

# CCBHC financial value analysis in Kansas

Discussion document

December 2024

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# Executive Summary

## HIGHLY PRELIMINARY

**The Kansas Certified Community Behavioral Health Clinic (CCBHC) program is expected to cost \$344M (federal and state) in 2025. This is ~3x greater than the 2021 pre-CCBHC costs (\$117M) with Community Mental Health Clinics (CMHC). While the overall program (federal and state) may have increased, the state general fund share has remained steady and/or decreased**

**There are four drivers that contribute to higher projected costs for CCBHCs vs. CMHCs**

- (1) Enhanced access to care may result in an overall increase in the number of patient visits
- (2) Higher PPS rates may result in overall cost increases for the CCBHC program
- (3) Enhanced FMAP during the demonstration may result in cost redistribution between states and federal government
- (4) Additional costs avoided in the healthcare system (e.g., ED visits, IP stays) may result in net cost reduction for the CCBHC program

**First, CCBHCs increase access to care**

- CCBHCs are estimated to result in ~2X access to care with 42K visits annually compared to CMHCs with 24K visits annually
- If CMHC rates were adjusted for compounded YOY increase and visits were adjusted to match CCBHC level of access, the total cost of a projected CMHC scenario in 2025 would be ~\$241M, of which \$92M would be state costs

**Second, CCBHCs transform the payment model – from fee-for-service (FFS) to value-based prospective payment system (PPS)**

- With CCBHCs, higher PPS rates raise total Medicaid spend by \$103M, and the enhanced FMAP (73.31%) that Kansas will receive as part of the CCBHC demonstration may shift \$39M from state general funds to federal funds. These changes in the payment model result in a total CCBHC program cost of ~\$344M, of which \$92M is state costs

**Third, by expanding access and upstream prevention services, CCBHCs may result in savings across healthcare settings**

- CCBHCs may result in \$5M in costs avoided from ED visits and \$42M in costs avoided from IP stays
- When considering the costs avoided from CCBHCs (\$47M), total Medicaid spend for CCBHCs may be reduced from \$344M to \$298M

**Considering all of these factors, CCBHCs may increase access by ~75% (24k vs. 42k visits) for ~40% extra cost to the state (\$52M vs. \$74M)**

- However, if CMHCs were to match access of CCBHCs, then CCBHCs may save \$18M in state costs (\$74M for CCBHC scenario with costs avoided vs. \$92M for CMHC scenario with full access)

**CCBHCs may cost more than CMHCs, especially after the demonstration ends in ~2029, given the change in FMAP. There are a few options available to help make the CCBHC program net-neutral after demonstration while still maximizing access**

- For example, PPS-3 may result in cost savings after demonstration depending on crisis services utilization and rates

# While CCBHCs may create both financial and non-financial value in Kansas, this analysis focuses on the potential financial value of CCBHCs in terms of state costs for CCBHCs relative to the prior CMHC program

HIGHLY PRELIMINARY

■ Details to follow

## Financial value

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- How do **CCBHC costs compare to baseline CMHC costs**?
- What impact do CCBHCs have on costs avoided, including **emergency department visits, inpatient stays, and justice-related encounters**?
- Will CCBHCs be **cost-effective after the demonstration period** ends?

## Non-financial value

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- What impact do CCBHCs have on **access** to behavioral health services?
- What impact do CCBHCs have on the **quality of care** available to residents?
- What impact do CCBHCs have on **other social determinants of health** (e.g., homelessness, incarceration)?

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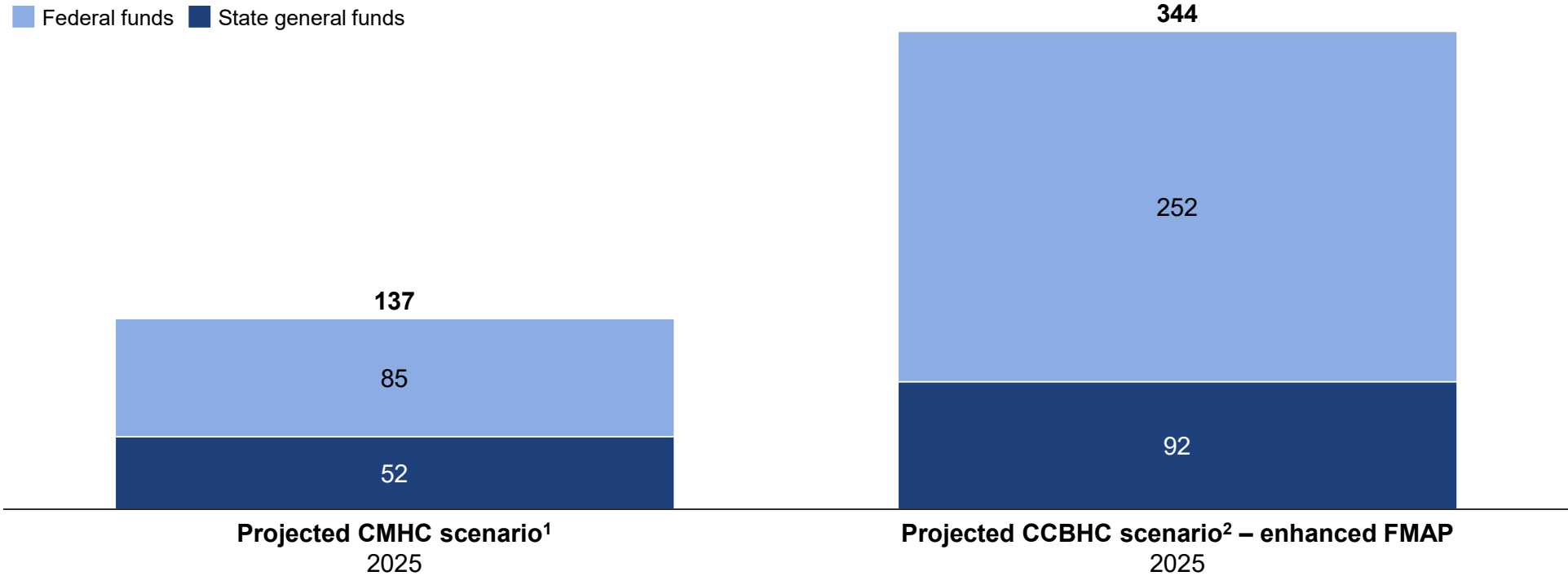
**Financial value of CCBHCs in Kansas**

Appendix

# Preliminary comparison of projected CMHC costs to CCBHC costs before considering changes of the CCBHC model on behavioral healthcare

