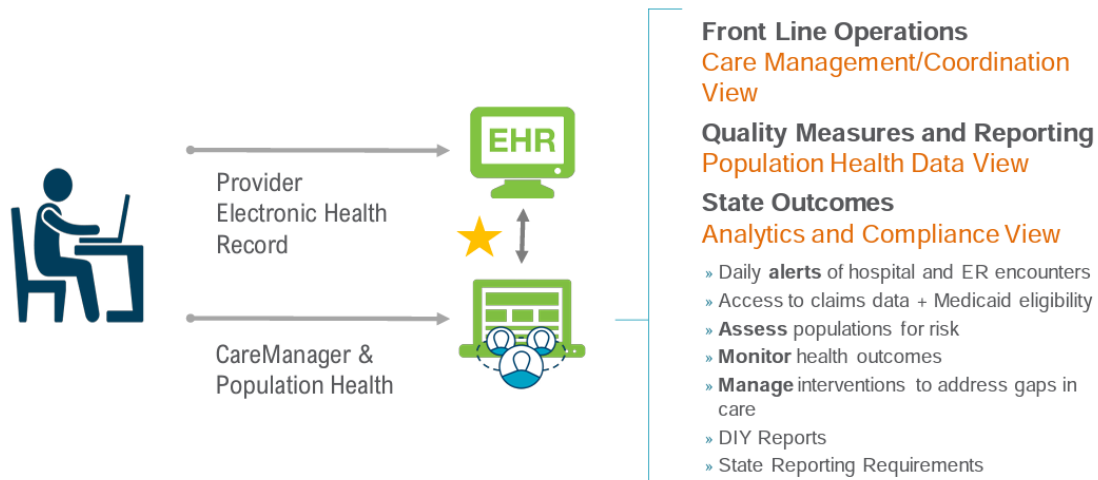


## Develop data collection and reporting capacities:

Strengthening of data collection and analyses through the CCBHC model benefits the state in many ways. From understanding the true disease burdens within mental health and substance use populations to being better able to calculate additional supports needed, using these quality report will help improve funding request with the legislature or grant providers. To achieve CCBHC data collection and report needs, the National Council recommends that Indiana:

- Establish State-specific Data and Quality Reporting Requirements
- Assess quality reporting infrastructure
- Provide training and technical assistance to CCBHCs

**Establish State-specific Data and Quality Reporting Requirements:** With input from prospective CCBHCs and the advisory committee, Indiana may finalize CCBHC reporting requirements, including those applicable both to clinics (e.g., metrics drawn from EHR data or other clinic-specific sources) and those applicable to the state (e.g., metrics drawn from claims data). States implementing the CCBHC model outside of the demonstration are not required to use the 21 required CCBHC measures<sup>34</sup> listed in the Appendix C, but the National Council encourages states to strongly consider aligning their quality reporting with these national metrics. Any additional measures or data elements needed for quality bonus payments, program evaluation or other purposes may be added as desired. Consideration may be given to existing data reporting requirements in place at the federal, state and local level, with efforts made to align and streamline CCBHC reporting requirements. Technical specifications for all measures may be shared with CCBHCs and training for CCBHC staff may be provided to ensure clinics are equipped to collect and report on these measures. SAMHSA has provided technical specifications for the demonstration quality measures.<sup>35</sup> As Missouri's experience is one that Indiana would like to replicate, the following graphic outlines how Netsmart's CareManager platform streamlines data and technology needs:



<sup>34</sup> Department of Health and Human Services, Assistant Secretary for Planning and Evaluation. (2019). Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2018. Requirement 5: Quality and Other Reporting. Retrieved from <https://aspe.hhs.gov/report/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2018/requirement-5-quality-and-other-reporting>

<sup>35</sup> SAMHSA. (2018). Quality Measures. Retrieved from <https://www.samhsa.gov/section-223/quality-measures>

**Assess Quality Reporting Infrastructure:** DMHA recently retained Brilljent, LLC (Briljent) to assess its data and information technology (IT) systems. In the review of DMHA systems and associated systems management processes, Brilljent identified several strong, mature practices, as well as new practices with the potential to mature with time and focus. Of note in the report was the finding that DMHA client data is fragmented with clients appearing in different siloed systems- an issue that CCBHC can be used to remediate as it will purposefully redesign data systems as part of its CCBHC implementation.

