

The CCBHC Model, Philosophy, and Background

The aim of Certified Community Behavioral Health Clinics (CCBHCs) is to improve access, quality, and outcomes of outpatient behavioral health services by adhering to standard criteria for services.ⁱ Per the criteria, services provided by CCBHCs must be holistic, person- and family-centered, recovery-oriented, and trauma-informed. CCBHCs must also provide coordinated care that addresses both behavioral and physical health conditions.

CCBHC demonstration projects were authorized in April 2014 through the Protecting Access to Medicare Act (PAMA). In 2015, 24 states were awarded planning grants to support the development of a CCBHC certification program, establish prospective payment systems (PPS) for Medicaid reimbursable services, and prepare an application to complete to be part of the CCBHC demonstration program. In 2016, from the original 24 planning grant states, eight were selected to participate in the demonstration phase. During this phase, the states worked with the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to certify CCBHCs and develop PPS reimbursement for CCBHCs. In 2020, two additional states were added to the demonstration program.

In addition to the CCBHC demonstration grants to states, SAMHSA began to directly fund community-based behavioral health clinics to become certified as CCBHCs through its CCBHC Expansion Grant program. The program has expanded considerably since its inception, with additional rounds of funding awarded yearly since 2018 for 2-year CCBHC Expansion Grants and clinics from all 50 states eligible since 2020. There are now 431 CCBHCs operating in 41 states, Washington DC, and Guam.ⁱⁱ

How CCBHCs Operate

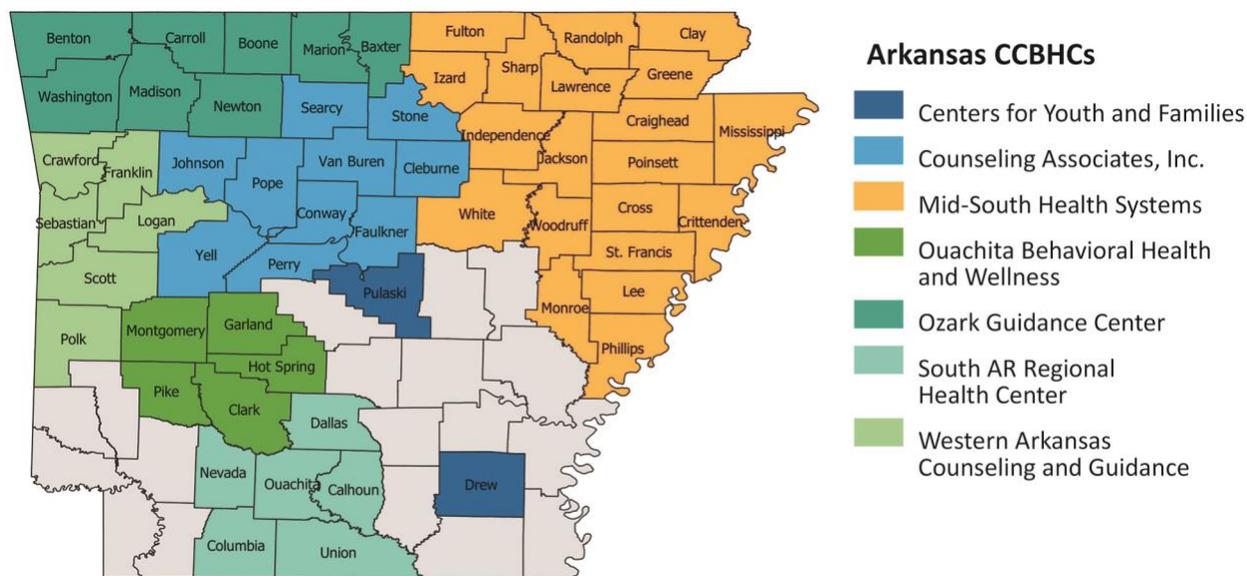
CCBHCs are nonprofit organizations or local government behavioral health authority sites that commit to providing, either directly or through contracted partnerships, comprehensive care through nine core services, with a focus on care coordination, 24-hour crisis services, evidence-based practices, and integration of primary care. To overcome the long-standing financial barrier to providing high-quality behavioral health care, a new Medicaid PPS was developed for the demonstration sites to support the total cost of comprehensive care at CCBHCs. The aim of the PPS was to bring payment in line with the actual cost of providing high-quality, holistic care and to offer financial incentives for performance on quality measures.