HIGHLY PRELIMINARY

## Estimated total Medicaid expense of CMHC scenario vs. CCBHC scenario, \$M



1. 2025 assumptions based on 2021 assumptions: 26 clinics (0% growth per year), \$187 FFS cost per visit (5% growth through 2024, then 1% growth from 2024 to 2025), 24k visits per clinic (5% growth through 2024), 61.87% FMAP for estimated \$117M spend  
2. 2024 base assumptions: 26 clinics (0% growth per year), \$309 FFS cost per visit (1% growth per year), 39k visits per clinic (6.17% growth), 73.31% FMAP, costs avoided (ED, IP)

Source: CCBHC value analysis model, interviews with Kansas CCBHC leaders, Kansas Medicaid claims via TMSIS, KDADS CCBHC Program Information sheet, Missouri's Impact Report (Year 5): Improving Outcomes & Access to Care, KFF Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier (FY2025), KFF Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP (FY2025), Statista: Arrest rate for all offenses in the United States from 1990 to 2022, National Council for Mental Wellbeing: CCBHC Impact Report: Leading A Bold Shift in Mental Health & Substance Use Care

# CCBHCs change several aspects of behavioral healthcare

HIGHLY PRELIMINARY

## **Enhanced access**

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CCBHCs increase the number of visits, and thus access to care, through the “same day access” certification requirement

## **Payment rates**

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CCBHCs rates increase when switching from FFS to PPS, and the PPS methodology selected may further impact rates (e.g., PPS-1 vs. PPS-3)

## **Federal match**

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CCBHCs have an enhanced federal match (i.e., FMAP) rate during the federal demonstration period, lowering state share of costs

## **Costs avoided**

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CCBHCs can lead to reduction of total costs in the health system (e.g., ED visits, IP stays) and non-health systems (e.g., justice-related, housing, foster care)

# In sum, these changes contribute to changes in costs for CCBHCs in comparison to CMHCs

HIGHLY PRELIMINARY



## Drivers of cost increases<sup>1</sup>

Number of visits	75% increase in number of visits (24K to 42K)
Payment rates (e.g., PPS)	43% increase in rates (\$218 to \$312)



## Drivers of cost redistribution

Reduced state share via enhanced federal match (e.g., FMAP rates)	18% reduction in state share (FMAP rate from 62% to 73%)
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## Drivers of cost reductions

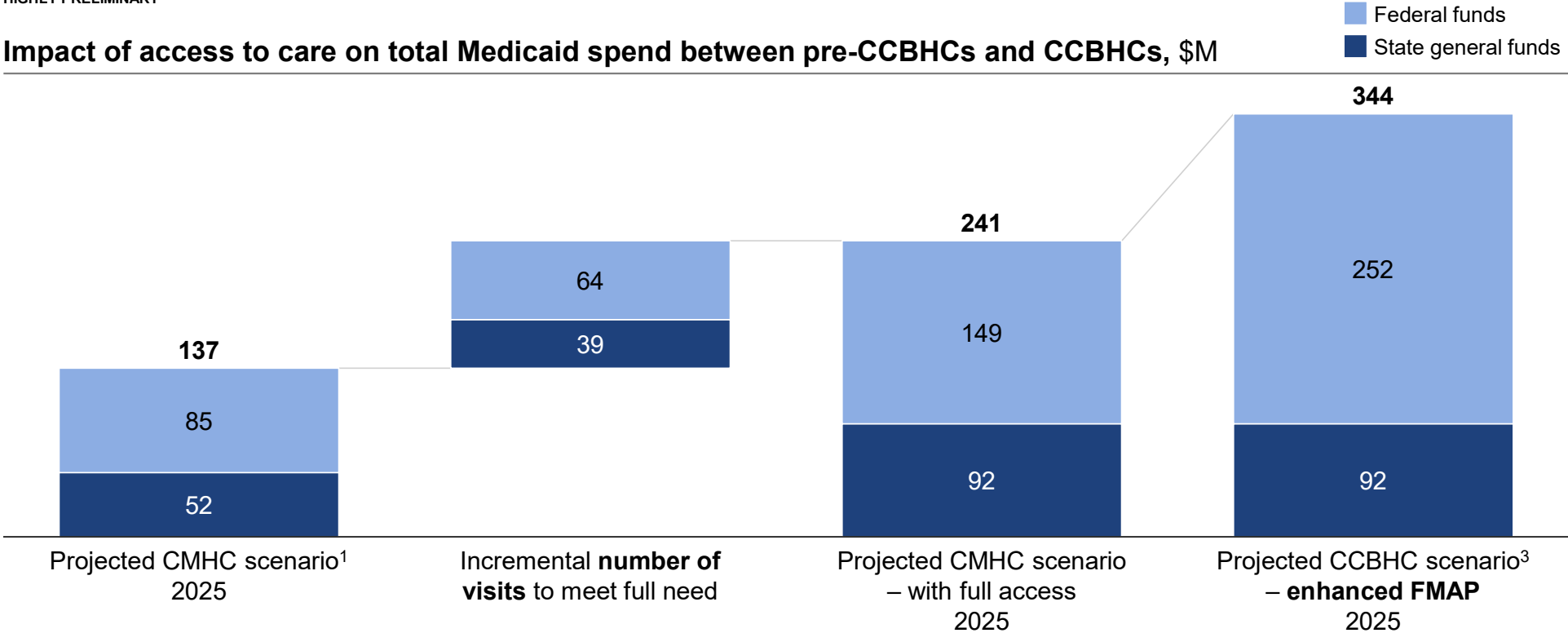
Costs avoided	\$47M in healthcare costs avoided
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1. Increased acuity of the population served within CCBHCs may also drive increased costs; however, given CCBHC's cost-based reporting methodology this should be accounted for by the higher rate per visit