Additionally, Indiana may modify or design and implement data collection systems—including registries or electronic health record functionality that report on access, quality, and scope of services using various types of data, including, CCBHC administrative data and personnel records, claims, encounter data, patient records, and patient experience of care data needed to support CCBHC activities and program evaluation. The report also indicates that data management and governance have started within DMHA. Recent actions show an organizational commitment to a stronger data-based culture. The establishment of the position of Executive Director of Data Strategy, recent work to contribute DMHA data to FSSA’s Enterprise Data Warehouse (EDW), and the availability of a strong set of data management tools associated with the EDW provide a foundation from which to grow.<sup>36</sup> This work should continue and be supported by the development of CCBHC reporting infrastructure across the state. Lastly, the state may also ensure they have data collection systems and reporting systems in place to understand program costs and savings across the full spectrum of state systems that reap the benefit of improved access to behavioral health care (e.g., criminal justice, school, broader welfare systems). Appendix D outlines quality measures for the CCBHCs.

**Provide Training and Technical Assistance to CCBHCs:** Providing training and technical assistance, facilitated by the state or other external partners, will assist CCBHCs with preparing to use data to inform and support continuous quality improvement processes within CCBHCs, including fidelity to evidence-based practices, and person-centered, and recovery-oriented care. Given the goals, metrics related to children’s health, forensic care or monitoring, and screening referrals for inpatient care may be helpful to ensure the goals of the CCBHC model are being achieved.

Indiana leaders may engage with CCBHCs to determine a regular, collaborative review of metrics and performance. Before identifying any data requirements, conversations with providers should occur to ensure as little administrative burden as necessary. The following infographic has examples of data that may be track by a CCBHC to provide person-centered care:



<sup>36</sup> Larimer, L., Indiana Division of Mental Health and Addiction Data Systems Assessment Report (2022).



## Apply for the CCBHC Planning Grant or a SPA

Drafting a SPA or Medicaid waiver can require multiple staff within the Indiana Division of Mental Health and Addiction and the Office of Medicaid Policy and Planning. DMHA and OMPP need adequate staff to ensure final approval of a waiver or SPA with CMS. Steps for the SPA or Waiver include:

- **Select Approach and determine if Indiana will apply for Demonstration Planning Grant**
- **Design, Draft, and File SPA or Waiver**

**Select SPA or Waiver Approach and/or Apply for Demonstration Planning Grant:** For states like Indiana that are not currently part of the CCBHC demonstration, there are three options for implementing CCBHCs in Medicaid: A State Plan Amendment (SPA) or waiver (typically a Section 1115 waiver, but other waiver types may be possible depending on the state-specific context), and concurrently applying for the federal demonstration planning grant. Specifically, the new Federal Demonstration will begin July 1, 2024, and every 2 years thereafter, up to 10 additional states may participate in the demo. New states will get 4 years of enhanced match, and as noted planning grants will be available for new states to develop proposals to participate. Participation in the demo appears to be open to states that either received a planning grant in 2016 or those that receive new planning grants under this law. States wishing to participate must submit a new application. In conjunction Indiana could also pursue independent CCBHC development to be time effective. CMS has approved both SPAs and waivers for CCBHC implementation, with each offering distinct differences in how it enables states to pay and certify clinics:

SPA	1115 Waiver	Federal Demonstration
Enables states to permanently amend Medicaid plans to include CCBHC provider type, scope of services, etc.	Enables states to experiment with delivery system reforms	Enables states to experiment with delivery system reforms
Does not require budget neutrality	Requires budget neutrality across the scope of the entire waiver (not specific to any single component)	Does not require budget neutrality and provides an enhanced FMAP for states
Does not need to be renewed; if programmatic changes are desired in the future, a new SPA must be filed	Must be renewed every 5 years; offers opportunity for iterative programmatic changes without opening up the state plan	Demonstration period is 4 years with flexibility for states to add new providers during the course of the demonstration
States generally cannot waive “state wideness”; states may consider the degree to which they are willing to allow qualified providers across the state to become certified CCBHCs	Provides states the flexibility to limit the number or location of providers to be certified as CCBHCs	State may limit the number of clinics selected to receive the PPS rate
Provides the ability to implement PPS, but to date, CMS has not allowed anticipated costs to be included in first-year cost reports; states have identified alternate strategies for CCBHCs’ first-year costs	Provides the ability to implement PPS and may offer a more flexible mechanism to support CCBHCs’ anticipated costs in the first year of operations	State may limit the number of clinics selected to be certified as CCBHCs and receive the PPS rate

