

Recommendations for the CCBHC Quality Incentive Program

Background Information about the CCBHC Program

The six Certified Community Behavioral Health Clinics (CCBHCs) and the Minnesota Department of Human Services (DHS) are required to collect and report on quality, client perception of care, and impact data as a condition of participation in the CCBHC Section 223 federal demonstration program. The data reporting requirements are designed to evaluate whether the priorities of the CCBHC program are met: to improve access to care and high-quality services.

Currently, CCBHC federal reporting requirements include 22 quality measures: nine measures calculated by CCBHCs from clinical data collected in their electronic health records; ten measures calculated by DHS from claims data; one measure calculated based on client level data from the CCBHCs; and two client experience of care surveys (one for adults and one for families and children). See Appendix A for a list of the current quality measures. Beyond the 22 federally required quality measures, the CCBHC program is also evaluated on eight Minnesota impact measures.

Under the current CCBHC Section 223 federal demonstration payment policy, six of the federally required measures – Suicide Risk Assessment for adults and children, Adherence to Antipsychotics for Individuals with Schizophrenia, Follow up after Hospitalization for Mental Illness for adults and children, and the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – are tied to financial incentives. Specifically, a quality bonus payment (QBP) is paid annually as a lump sum in addition to the basic prospective payment system (PPS) rate to any CCBHC that meets the minimum performance targets set forth for all six measures. Beginning in demonstration year two (DY2) a portion of the QBP is available to CCBHCs who meet two additional optional measures – Plan All Cause Readmission and Screening for Clinical Depression and Follow-up Plan.

Recently, the MN State legislature has required the DHS Commissioner to develop recommendations for a Minnesota-specific quality incentive program for CCBHC. Recommendations will be included in a legislative report on CCBHC rate methodology to be considered for the state plan amendment (SPA) submission. The quality incentive program recommendations are to be developed in consultation with DHS quality staff and stakeholders and must be consistent with measures used for other health care programs. The legislative direction states, “quality payments must be in addition to the prospective payment rate and must not exceed an amount equal to five percent of total medical assistance payment for CCBHC services provided during the applicable time period and the same terms of performance” and must apply to all CCBHCs. (Minnesota Session Laws – 2019, 1st Special Session, Chapter 9--S.F. No. 12, Article 6, Sec.79).

DHS acknowledges the possibility of a congressional extension of the CCBHC Section 223 federal demonstration for additional years. In the event that the federal demonstration is extended, DHS and CCBHC providers are obligated to follow the reporting requirements and quality bonus program defined by the Centers for Medicare and Medicaid (CMS) for the Section 223 program. An extension would impact the current six CCBHCs certified under the federal demonstration. However, this contingency may not impact new CCBHC programs operating

under an 1115 waiver or a state plan amendment (SPA). DHS intends to align data reporting requirements and quality bonus program expectations.

DHS Medicaid Program Priorities

DHS aims to ensure access to quality health care for all people. DHS works with stakeholders to improve access, quality and continuity of care. DHS has continuously engaged in various quality improvement initiatives for its Medicaid program. The CCBHC model aligns with the priorities of the state Medicaid program by improving quality of care, increasing access to services, creating a comprehensive continuum of care that provides coordinated care, and reducing disparities for American Indians, communities of color, veterans, and other cultural groups.

These priorities and goals guided the recommendation to incentivize performance improvement on certain measures. Quality measures recommended for the quality incentive program are consistent with measures used for other health care programs such as Integrated Health Partnership (IHP) and Behavioral Health Homes (BHH). The recommendations presented below by DHS align with the priorities and goals of Minnesota's Medicaid program and the CCBHC model.

Evolution of Quality Measures

DHS acknowledges that Quality Measurement is a dynamic field and change is continuous. Quality measures, value sets, clinical guidelines and priorities may change year to year. The initial goal is to define the priorities of the CCBHC program and the quality measures that will assess and support those priorities. As change occurs, the assessment measures will evolve. DHS recommends implementing an annual review of the quality program and the specific measures to ensure the measures meet the needs of the beneficiaries, providers and the state. See recommendation six below.

