



September 2021

MEDICAID BEHAVIORAL HEALTH

CMS Guidance Needed to Better Align Demonstration Payment Rates with Costs and Prevent Duplication



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GAO@100 Highlights

Highlights of [GAO-21-104466](#), a report to congressional committees

Why GAO Did This Study

Behavioral health conditions affected an estimated 61.2 million adults in 2019. Congress has taken steps to expand access to behavioral health treatment, including authorizing the CCBHC demonstration, which is intended to improve the availability of community-based behavioral health services.

The CARES Act included a provision for GAO to report on states' experiences participating in the CCBHC demonstration. Among other objectives, this report describes what states reported about how the CCBHC demonstration affected state spending on behavioral health services; and examines CMS guidance for states on Medicaid CCBHC payments.

GAO reviewed documentation from and interviewed Medicaid and behavioral health officials from the eight CCBHC demonstration states, as well as federal officials tasked with demonstration oversight. GAO also reviewed documentation and interviewed officials from a nongeneralizable sample of three CCBHCs, which GAO selected for a number of reasons, including variation in geographic location.

What GAO Recommends

GAO is making two recommendations, including that CMS issue clear and consistent written guidance to help states (1) better align payment rates with clinics' costs; and (2) avoid potential duplication between CCBHC and other Medicaid payments.

HHS concurred with GAO's recommendations, and provided technical comments, which were incorporated as appropriate.

View [GAO-21-104466](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov

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CMS Guidance Needed to Better Align Demonstration Payment Rates with Costs and Prevent Duplication

What GAO Found

In 2016, the Department of Health and Human Services (HHS) selected eight states to participate in a time-limited demonstration to establish certified community behavioral health clinics (CCBHC). These states, in turn, certified 66 behavioral health clinics as CCBHCs. Required to provide a broad range of behavioral health services—mental health and substance use services—CCBHCs are reimbursed by state Medicaid programs using clinic-specific rates designed to cover expected costs. Under the demonstration, states receive enhanced federal funding for CCBHC services provided to Medicaid beneficiaries.

GAO found that five of the eight demonstration states reported generally increased state spending on CCBHCs, which officials from these states attributed to an increased number of individuals receiving treatment, an increased array of services provided, or both. In contrast, officials from the other three demonstration states did not report that the demonstration resulted in greater state spending. Officials from two of these states noted that the demonstration resulted in spending decreases, citing factors such as the demonstration's enhanced federal Medicaid funding. Officials from the remaining state said the effects on spending were unknown. In addition, four of the eight states assessed potential cost savings from the demonstration resulting from reductions in the use of more expensive care, such as emergency department visits. Officials from three of the four states viewed the results of their assessments as suggestive of potential cost savings, while officials from the fourth state did not.

GAO's review of payment guidance for the demonstration from the Centers for Medicare & Medicaid Services (CMS), an agency within HHS that oversees Medicaid at the federal level, found that the guidance lacked clear and consistent information on better aligning CCBHC payment rates with costs and preventing duplicate payments. For example:

- CMS guidance gives states the option to rebase their initial payment rates after the first demonstration year (i.e., use data on actual costs incurred and number of client visits during the first demonstration year to recalculate rates for subsequent years). CMS officials said rebasing would mean states would not have to rely on anticipated cost and client visit data after the first year, and would align rates more closely with costs. While officials said CMS expected all states to rebase their rates at some point, CMS's guidance does not reflect this expectation, or provide details on rebasing, such as suggested time frames.
- CMS guidance conflicts as to whether CCBHCs that are also Federally Qualified Health Centers (FQHC)—safety net providers that generally provide some behavioral health services—should receive CCBHC and FQHC payments for the same client on the same day if provided services overlap.

Addressing these weaknesses is important to help ensure that Medicaid CCBHC payments meet requirements for Medicaid payments under federal law, including that they be consistent with efficiency, economy, and quality of care, and are sufficient to ensure access to care.

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Abbreviations

CCBHC	certified community behavioral health clinic
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
FQHC	Federally Qualified Health Center
HHS	Department of Health and Human Services
PAMA	Protecting Access to Medicare Act of 2014
PPS	prospective payment system
SAMHSA	Substance Abuse and Mental Health Services Administration

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September 27, 2021

The Honorable Ron Wyden
Chairman
The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate

The Honorable Frank Pallone, Jr.
Chairman
The Honorable Cathy McMorris Rodgers
Republican Leader
Committee on Energy & Commerce
House of Representatives

Behavioral health conditions—mental health conditions, such as depression, and substance use disorders, such as opioid use disorder—affect a substantial number of adults in the United States. In 2019, about 61.2 million adults had a behavioral health condition, according to the most recent estimates from the Substance Abuse and Mental Health Services Administration (SAMHSA).¹ Research has shown that low-income individuals, such as those enrolled in Medicaid—the joint federal-state program that finances health care coverage for certain low-income and medically needy individuals—are at greater risk for developing behavioral health conditions.² Comprehensive and coordinated care is especially important for individuals with behavioral health conditions, because these individuals may have co-occurring conditions (i.e., a

¹See Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health* (Rockville, Md.: 2020).

²In 2019, a greater percentage of individuals covered by Medicaid and the Children's Health Insurance Program experienced mental health conditions and co-occurring mental health conditions and substance use disorders than individuals with private insurance. See Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *Results from the 2019 National Survey on Drug Use and Health: Detailed Tables* (Rockville, Md.: August 2020).

mental health and a substance use condition at the same time), and experience higher rates of physical health conditions.³

However, SAMHSA's survey data show that, in 2019, most individuals with behavioral health conditions—about 55 percent of adults with mental health conditions and almost 90 percent of individuals aged 12 and older with substance use disorders—did not receive treatment. Even when individuals with behavioral health conditions do receive treatment, they may not receive the full range of services needed to fully recover.⁴ Since March 2020, concerns about access to care have intensified due to the Coronavirus Disease 2019 (COVID-19) pandemic, and as we previously reported, evidence suggests that during the pandemic the prevalence of behavioral health conditions has increased, while access to in-person behavioral health services has decreased.⁵

Prior to the pandemic, Congress took steps to expand access to treatment for individuals with behavioral health conditions. The Protecting Access to Medicare Act of 2014 (PAMA) authorized funding for a time-limited demonstration program for certified community behavioral health clinics (CCBHC) in eight states, and tasked the Department of Health and

³The Medicaid and CHIP Payment and Access Commission found that adult Medicaid beneficiaries with a behavioral health diagnosis were more likely to have a chronic medical condition, such as heart disease or diabetes, than those without a behavioral health diagnosis. See Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (Washington, D.C.: June 2015).

⁴Comprehensive behavioral health treatment can involve psychosocial, medical, and supportive services. Psychosocial services refer to regular meetings with a health care provider with expertise in mental health or substance use. Medical services refer to services provided by a clinician, such as a physician, including the prescription of medications. Supportive services refer to other services that are designed to help individuals manage their mental health or substance use conditions and maximize their potential to live independently in the community.

⁵See GAO, *Behavioral Health: Patient Access, Provider Claims Payment, and the Effect of the COVID-19 Pandemic*, [GAO-21-437R](#) (Washington, D.C.: Mar. 31, 2021).

We regularly issue government-wide reports on the federal response to COVID-19. For the latest report, see GAO, *COVID-19: Continued Attention Needed to Enhance Federal Preparedness, Response, Service Delivery, and Program Integrity*, [GAO-21-551](#) (Washington, D.C.: July 19, 2021). Our next government-wide report will be issued in October 2021 and will be available on GAO's website at <https://www.gao.gov/coronavirus>.

Human Services (HHS) with its implementation.⁶ CCBHCs are required to provide access to nine categories of services, including outpatient mental health and substance use services, and primary care screening and monitoring, without regard for clients' ability to pay.⁷ According to HHS, CCBHCs are intended to ensure access to, and coordination of, care so that individuals receive timely diagnostic, treatment, and supportive services.

PAMA directed the Centers for Medicare & Medicaid Services (CMS), the agency within HHS that oversees Medicaid at the federal level, to issue guidance to establish a payment system to reimburse CCBHCs for services provided to Medicaid beneficiaries. In 2015, CMS issued guidance establishing a payment system for the demonstration, one that uses clinic-specific rates designed to cover the expected cost of providing the full range of required services. PAMA also required HHS to evaluate the effects of the CCBHC demonstration on access to community-based behavioral health services for individuals enrolled in Medicaid in participating areas of the state compared with non-participating areas; the scope and quality of CCBHC services compared to non-participating areas of the state and non-participating states; and the demonstration's effect on federal and state costs.⁸ Participating states are not required to conduct evaluations, and little is known about whether states have assessed the effects of the demonstration on outcomes or costs in their states.

The CARES Act included a provision for GAO to report to Congress on states' experiences participating in the CCBHC demonstration, including states' efforts to measure the effects of CCBHCs on clients' health and

⁶Pub. L. No. 113-93, § 223, 128 Stat. 1040, 1077-83. The demonstration was initially authorized for a 2-year period, which began in 2017. However, the demonstration has been extended multiple times through legislative action; most recently, the demonstration was extended through September 30, 2023.

⁷For the purpose of this report, we use the term client to refer to individuals who have received outreach, screening, assessment, or treatment services from a CCBHC.

⁸HHS was required to complete its evaluation by December 31, 2021. For more information about HHS's evaluation of the CCBHC demonstration, see GAO, *Medicaid: HHS's Preliminary Analyses Offer Incomplete Picture of Behavioral Health Demonstration's Effectiveness*, [GAO-21-394](#) (Washington, D.C.: May 17, 2021).

cost of care, and the accuracy of Medicaid payments to CCBHCs.⁹ In this report, we

1. describe steps states took to measure the effects of the CCBHC demonstration on quality of care, including clients' health outcomes;
2. describe what states reported about how the CCBHC demonstration affected state spending on behavioral health services; and
3. examine CMS guidance for states on Medicaid CCBHC payments.

To describe steps states have taken to measure the effects of the CCBHC demonstration on quality of care, including clients' health outcomes, we reviewed documentation provided by officials from the eight original demonstration states: Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania. We also reviewed other relevant documentation describing provision of care and services, including information provided by officials or publicly available information published by federal evaluators and relevant stakeholders, such as a behavioral health research organization and an advocacy group. In addition, we interviewed officials from state Medicaid agencies, behavioral health agencies, or both, from the eight demonstration states between November 2020 and April 2021. We focused our analysis on the states' voluntary efforts to examine quality of care beyond what was required under the demonstration; for example, we asked states about the types of measures and tools they used.¹⁰ We also interviewed officials from selected CCBHCs to obtain their perspectives about the CCBHC model and clinic evaluation efforts. We selected a non-generalizable sample of three CCBHCs to achieve variation with regard to geographic location, Medicaid delivery systems, and CCBHC payment models.¹¹

To describe what states reported about how the CCBHC demonstration affected state spending on behavioral health services, we requested documentation from, and conducted interviews with, officials from state

⁹Pub. L. No. 116-136, § 3814(c), 134 Stat. 281, 431–32 (2020). In response to this provision, we also separately examined HHS's efforts to evaluate the CCBHC demonstration program. See [GAO-21-394](#).