## Next Steps

This document outlines six key steps to support state officials, CCBHCs, the Indiana Council and the General Assembly in assessing the CCBHC model with recommendations on how the model may be customized to Indiana's current health care infrastructure and population health needs. To date, the state has identified some goals, key members of its leadership team, and how the current model in the state's Community Mental Health Centers and other provider types align with the CCBHC model. Additionally, Indiana's legislature can appropriate funding to create either a SPA or waiver for CCBHC or apply to enter the demonstration with additional fundings to support implementation if deemed necessary. The CCBHC model has been effective in addressing the workforce issues experienced in behavioral health and substance abuse services, however legislative support to review professional licensure requirements for behavioral health and substance abuse treatment providers is recommended to help address the workforce shortages in Indiana. An Indiana CCBHC model would elevate, enhance, and expand the current behavioral health and addictions infrastructure, and such expansion will also require an expansion to DMHA and other state agencies' infrastructure to support the implementation, monitoring, certification, and oversight of the new model. DMHA intends on applying for the CCBHC Planning Grant and to subsequently apply to the CCBHC demonstration, to maximize the opportunity of federal dollars to expand and enhance our current behavioral health and substance abuse services provided to the 92 counties across Indiana. The National Council is available to provide continued support through the CCBHC Success Center and welcomes further discussion with the state.

## APPENDIX A – Areas for State Discretion

### Organizational authority and governance

- Indiana must approve any alternate approach (to 51% participation by consumers, people in recovery, and family members) that a CCBHC proposes to use, to ensure meaningful participation by consumers, persons in recovery, and family members
  - Indiana determines if proposed alternatives to the board membership participation by these groups is acceptable
  - If the alternative is not acceptable, Indiana must require that additional or different mechanisms be established to assure that the board is responsive to the needs of CCBHC consumers and families
- Based off the community needs assessment, Indiana may determine specific CCBHC requirements in the following areas:
  - Cultural, linguistic, and treatment needs of the populations to be served
  - Staffing plans including size and composition appropriate to the needs of the CCBHC consumers
  - Other aspects of treatment planning based on the needs of populations served
  - Evidence-based practices specific to the CCBHC site, including psychiatric rehabilitation services
  - The geographic boundaries of the service area or catchment area

### Staffing and other workforce requirements

- If physicians are unavailable as medical directors, Indiana may approve the CCBHC's approach to fill these positions, to ensure compliance with state laws on the prescription and management of medications (Note: A delay in hiring may affect the rate calculation)
- Indiana may specify which staff disciplines they will require to certify CCBHCs, to assure compliance with laws and regulations
- Additional staff training may be required by states to ensure compliance with standards
- Indiana may determine that CCBHCs comply with federal and state confidentiality and privacy requirements

### Access and availability to care

- Indiana laws and Medicaid regulations set standards for mobile in-home services, telehealth/telemedicine, and online treatment
- Indiana's standards may address provision of voluntary and court-ordered services
- Indiana's standards for evaluation content and time-frames may be more stringent than the federal standard
- Indiana may have protocols to address consumers seeking services from outside the service (catchment) area, including:
  - Using the needs assessment to determine the service area; and
  - Coordinating protocols across CCBHCs

### Care coordination

- Indiana may apply its own privacy laws to communications between CCBHCs and DCOs about patients

- If CCBHCs are unable to establish care coordination agreements with community agencies, Indiana may decide whether to allow contingency plans

#### Scope of Services

- Indiana and the state’s CBHCs may decide which of five required services will be provided directly by CCBHCs or by DCOs
- Indiana may decide what level of licensed BH professional will conduct consumer evaluations
- Indiana can specify requirements for consumer evaluations in its consideration of other evaluation criteria
- Indiana may require other specific screening and monitoring of mental health and substance use as well as primary care services at the CCBHCs
- Indiana may set standards for other aspects of treatment planning based on the needs assessments and must set a minimum for evidence-based practices used at the CCBHCs (e.g., medication-assisted treatment) and clearly identify which services are to be provided
- Indiana may specify the scope of peer and family services as well as additional targeted case management services based on the needs of the populations being served in the state
- For crisis response services, Indiana must determine if there is an existing state-sanctioned, certified, or licensed system of mental health and substance use crises. If there is no state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services, then the CCBHC directly provides them. One of the outcomes of DMHA’s 988 initiative, will be the development a statewide 988 software system to provide centralized dispatch of 988 calls in Indiana. Indiana will therefore require CCBHCs to link with the upcoming 988 center software for centralized mobile crisis dispatch. CCBHCs must also have an established protocol specifying the role of law enforcement during the provision of crisis services. The state defines and ensures inclusion of these crisis services:
  - 24-hour mobile crisis teams
  - Emergency crisis intervention services
  - Crisis stabilization services
  - Suicide crisis response
  - Services capable of addressing crises related to substance abuse and intoxication, including ambulatory and medical detoxification