Summary of Recommendations

Recommendations were informed by the quality staff across the Department's Healthcare Research and Quality (HRQ) and Behavioral Health Divisions and the CCBHC providers. The DHS quality staff are experienced with quality measures for CCBHC, IHP, and BHH programs. The DHS quality staff recommend that the CCBHC quality incentive program build on measures currently tied to the CCBHC Section 223 quality bonus program, as well as expand the current scope to include new outcome and process measures related to primary care and social determinants of health. The expansion of the scope of measurement to include primary care and social determinants of care emphasizes the role of CCBHCs in coordinating high quality whole person care to Medicaid enrollees. DHS acknowledges that it would be helpful for providers to gain access to care management reports and other data. The CCBHC providers recommend having access to reports such as those currently available in the BHH Partners Portal to help with performance, quality improvement and care coordination. See recommendation seven below.

Recommendations for the Quality Incentive Program

Recommendation 1a: DHS quality staff recommend grandfathering in the following behavioral health measures:

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)
- Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (FUH-BH-A)
- Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (FUH-BH-C)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)

Reasoning: CCBHCs have committed resources to improve on these measures but have not been able to meet the targets yet. Also, these behavioral health measures are consistent with measures used for other health care programs such as BHH, IHP, and the Medicaid Adult and Child Core Set. In 2024, these behavioral health measures will become mandatory for federal reporting. These measures are calculated from DHS claims and would not require providers to submit additional data to DHS.

The CCBHC providers recommend DHS quality staff explore the possibility of adding additional services to the value sets for these measures, such as peer services, targeted case management (TCM), children's therapeutic services and supports (CTSS) to better align the measures with the CCBHC model. These are typical follow-up services after an individual is hospitalized. DHS quality staff will analyze the data to assess if adding these additional services to the value sets will result in significant changes in the rates for these measures. The CCBHC providers and DHS quality staff acknowledge that non-billable activities will not appear in the claims data and therefore, will not be included in the measure calculations.

Recommendation 1b: DHS quality staff recommend grandfathering in the following clinic-reported quality measures:

- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)
- Major Depressive Disorder: Suicide Risk Assessment (SRA-A)

Reasoning: While DHS acknowledges that the two suicide risk assessment measures have been identified as problematic, the CCBHCs will be responsible for collecting and reporting on these measures to DHS as a requirement of Minnesota's continued participation in the Section 223 federal demonstration should Congress decide to extend the demonstration for one full year (July 2019-June 2020). DHS considered the following options:

- 1) Do not recommend the SRA measures to be grandfathered into the new Minnesota-specific Quality Incentive Program because of the feedback gathered from CCBHCs providers. However, to align reporting requirements for all CCBHCs (Section 23 demonstration and all others) we recommend continuation of these measures at this time. In particular, the requirements for these measures are that a person is assessed for suicide risk at every visit. Although this is a relevant requirement for primary care settings or clients seen infrequently in a behavioral health setting; the providers reported that it is not clinically sound to assess for suicide risk on a daily basis when a person is in day treatment, for example. The CCBHC providers and DHS quality staff acknowledge that these measures may result in perverse incentives for the provider, but may not be in the best interest of the person being served. Perhaps a lower rate of suicide risk assessment may be an indicator of a more person-centered approach.
- 2) Due to the above concerns DHS will work with evaluation staff from the states participating in the Section 223 demonstration to formulate joint recommendations regarding this measure and seek approval by CMS/SAMHSA/ASPE to remove or modify the SRA measures from the quality bonus program.

Recommendations 2 and 3

The following recommendations relate to the expectations of CCBHCs to coordinate care with the primary care providers of the people they serve within their behavioral health clinic. One of the primary goals of CCBHC is to integrate mental health and substance use disorder services as well as coordinate with primary care. Although CCBHCs would not administer some of the primary care screenings and preventive services below, we recommend incentivizing performance to assist the people they serve with scheduling and completing these screenings in order to reach the goal of improving a person's overall health.