# High-level comparison of CMHC costs to CCBHC costs

HIGHLY PRELIMINARY

### Impact of access to care on total Medicaid spend between pre-CCBHCs and CCBHCs, \$M



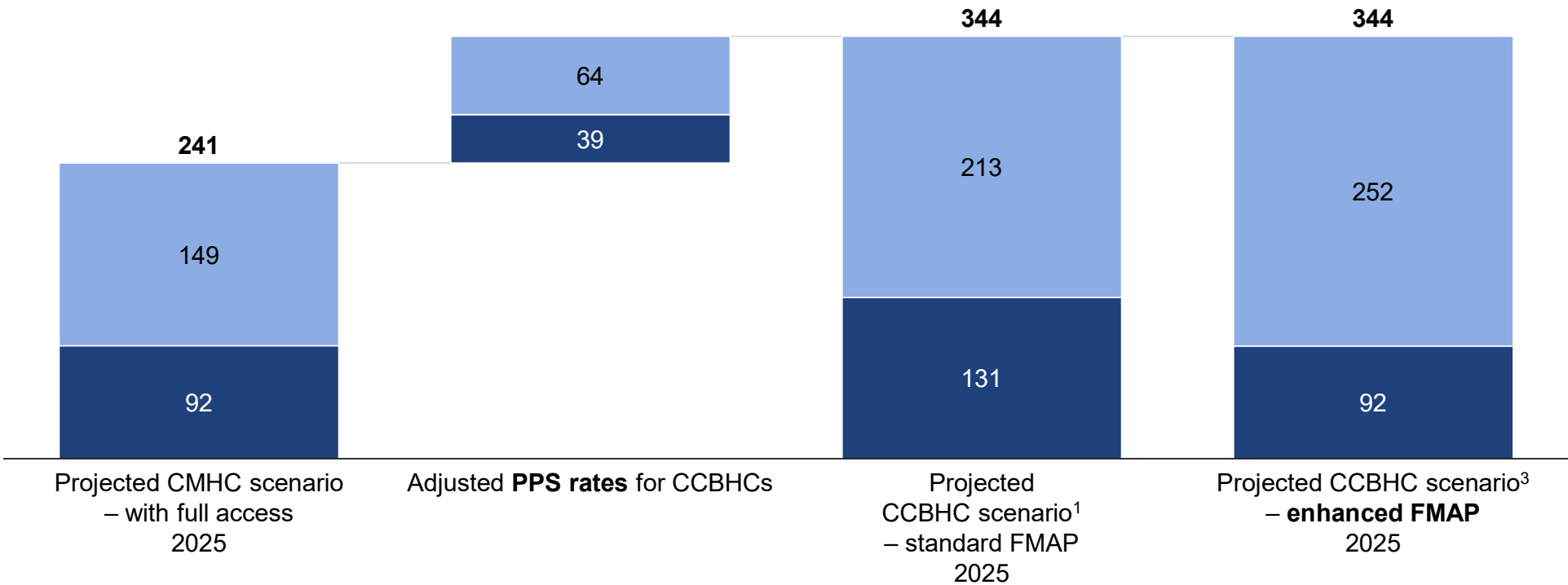
1. 2025 assumptions: 26 clinics, \$218 FFS cost per visit (5% compounded annual growth in PPS rates from 2021 to 2024 and 1% growth from 2024 to 2025), 24k visits per clinic, 61.87% FMAP | 3. 2025 assumptions: 26 clinics, \$312 PPS rate per visit, 42k visits per clinic, 73.31% FMAP, \$47M costs avoided (ED, IP)  
Source: CCBHC value analysis model, interviews with Kansas CCBHC leaders, Kansas Medicaid claims via TMSIS, KDADS CCBHC Program Information sheet, Missouri's Impact Report (Year 5): Improving Outcomes & Access to Care, KFF Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier (FY2025), KFF Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP (FY2025), Statista: Arrest rate for all offenses in the United States from 1990 to 2022, National Council for Mental Wellbeing, CCBHC Impact Report: Leading A Bold Shift in Mental Health & Substance Use Care

# PPS rates increase total Medicaid spend for CCBHCs while enhanced FMAP adjusts state share of CCBHCs to be the same as state share of CMHCs

HIGHLY PRELIMINARY

Impact of PPS rates and FMAP on total Medicaid spend between pre-CCBHCs and CCBHCs, \$M

Federal funds  
State general funds



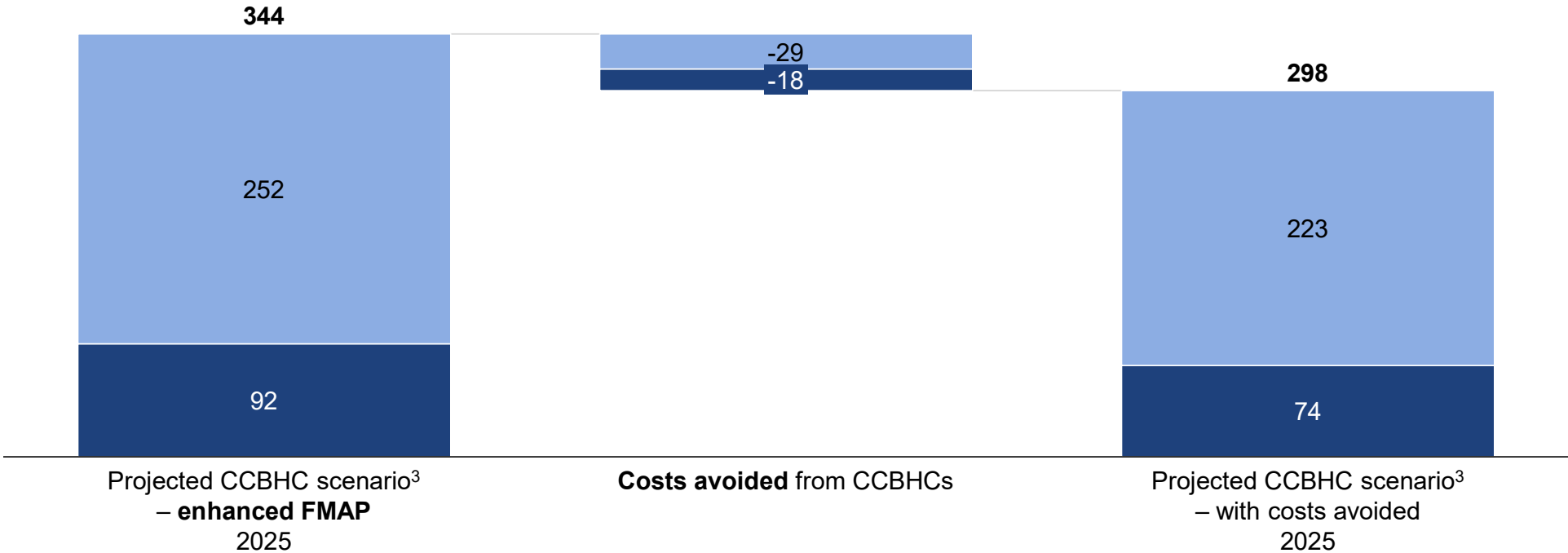
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# Expanded access and upstream prevention services via fewer ED visits and IP stays further reduces CCBHC costs