Arkansas Certified Community Behavioral Health Clinics

Delivering High-Quality, Person-Centered, Holistic Care to People with Serious Mental Illness

Although helping to expand the CCBHC model, the Expansion Grants appropriated since 2018 are direct grants to the CCBHCs and do not require state Medicaid agencies in non-demonstration states to adopt the Medicaid PPS. Without a state Medicaid cost-based payment system, clinics are unlikely to have the financial foundation to sustain CCBHC activities in the long term. Expansion grantees are at risk of losing their funding every 2 years as their grants end.ⁱⁱⁱ Other states are using a variety of Medicaid authorities, such as Medicaid 1115 waivers and State Plan Amendments, to reimburse the financial models necessary to sustain the CCBHC model. Likewise, Arkansas has the opportunity to find innovative solutions to continue the work of CCBHCs to increase access to high-quality, evidence-based behavioral health care.

Arkansas CCBHC Expansion Grantees



Arkansas has seven CCBHC expansion grantees: three were funded mid-year 2020, the fourth received notification of funding in early 2021, and three additional clinics were notified of awards in July 2021. Arkansas is not a demonstration grant state and, therefore, does not receive the enhanced Medicaid match for the nine core services. All seven centers serve individuals with serious mental illnesses (SMI), substance use disorders (SUD), co-occurring SMI and SUD, and children with serious emotional disturbance. Mid-South Health Systems serves a 20-county catchment area in Northeast Arkansas, Ozark Guidance Center serves eight counties in Northwest Arkansas, Ouachita Behavioral Health and Wellness serves a five-county service area in South Central Arkansas (including Hot Springs), and Western Arkansas Counseling and Guidance Center covers a six-county catchment area in the westernmost portion of the state, which includes one urban area (Fort Smith) but is otherwise predominantly rural. Centers for Youth and Families, Inc.—with facilities in Pulaski County (Little Rock) and Drew County—primarily serves people from these

counties but also provides residential services to individuals from across the state. Counseling Associates, Inc. serves 10 counties in Central Arkansas. South Arkansas Regional Health Center serves six counties in the southernmost part of the state.

The Role CCBHCs Play in Addressing Population Health

To improve the health of people who experience SMI, Arkansas must adopt a population health perspective, going beyond considering the health of one person at a time to considering the health outcomes of a group of people, and going beyond a disease focus to an emphasis on prevention and wellness.^{iv} Perhaps the most important role CCBHCs can play in addressing population health is providing primary care for people with more complex mental health conditions.

Several studies have demonstrated the negative lifetime health outcomes, higher medical costs, and lower economic productivity experienced by people with SMI. In the United States, average life expectancy is 78.5 years. But for people with SMI, life expectancy is 10–25 years lower. A recent study examining the lifetime impact of

SMI used statistical modeling to estimate health trajectories based on health and economic factors. The simulations resulted in findings that echoed previous studies comparing average outcomes of actual cohorts: individuals diagnosed with an SMI by age 25 have a life expectancy about 10 years lower than the simulated cohort not diagnosed with SMI by age 25. The simulations found that individuals in the SMI cohort spent \$96,000 (24%) more on medical costs over a lifetime.^{vi}

Arkansas is ranked 48th out of 50 states in overall health.^v

- Average life expectancy in Arkansas (75.8 years) is shorter than the U.S. average (78.6 years). Almost 44% of the state's population live in rural areas. People living in rural areas also have shorter life expectancies.
- The majority of leading causes of death in Arkansas are chronic diseases, including heart disease, cancer, stroke, diabetes, and chronic lung disease.
- Arkansas has very high rates of obesity, high blood pressure, physical inactivity, and tobacco use, which are all linked to early death from chronic disease.
- Drug-related deaths are the second leading cause of unintentional injury-related death in the state.
- The portion of people living with a disability in Arkansas (18%) is higher than the U.S. rate (13%).