#### Quality Measures

- Indiana will review and approve the continuous quality improvement (CQI) plan of each CCBHC. Elements of the CQI are determined by the state but may include:
  - Suicide deaths or attempts
  - 30-day readmissions
  - Other events to be examined and remediated as part of the CQI plan

## **APPENDIX B – Cost Considerations in CCBHC Program Design**

Please note this chart is intended as a general guide and does not capture items that may be specific to any individual state. The list is not exhaustive; states may encounter additional sources of variation in program cost or savings not reflected here.

Source of Cost Variation	Considerations	Suggested Approach for Indiana
Number of CCBHC sites certified	States may choose to certify a limited number of CCBHCs at first (through a waiver) and phase up over time. Alternately, a state could choose to pursue a State Plan Amendment (SPA) and would then have to certify any willing and qualified providers. Note that states can establish eligibility and certification criteria to delimit who may apply for certification.	<ul style="list-style-type: none"> <li>• Determine desired number of CCBHC sites to certify if contemplating a waiver.</li> <li>• Estimate number of clinics that could meet certification requirements if contemplating a SPA.</li> </ul>
Anticipated increase in number of Medicaid enrollees served	On average, the 8 demonstration sites experienced a 25% increase in <u>total</u> number of clients served during the first two years of the program. (The National Council does not have data on what proportion of these individuals were enrolled in Medicaid.)	<ul style="list-style-type: none"> <li>• Estimate anticipated increase in number of clients to be served.</li> <li>• Estimate proportion of the above increase that represents a shift from other providers and is therefore already included in the state’s budget forecast.</li> <li>• Estimate percentage of these new clients enrolled in Medicaid (distinguishing between expansion and non-expansion enrollees, if applicable)</li> </ul>
Scope of CCBHC services relative to Medicaid state plan	Some states may not currently cover the entire array of CCBHC services and activities. To the degree these are not already covered in Medicaid, states may experience additional costs when they are wrapped into the CCBHC payment rate.	<ul style="list-style-type: none"> <li>• Crosswalk CCBHC criteria with existing state plan to identify where any gaps exist that will affect state expenditures on CCBHCs.</li> <li>• Estimate the increase in service utilization that may occur due to uncovering unmet need and/or integration of service offerings.</li> </ul>
Level of CCBHC reimbursement relative to current Medicaid payment rate(s)	As CCBHCs complete their cost reports, states will understand the degree to which their anticipated costs differ from what would normally be paid under Medicaid. States will establish their own certification and cost report requirements so will have a period of discussion, negotiation and actuarial analysis prior to final rate setting. States may wish to benchmark clinics against one another and open discussions about the reasoning behind any significant variances in estimated costs.	<ul style="list-style-type: none"> <li>• Estimate the degree to which (if at all) current Medicaid reimbursement falls short of costs that will be included in the PPS.</li> </ul>