HIGHLY PRELIMINARY

### Impact of cost savings on total Medicaid spend between pre-CCBHCs and CCBHCs, \$M

Federal funds  
State general funds



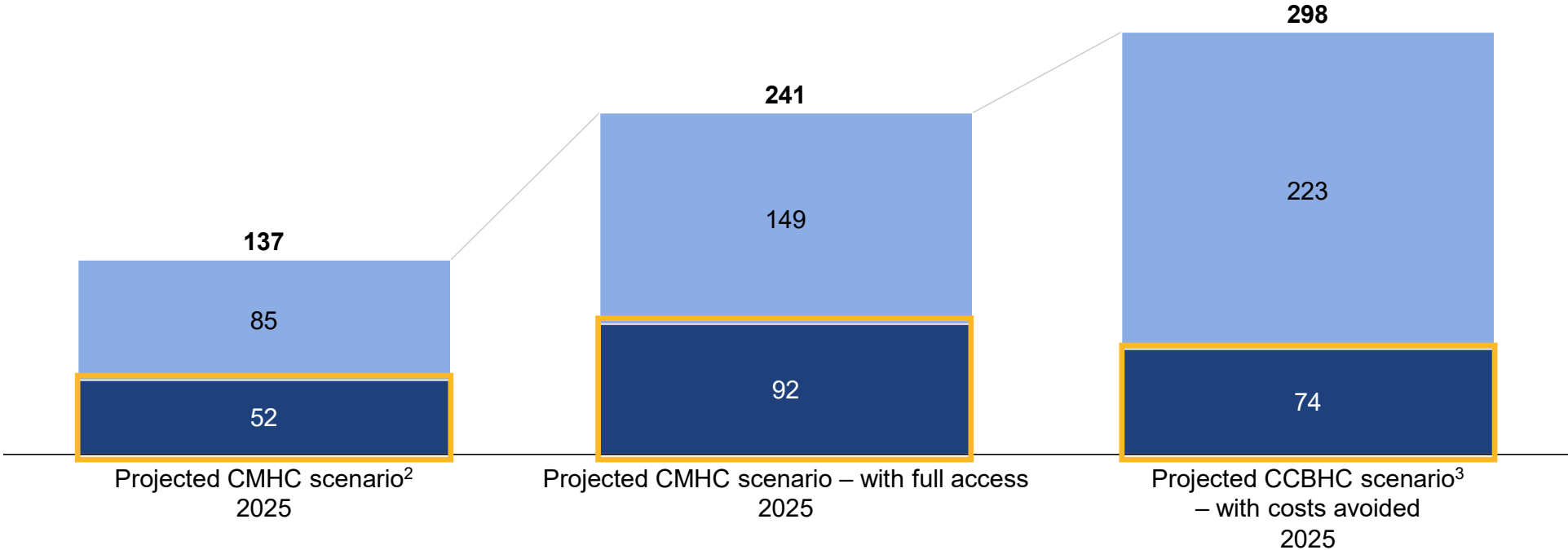
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# CCBHCs increases access by ~75% (24k vs. 42k visits) for ~40% increase in state cost (\$52M vs. \$74M), rather than ~77% increase (\$52M vs. \$92M)

HIGHLY PRELIMINARY

### Total potential Medicaid spend differences between pre-CCBHCs and CCBHCs, \$M

■ Federal funds  
■ State general funds



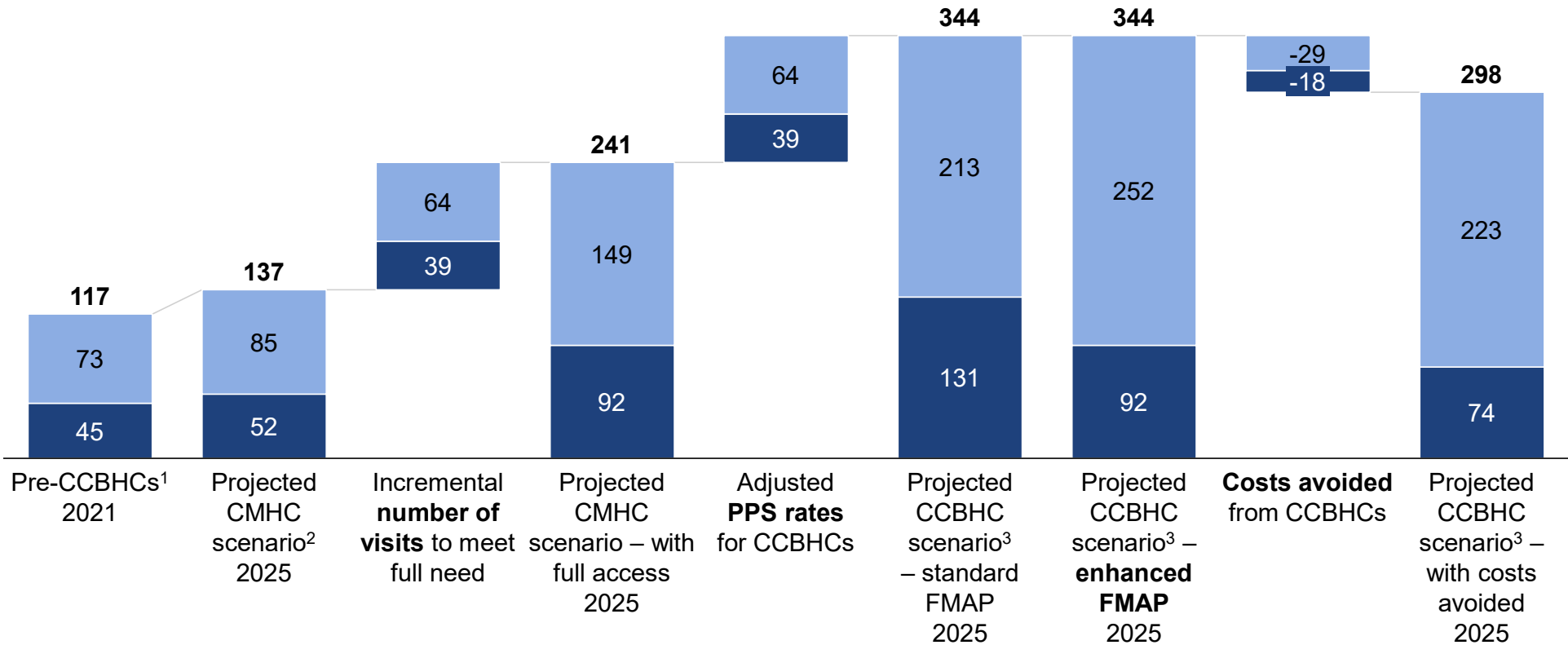
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# Detailed comparison of CMHC costs to CCBHC costs, including key drivers of cost difference