Achieving Better Outcomes and Lower Overall Costs

Despite some assumptions that people with serious mental illnesses (SMI) die earlier because of suicide or overdoses, much of the disparity in life expectancy for adults with SMI

Arkansas Certified Community Behavioral Health Clinics

Delivering High-Quality, Person-Centered, Holistic Care to People with Serious Mental Illness

results from preventable and unmanaged chronic physical health conditions such as diabetes and hypertension. People with SMI often have unstable housing situations, low socioeconomic status, and difficulty following through with medication and treatment advice. Unmanaged chronic conditions end up costing the health care system and tax payers more money when late or crisis stage treatment for these diseases is sought.^{vii} One study found that three of the top five comorbid conditions experienced by the highest cost 5% of Medicaid beneficiaries included SMI, and that fewer than 5% of beneficiaries account for more than 50% of overall Medicaid costs.^{viii} Integrating primary care into specialty behavioral health care brings these services together at a location that people with SMI are already connected to and familiar with. This integration also reduces transportation barriers by creating a one-stop shop for individuals already facing multiple challenges.

Outpatient primary care screening and monitoring of key health indicators and health risks are essential services that CCBHCs are required to provide. For example, beyond treating mental illnesses, these clinics screen for tobacco use and provide cessation interventions. CCBHCs also collect and report information about body mass and weight, care for high blood pressure, and monitor diabetes and cardiovascular health for individuals with SMI or who are taking antipsychotics. These population health management activities go hand in hand with the Arkansas Health and Opportunity for Me (ARHOME) Program, the state's Medicaid expansion program that will begin in January 2022. ARHOME aims to improve the health of Arkansans, including addressing gaps in the continuum of care for people with SMI and substance use conditions, increasing the use of health screenings, providing intensive care coordination for members most at risk of chronic health issues, and preventing the use of costly and intensive emergency department and inpatient hospital use.^{ix}

The Arkansas organizations that began their CCBHC grants in 2020 all agreed that becoming a CCBHC has been instrumental to primary care integration. One project director commented, "We would not have pursued integrated care on our own, outside the grant. I would have been terrified about not knowing the medical side." Another shared, "There is no way we could have. It's so expensive to start up. We had to renovate a building and hire an MD and APRNs with expensive salaries." Not all CCBHCs bring primary care in-house. Some partner with Federally Qualified Health Centers in a facilitated referral model that allows for close coordination. One clinic reported seeing 41 clients in the first month for primary care services, with a heavy focus on wound care for diabetes—an issue that can progress to a much more costly condition if not managed well early on. Becoming a CCBHC has allowed these organizations to "enhance care and provide readily available treatment in a single location."

CCBHC Model Emerging Findings

Analyses of outcomes based on Medicaid claims and encounter data from the demonstration grant sites are not yet available. However, implementation findings related to increased access and expanded scope of services from the national evaluation of the initial 66 CCBHCs in the eight demonstration states and the National Council for Mental Wellbeing's (National Council) latest report based on 128 expansion grantees, including non-demonstration sites, provide some indication of the promise of the CCBHC model.^{x,xi} Among the demonstration states that have had CCBHCs for longer periods, some are starting to report promising outcomes, such as those shared below from Missouri.^{xii} Themes from these findings are echoed in the interviews with the project directors from each of the Arkansas CCBHC expansion grantees.