<p>Treatment of anticipated costs for initial rate setting</p>	<p>Because many CCBHC activities and services have not historically been reimbursed and may be newly added as a result of certification, historical cost data does not typically paint a full picture of what a CCBHC’s first-year costs will be. Most demonstration states utilized the CMS cost report developed for the demonstration, which allows anticipated costs to be included in the first-year rate. However, CMS has pushed back against the inclusion of anticipated costs in initial rate-setting for states filing a CCBHC SPA. States have developed different methodologies to address first-year rate setting, typically followed by a rebasing process in the second year based on first-year actual costs.</p>	<ul style="list-style-type: none"> <li>• Determine whether and how your state will account for CCBHCs’ anticipated costs when developing a methodology for first-year rate setting.</li> </ul>
<p>Potential for including current unmatched state expenditures in CCBHC scope</p>	<p>Many states have established state-funded programs to provide behavioral health services outside the scope of the Medicaid plan or in settings not otherwise reimbursable by Medicaid. These activities may be funded through state health care or behavioral health budgets, as well as education, criminal justice agencies, or others. To the degree these services or activities can be wrapped into the scope of the CCBHC program and include costs that are allowable within Medicaid (e.g., NOT room and board, etc.), states may be able to draw down a federal match for previously unmatched expenditures.</p>	<ul style="list-style-type: none"> <li>• Assess whether there are any existing state-funded programs for Medicaid enrollees that can be included in the CCBHC scope of services or activities; calculate the federal match that would accrue to the state when these activities are wrapped into CCBHCs’ PPS rate</li> </ul>
<p>Costs to state of administering and overseeing the program</p>	<p>Some expenditures will be required on the part of states to administer the CCBHC program (e.g., certification, data collection, modifications to billing systems, etc.). Some states in the demonstration have shifted certain <u>Medicaid-allowable costs/functions</u> to CCBHCs as part of their obligations for certification. These costs can then be wrapped into the CCBHC cost report and payment (drawing down a federal match).</p>	<ul style="list-style-type: none"> <li>• Assess whether there are any expenditures (e.g., training, accreditation, data collection) that could be shifted from states to CCBHCs and included in the PPS rate</li> <li>• Assess whether federal Medicaid administrative match is available for state CCBHC administrative costs.</li> </ul>
<p>Anticipated savings or costs attributable to specific planned state initiatives</p>	<p>States have the ability to supplement the baseline CCBHC criteria with additional required services and activities designed to meet states’ goals for reaching difficult-to-serve populations or achieving key outcomes. Examples of such state-specific requirements could include activities like ED diversion programs, mobile crisis programs involving state-selected required partnerships or</p>	<ul style="list-style-type: none"> <li>• Estimate the reach and projected savings attributable to any state-specific CCBHC required programs or activities.</li> <li>• Due to high levels of unmet need, these initiatives may have a net</li> </ul>



	activities, or hospitalization follow-up with medication reconciliation, among many others.	cost, but that cost could now draw down federal match.
Anticipated health care savings resulting from improved care and quality bonus incentives	States participating in the demonstration have reported savings from reduced hospitalizations and emergency department visits. SAMHSA reports that as of January 2020, clients receiving services in the CCBHC expansion grant program have experienced a 61.6% percent reduction in hospitalization and 62.1% percent reduction in Emergency Department (ED) visits. Clinics that have shared their own data with the National Council have seen reductions of anywhere from 18% to 95%. Additional sources of savings may include improved management of chronic physical health conditions, reduction in polypharmacy, and more. Preliminary data from states in the demonstration appear to indicate that any savings accrue faster for clients that are already engaged in care, with clients who are new to care apparently having a higher level of complex unmet health needs that may require more time to fully realize savings.	<ul style="list-style-type: none"> <li>• Determine expectations for CCBHCs regarding reduced hospital/ED utilization or other high-cost health care services</li> <li>• Ensure the appropriate activities designed to achieve these outcomes are included within CCBHC criteria; consider quality bonus payments to further incentivize.</li> <li>• Estimate anticipated savings.</li> <li>• Consider anticipated costs for appropriate increases in housing, community supports and other services due to the CCBHC identifying unmet needs.</li> </ul>
Anticipated non-health savings resulting from improved collaboration	States participating in the demonstration have reported savings to law enforcement, courts, schools, and other public-serving entities who frequently work with individuals living with mental illness or addiction. While these savings will not accrue to state Medicaid budgets, they may have an important impact on overall state budgets and may be considered.	<ul style="list-style-type: none"> <li>• Determine expectations for CCBHCs regarding collaborations with external partners and the degree to which activities designed to reduce costs by improving care will be built into CCBHC criteria</li> <li>• Estimate anticipated savings.</li> </ul>
Impact on MCOs	If MCOs will be responsible for CCBHC services, actuarial analysis is required to determine impact on MCO capitation rates. If a state plans to require MCOs to pay the state-approved PPS rate, CMS approval is required for directed payments. If MCOs are used to process PPS claims, additional time may be necessary for MCOs to develop the necessary claims processing capability.	<ul style="list-style-type: none"> <li>• Work with your MCOs to develop an implementation plan with enough time for all of the changes MCOs will need to make.</li> </ul>
Impact on state MMIS claims processing	Unless all claims will be processed by MCOs, the state's MMIS and IT systems need to develop appropriate claims processing capability. The innovative nature of the CCBHC payment model may require significant changes in claims processing methodology, involving both cost and time.	<ul style="list-style-type: none"> <li>• Work with your MMIS and IT systems to develop an implementation plan with enough time for all of the changes needed.</li> </ul>