HIGHLY PRELIMINARY

Impact of cost savings on Medicaid spend between pre-CCBHCs and CCBHCs, \$M

Federal funds  
State general funds



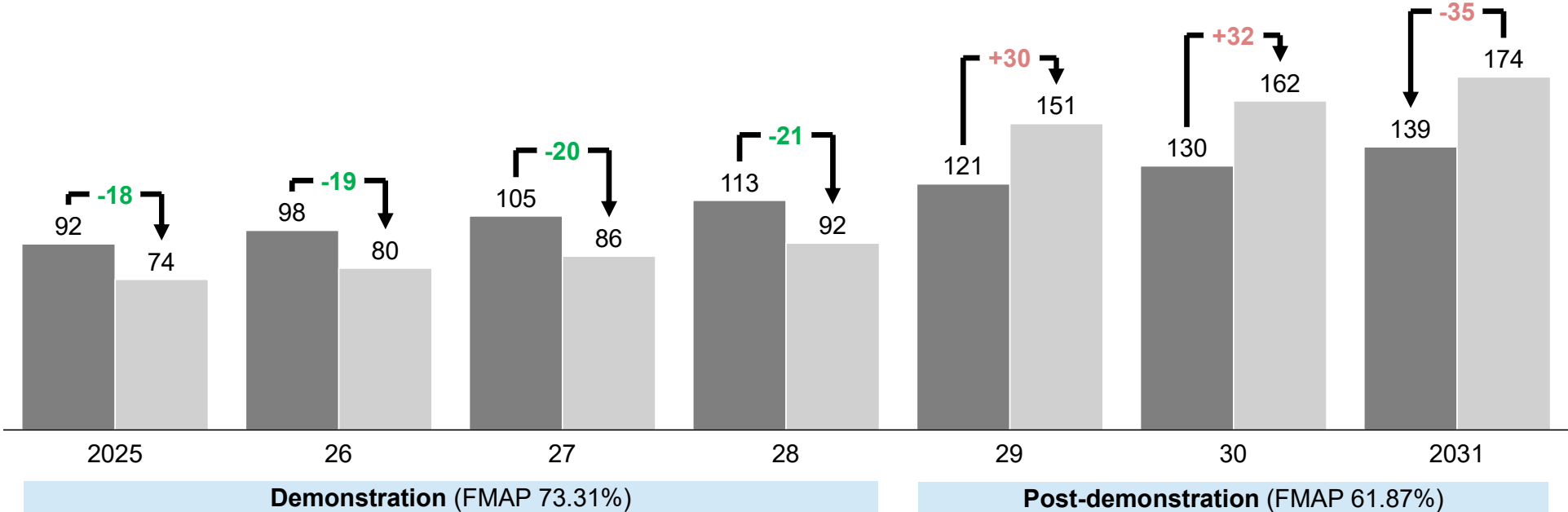
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# CCBHCs may cost more than pre-CCBHCs after demonstration given the change in FMAP

HIGHLY PRELIMINARY

### Estimated state costs for pre-CCBHCs vs. CCBHCs in PPS-1, 2025-2031, \$M

Net state savings (green)    Pre-CCBHCs<sup>1</sup> (dark grey)  
Net state costs (red)        CCBHCs<sup>2</sup> (light grey)



1. 2025 assumptions: 26 clinics (0% growth per year), \$218 FFS cost per visit (5% growth through 2024), 29k visits per clinic (5% growth through 2024), 61.87% FMAP | 2. 2025 assumptions: 26 clinics (0% growth per year), \$312 PPS rate per visit (1% growth per year), 42k visits per clinic (6.17% growth), 73.31% FMAP, costs avoided (ED, IP)  
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# There are a few options available to states to help make the CCBHC program net-neutral after demonstration while still maximizing access