In the first 6 months, 87% of the demonstration state CCBHCs reported an increase in the number of clients served.^{xiii} Most CCBHCs reported that they increased access by introducing open-access scheduling, a method that allows clients to receive an appointment on the same day they call or visit. The larger pool of CCBHCs surveyed by the National Council reported that increased access was accompanied by a decrease in wait times, with 50% of clinics providing same-day access, 84% reporting that they can offer an appointment within one week, and 93% seeing clients within 10 days, compared to national average wait time for services, which can be as long as 48 days.^{xiv} Also, individuals receiving services from CCBHCs in Missouri reported positive experiences about access (89%), quality (90%), and engagement (93%).

One Arkansas project director shared that although telehealth has been helpful, oftentimes internet connection in their area is not reliable enough for a sufficient connection. To compensate, their clinic purchased an RV to do outreach to their very large, rural catchment area. The clinic will drive to a community senior center or even to a client's house to deliver behavioral health services, and sometimes primary care services.

Another means of increasing access is to hire more staff. A 2019 nationwide study of CCBHCs found that all participating CCBHCs added new staff, and half of the respondents reported an average staffing increase of up to 10%.^{xv} Participating clinics also reported increased staff retention rates. The national evaluation of the demonstration state sites indicated that CCBHCs most often hired case managers, peer specialists/recovery

coaches, and family support workers, noting that these hires may reflect efforts to meet the criteria for improving care coordination and person- and family-centered care.^{xvi} The demonstration state CCBHCs also reported that the increased financial resources allowed them to add psychiatric care, with 99% employing a psychiatrist and 76% having a child and adolescent psychiatrist on staff in the first year of operations. These were positions they had difficulty filling in the past because of inadequate reimbursement.

Arkansas' CCBHCs have had a more challenging start with respect to workforce recruitment. One site project director reported moderate success at recruiting and hiring staff. But the other three Arkansas project directors interviewed said that hiring has been a challenge. One director's site is already approved as a National Health Service Corps (NHSC) site, which positions them to hire professionals who can receive loan repayment for their service. However, this director said, "I hear it statewide. Professionals are very hard to come by right now. We have 26 openings." Another director noted, "We had a lot of challenges early on. Not as much competition with other CCBHCs, but more internal processes. COVID hit and became a challenge. Greatest challenge is Mississippi County—just hard to get people in, and we pay mental health professionals a premium to work in those areas." This provider is also an NHSC site, and its project director reported that clinicians have been taking advantage of loan repayment. Although one project director said that hiring paraprofessionals has been easier, other directors have had a different experience, noting the difficulty of getting peer support specialists certified by the state. This challenge seems to be, in part, a result of the fact that peer specialist is a relatively new role in Arkansas, one traditionally filled by someone with lived experience of drug addiction who helps others overcome addictions, rather than someone who focuses on recovery from SMI.^{xvii}



Care Coordination

All of the Arkansas project directors agreed that better care coordination has been one of the most valuable aspects of the CCBHC model. As one director noted, "The care coordinators connect clients with primary health care or other health resources they need, help them to navigate the health systems, and assist them in getting medication." This coordination has also helped CCBHCs be more informed of their clients' needs. For example, in the first year of operating as a CCBHC, 88% of the demonstration sites were notified when one of their patients received treatment in a hospital, and 72% were notified when their patients were treated in an emergency department.

Another director noted the importance of coordinating care for clients coming out of intensive services. Care coordination increases the likelihood that clients get to follow-up appointments and helps with transportation, which is often cited as an access barrier for specialty care appointments to which clients have been referred. As one project director noted, although Medicaid beneficiaries have access to some transportation services, these services are sometimes unreliable. Care coordinators fill in the gaps by arranging or providing transportation for clients, especially in rural areas.