¹⁰See [GAO-21-394](#) for more information about the quality of care data collection and reporting that was required of states under the demonstration.

¹¹We selected one CCBHC in each of three demonstration states. To preserve clinic officials' ability to share candid perspectives on participating in the CCBHC demonstration, we do not identify the selected clinics by name in this report.

Medicaid agencies, behavioral health agencies, or both, from the eight original demonstration states and officials from three selected CCBHCs. We reviewed any documentation provided by these officials, which included summary information and results from state assessments that states voluntarily undertook to examine the demonstration's effects on state spending on behavioral health services. We also reviewed other relevant documentation describing state-related demonstration costs, spending, and planning, including information available on state and federal websites, such as budget documentation and state plan amendments.

To examine CMS's guidance for states on Medicaid CCBHC payments, we reviewed CMS's 2015 guidance on establishing and updating clinic-specific reimbursement rates, sets of questions and answers regarding CCBHC payments that CMS published on its website, and presentation slides from technical assistance webinars related to CCBHC payments that CMS conducted in 2015 and 2016. We interviewed officials from the three HHS agencies with responsibility for the CCBHC demonstration: SAMHSA, CMS, and the Office of the Assistant Secretary for Planning and Evaluation, which is tasked with conducting HHS's evaluation of the CCBHC demonstration. We also reviewed HHS's evaluation reports on the demonstration, and interviewed officials from the eight original demonstration states and three selected CCBHCs previously mentioned. We assessed CMS's CCBHC payment guidance to determine the extent to which it helps ensure that Medicaid CCBHC payments meet requirements for Medicaid payments under federal law, which require that they be consistent with efficiency, economy, and quality of care, and are sufficient to ensure access to care.¹²

We conducted this performance audit from August 2020 to September 2021 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹²42 U.S.C. § 1396a(a)(30)(A).

Background

Medicaid

Medicaid is one of the nation's largest sources of funding for health care services for low-income and medically needy individuals, covering an estimated 77 million people and spending an estimated \$673 billion in total federal and state spending in fiscal year 2020.¹³ Medicaid is the largest single payer of behavioral health services in the nation. In 2014, SAMHSA projected that Medicaid spending on behavioral health services would reach \$84 billion by 2020, and account for 30 percent of total behavioral health services spending.¹⁴

States and territories administer their Medicaid programs within broad federal rules and according to state plans approved by CMS. Among other things, Medicaid state plans describe the beneficiaries and services covered and the providers eligible to receive payments. If a state wishes to make changes to its state plan, such as by adding new services or eligible providers, the state must submit a proposed state plan amendment to CMS for review.

CMS is responsible for federal oversight of the Medicaid program, which includes establishing how the program should be administered in accordance with the Medicaid statute. This includes ensuring that state payments are consistent with Medicaid payment principles; for example, payments must be consistent with efficiency, economy, and quality of care, and be sufficient to ensure access to care. CMS may issue regulations, or may use its State Medicaid Manual, letters to state Medicaid directors, and guidance documents to provide information to states on the administration of their programs. CMS also provides technical assistance to states, which may take the form of trainings or consultations on specific topics.

Certified Community Behavioral Health Clinics Demonstration

To improve the availability and quality of services provided in community mental health centers, section 223 of PAMA created a 2-year demonstration program for up to eight states, and tasked HHS with its implementation. HHS published criteria in 2015 by which states were to certify community mental health centers or other behavioral health

¹³Department of Health and Human Services, Centers for Medicare & Medicaid Services, *2018 Actuarial Report on the Financial Outlook on Medicaid* (Baltimore, Md.).

¹⁴See Substance Abuse and Mental Health Services Administration, *Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010–2020*, HHS Publication No. SMA-14-4883 (Rockville, Md.: October 2014). SAMHSA's 2014 report is its most recent publication projecting national behavioral health spending.

facilities as CCBHCs—including the required scope of services CCBHCs were to provide—and issued guidance to states on the establishment of reimbursement rates for CCBHC services provided to Medicaid beneficiaries.

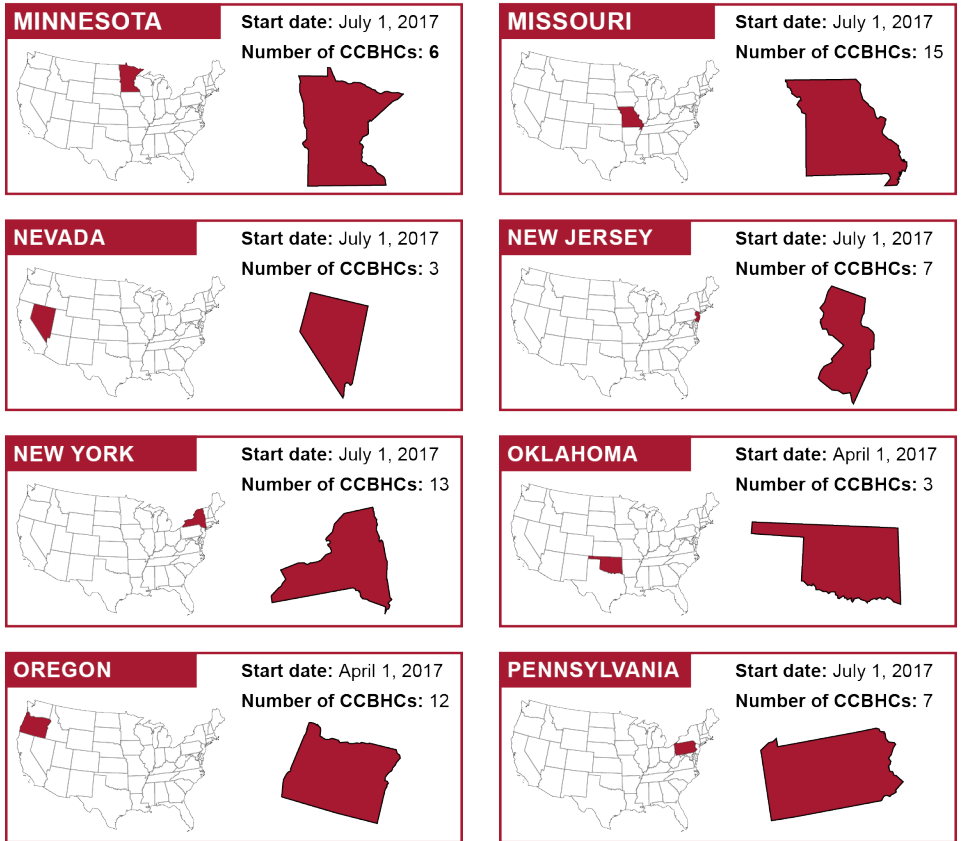
In 2015, HHS awarded planning grants to 24 states to support states to develop and certify clinics, establish clinic-specific payment rates, collect data, and apply for participation in the demonstration. By October 31, 2016—the end of the planning grant period—19 of the 24 states submitted applications for the CCBHC demonstration. Of these, HHS selected eight states in December 2016 to participate in the CCBHC demonstration. These states, in turn, certified 66 behavioral health clinics as CCBHCs.¹⁵ HHS provided these states the flexibility to launch their programs by July 1, 2017. Two states (Oklahoma and Oregon) launched their programs on April 1, 2017, while the other six states launched their programs on July 1, 2017. More recent legislative action has expanded the demonstration beyond the eight original participating states to include two additional states (Kentucky and Michigan).¹⁶ (See fig. 1.)

¹⁵The demonstration initially included 67 CCBHCs in eight states. In March 2018, one CCBHC withdrew from the demonstration after Nevada revoked its certification. In 2019, Pennsylvania withdrew from the demonstration.

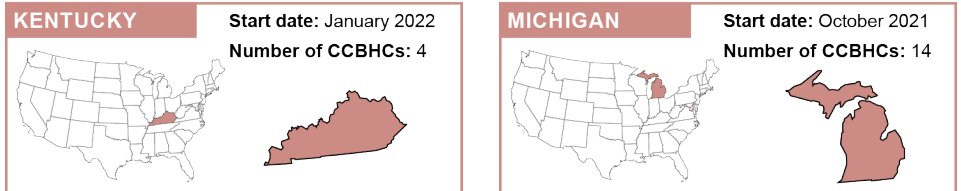
¹⁶CARES Act, Pub. L. No. 116-136. § 3814, 134 Stat. 281, 430 (2020).

Figure 1: Certified Community Behavioral Health Clinics Demonstration States

ORIGINAL DEMONSTRATION STATES SELECTED IN 2016



DEMONSTRATION STATES ADDED IN 2020



Legend: CCBHC=Certified Community Behavioral Health Clinics

Source: GAO analysis of information from the Department of Health and Human Services (data); Map Resources (map). | GAO-21-104466

Note: In 2019, Pennsylvania withdrew from the demonstration. According to officials from the Centers for Medicare & Medicaid Services, as of September 2021, Michigan and Kentucky anticipated launching their CCBHC programs in October 2021 and January 2022, respectively.