HIGHLY PRELIMINARY

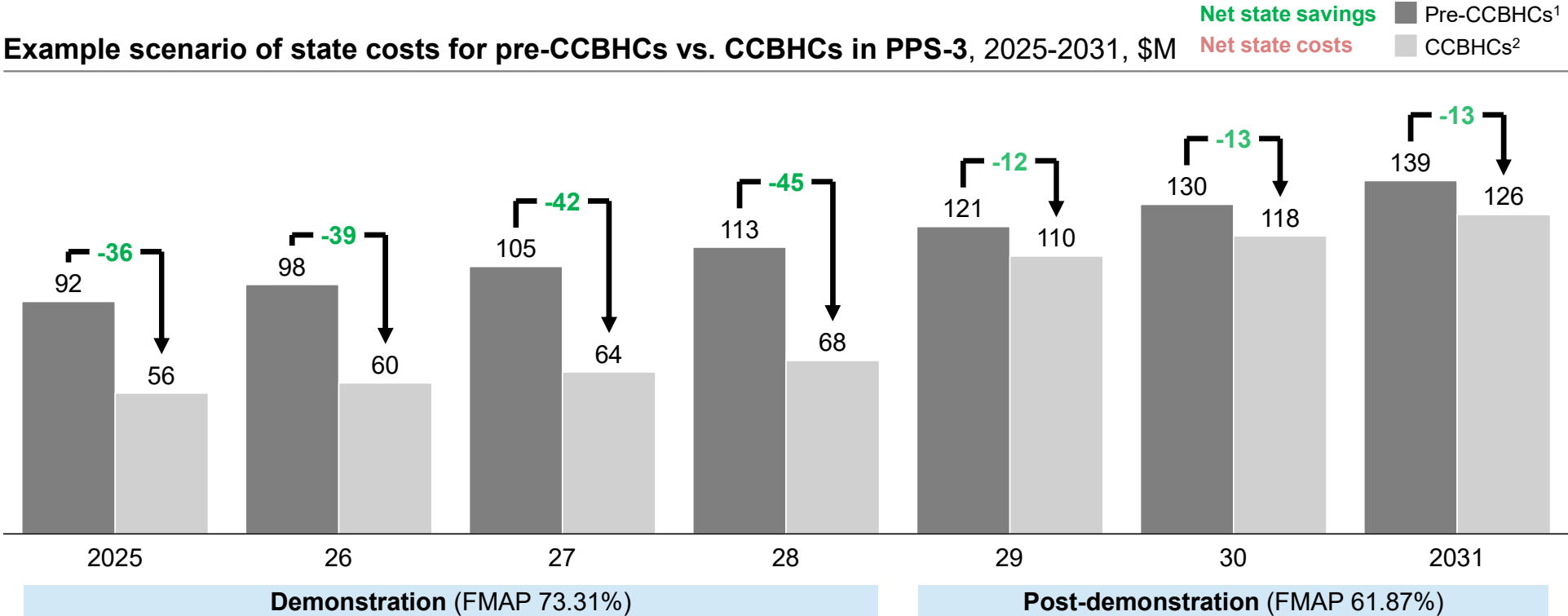
■ Details to follow

Lever	Approach
Maximize costs avoided	Strengthen CCBHCs' <b>community partnerships</b> to more proactively support lower acuity population
	Develop a <b>data and IT infrastructure</b> to track impact of CCBHCs (e.g., HIE data integration, CCBHC data dashboards)
	Develop an <b>incentive program</b> to improve performance and quality of CCBHCs (e.g., offer Quality Bonus Payments)
	Stand up a <b>governance structure</b> to manage performance of CCBHCs (e.g., access, costs, costs avoided)
Minimize cost increases	<b>Cap annual increases</b> for PPS rates
	Transition to a <b>different PPS methodology</b> that may lower overall PPS rates (e.g., PPS-3)

# ILLUSTRATIVE: For example, PPS-3 may result in cost savings after demonstration depending on crisis services utilization and rates

HIGHLY PRELIMINARY      EXAMPLE DATA

Example scenario of state costs for pre-CCBHCs vs. CCBHCs in PPS-3, 2025-2031, \$M



1. 2025 assumptions: 26 clinics (0% growth per year), \$218 FFS cost per visit (5% growth through 2024), 29k visits per clinic (5% growth through 2024), 61.87% FMAP | 2. 2025 assumptions: 26 clinics (0% growth per year), \$187 PPS for standard visits and \$390 PPS for crisis visits (1% growth per year), 42k visits per clinic (6.17% growth) and 3% of visits are for crisis, 73.31% FMAP, costs avoided (ED, IP)  
Source: CCBHC value analysis model, interviews with Kansas CCBHC leaders, Kansas Medicaid claims via TMSIS, KDADS CCBHC Program Information sheet, Missouri's Impact Report (Year 5): Improving Outcomes & Access to Care, KFF Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier (FY2025), KFF Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP (FY2025), Statista: Arrest rate for all offenses in the United States from 1990 to 2022; National Council for Mental Wellbeing; CCBHC Impact Report: Leading A Bold Shift in Mental Health & Substance Use Care

## Questions for discussion

HIGHLY PRELIMINARY

- How can you ensure sustainability of the CCBHC program by improved demonstration of financial benefits?
- Are there other state BH programs we may look to for approaches in ensuring sustainability?
- Are there future changes to the CCBHC program we may consider to increase
- likelihood of reaching continued benefits for the state?

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- Financial value analysis additional views
- PPS and QBP methodologies
- Kansas Medicaid claims output

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# Kansas has been implementing CCBHCs since it passed a State Plan Amendment (SPA) in 2021

HIGHLY PRELIMINARY

Kansas became the first state to pass legislation identifying the CCBHC model as a solution to the mental health and substance use crisis and began transitioning the state's 26 CMHCs to CCBHCs

Kansas is awarded \$12.6 million as part of the Bipartisan Safer Communities Act for new and existing CCBHCs to expand access

Kansas received a \$1 million, one-year federal planning grant from HHS SAMHSA to support the transition CMHCs to CCBHCs

Kansas, along with 9 other states, is added to the CCBHC Medicaid Demonstration Program



Kansas will join the CCBHC Medicaid Demonstration Program, with enhanced FMAP



Source: [Kansas Office of the Governor, "Governor Kelly Announces Kansas Selected to Expand Mental Health and Substance Use Services"](#); [Kansas Office of the Governor, "Governor Kelly Announces Kansas to Receive \\$1 Million to Expand Community-Based Mental Health Care Model"](#)

# CCBHCs are required to adhere to specific standards

HIGHLY PRELIMINARY

 CCBHC must directly provide  May be provided by CCBHC and/or DCO (Designated Collaboration Organizations)

## CCBHCs need to satisfy 6 requirements, including provision of 9 distinct service types (directly or via partnerships)

- 1 Scope of Services**
- 2 Staffing:** staff structure and linguistic competence – based on community need assessment; psychiatrist in role of a Medical Director; training plan and skill assessments for personnel; etc.
- 3 Availability and accessibility of services:** 24/7 crisis management; 1 business day wait time for urgent needs, 10 for routine treatment; no refusal due to inability to pay or residence; etc.
- 4 Care coordination:** partnerships with adjacent organisations (e.g., hospitals, housing support), maintaining EHR (electronic health records), cross-functional care; etc.
- 5 Quality and other reporting:** collecting and reporting data on population served, staffing, use of services, costs (e.g., annual submission of a cost report), outcomes, etc.; developing data-driven Continuous Quality Improvement plans; etc.
- 6 Organizational Authority and Governance:** annual independent financial audit; governance informed by community representatives including those with MH / SU lived experience; state certification or SAMHSA attestation; etc.

-  Crisis MH services, including 24-hour mobile crisis teams, emergency crisis intervention, and crisis stabilization
-  Screening, diagnosis and risk assessment
-  Person- and family-centered treatment planning
-  Outpatient mental health and substance use services
-  Outpatient primary care screening and monitoring of key health indicators and health risk
-  Targeted case management
-  Psychiatric rehabilitation services
-  Peer support, family support and counselor services
-  Community-based mental health care for veterans