Enhanced Services

Most demonstration state CCBHCs expanded their scope of services to meet the certification requirements, with 94% of CCBHCs reporting an increase in the number of clients receiving addiction treatment, 51% adding crisis services, and 49% adding peer support services.^{xviii} According to the broader National Council survey that included non-demonstration state CCBHCs, 89% of responding sites offer one or more forms of medication-assisted treatment (MAT), compared to only 56% of clinics nationwide that provide substance use services. Sixty percent of responding clinics were able to add MAT for the first time by becoming a CCBHC. Additionally, 91% of CCBHCs are providing innovative crisis services through various partnerships. One CCBHC in Oklahoma reported a 93% decrease in the need for psychiatric inpatient hospitalization, and a CCBHC in Texas experienced a 98% jail diversion rate because of their Crisis Intervention Team, which pairs law enforcement and mental health professionals to respond to 911 calls.^{xix} CCBHCs were also able to add and sustain a range of evidence-based practices such as motivational interviewing, individual and group cognitive behavioral therapy, multisystemic therapy, supported employment, and peer support services across demonstration years.

CCBHCs also have improved collaboration with law enforcement, courts, and juvenile justice agencies. In Missouri, for example, law enforcement collaborations were cited as a major success of the CCBHC program, reporting 53,295 referrals from law enforcement over an almost 4-year period. This type of improved collaboration is evident at one Arkansas clinic that is using the CCBHC grant to provide crisis intervention, therapy, and anger management on site at a local juvenile detention center. The clinic's project director explained that it would have been difficult to provide these services without the CCBHC grant because the clinic is not able to bill Medicaid for services at the detention center. The arrangement benefits all parties. Youth are typically only at the facility for one or two weeks. After they are released, they are able to see the same therapist at the clinic. This provides continuity of care for the youth and

a referral to services for the clinic, which the clinic can bill Medicaid for after the youth's release.

This CCBHC is also providing training to detention center staff on trauma-informed approaches to working with youth. The detention center staff did not previously have a trauma-informed lens. The CCBHC has received good feedback on the training from the detention center, which reported a reduced need to send youth to inpatient hospitalization.

Bringing Intensive Community-Based Services to High-Need Individuals

Assertive Community Treatment (ACT) is a community outreach treatment approach for individuals with SMI that delivers intensive services to high-need clients experiencing or at risk for homelessness, hospitalization, and criminal justice involvement. ACT teams have been found to reduce emergency room visits and psychiatric hospitalizations, increase stability of housing, decrease criminal activity, and increase clients' satisfaction with treatment.^{xx} All four Arkansas project directors interviewed expressed that sustaining an ACT program is not possible without the kind of support provided by CCBHC funding: "We had ACT teams before. When the Medicaid system changed, we had to pay case managers a lower rate and were not able to maintain the program." This project director's site and another brought back their ACT teams through the CCBHC grant.

The effects of these services for high-need individuals are evident in data from the demonstration state sites released as part of the FY 2021 federal budget. According to these data, CCBHC clients reported a 61.6% reduction in hospitalization and a 62.1% decrease in emergency room visits. Missouri, for example, has seen a 23% increase in patient access to care from baseline to Year 3, a 36% decrease in emergency room visits, and a 20% decrease in hospitalizations.

Closer to home, an Arkansas project director shared that the clinic's ACT team served a client who was having trouble being in public because of severe social anxiety and other mental health issues and who was experiencing frequent hospitalizations. Through work with the ACT team, the client was able to shop in a grocery store for 10 minutes and eat in a restaurant for an hour—small but important wins on her recovery journey.

At another Arkansas CCBHC, a consumer in his 20s had been seeking help at the emergency room of a local hospital several times a week, a costly way to get services. He was rarely admitted, and staff reported that he would visit the hospital "just because he felt like he needed to." The ACT team developed a relationship with the client and the emergency room. The team has been working with the client on alternative ways to cope and making better choices when seeking help. Now he is down to visiting the emergency room about

twice per week. The team shared that they have been able to intercept him on the road while doing outreach in the neighborhood and divert him from using emergency room services.

In responding to a question about what he hopes will come out of the CCBHC grant project, one project director said, “I hope to see a fair reduction in the amount of intensive (residential, hospitalization, jail) services and situations for people who could be functioning at a higher level and have an opportunity to have a better life.”