In selecting states to participate in the CCBHC demonstration, PAMA directed HHS to prioritize selections based on the capacity of states' CCBHCs to meet one or more of the following goals:

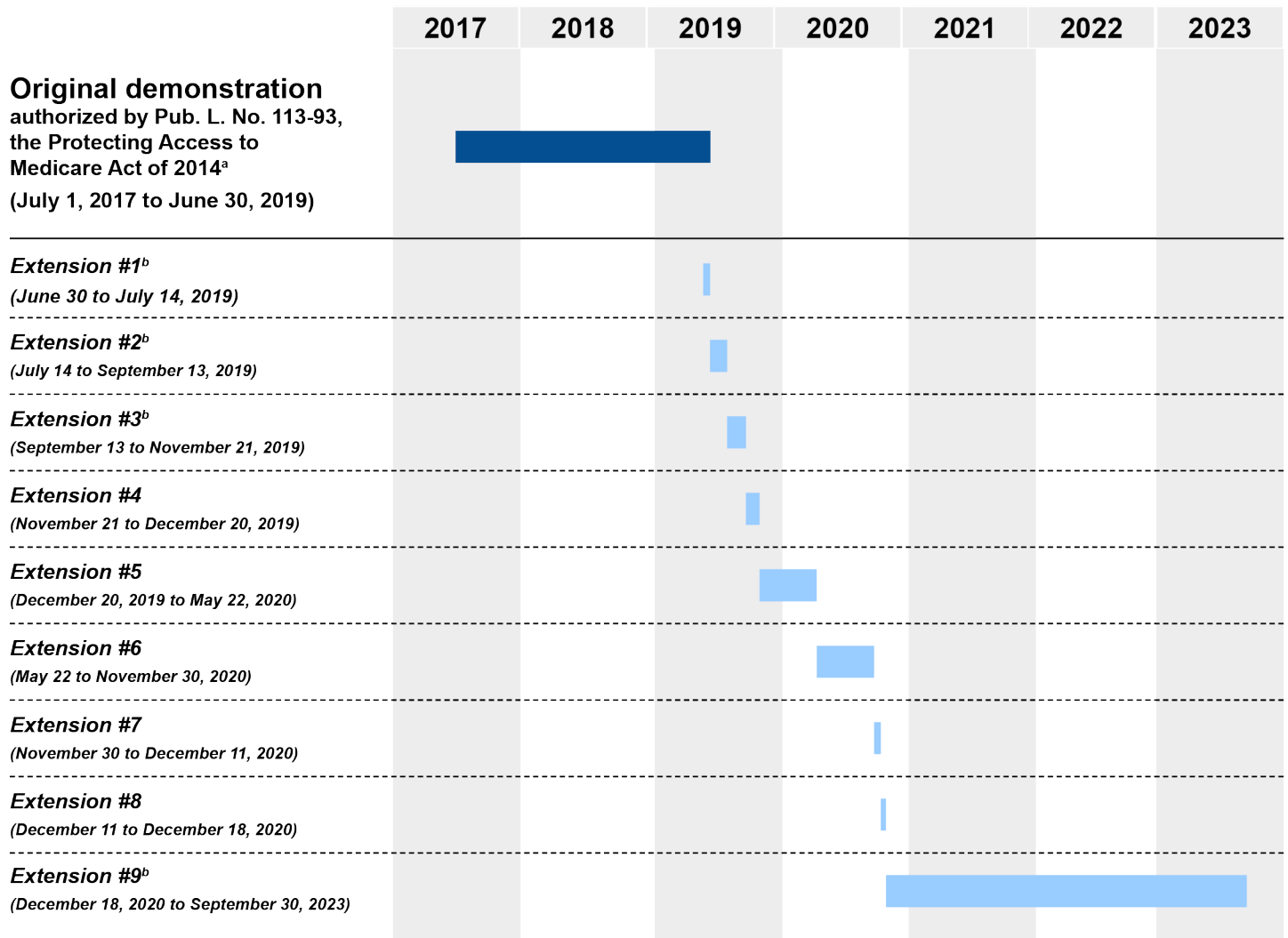
- Provide the most complete scope of services to individuals eligible for medical assistance under the state Medicaid program;
- Improve the availability of, access to, and participation in, services for individuals eligible for medical assistance under the state Medicaid program;
- Improve availability of, access to, and participation in assisted outpatient mental health treatment in the state; or
- Demonstrate the potential to expand available mental health services in a demonstration area, and increase the quality of such services without increasing net federal spending.

States had flexibility in applying for participation, including selecting one or more of these goals as a focus of their demonstration.

Originally authorized under PAMA as a 2-year demonstration, the CCBHC demonstration has been extended by legislative action nine times. These extensions vary in length, and in several instances, authorized the program to continue for additional days or weeks. (See fig. 2.) In December 2020, the Consolidated Appropriations Act, 2021 was enacted, which extended the demonstration through September 2023.¹⁷

¹⁷Pub. L. No. 116-260, div. CC, tit. II, § 206, 134 Stat. 1182, 1578.

Figure 2: Timeline of the Original Certified Community Behavioral Health Clinics Demonstration and Legislative Extensions



Source: GAO analysis of legislation. | GAO-21-104466

^aStates had flexibility regarding the start date of their demonstrations. Six states began on July 1, 2017, with the original 2-year time frame to end on June 30, 2019. The remaining two states began their demonstrations on April 1, 2017, with an end date of March 31, 2019.

^bFour of the extensions (extensions 1, 2, 3, and 9) were enacted after the original demonstration or previous extension had expired. Officials from the Centers for Medicare & Medicaid Services told us these delays did not adversely affect the demonstration continuation because (1) the extending legislation was retroactive effective to the end date of the prior extension; and (2) state claims for payments lag behind the actual date services are provided and states can claim payment retroactively for prior periods.

Certified Community Behavioral Health Clinics Criteria

SAMHSA was responsible for developing the criteria for states to certify existing behavioral health clinics as CCBHCs, including the types of services clinics must provide. The criteria that were developed included nine categories of services, as required by PAMA, but offered states flexibility in determining the specific services CCBHCs were to provide within each of those categories. (See table 1.)

Table 1: Required Service Categories and Examples of Services Offered by Certified Community Behavioral Health Clinics (CCBHC)

Required service category	Examples of services
Crisis behavioral health	<ul style="list-style-type: none"> 24-hour mobile crisis teams Emergency crisis intervention services
Screening, assessment, and diagnosis	<ul style="list-style-type: none"> Mental screening and diagnostic services Substance use disorder screening and diagnostic services
Person-centered treatment planning	<ul style="list-style-type: none"> Person-centered treatment planning, including risk assessment and crisis planning
Outpatient mental health and substance use	<ul style="list-style-type: none"> Medication-assisted treatment for alcohol and opioid use disorders Cognitive behavioral therapies
Primary care screening and monitoring	<ul style="list-style-type: none"> Body mass index screening Diabetes screening
Targeted case management	<ul style="list-style-type: none"> Targeted case management
Psychiatric rehabilitation	<ul style="list-style-type: none"> Supported employment Financial management
Peer and family support	<ul style="list-style-type: none"> Peer crisis support and peer bridge services Parent training
Intensive mental health services for veterans and armed service members	<p>HHS does not describe specific services, but lists standards for any mental health care provided to this group, including that</p> <ul style="list-style-type: none"> care is consistent with minimum clinical guidelines established by the Veterans' Health Administration; and each veteran is assigned a Principal Behavioral Health Provider.

Source: GAO analysis of information from the Department of Health and Human Services (HHS). | GAO-21-104466

Note: The Protecting Access to Medicare Act of 2014 requires CCBHCs to provide services in nine specified categories. For each category, the Department of Health and Human Services (HHS) describes services CCBHCs can include. While CCBHCs must provide some services in each of the nine categories, they are not required to provide all services described by HHS.

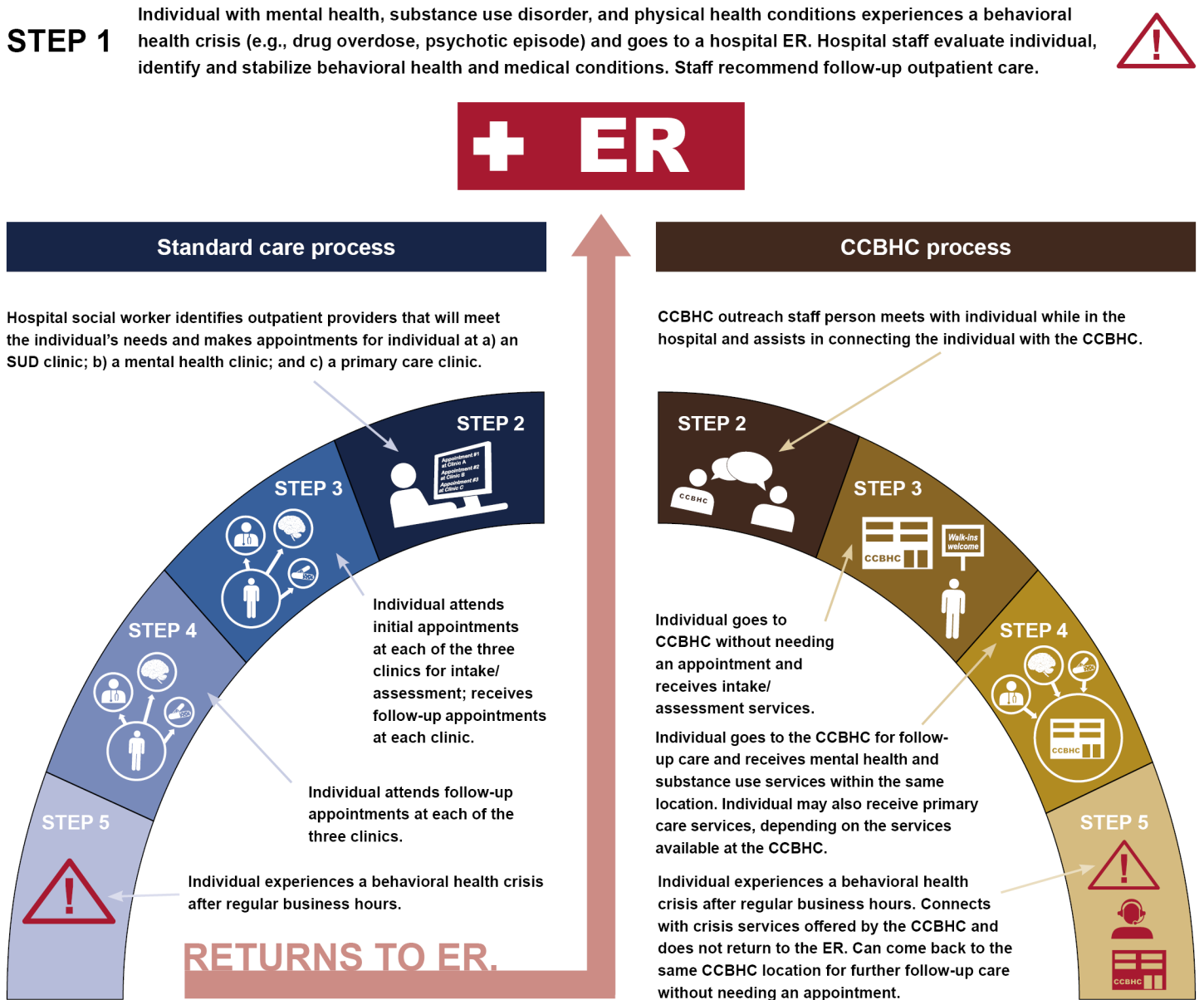
In addition to requirements on the scope of services, SAMHSA's CCBHC criteria include elements aimed at increasing access to services. For example, CCBHCs are required to

-
- provide services during times that meet clients' needs, including some night and weekend hours;¹⁸
 - engage in outreach and engagement activities to assist clients and their families to access behavioral health treatment;
 - provide crisis management services that are available and accessible 24-hours a day and delivered within 3 hours;
 - maintain working relationships with local emergency departments, including establishing protocols for CCBHC staff to address the needs of CCBHC clients in psychiatric crisis who visit emergency departments;
 - create crisis plans for clients following a psychiatric emergency in order to prevent and de-escalate future crisis situations; and
 - serve clients without regard for their ability to pay, or their place of residence.