Recommendation 2: DHS quality staff recommend including primary care access and preventive health measures, such as:

- Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)
- Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)
- Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)

Reasoning: These measures will set forth incentives for CCBHC providers to coordinate healthcare services with primary care providers to achieve a whole person care approach. A better provision of primary care services may lead to lower costs by helping patients receive appropriate services at appropriate healthcare settings. CCBHCs have already committed resources to collect and report data on these measures around screening for body mass index, tobacco use, and unhealthy alcohol use.

DHS quality staff recommend phasing in additional preventive health measures such as Adolescent Well-Child Visits and Dental Visits for Adults and Children. However, DHS quality staff and the CCBHC providers recommend analyzing historical data for claim-based primary care and preventive health measures before the final measures are selected for the CCBHC quality incentive program. These preventive and access measures are consistent with measures used for other health care programs such as BHH, IHP, and the Medicaid Adult and Child Core Set. In 2024, the child core set measures will become mandatory for federal reporting. These measures are calculated from DHS claims and would not require providers to submit additional data to DHS. The CCBHC providers recommend that DHS research additional preventive care measures around diabetes and cardiovascular screening for potential inclusion in the quality program.

Recommendation 3: DHS quality staff recommend incentivizing providers to focus on process outcomes related to coordination of care with primary care as well as community organizations to address social determinants of health. The following measures are being recommended:

- The number of enrollees with an identified primary care provided on file.
- Referrals to primary care provider: make an appointment, and close the loop by following up with the provider and the patient.
- Referrals to community-based organization: make an appointment, and close the loop by following up with the community-based organization and the patient for services like legal services, housing and food insecurity.

Reasoning: Improvements in health outcomes are often not possible when clients are struggling with basic human needs like access to food or stable housing. Likewise, coordination with primary care services is not possible without establishing a relationship with a primary care provider. Including these measures will create incentives for CCBHCs to support whole person care; referring clients for medical and social needs and closing the loop after the referral. Also, these types of measures concerned with equity are consistent with

incentives used in other health care programs such as BHH and IHP. These measures would require a direct data collection from CCBHCs, similar to the data collected from EHRs currently used by CCBHCs to report on the clinic-led measures. CCBHC providers recommend identifying clinic specific measures based on the needs of the communities served by the clinic.

Recommendations 4 and 5

The following recommendations relate to the payment process of the CCBHC quality incentive program and establishing minimum performance thresholds. Quality bonus payments are in addition to the basic PPS rate and will be made to the CCBHCs annually if they meet minimum performance thresholds.

Recommendation 4: DHS quality staff recommend that the performance on the measures listed above be tied to payment in a similar way to how it is done under the current CCBHC Section 223 quality bonus program. Currently, a lump sum is paid to any CCBHC that meets the minimum thresholds for all six quality measures. An additional payment can be made to those CCBHCs who meet the thresholds for all six quality measures and also meet thresholds for two additional optional measures. In the second demonstration year, the payments are made to CCBHCs who exceed their performance on quality measures by fixed percentage points.

CCBHC Demonstration – Quality Bonus Program Payment Formula

The overall bonus pool is equal to 5% of the total PPS payments (not just the wrap portion) – for the year being measured.

- 25% of the overall bonus pool is allocated equally across all Demonstration clinics
- 75% of the overall bonus pool is allocated in proportion to the clinics' number of overall visits

Only the clinics that meet the criteria are awarded their allocation of the overall bonus pool.

Source – Section 223 Demonstration - CCBHC Application Part 3: Prospective Payment System Methodology Description - Minnesota

Reasoning: DHS and CCBHC providers are familiar with the current payment methodology that allocates five percent of the total CCBHC payments to support the quality bonus payments for each demonstration year. Consistent with the current payment methodology, the 2019 MN State legislature required that payments from the new quality incentive program be made in addition to the PPS rate and that they do not exceed the five percent to the total CCBHC payment amount for one demonstration year.

Recommendation 5: The minimum performance thresholds should be established before the new quality incentive program is implemented. DHS quality staff will use a systematic process which will include engaging stakeholders. DHS quality staff will use standard practices when establishing minimum performance thresholds. For example:

- A minimum of 30 clients/visits (i.e., denominator size) for each CCBHC must be present in order for DHS to calculate any given measure. For measures with multiple reported rates, the minimum denominator size will need to be met for all rates calculated under the measure (e.g., 7 day and 30 day follow up measures).
- DHS quality staff will review historical data and will analyze trends to inform benchmarks.
- DHS quality staff will also consider regional and national benchmarks as well as MN statewide averages and performance of comparable non-CCBHC providers.