Shifting the Organizational Paradigm and Raising the Standard of Care

When asked about the “heaviest lift” thus far in implementing the CCBHC model, Arkansas project directors overwhelmingly agreed that communicating the CCBHC model to staff has been the greatest challenge, namely “educating our staff and getting them to understand what we are doing” and “getting staff to recognize that [our clinic] is a CCBHC. It’s not a side program. It’s where we are, and where our mission is going.” Although this challenge is not strongly reflected in the national outcome studies, it is a foundational issue both for the CCBHCs and for the states and financing systems in which they are located.

With the current financing structure, it is not only the CCBHC staff who have to make this shift, but also community partners, stakeholders, policymakers, and legislators. If the CCBHC model is going to realize its promise in Arkansas, behavioral health funding must be more sustainable. As noted above, evidence-based practices such as ACT are not financed by Arkansas Medicaid in such a way that providers can financially maintain these cost-effective services. ACT, for example, provides support, treatment, and stabilization to individuals who would otherwise need inpatient psychiatric hospitalization, and it provides psychiatric rehabilitative services post-hospital discharge to prevent readmission.

Beyond these regular concerns, a report issued in February 2021 by the National Association of Medicaid Directors noted the destabilizing effect the COVID-19 pandemic has had on the nation’s behavioral health and on the systems needed to respond. The report outlines a framework for promoting the health and well-being of Medicaid enrollees and increasing their access to behavioral health services. Among the strategic options are the promotion and advancement of integrated physical and behavioral health services, a comprehensive approach to addiction treatment, and the strengthening and broadening of crisis response systems. These recommendations and the action items that accompany them are strongly aligned with the programmatic criteria that CCBHCs are required to implement.

Arkansas Certified Community Behavioral Health Clinics

Delivering High-Quality, Person-Centered, Holistic Care to People with Serious Mental Illness

The Provider-Led Arkansas Shared Savings Entity (PASSE) program serves Medicaid enrollees with complex behavioral health issues, and developmental or intellectual disabilities, with the goal of monitoring clients' health care needs, ensuring their health and supporting them in reaching their full potential.^{xxi} CCBHCs share this goal and can work in conjunction with the PASSEs in providing the best possible services to the people of Arkansas experiencing SMI.

For example, by mid-2022, the national 988 crisis number will connect callers directly to mental health or suicide crisis services. All communities will need to develop a mechanism for connecting the 988 system with crisis response teams. In addition, the ARHOME program will also be funding acute mental health crisis services in the state.

CCBHCs are uniquely situated to support the success of PASSEs, the 988 system, and the ARHOME program. CCBHCs are mandated to provide mobile crisis intervention and other effective behavioral treatments, deterring individuals from more intensive services and giving clinics the readiness to partner on these important crisis service initiatives. CCBHCs are also well equipped to provide team-based and evidence-based practices such as ACT and First Episode Psychosis/Coordinated Specialty Care programs for adults and intensive in-home services for children and youth (e.g., Multisystemic Therapy, Functional Family Therapy), making them valuable partners for the PASSEs in providing these services. To sustain the accessible, comprehensive, and high-quality services offered by CCBHCs, a path for integrating this innovative model with the PASSE program, 988 call system, and ARHOME program will need to be identified and financed.