See figure 3 for an example of how care provided by CCBHCs may differ from standard care for behavioral health conditions.

¹⁸According to HHS, the most common strategy that CCBHCs used to increase service access was the introduction of open-access scheduling. Open-access scheduling is a method of scheduling in which all patients can receive an appointment slot on the day they call. In addition, some CCBHCs have walk-in appointments available where no appointment is necessary.

Figure 3: Example of Treatment for Behavioral Health and Other Medical Conditions at Certified Community Behavioral Health Clinics Compared with Standard Care



Legend: CCBHC=certified community behavioral health clinic; ER=emergency room; SUD=substance use disorder.

Source: GAO analysis of CCBHC demonstration documentation and interviews with CCBHC officials. | GAO-21-104466

Note: This figure—which provides an illustrative example that is not comprehensive of all potential client behavioral health conditions and needs—shows how individuals receiving care from a CCBHC could access services in one location and avoid emergency department visits. Services available at CCBHCs vary; for example, not all CCBHCs provide primary care services beyond the required primary care screening and monitoring. Further, decisions about source of care and treatment, and the course of behavioral health conditions, including the need for urgent or emergent care, depend on many factors.

Certified Community Behavioral Health Clinics Payment

CMS was tasked with the issuance of guidance to facilitate states' development of a prospective payment system (PPS) to reimburse CCBHCs for services provided to Medicaid beneficiaries. Per CMS's 2015 PPS guidance, states were to develop clinic-specific rates that were based on each clinic's historical costs and visits, and changes in scope of services provided. States were permitted to select one of two PPS models developed by CMS that pay a fixed amount for CCBHC services provided to a Medicaid beneficiary, regardless of the type or volume of services received. One model pays a daily fixed rate and the other pays a monthly fixed rate. Under the demonstration, states receive an enhanced federal matching rate for CCBHC services provided to Medicaid beneficiaries.¹⁹ During fiscal years 2017 through 2019, states reported about \$1.2 billion in Medicaid CCBHC expenditures, with federal expenditures of about \$900 million, and state expenditures of about \$300 million.²⁰

Certified Community Behavioral Health Clinics Evaluation

PAMA required HHS to assess the effectiveness of the CCBHC demonstration during its initial 2 years, which spanned from 2017 to 2019.²¹ Specifically, HHS was to assess the demonstration's effectiveness on service access, the impact on federal and state costs of providing mental health services, and the quality and scope of services,

¹⁹The federal matching rate—or the Federal Medical Assistance Percentage—is a statutory formula used to calculate the share of Medicaid expenditures that are matched with federal funds. 42 U.S.C. § 1396d(b). The minimum is 50 percent, and the formula is designed such that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average. For certain services and emergencies, Congress has taken action to adjust the federal matching rate for certain beneficiaries or services.

²⁰States use a web-based system, the Medicaid Budget and Expenditure System, to report their total aggregate Medicaid expenditures by service category to CMS for the purpose of claiming the federal share of their payments to providers and for other approved expenditures. States are required to use this system to input and transmit electronically a form referred to as the CMS-64 on a quarterly basis. CMS added new lines to the CMS-64 for demonstration states to report their expenditures for CCBHC services.

²¹Pub. L. No. 113-93, § 223(d)(7)(A), 128 Stat. at 1082.

and to issue annual reports summarizing its findings. In addition to the annual reports, PAMA required HHS to issue a report with recommendations for the continuation, expansion, modification, or termination of the demonstration by December 31, 2021.²² To support those efforts, states were required to submit quality measure and cost report data to HHS. States were not required to evaluate their CCBHC demonstration programs.

As of July 2021, HHS had issued four annual reports to Congress, each of which assessed different aspects of the demonstration, from access and costs to quality and implementation experiences of demonstration states and CCBHCs.²³ We previously examined HHS's evaluation efforts and found that the department's assessments had yielded an incomplete picture of the CCBHC demonstration's effectiveness. Specifically, our review found that while HHS identified some changes to access, costs, and quality, its efforts to assess the demonstration's effectiveness were complicated by data limitations.²⁴

States Took Some Initial Steps to Measure Quality of Care; State Officials Indicated Interest in Future Study of Demonstration's Effect on Health Outcomes

²²Pub. L. No. 113-93, § 223(d)(7)(B), 128 Stat. at 1082.

²³HHS issued three annual reports in August 2018, September 2019, September 2020, and transmitted the fourth annual report to Congress in summer 2021 (as of July 2021). HHS's final report is due by December 31, 2021.

²⁴See [GAO-21-394](#).

States' Steps to Measure Quality of Care Included Periodic Collection of Additional Quality Measures and One-Time Assessments

Our review of state documentation and interviews with state officials found demonstration states and CCBHCs took some voluntary steps to measure quality of care beyond what was required under the demonstration.²⁵ These voluntary efforts generally involved collecting information on some aspects of quality of care, from periodic reporting of quality measures to one-time assessments on specific quality of care issues. (See app. I for more information on the required quality measures.)

At least three states—Minnesota, New Jersey, and Oklahoma—required CCBHCs to periodically report additional state-specific quality measures beyond the 21 demonstration-required measures.

- **Expanded access to services.** All three states collected information on the use of peer specialists, family support services, employment services, or telehealth services. These states generally reported increased use of these services. For example, Minnesota and Oklahoma measured the use of peer support services and showed higher uptake of these services during the demonstration years compared with the time period before the demonstration.²⁶ Similarly, New Jersey reported increased use of peer support services in the second demonstration year compared with the first demonstration year.

²⁵Under the demonstration states were required to report information on 21 quality measures, including screening and treatment of specific conditions, follow-up and readmission, and consumer and family experiences of care. HHS's evaluation of the demonstration includes an evaluation of these required quality measures. For example, HHS's preliminary assessments describe activities undertaken by CCBHCs to collect data on these quality measures, such as the implementation of new electronic health record systems (Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation and Office of Behavioral Health, Disability, and Aging Policy, *Preliminary Cost and Quality Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration* (Washington, D.C.: September 2020). HHS's fourth annual report described CCBHC performance on the quality measures in the first demonstration year. HHS plans to describe performance for the second demonstration year and any changes in CCBHC performance on the quality measures between the initial 2 years of the demonstration in the final report to Congress. See also [GAO-21-394](#) for more information about the quality of care data collection and reporting that was required of states under the demonstration.

²⁶According to SAMHSA, peer support services encompass a range of activities and interactions between individuals who share similar experiences of being diagnosed with a behavioral health condition. Peer providers share their own lived experience of recovery along with practical guidance to assist others to initiate and maintain recovery and enhance their quality of life.

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- **Functional assessments.** Minnesota and Oklahoma made efforts to use standardized tools to assess the functioning level of their CCBHC clients.²⁷ For example, Oklahoma monitored the ability of clients to perform functional tasks in the areas of interpersonal, medical/physical, and self-care/basic needs, finding that the results varied by CCBHC and by year.²⁸
 - **Targeted outreach.** Minnesota developed additional measures collaboratively with the CCBHCs to show the effect of the demonstration on the target populations served by the CCBHCs. For example, Minnesota officials collected information on utilization of CCBHC services among non-primary English speakers and found that the utilization increased during the demonstration period compared with the utilization prior to the demonstration.

In addition, at least two states undertook one-time assessments of specific issues related to quality of care. One state assessment focused on describing CCBHCs' clinical practice, while the other state assessment focused on understanding drug use among their CCBHC clients.

- **Integration of clinical practice.** New York officials said that they used standardized tools along with onsite evaluation to assess the degree of integration of mental health and substance use disorder services.²⁹ Higher scores indicate the CCBHCs' ability to treat clients with co-occurring substance use disorders and mental health conditions. State officials said that CCBHCs, on average, scored in

²⁷Two such tools mentioned are the Daily Living Activities–20, which is a functional assessment measure for adults with severe mental disorders in 20 different areas of daily living, such as coping skills, mental and physical health care practices, time management, nutrition, money management, problem solving, family relationships, safety, and alcohol and drug use; and the Client Assessment Record, which evaluates the functioning level of clients, with six levels of functioning across the nine domains that include feeling/mood/affect, thinking/mental process, substance use, medical/physical, family, interpersonal, role performance, socio-legal, and self-care/basic needs.

²⁸Oklahoma also monitored the outcome of mental health services for children and adolescents using a standardized tool, Ohio Scales for Youth. Preliminary results suggest that children's behavioral clinical outcomes improved by 16 percentage points within the first 12 months of the demonstration.

²⁹New York used Dual Diagnosis Capability in Mental Health Treatment and Dual Diagnosis Capability in Addiction Treatment to assess the degree of integration of mental health and substance use disorder services for its CCBHCs. For example, state officials noted that Dual Diagnosis Capability in Mental Health Treatment measures the extent to which mental health-only providers were able to integrate substance use disorder treatment into their program models.

the moderately high range for integration of mental health and substance use disorder services, and that protocols and policy were in place to evaluate practice and make continual improvement.

- **Drug use.** New Jersey reported a one-time assessment of CCBHC clients identified as unhealthy drug users and, using the results, initiated cessation intervention. The state found that more than half of clients identified with, and treated for, alcohol and other drug issues did not have a primary substance use disorder diagnosis.³⁰

Individual CCBHCs also collected data on additional measures that align with clinic-identified specific goals and areas of focus. For example, to assess the effects of the CCBHC beyond health care settings, officials from one clinic we interviewed told us they studied the CCBHC's effect on reducing driving miles for police officers, who can be called in for support when crisis services are not available or accessible.³¹

Officials from Most States Indicated Interest in Studying the Effects of the Demonstration on Health Outcomes, but Identified Constraints that May Complicate Such an Evaluation

Officials from seven of the demonstration states expressed interest in studying the effects of the demonstration on health outcomes among CCBHC clients, but as of June 2021, had not conducted such studies.³² Under the demonstration, states are not required to evaluate their CCBHC demonstration programs. Officials we spoke with generally reported increases in access, utilization, and coordination of services. For example, officials from seven of the demonstration states reported increased access to behavioral health services, which the officials generally attributed to features such as open access scheduling and extended hours of services. While the reported increases in access, utilization, and coordination do not reflect health outcomes, officials from three clinics we interviewed stated that the CCBHC model appeared to be associated with improved health outcomes for clients. However, most

³⁰Oklahoma also monitored drug use among CCBHC clients periodically, pending evaluation.