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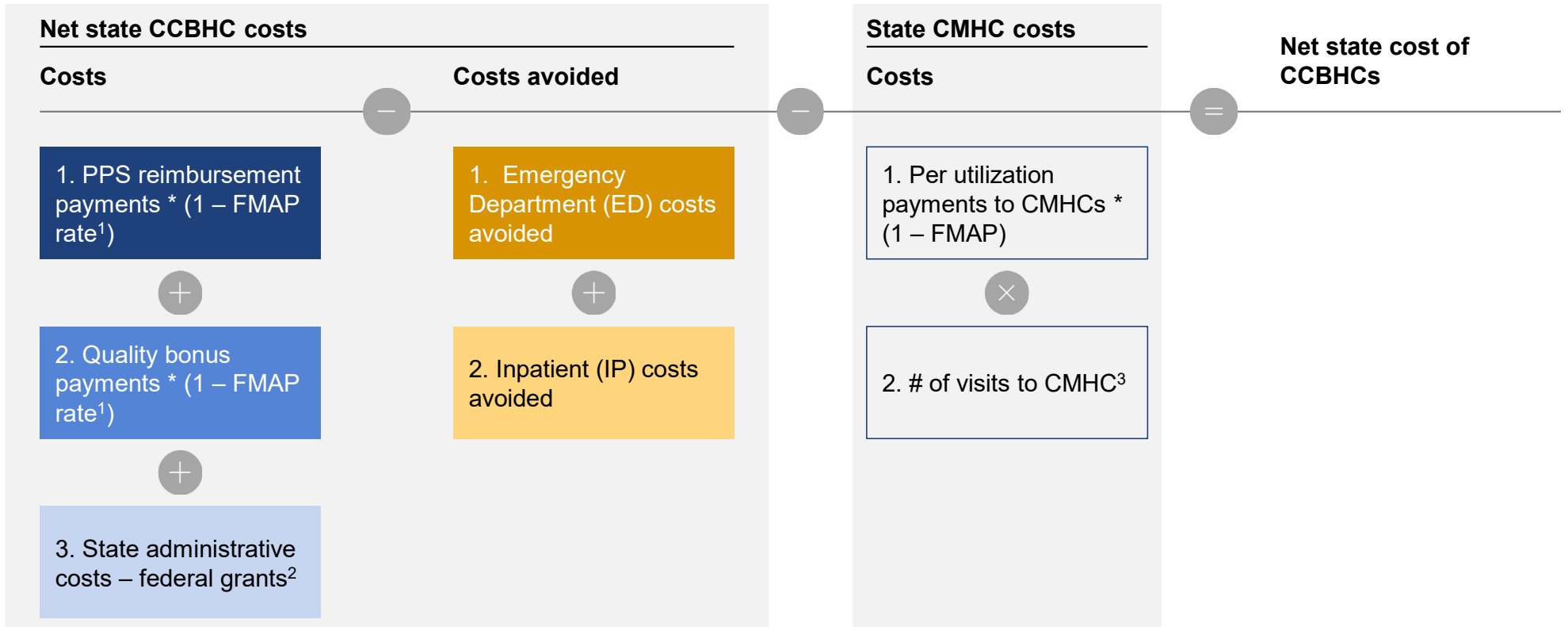
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# The CCBHC financial value analysis compares state CCBHC costs to expected state CMHC costs if access were to increase at the same scale

HIGHLY PRELIMINARY



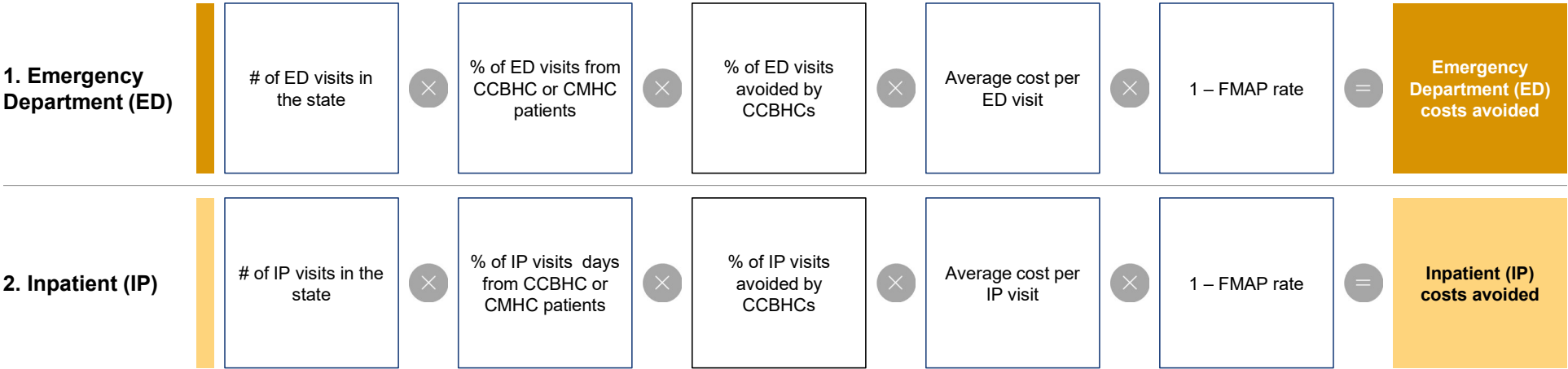
1. Enhanced FMAP rate applies to demonstration period (2025-2028), Standard FMAP rate applies for years prior to 2025 and after 2028
2. Federal grants may only apply for certain years (e.g., 2023 SAMHSA 1-year expansion grant)
3. Assumes same increase in access (# of visits) as CCBHC scenario



# Net state CCBHC costs: Approach (2/2)

HIGHLY PRELIMINARY

Annual costs =



# The model compares current CCBHC implementation to a scenario in which CMHCs continued in Kansas without CCBHC implementation