- DHS quality staff may consider establishing benchmarks that are clinic-specific. DHS quality staff acknowledge that each CCBHC has a different level of experience with quality measures and data collection. In addition, the measures are not risk-adjusted to account for the differences in the client population at each CCBHC.
- DHS quality staff will work with each CCBHC to establish minimum performance thresholds that are reasonably achievable but represent opportunities to incrementally improve performance compared to historical performance.

Recommendations 6 and 7

The following recommendations relate to the measure review process of the CCBHC quality incentive program and access to data. Data is a critical component of the measure review process and performance. DHS also acknowledges that it would be helpful for providers to gain access to care management reports and other data to help with performance on the measures.

Recommendation 6: DHS quality staff recommend establishing a process for periodically reviewing and revisiting the CCBHC quality incentive program. DHS is aware that quality measures can evolve over time and that quality measure criteria, value sets, clinical guidelines and priorities may change from year to year. The CCBHC quality incentive program will progress with the needs and priorities of CCBHC. It is recommended that the process for reviewing, revisiting and finalizing the measures to include in the CCBHC quality incentive program begin in Spring 2020. DHS quality staff will use a systematic process in reviewing measures. For example:

- DHS quality staff will engage stakeholders in its measure review process. This will allow stakeholders to participate, engage, and influence decisions made around quality incentive program measures. This will also allow for transparency around the measure review process.
- DHS quality staff and stakeholders will review the quality incentive program measures on an annual basis for the coming year to:
 - Make note of any changes to the measurement specifications that may occur in the coming year.
 - Ensure that the measures continue to align with other DHS health programs, the state Medicaid program, and goals and priorities of the CCBHC model.
 - Review performance on the measures and take into consideration if a measure should be continued or removed from the CCBHC quality incentive program.
 - Review performance to address topped out measures.
 - Consider additional measures to the CCBHC quality incentive program.
- DHS quality staff will document all measure review processes and decisions made around quality incentive program measures.
- DHS quality staff and stakeholders will complete measure review before performance thresholds are established for the coming year. For example, measures will be reviewed in November and thresholds will be established in December for a performance period beginning January 1.

Recommendation 7: CCBHC providers recommend having access to reports such as those currently available in the BHH Partners Portal to help with performance, quality improvement and care coordination.

Reasoning: The CCBHC providers acknowledge that they have an indirect impact on some of the quality measures, especially the measures being calculated based on DHS Medicaid claims data. The providers would like access to

timely data (such as on a quarterly basis) to help the providers with performance as well as quality improvement. The CCBHC providers will also be able to use the data to better meet expectations for care coordination.

Appendix A

Clinic-Led Measures (Data source: CCBHC)

Measure Name	Measure Steward
Time to Initial Evaluation (I-EVAL)	SAMHSA
Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	CMS
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-BH)	NCQA
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	AMA-PCPI
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	AMA-PCPI
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	AMA-PCPI
Major Depressive Disorder: Suicide Risk Assessment (SRA-A)	AMA-PCPI
Screening for Clinical Depression and Follow-Up Plan (CDF-BH)	CMS
Depression Remission at Twelve Months (DEP-REM-12)	MNCM

State-Led Measures (Data source: DHS MMIS)

Measure Name	Measure Steward
Housing Status (HOU)*	SAMHSA
Patient Experience of Care Survey (PEC)^	SAMHSA
Youth/Family Experience of Care Survey (Y/FEC)^	SAMHSA
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	NCQA
Plan All-Cause Readmission Rate (PCR-BH)	NCQA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD)	NCQA
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)	CMS
Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (FUH-BH-A)	NCQA
Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (FUH-BH-C)	NCQA
Follow-up care for children prescribed ADHD medication (ADD-BH)	NCQA
Antidepressant Medication Management (AMM-BH)	NCQA

Measure Name	Measure Steward
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)	NCQA

*Calculated from client level data provided by CCBHCs