³¹According to SAMHSA's report on safe policing, law enforcement officers may be charged with responding to behavioral health emergencies and may need to travel long distances to transport people with mental illness from one facility to another (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Executive Order Safe Policing for Safe Communities: Addressing Mental Health, Homelessness, and Addiction Report* (Rockville, Md.: December 2020).

³²Health outcome measures refer to the effects of health care on the health status of patients and populations, such as improvements in depressive symptoms or recovery from substance use disorders.

state and clinic officials we spoke with were not aware of any published data that could confirm these effects.

State officials identified several constraints that would complicate and hinder states' ability to evaluate the demonstration's effects on quality of care, including clients' health outcomes. These include the following:

- **Demonstration time frame.** Officials from seven of the demonstration states said that the original 2-year demonstration time frame presented challenges, such as identifying a stable period for evaluation, and some affected clinic operations due to uncertainty of demonstration funding. For example, some officials stated that the first demonstration year involved getting clinics familiar with processes, hiring providers, and using electronic health records and cost reports to meet the demonstration requirements. Some states reported that the potential of the demonstration ending limited states' and clinics' efforts to expand resources to support CCBHC activities or conduct evaluations.
- **COVID-19 pandemic.** The COVID-19 pandemic affected the third year of the CCBHC demonstration, creating challenges to evaluations, because of associated changes in access, behavioral health needs, and utilization of services. We previously reported that the prevalence of behavioral health conditions increased during the pandemic, while access to in-person behavioral health services decreased.³³ Officials from one clinic we spoke with stated concerns about loss of services and lack of accountability for their clients, given that some of their service providers were shut down or had limited face-to-face interactions.
- **Data limitations.** Officials from all eight demonstration states cited data limitations that would complicate efforts to assess the impact of the CCBHC demonstration on quality of care, including clients' health outcomes. These limitations included identifying comparison populations and the lack of outcome measures, which are consistent with the data limitations we previously identified in assessing HHS evaluation efforts.³⁴ Officials from six states noted that the quality measures demonstration states were required to report lacked sufficient measures of behavioral or physical health outcomes. For example, New York officials said they would like to know how effective CCBHCs are at addressing mental health conditions like anxiety, not

³³See [GAO-21-437](#).

³⁴See [GAO-21-394](#).

just what percentage of clients received screenings. Oklahoma officials said they would like to examine “real life” outcomes, such as fewer days of psychiatric hospitalization, more days of stable housing, and clients obtaining meaningful employment.

Officials from Most States Reported Increased State Spending on Behavioral Health under the Demonstration, and Results of Related State Assessments Varied

Most States Reported Increased State Behavioral Health Spending for Demonstration Clinics, with Related Increases in Clients Served and Services Provided

Officials we interviewed from five of the eight CCBHC demonstration states—Minnesota, Missouri, New Jersey, New York, and Oregon—stated that the demonstration generally resulted in increased behavioral health spending by the state on CCBHC services. For example, one state calculated an increase in state CCBHC spending of more than \$25 million from the first to the third year of the demonstration (fiscal years 2018 to 2020). Another state estimated an increase of approximately \$40 million—a 100 percent increase—in state and federal spending on CCBHCs in the first demonstration year compared with spending before the demonstration.

Officials from these five states and clinic officials also stated that the increased spending reflected an increased number of individuals with behavioral health needs receiving treatment, an increased array of services provided by CCBHCs, or both. For example:

- Officials from Oregon told us that, whereas they had anticipated their CCBHCs providing services to between 30,000 and 35,000 individuals in each of the first 2 years of the demonstration, they found that over 50,000 individuals received CCBHC services in each of these 2 years. According to these officials, serving more individuals will necessarily mean increased state spending.

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- Minnesota officials estimated that the demonstration payment rates for CCBHCs effectively doubled behavioral health provider payment rates, and were now covering providers' costs. Officials estimated that the rates paid prior to the demonstration, in contrast, covered about half of providers' costs. These officials noted that the demonstration focused on addressing access and quality, rather than making cost efficiency the priority.³⁵

In addition, officials we interviewed from the three CCBHCs added that the PPS payment structure allowed them to provide services and hire staff, including staff for community engagement. For example, officials from one clinic said the PPS payment structure allowed them to commit resources toward helping clients find employment, live on their own, or leave an institutional setting and return to living in the community, services that were not possible before the demonstration, because they were not directly billable under a fee-for-service payment structure. Officials from another clinic said the demonstration PPS enabled them to hire doctors, nurses, and medical assistants so they could build a "one-stop shop" where all necessary services could be accessed and utilized onsite the same day, allowing them to provide services like medication management, medication-assisted treatment, and psychiatric evaluations without referring clients to other facilities and without a wait.

In contrast, officials from the other three demonstration states did not report that the demonstration resulted in greater state spending. Officials from two of these states told us the demonstration resulted in decreases in such spending, citing factors such as the demonstration's increased federal Medicaid support or savings from care improvements that resulted in cost savings elsewhere.³⁶ Officials from the third state said the effects on spending were unknown.

³⁵Six states did not identify a demonstration goal related to cost efficiency when originally applying for the demonstration, and instead selected goals related to increasing access to, or providing a complete scope of, services.

³⁶The CCBHC demonstration includes an enhanced federal matching rate—the share of expenditures for Medicaid services that are matched with federal funds—for CCBHC services provided to Medicaid beneficiaries.

Four States Had Varied Results in Assessing the Demonstration’s Effect on the Utilization of More Expensive Care, and Cited Challenges to Conducting Such Assessments

Officials from four of the eight demonstration states—Missouri, New York, Oklahoma, and Oregon—told us their state assessed potential cost savings resulting from the demonstration. Based on our review of state documentation and interviews with state officials, we found that these assessments examined the extent to which utilization of CCBHC services resulted in cost savings to the state in the form of reductions in the use of more expensive care: emergency department visits and inpatient hospitalizations. While the results of the state assessments varied, officials from three of the four states viewed the results of their assessments as suggestive of potential cost savings. Officials from the fourth state did not. (See table 2.)

Table 2: State Assessments of Potential Cost Savings Resulting from the Certified Community Behavioral Health Clinics (CCBHC) Demonstration

Demonstration state	Background and measurement	Findings
<i>State assessment suggested cost savings resulting from the demonstration</i>		
Missouri	<ul style="list-style-type: none"> Examined emergency room visits and hospitalizations after 6 months for clients engaged in the Emergency Room Enhancement initiative. Missouri incorporated this initiative into the demonstration to engage individuals leaving the emergency room in receiving coordinated, wraparound care to improve client health and reduce future emergency room visits.^a 	<ul style="list-style-type: none"> Identified a decrease in emergency room visits and hospitalizations of over 70 percent after 6 months for clients engaged in the Emergency Room Enhancement initiative program. Though it did not calculate cost savings resulting from the initiative, state officials said that spending on behavioral health more generally does result in cost savings, and provided an example of such savings from a related behavioral health program with overlapping services.^{b,c}
New York	<ul style="list-style-type: none"> Estimated the difference in costs for utilization of inpatient hospitalizations and emergency room visits for CCBHC clients in demonstration year one compared to the period before the demonstration. 	<ul style="list-style-type: none"> For CCBHC clients in demonstration year one, monthly inpatient hospitalization costs and monthly emergency room costs each decreased over 25 percent, resulting in monthly cost savings of over \$1 million from decreased hospitalizations and nearly \$100,000 from decreased emergency room visits. Officials said reduced inpatient hospitalization and emergency department costs represent a return on their investment of state demonstration spending, which they also identified, albeit to a lesser extent, in subsequent years.^b

Demonstration state	Background and measurement	Findings
Oklahoma	<ul style="list-style-type: none"> Examined inpatient psychiatric hospitalization utilization for CCBHC clients in 6 month intervals, and compared annual costs of CCBHCs and Community Mental Health Centers. 	<ul style="list-style-type: none"> Inpatient psychiatric hospitalizations decreased by approximately 1,400 days for CCBHC clients after 6 months of CCBHC services. Primarily through a reduction in psychiatric inpatient hospitalizations and crisis intervention, the CCBHC model resulted in annual savings of over \$2 million compared with the Community Mental Health Center model.^b Oklahoma's fiscal year 2022 Executive Budget stated that the CCBHC model allows the treatment provider network to better meet the needs of Oklahomans on an outpatient basis, realizing a significant decrease in use of higher, more costly levels of care.
<i>State assessment did not suggest cost savings resulting from the demonstration</i>		
Oregon	<ul style="list-style-type: none"> Compared (1) the utilization rates of inpatient hospitalizations and emergency department visits, and (2) the cost of broader services, in demonstration year two and the year before the demonstration. For both of these comparisons, Oregon used a target population of CCBHC clients—those diagnosed with Serious Persistent Mental Illness—and a control group with the same diagnoses who were not CCBHC clients. 	<ul style="list-style-type: none"> (1) Inpatient hospitalization and emergency department visits increased more for CCBHC clients than for non-CCBHC clients of the target population from the pre-demonstration year to demonstration year two; and (2) similar increases in the broader costs of services resulted in approximately \$765,000 in additional cost to the state for these services for CCBHC clients when compared with non-CCBHCs.^d Oregon's assessment stated that more time would be needed to observe significant change in utilization of inpatient and emergency care by CCBHC clients and any corresponding cost savings.

Source: GAO analysis of CCBHC demonstration state assessment documentation and interviews with demonstration state officials. | GAO-21-104466

Notes:

^aMissouri conducted this assessment with the Missouri Behavioral Health Council and the Missouri Institute of Mental Health.

^bState provided us assessment results or summary documentation.

^cMissouri officials provided a related assessment of its behavioral health home program, which provides services that overlap with those provided by CCBHCs. Missouri calculated average annual cost savings of over \$50 million resulting from this program.

^dIn addition to inpatient hospitalization and emergency department visits, broader services included outpatient hospital, primary care visits, outpatient substance use disorder services, prescription drugs, non-emergent medical transportation, and dental services, among others.

Although it did not study potential cost savings, Pennsylvania assessed the number of services provided per CCBHC visit under its daily PPS rate, using data from its Medicaid Management Information System. Officials reported that their assessment found that clinics were not providing multiple services in a single visit as they expected under the daily payment rate; the state reported an average of just over one service provided per visit. Officials noted these results suggested a lack of efficiency in care delivery, which could affect spending.