## APPENDIX C – Quality Measures for States

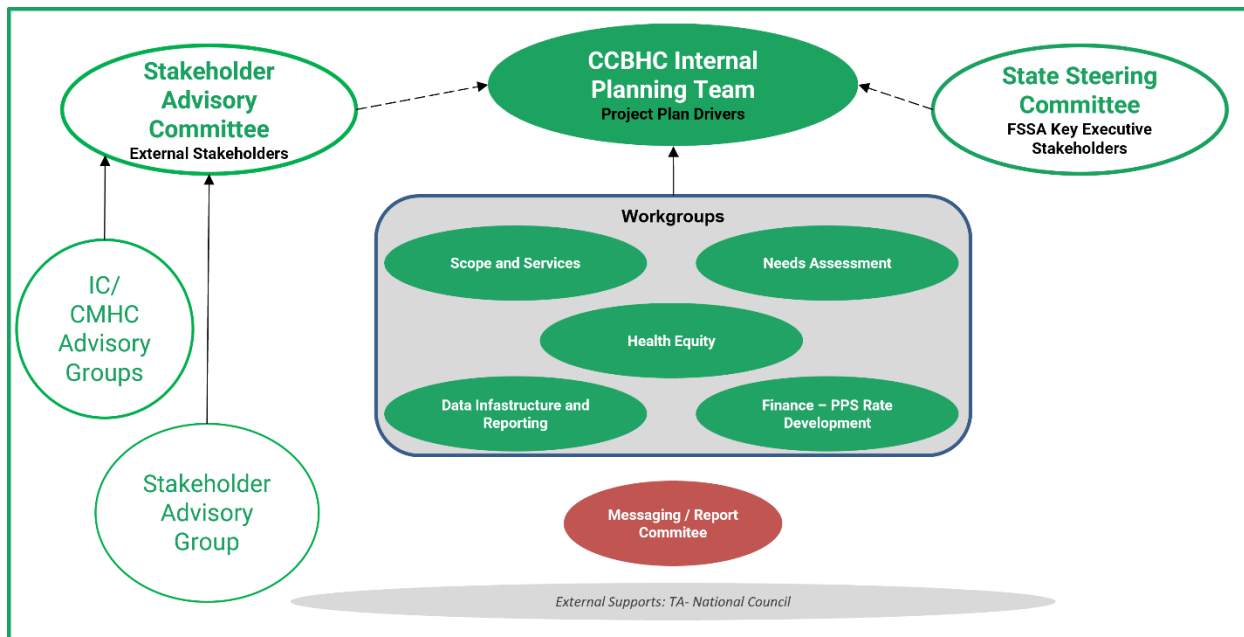
State Reporting Measure or Other Reporting Requirement	National Quality Forum Endorsed
Housing Status (Residential Status at Admission or Start of the Reporting Period Compared to Residential Status at Discharge or End of the Reporting Period)	N/A
Follow-Up After Emergency Department for Mental Health	2605
Follow-Up After Emergency Department for Alcohol or Other Dependence	2605
Plan All-Cause Readmission Rate (PCR-AD) (see Medicaid Adult Core Set)	1768
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications	1932
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (see Medicaid Adult Core Set)	N/A
Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (see Medicaid Adult Core Set)	0576
Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (see Medicaid Child Core Set)	0576
Follow-up care for children prescribed ADHD medication (see Medicaid Child Core Set)	0108
Antidepressant Medication Management (see Medicaid Adult Core Set)	0105
Initiation and engagement of alcohol and other drug dependence treatment (see Medicaid Adult Core Set)	0004
Patient experience of care survey; Family experience of care survey	N/A

## APPENDIX D – Quality Measures for Clinics

Measure or Other Reporting Requirement	National Quality Forum Endorsed
Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients	N/A
Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up	0421

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (see Medicaid Child Core Set)	0024
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	0028
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	2152
Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment (see Medicaid Child Core Set)	1365
Adult major depressive disorder (MDD): Suicide risk assessment (use EHR Incentive Program version of measure)	0104
Screening for Clinical Depression and Follow-Up Plan (see Medicaid Adult Core Set)	0418
Consumer follow-up with standardized measure (PHQ-9) Depression Remission at 12 months	0710

## APPENDIX E – Proposed CCBHC Initiative Governance Structure



Note: This visual describes the current proposed governance structure for the CCBHC initiative. As such, the governance structure is dependent on multiple variable and variations of the proposed structure may occur during the planning grant period.