Notes

-
- ⁱ U.S. Department of Health and Human Services. (2020, September). *Certified community behavioral health clinics demonstration program: Report to Congress, 2019*. <https://aspe.hhs.gov/pdf-report/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2019>
- ⁱⁱ National Council for Mental Wellbeing. (n.d.). *CCBHC Success Center: Overview*. <https://www.thenationalcouncil.org/ccbhc-success-center/ccbhcta-overview/>
- ⁱⁱⁱ National Council for Mental Wellbeing. (n.d.). *CCBHC Success Center: Take action to expand and sustain CCBHCs*. <https://www.thenationalcouncil.org/ccbhc-success-center/take-action/>
- ^{iv} New York State Department of Health. (n.d.). *Making New York the healthiest state: Achieving the Triple Aim. Population Health Summit*. https://www.health.ny.gov/events/population_health_summit/docs/what_is_population_health.pdf
- ^v Arkansas Department of Health. (2020). *State health assessment 2020: Arkansas's big health problems*. <https://drive.google.com/file/d/1TtRZQOcf5bUh2-Ed0NQfimkmdYeQBgvX/view>
- ^{vi} Seabury, S. A., Axeen, S., Pauley, G., Tysinger, B., Schlosser, D., Hernandez, J. B., Heun-Johnson, H., Zhao, H., & Goldman, D. P. (2019). Measuring the lifetime costs of serious mental illness and the mitigating effects of educational attainment. *Health Affairs, 38*(4), 652–659. <https://doi.org/10.1377/hlthaff.2018.05246>
- ^{vii} Hackbarth, N. S. (2015, June). *Financing integrated care for adults with serious mental illness in community mental health centers. An overview of program components, funding environments, and financing barriers*. (Rand Health Working Paper No. WR-1084). https://www.rand.org/content/dam/rand/pubs/working_papers/WR1000/WR1084/RAND_WR1084.pdf
- ^{viii} Kronick, R., Bella, M., & Gilmer, T. P. (2009, October). *The faces of Medicaid III: Refining the portrait of people with multiple chronic conditions*. https://www.chcs.org/media/Executive_Summary_-_Faces_III1.pdf
- ^{ix} Arkansas Department of Human Services. (2021, June 11). *Notice of application for proposed ARHOME 1115 demonstration project*. <https://humanservices.arkansas.gov/wp-content/uploads/AHOME-Packet-for-Posting.pdf>
- ^x U.S. Department of Health and Human Services (2020, September).
- ^{xi} National Council for Mental Wellbeing. (2021, May). *Leading a bold shift in mental health and substance use care: CCBHC impact report*. https://www.thenationalcouncil.org/wp-content/uploads/2021/05/052421_CCBHC_ImpactReport_2021_Final.pdf
- ^{xii} Missouri Coalition for Community Behavioral Healthcare. (2020, November). *Missouri's certified community behavioral health clinics: Improving outcomes and access to care: Missouri's impact report year 3*. https://41e56e24-d282-42b5-b0f1-f16abf1bc04b.filesusr.com/ugd/6dadf9_4e13722f483644bc9f2e31ee5190a471.pdf
- ^{xiii} U.S. Department of Health and Human Services. (2020, September).
- ^{xiv} National Council for Mental Wellbeing. (2021, May).
- ^{xv} Foney, D., Mace, S., & Boccanelli, A. (2019, August). *Reaching the Quadruple Aim: Workforce and service delivery within Certified Community Behavioral Health Clinics*. National Council for Behavioral Health, University of Michigan School of Public Health Behavioral Health Workforce Research Center. https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/10/NC-CCBHC_Full-Report.pdf
- ^{xvi} U.S. Department of Health and Human Services. (2020, September).
- ^{xvii} Arkansas Department of Human Services. (2019, October). *Peer recovery professionals make a difference*. https://humanservices.arkansas.gov/featured_stories/peer-recovery-professionals-make-a-difference/
- ^{xviii} U.S. Department of Health and Human Services. (2020, September).
- ^{xix} National Council for Mental Wellbeing. (2021, May).
- ^{xx} Washington State Institute for Public Policy. (2014, May). *Assertive Community Treatment. Adult mental health: Serious mental illness*. <https://www.wsipp.wa.gov/BenefitCost/Program/283>
- ^{xxi} Arkansas Department of Human Services, Division of Medicaid Services. (n.d.) *PASSE – Provider-Led Arkansas Shared Savings Entity*. <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/healthcare-programs/passe/>