Additionally, officials we interviewed from one clinic told us they assessed potential cost savings from reductions in the use of hospital-based care. Clinic officials reported that they found that utilization of CCBHC services was associated with a reduction of nearly 90 percent in client hospitalizations from 2015 to 2019, in addition to savings accruing to law enforcement during a shorter period from reduced interactions with clinic clients. Clinic officials attributed this to the clinic's proprietary mobile application used to increase client access to CCBHC services.³⁷

Officials from states that conducted assessments noted challenges to their ability to fully detect demonstration effects on state spending and determine the demonstration's long-term effectiveness. Similar to the challenges related to measuring health quality, most officials said that assessing potential cost savings may have been affected by the focus on service provision and data collection at the start of the demonstration, and the uncertainty of the program's continuation on full implementation of the CCBHC model. Another challenge program officials from these states commonly cited was that the length of the demonstration may have been too short for cost savings to fully materialize. For example:

- Officials from Oregon said the identified spending increases may have resulted from the CCBHC model increasing access to a larger population of individuals with severe mental illness. By CCBHCs offering increased care coordination and outreach, more individuals sought treatment, thus driving up spending in the short term. Officials added that a possible reason they did not find CCBHC-related cost savings was that the savings from any interventions may not have materialized within the initial 2 years of the demonstration.
- Officials from New York said the 2-year demonstration period was not enough time to establish program effects. Officials added that nearly one-quarter of individuals who received services at a CCBHC had not received behavioral health services in the previous 3 years, which contributed to the state's increase in spending.
- Officials from Missouri similarly said the demonstration's 2-year length was likely not enough time to detect cost savings, but did note that the state had identified savings from its behavioral health home program over a longer period of time. Officials told us the state also assessed

³⁷Clinic officials said that, as part of their demonstration program, they worked to create a software application to run on iPads they provided to clients, clinicians, and law enforcement. According to officials, this application, which connected individuals to the clinic and services, increased access and reduced escalation to inpatient hospitalization.

changes in the CCBHC client population over time and the state reported a larger increase in the number of clients between the first 2 years and a slower increase by year three. State officials said the demonstration's outreach and engagement may take longer to materialize into cost savings for the state, such as through reduced utilization of emergency room and hospital services.

As cost savings may take longer to materialize, some state officials expressed an interest in evaluating the CCBHC model's ability to avoid certain client outcomes that drive increased state spending on medical care, such as inpatient hospitalizations, or the model's ability to reduce costs for other state government functions, such as law enforcement.³⁸ Some officials said they would like to use this information to manage the program over time or justify continued state investment in the program to their legislatures.

Officials from seven of the eight demonstration states told us they plan to continue their participation in the demonstration through September 2023.

- Officials from five of these states said they plan to seek CMS approval to offer CCBHC services under their Medicaid state plans once the demonstration ends.
- Officials from the sixth state said they were discussing seeking CMS approval to offer CCBHC services under their Medicaid state plan, but had not yet done so.
- Officials from the seventh state said they were discussing inclusion of CCBHCs in an upcoming section 1115 demonstration.³⁹

One state—Pennsylvania—discontinued the demonstration as of June 30, 2019, in favor of an alternative that officials said provided more certainty in funding continuity and control over payment under its

³⁸For example, officials from New Jersey noted that the state had four cost saving measures under development as of June 2021, including changes in emergency department use after CCBHC enrollment.

³⁹Under Medicaid section 1115 demonstrations—which allow states to test and evaluate new approaches for delivering services under the federal-state Medicaid program—the Secretary of Health and Human Services may waive certain federal Medicaid requirements and approve new types of expenditures that would not otherwise be eligible for federal Medicaid matching funds for experimental, pilot, or demonstration projects that in the Secretary's judgment are likely to promote Medicaid objectives.

managed care program.⁴⁰ Pennsylvania officials cited several additional factors contributing to their decision to end the CCBHC demonstration in their state, such as the uncertainty of continued federal funding, requirements for quality measures focusing on process rather than outcomes, and the additional requirements associated with monthly PPS rates compared with the demonstration's daily PPS rates.⁴¹ The officials added that they transitioned to a monthly prospective payment system under the program with which they replaced their demonstration.

CMS Guidance Lacks Clear and Consistent Information to Help States Align Medicaid Payment Rates with Clinics' Costs and Avoid Potential Duplicate Payments

CMS Provided Guidance and Technical Assistance to States on Rate Setting, but Guidance Lacks Clear and Detailed Information on Aligning Payment Rates with Clinics' Costs

To support the development of clinic-specific, cost-based PPS rates, CMS provided a cost report template and instructions for clinics to report their costs, issued written guidance for states on CCBHC payments, and hosted a series of 12 technical assistance webinars in 2015 and 2016.⁴² States were instructed to base rates for the first demonstration year on clinics' reports of their historical service costs and number of visits, as well as anticipated costs, such as the cost to add staff or provide CCBHC services that clinics did not provide before the demonstration. States collected this information from cost reports clinics submitted during the planning grant phase in 2015 and 2016, before the demonstration began,

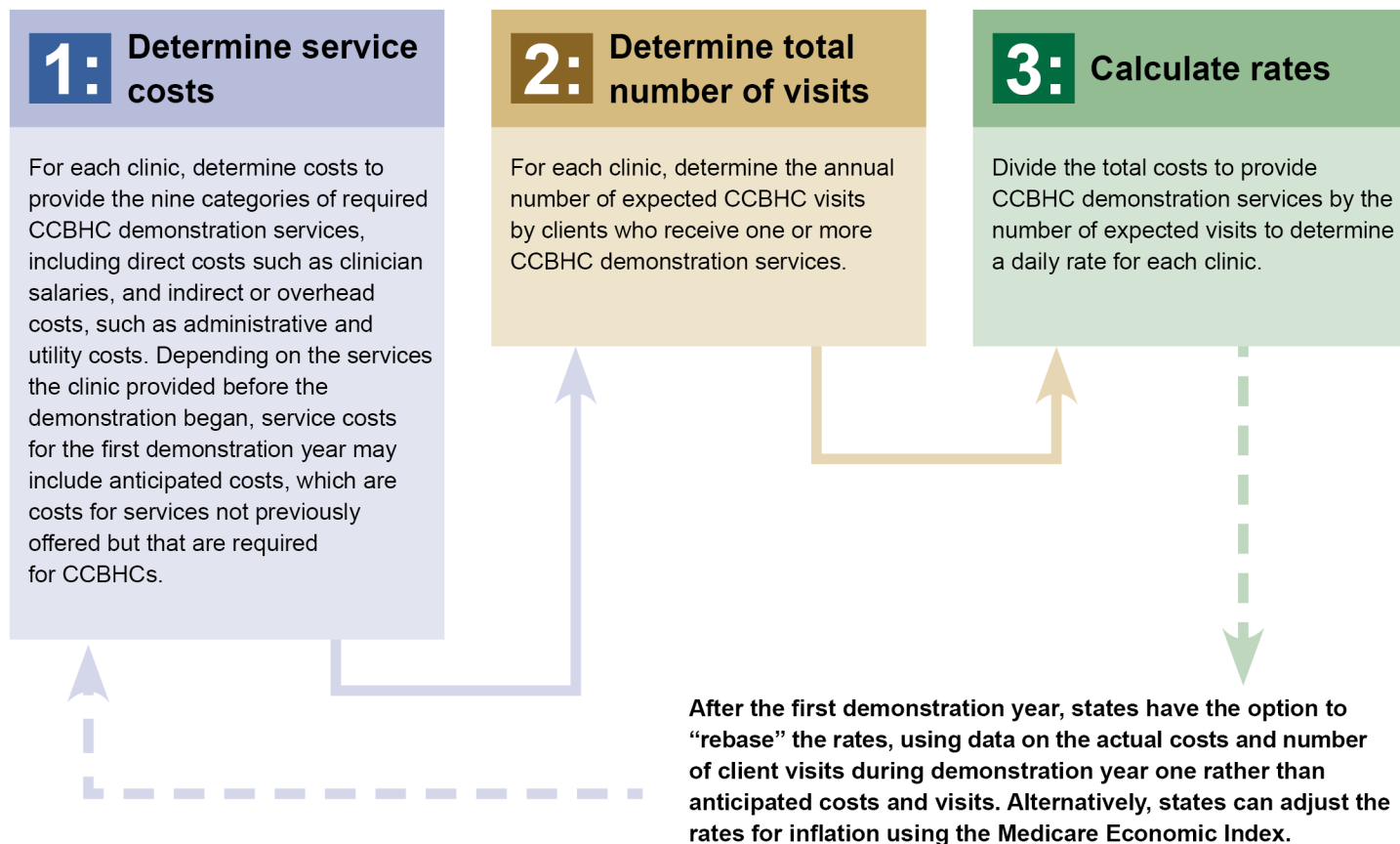
⁴⁰Pennsylvania operates its Medicaid program through a Medicaid section 1915(b) waiver, which allows states to mandate beneficiary enrollment in managed care.

⁴¹For example, states that selected the monthly PPS rate were required to develop—in addition to a standard monthly rate—monthly PPS rates that vary according to clients' clinical conditions, such as for children and adolescents with serious emotional disturbance who require higher intensity services. States that selected the daily PPS rate were not required to develop these separate rates.

⁴²CMS also published four sets of questions and answers regarding CCBHC payments on its website, and provided a dedicated email address for states to submit PPS-guidance-related questions and receive responses.

to develop estimated rates for the first demonstration year. For the second demonstration year, CMS guidance provides states the option to rebase their rates based on the actual costs for CCBHC services provided and the number of client visits from the first year—as recorded in clinic cost reports—rather than anticipated costs and visits. Alternatively, states could choose to adjust rates for inflation based on the Medicare Economic Index. See figure 4 for information on the development of daily PPS rates.

Figure 4: Centers for Medicare & Medicaid Services Process for States to Develop Daily Clinic-Specific, Cost-Based Prospective Payment Rates for Certified Community Behavioral Health Clinics (CCBHC)



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) guidance and interviews with knowledgeable CMS officials. | GAO-21-104466

Note: Under the demonstration, states had the option to develop monthly prospective payment rates rather than daily rates. States that opted to use monthly rates were required to develop—in addition to a standard monthly rate—monthly rates that vary according to clients’ clinical conditions.

CMS officials said they provided the option for states to rebase rates, because some CCBHCs may not have had experience providing the full range of services prior to the demonstration, so states would not have had historical data on which to base their first year rates. Agency officials said rebasing would mean states would not have to rely on anticipated cost and client visit data after the first year, and would align rates more closely with costs in subsequent demonstration years. CMS officials said the agency did not require rebasing, in part, because the demonstration was originally authorized for only 2 years and some state officials believed they needed more than a single year's worth of data to appropriately rebase the rates. As of September 2020, six of the eight demonstration states had rebased their CCBHC payment rates.

HHS's analysis of CCBHC payment rates highlights the importance of rebasing rates based on actual costs. Specifically, HHS's analysis of cost report data from the first demonstration year—2017 to 2018—showed that states' average payments to CCBHCs typically exceeded average CCBHC costs.⁴³ HHS found that for four of the six states that used the daily payment model, average payments to CCBHCs were higher than average costs, ranging from 15 percent higher in Missouri to 52 percent higher in Pennsylvania.⁴⁴

CMS guidance does not emphasize the importance of rebasing rates to better align rates with clinics' costs, or contain detailed information to support rebasing. CMS officials said that although the guidance does not require rebasing, it was the agency's expectation that all states would rebase their rates at some point. However, as of September 2020, two of the eight states had not rebased their rates.⁴⁵ In addition, CMS's guidance does not provide detailed information on rebasing, such as suggested time frames, or the magnitude of differences between costs and rates that should trigger states to consider rebasing.

Absent additional guidance, CMS cannot ensure that state Medicaid program payments meet requirements for Medicaid payments under

⁴³For participating states, HHS's issued reports include information on selected payment models, payment rates, and preliminary information on CCBHC costs and payments from the first year of the demonstration. HHS updated these data, analyzed similar data from the second year of the demonstration, and included these findings in the interim reports, which we reviewed, but were not publicly available as of June 2021.

⁴⁴Average payments to CCBHCs were 12 percent lower than actual costs in Oregon. Nevada was excluded from HHS's analysis due to data limitations.

⁴⁵Missouri and Oregon did not rebase their rates.

federal law—including that they are consistent with economy, efficiency, and quality of care, and are sufficient to ensure access to care. While rates that exceed costs are not an efficient use of limited resources, rates that fall below costs could threaten the sustainability of the demonstration and lead to diminished access to services. Clearer written guidance that reflects CMS’s expectation that states rebase their PPS rates, with additional information for states on how to rebase, could help states better align Medicaid CCBHC payments with clinics’ costs. Such guidance could be beneficial for the two states that have not rebased, the two new demonstration states, and any states that join the demonstration in the future.

CMS Guidance Lacks Consistent and Clear Information for States on Preventing Potential Duplication between CCBHC Payments and Other Medicaid Payments

CMS’s 2015 CCBHC payment guidance, and some of the presentation slides from its 2015 and 2016 technical assistance webinars, include information on how to reimburse CCBHCs for services provided. However, one potential challenge is that a CCBHC may also be certified to receive Medicaid payments as another provider type, which may offer services that overlap those covered under the demonstration. This raises the question of whether CCBHCs could receive duplicate Medicaid payments (i.e., a CCBHC payment and an additional Medicaid payment as another provider type for the same service). Our review of CMS’s CCBHC payment guidance and technical assistance found that CMS has not provided consistent and clear information on preventing duplication when there is overlap between CCBHC services and services included in payment rates for two other Medicaid provider types: Federally Qualified Health Centers (FQHC) and behavioral health homes. CMS officials stated that when the PPS guidance was written, the CCBHC demonstration was brand new, and they did not know whether and to what extent clinics that would become certified as CCBHCs would also be certified as other provider types.

Inconsistent guidance for CCBHCs that are also Federally Qualified Health Centers. CMS has provided conflicting guidance on payments for CCBHCs that are also certified as FQHCs—clinics that also receive cost-

Federally Qualified Health Centers

State Medicaid programs are required to cover services provided at Federally Qualified Health Centers (FQHC), safety net providers that provide services in underserved areas without regard for the ability to pay.

FQHCs provide primary care and preventive services, and most also provide some behavioral health services. According to the Health Resources and Services Administration, in 2019, 96 percent of health centers funded by the agency—which include FQHCs—provided mental health services and 76 percent provided substance use disorder services.

Source: GAO analysis of information from the Department of Health and Human Services, the Medicaid and CHIP Payment and Access Commission, and the National Association of Community Health Centers. | GAO-21-104466

based PPS payments under Medicaid.⁴⁶ According to HHS, as of 2018, there were four CCBHCs located in one CCBHC demonstration state that were certified as FQHCs. CMS's CCBHC payment guidance specifies that clinics that are CCBHCs and certified as FQHCs are entitled to receive both types of PPS payments for the same client on the same day, even if there is an overlap between services covered under each rate. By contrast, presentation slides from a 2016 CMS technical assistance webinar state that clinics are only eligible for both payments if non-overlapping services are provided.⁴⁷

CMS officials we interviewed said the agency intended for states to apply the latter guidance, (i.e., provide both PPS payments only in cases of non-overlapping services). For example, a CCBHC also certified as an FQHC may provide mental health counseling and a dental cleaning for the same client on the same day, and CMS officials said payment of both PPS payments for this client would be appropriate. In contrast, providing a client with mental health counseling and a primary care screening service on the same day should not trigger both types of payments, because both of these services are already included in CCBHC prospective payment rates. In this case, CMS officials told us states should pay only the CCBHC rate.

⁴⁶The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required the establishment of PPS payments under Medicaid for FQHCs and certain other clinics effective January 1, 2001. Pub. L. No. 106-554, App'x F, § 702, 114 Stat. 2763A-572. Similar to the CCBHC PPS, the PPS for FQHCs established provider-specific rates. States were also required to increase payment rates annually to account for inflation and to adjust rates when necessary to reflect changes in the scope of services provided.

⁴⁷These webinars took place in 2015 and 2016, and presentation slides were shared with the 24 planning grant states at that time. However, CMS officials told us that the presentation slides were not published on CMS's website.

Behavioral Health Homes

The Patient Protection and Affordable Care Act established a health home option under Medicaid to coordinate care for beneficiaries with chronic conditions; when states choose to limit eligibility for health homes to individuals with behavioral health conditions, they may be referred to as behavioral health homes.

Behavioral health homes are required to provide six core services: (1) comprehensive care management, (2) care coordination, (3) health promotion, (4) comprehensive transitional care or follow up, (5) individual and family support, and (6) referral to community and social support services.

As of December 2020, the District of Columbia and 19 states—including five certified community behavioral health clinics demonstration states—had state plan amendments to implement behavioral health homes approved by the Centers for Medicare & Medicaid Services.

Source: GAO analysis of information from the Centers for Medicare & Medicaid Services. | GAO-21-104466

Unclear guidance for CCBHCs that are also behavioral health

homes. CMS's CCBHC payment guidance does not specifically address reimbursement of CCBHCs that are also behavioral health homes.⁴⁸ CMS officials told us the agency intended for the guidance on providers of clinic services under Medicaid to also apply to behavioral health homes. The portion of the CCBHC payment guidance on providers of clinic services notes that states should pay the CCBHC PPS rate whenever a demonstration-covered service is provided, and the clinic services rate—authorized through the Medicaid state plan—whenever a non-CCBHC service is provided by the CCBHC. While the guidance for providers of clinic services does address potential duplication, it does not clearly communicate that this guidance applies to behavioral health homes specifically.

In contrast, presentation slides from one of CMS's technical assistance webinars separately identify and provide guidance for behavioral health homes; however, the guidance does not require states to prevent duplicate payments. For behavioral health homes, the webinar presentation slides specify that states should pay behavioral health homes for CCBHC services whenever demonstration-covered services are provided, and further advises that states may consider adjusting their CCBHC rates to reflect the portion of cost also reimbursed by state Medicaid behavioral health home payments. However, CMS officials told us this is not a requirement; thus, states are not required to adjust behavioral health home payments to reflect reimbursement for services that are included in the CCBHC rate, such as care coordination.⁴⁹

In the absence of clear and consistent guidance from CMS, the five demonstration states with CCBHCs that are also certified as FQHCs or behavioral health homes reported taking varied approaches to avoid payment duplication.

- **Missouri:** Missouri is the only demonstration state that has reported having CCBHCs that are also FQHCs. Missouri officials said the state chose to require CCBHCs to separate services provided under the

⁴⁸States have flexibility with respect to behavioral health home payments. One option is a per member per month payment to providers to cover the six required core behavioral health home services.

⁴⁹Care coordination is one of the six required core services for behavioral health homes and is also considered a required activity under the CCBHC demonstration. CMS officials told us that required activities like care coordination alone are not counted as a visit that triggers a PPS payment; however, care coordination is included in the CCBHC PPS rates.

CCBHC PPS rate and services provided under the FQHC rate to avoid potential duplication. For behavioral health homes, officials said Missouri ceased paying per member per month payments to behavioral health homes that were also CCBHCs as of July 1, 2017, when the demonstration began.

- **Oklahoma:** Oklahoma officials said the state initially allowed CCBHCs to operate as behavioral health homes and receive payment under both programs. However, officials said that starting October 1, 2018, Oklahoma ceased paying per member per month payments to behavioral health homes that were also CCBHCs.
- **Minnesota:** State officials said they required CCBHCs to identify behavioral health home services and exclude them from the eligible costs on their CCBHC cost reports.
- **New Jersey and New York:** State officials said they chose to keep CCBHC clients and behavioral health home clients as separate, non-overlapping groups in their payment systems, such that both payment types could not be charged for the same client.

Although states have taken steps to avoid duplication, officials from two states said additional federal guidance on avoiding payment duplication would be helpful. For example, officials from one state noted that they already had a full continuum of behavioral health services available when the demonstration began, and it was difficult for them to determine which services should and should not be included in the CCBHC PPS rate to avoid payment duplication.

As previously mentioned, CMS is responsible for federal oversight of the Medicaid program, including ensuring that state payments are consistent with efficiency, economy, and quality of care, and are sufficient to ensure access to care. Consistent and clear written guidance from CMS could help demonstration states avoid potential duplication of payment for clinics that are CCBHCs and also certified as another Medicaid provider type. This is especially important as two additional states prepare to launch their demonstrations, and there is congressional interest in expanding the program nationwide.

Conclusions

The CCBHC demonstration has allowed states to experiment with a new model of care, with the goal of ensuring access to comprehensive, coordinated, and timely care for individuals with behavioral health conditions. The length of the demonstration has been extended from 2 years to over 6 years, expanded to two additional states, and there is congressional interest in expanding the demonstration nationwide. As the

demonstration grows, it is critical that CMS provide consistent and clear guidance to states to ensure that payment rates are better aligned with clinics' costs and reduce the potential for duplicate Medicaid payments. Safeguarding resources intended to help ameliorate behavioral health conditions for vulnerable populations is especially important in the context of the COVID-19 pandemic, which has exacerbated behavioral health concerns across the nation and underscored the need for access to care.

Recommendations for Executive Action

We are making the following two recommendations to CMS:

The Administrator of CMS should issue clear and consistent written guidance that highlights the importance of rebasing CCBHC payment rates based on actual costs and provides more detailed information on when and how states should rebase their rates, such as suggested time frames. (Recommendation 1)

The Administrator of CMS should provide clear and consistent written guidance to states on how to avoid potential duplication between Medicaid CCBHC payments and other Medicaid payments. (Recommendation 2)

Agency Comments

We provided a copy of this draft report to HHS for review and comment. HHS provided written comments, which are reprinted in appendix II. In its comments, HHS noted the range of activities CMS had taken to provide guidance to states on Medicaid CCBHC payments, as reflected in our report, while also acknowledging the need to clarify guidance for the demonstration moving forward. HHS concurred with both of our recommendations, and stated that CMS will update its written CCBHC payment guidance to provide additional information for states on (1) rebasing rates based on actual costs, and (2) avoiding duplication between CCBHC payments and other Medicaid payments. HHS also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Other major contributors to this report are listed in appendix III.

A handwritten signature in black ink, appearing to read "Carolyn L. Yocom". The signature is fluid and cursive, with a long horizontal stroke at the end.

Carolyn L. Yocom
Director, Health Care

Appendix I: Quality Measures Required by the Department of Health and Human Services for the Certified Community Behavioral Health Clinics Demonstration

The Protecting Access to Medicare Act of 2014 required the Department of Health and Human Services to assess the certified community behavioral health clinics (CCBHC) demonstration, including assessing the quality and scope of services provided by the clinics.¹ To support the federal evaluation, states and CCBHCs participating in the demonstration were required to report quality data for 21 quality measures: 12 reported by states and nine reported by CCBHCs. (See table 3.)

Table 3: Quality Measures Required by the Department of Health and Human Services for the Certified Community Behavioral Health Clinics Demonstration

Required measures	Clinic or state reported	Measure type ^a
Time to initial evaluation	Clinic	Process
Child and adolescent major depressive disorder: suicide risk assessment	Clinic	Process
Adult major depressive disorder: suicide risk assessment	Clinic	Process
Screening for clinical depression and follow-up plan	Clinic	Process
Depression remission at 12 months	Clinic	Outcome
Adherence to antipsychotic medications for individuals with schizophrenia	State	Process
Antidepressant medication management	State	Process
Follow-up care for children prescribed attention-deficit hyperactivity disorder medication	State	Process
Adult body mass index screening and follow-up	Clinic	Process
Weight assessment for nutrition and physical activity for children/adolescents	Clinic	Process
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	State	Process
Tobacco use - screening and cessation intervention	Clinic	Process
Unhealthy alcohol use - screening and brief counseling	Clinic	Process
Initiation and engagement of alcohol and other drug dependence treatment	State	Process
Follow-up after emergency department for mental health	State	Process
Follow-up after emergency department for alcohol or other dependence	State	Process
Follow-up after hospitalization for mental illness, ages 21+	State	Process
Follow-up after hospitalization for mental illness, ages 6 to 21	State	Process
Plan all-cause readmission rate	State	Process
Patient (adult) experience of care survey and family experience of care survey	State	Patient experience
Housing status (residential status during the reporting period)	State	Outcome

Source: GAO analysis of information from the Department of Health and Human Services. | GAO-21-104466

^aQuality measures can assess processes, such as the time it takes new clients to receive an initial evaluation, or outcomes of health care treatments, such as changes in mortality or infection rates.

¹Pub. L. No. 113-93, § 223(d)(7), 128 Stat. 1040, 1083.

Appendix II: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

August 31, 2021

Carolyn L. Yocom
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "**MEDICAID BEHAVIORAL HEALTH: CMS Guidance Needed to Better Align Demonstration Payment Rates with Costs and Prevent Duplication**" (Job code 104466/ GAO-21-104466).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jeff Hild".

Jeff Hild
Acting, Assistant Secretary for Legislation

Attach

**Appendix II: Comments from the Department
of Health and Human Services**

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MEDICAID BEHAVIORAL HEALTH: CMS GUIDANCE NEEDED TO BETTER ALIGN DEMONSTRATION PAYMENT RATES WITH COSTS AND PREVENT DUPLICATION (GAO-21-104466)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on the GAO's draft report on states' experiences participating in the certified community behavioral health clinic (CCBHC) demonstration.

As noted in the GAO's report, Section 223 of the Protecting Access to Medicare Act of 2014 (P.L. 113-93) authorized the creation and evaluation of a demonstration program to improve community behavioral health services through the establishment of CCBHCs. In October 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA), in conjunction with the Centers for Medicare & Medicaid Services (CMS) and the Assistant Secretary of Planning and Evaluation (ASPE), awarded a total of \$22.9 million in planning grants to support 24 states in their efforts to identify and certify behavioral health clinics, develop clinic-specific payment rates, and collect data. Of these 24 planning grant states, HHS ultimately selected eight states—Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon and Pennsylvania—to participate in the CCBHC demonstration program, which was formally launched in each state by July 2017. More recently, the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136) expanded the demonstration by two states and the Consolidated Appropriations Act, 2021 (P.L. 116-260) extended the demonstration to 2023. HHS selected Michigan and Kentucky as the two additional states which plan to start the demonstration in October 2021 and January 2022, respectively, and as such were not included in the GAO's report.

At the start of the CCBHC demonstration, in May 2015, CMS issued guidance to states and clinics regarding the development of a Prospective Payment System (PPS) that was to be tested under the demonstration. This guidance was intended to assist states in determining the appropriate PPS rate for individual CCBHCs and included information on identifying, reporting and allocating allowable costs. As noted in the GAO's report, states participating in the demonstration were able to select one of two PPS rate methodologies, and the PPS methodology selected was to be used demonstration-wide to set CCBHC-specific rates. The primary difference between the two PPS options is that the unit of payment is daily versus monthly, and both PPS methodologies allow for states to reward clinics for improved quality of care using measures approved by CMS.

In addition to providing written guidance regarding the development of a PPS, CMS held a series of technical assistance webinars throughout 2015 and 2016 for the 24 planning grant states. The technical assistance webinars covered a variety of topics and were aimed at helping states develop and implement their PPS. CMS also created a real time public facing portal to share technical assistance documents with the planning grant states throughout the one-year planning phase of the demonstration. CMS also created a resource mailbox which allowed participating states to request information and resources, or raise questions as needed. Finally, CMS published a total of 41 Question & Answers on Medicaid.gov that covered a wide range of topics including,

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MEDICAID BEHAVIORAL HEALTH: CMS GUIDANCE NEEDED TO BETTER ALIGN DEMONSTRATION PAYMENT RATES WITH COSTS AND PREVENT DUPLICATION (GAO-21-104466)

but not limited to, claiming for the enhanced Federal Medical Assistance Percentage, Third Party Liability and considerations for states with Medicaid Managed Care.

States were required to develop a PPS rate that was based on a combination of historical cost and visit data as well as the anticipated cost of providing CCBHC services. In order to assist states in determining clinic-specific PPS rates for demonstration services, CMS released an Office of Management and Budget (OMB) approved cost report template, along with detailed instructions, in January 2016. CMS gave states the flexibility to adjust their rates between Demonstration Years (DY) by either trending the DY 1 rates forward by the Medicare Economic Index (MEI) or using the DY 1 cost reports to rebase the rates for DY 2. Since the demonstration was originally authorized for two years and some states felt that more than one year of data was needed to appropriately adjust the rate, CMS did not require states to rebase their PPS rates for DY 2.

To ensure that PPS rates are consistent with efficiency, economy, and quality of care, CMS included instructions in the 2015 guidance on how these providers should be paid when a beneficiary receives a service by a dually certified clinic authorized under both the Medicaid state plan and the CCBHC demonstration. For example, CMS recognizes that in some instances a CCBHC may already participate in the Medicaid program as a Federally Qualified Health Center (FQHC), clinic services provider, or Indian Health Service (IHS) facility and receive payment authorized through the Medicaid state plan. CMS further discussed the topic of dually certified clinics as part of the technical assistance webinar series, and indicated that dually certified clinics should be paid the CCBHC PPS rate whenever a distinct demonstration service is provided. While CMS instructed states that rates must be economic and efficient, in the event of overlapping services included in rates for dually certified clinics, the clinic-specific CCBHC rate should also be paid, as the statute did not require previously established payment rates to be dismantled. Also, as noted in the GAO's report, the five states with CCBHCs that are also certified as FQHCs or behavioral health homes have already implemented various approaches to avoid payment duplication.

GAO's recommendations and HHS' responses are below.

Recommendation 1

The Administrator of CMS should provide clear and consistent written guidance that highlights the importance of rebasing CCBHC payment rates based on actual costs and provide more detailed information on when and how states should rebase their rates, such as suggested time-frames.

HHS Response

CMS concurs with this recommendation. CMS is committed to providing demonstration states with clear and consistent guidance, and recognizes that additional guidance could provide further clarity for participating states. As such, as the demonstration time-frame continues to be

**Appendix II: Comments from the Department
of Health and Human Services**

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MEDICAID BEHAVIORAL HEALTH: CMS GUIDANCE NEEDED TO BETTER ALIGN DEMONSTRATION PAYMENT RATES WITH COSTS AND PREVENT DUPLICATION (GAO-21-104466)

extended, CMS will provide updated guidance that highlights the importance of rebasing CCBHC payment rates based on actual costs, including information on when and how states should rebase their rates.

Recommendation 2

The Administrator of CMS should provide clear and consistent written guidance to states on how to avoid potential duplication between Medicaid CCBHC payments and other Medicaid payments.

HHS Response

CMS concurs with this recommendation. While states are already taking actions to avoid payment duplication, CMS is committed to providing demonstration states with clear and consistent guidance, and recognizes that additional guidance could provide further clarity for participating states. As such, CMS will provide updated guidance to states on how to avoid duplication between Medicaid CCBHC payments and other Medicaid payments.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov

Staff Acknowledgments

In addition to the contact named above, Tim Bushfield (Assistant Director), Hannah Locke (Analyst in Charge), Sonia Chakrabarty, Sandra George, Taneeka Hansen, Suhna Lee, Drew Long, Alexandre Massey, Kimberly Perrault, Eric Peterson, and Vikki Porter made key contributions to this report.

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