HIGHLY PRELIMINARY

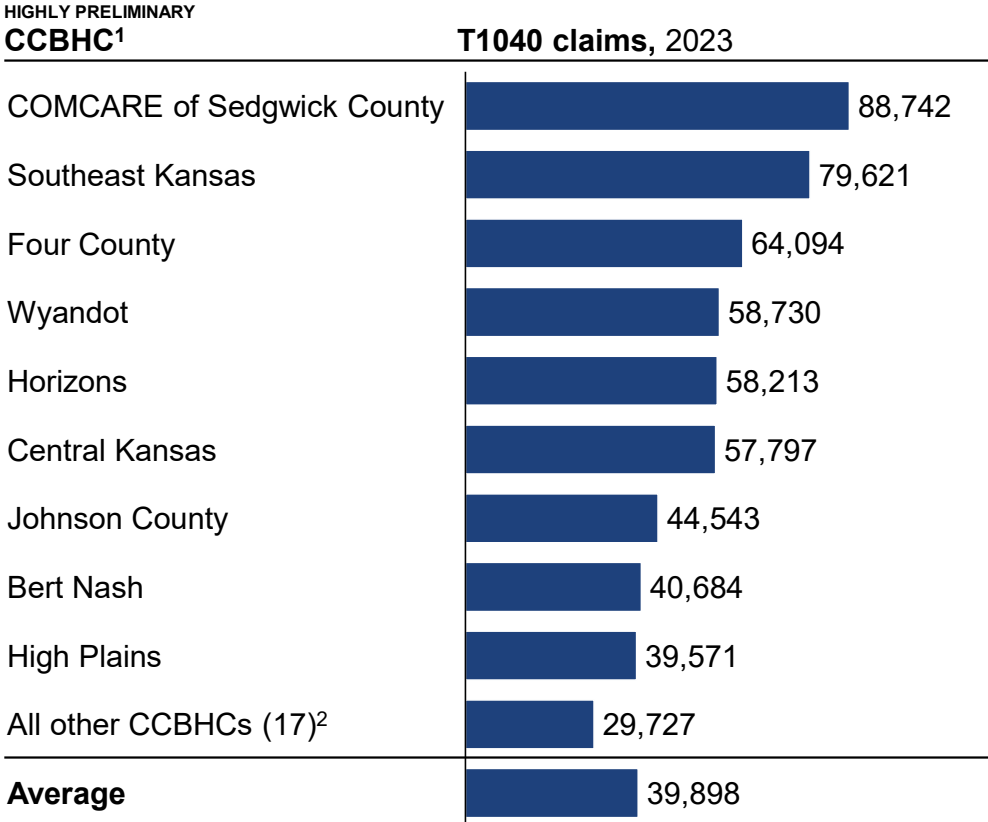
## Assumptions for each scenario

	CMHC scenario	CCBHC scenario <sup>1</sup>	PPS-2 scenario (illustrative)	Source
<b>Number of clinics</b>	26	26	26	<a href="#">ACMHCK</a>
<i>Growth rate</i>	0%	0%	0%	KDADS interviews
<b>Average rates</b>	\$216 (FFS)	\$309 (PPS)	\$187 standard visit (60% current PPS) \$390 crisis visit (125% current PPS)	KDADS CCBHC Program Information sheet <i>For discussion – CMHC assumption</i>
<i>Growth rate</i>	1%	1%	1%	KDADS interviews
<b>Average number of unique visits per clinic</b>	26k	37k <sup>2</sup>	37k 3% are crisis visits	KDADS Medicaid claims (Feb 2023-Jan 2024) <i>For discussion – CMHC assumption</i>
<i>Growth rate</i>	6.17%	6.17%	6.17%	<a href="#">Missouri's Impact Report</a>
<b>Percent of visits from Medicaid</b>	100%	100%	100%	<i>For discussion</i>
<b>FMAP</b>	61.87%	Demo (2025-2028): 73.31% Post-demo (2029+): 61.87%	73.31%	KFF ( <a href="#">standard</a> and <a href="#">enhanced</a> )

1. Assumes PPS-1 with no QBPs and no outlier reserve payments

2. Average of: 48k T1040 claims per clinic for the 9 CCBHCs in the claims data; assumes 31k T1040 claims per clinic for the remaining 17 CCBHCs not in the claims data (based on relative scale of 2021 unique members per clinic)

# Methodology: Number of visits per CCBHC



## Model assumptions – number of visits per CCBHC

**2021 – pre-CCBHCs**

27,929  
 $\div (1 + 5\%)^3$  (assumption, tested with KDADS)  
 = 24,126

**2024 – CMHC scenario**

38,898  
 $\times .7$  (assumption<sup>3</sup>, tested with KDADS)  
 = 27,929

**2024 – CCBHC scenario**

39,898 (based on T1040 claims from 2023)

**2025 – CCBHC scenario**

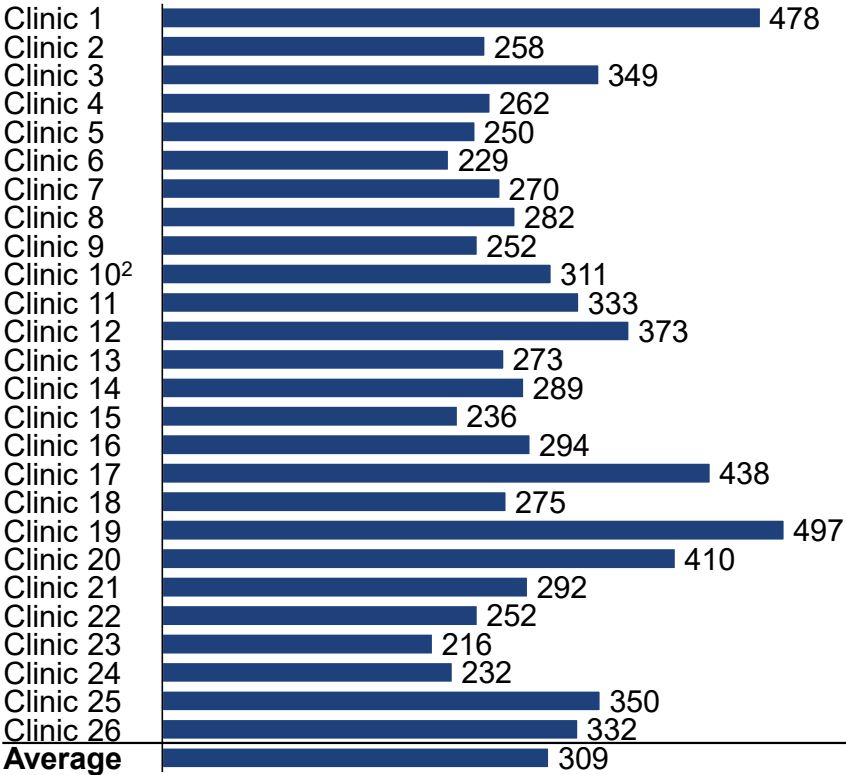
39,898  
 $\times (1 + 6.17\%)$  (based on Missouri data)  
 = 42,360

1. Only 9 CCBHCs had claims for T1040 in the most recent claims data  
 2. Assumed 29,727 T1040 claims on average for the remaining 17 CCBHCs, based on the ratio of "average unique members (2020-2022)" between the 9 CCBHCs with T1040 in 2023 claims data and the 17 CCBHCs without  
 3. Based on comparison of total number of unique members for 9 clinics that became CCBHCs in 2019 vs. 2022

# Methodology: PPS rates

HIGHLY PRELIMINARY

## CCBHC PPS rates<sup>2</sup>, \$, 2024



## Model assumptions – number of visits per CCBHC

### 2021 – pre-CCBHCs

\$216  
 $\div (1 + 5\%)^3$  (assumption, tested with KDADS)  
 = \$187

### 2024 – CMHC scenario

\$309  
 $\times .7$  (assumption<sup>3</sup>, tested with KDADS)  
 = \$216

### 2024 – CCBHC scenario

\$309 (based on T1040 claims from 2023)

### 2025 – CCBHC scenario

\$309  
 $\times (1 + 1\%)$  (assumption, tested with KDADS)  
 = \$316

1. Only 10 CCBHCs had full certification rates for 2024; the other 16 CCBHCs had provisional rates

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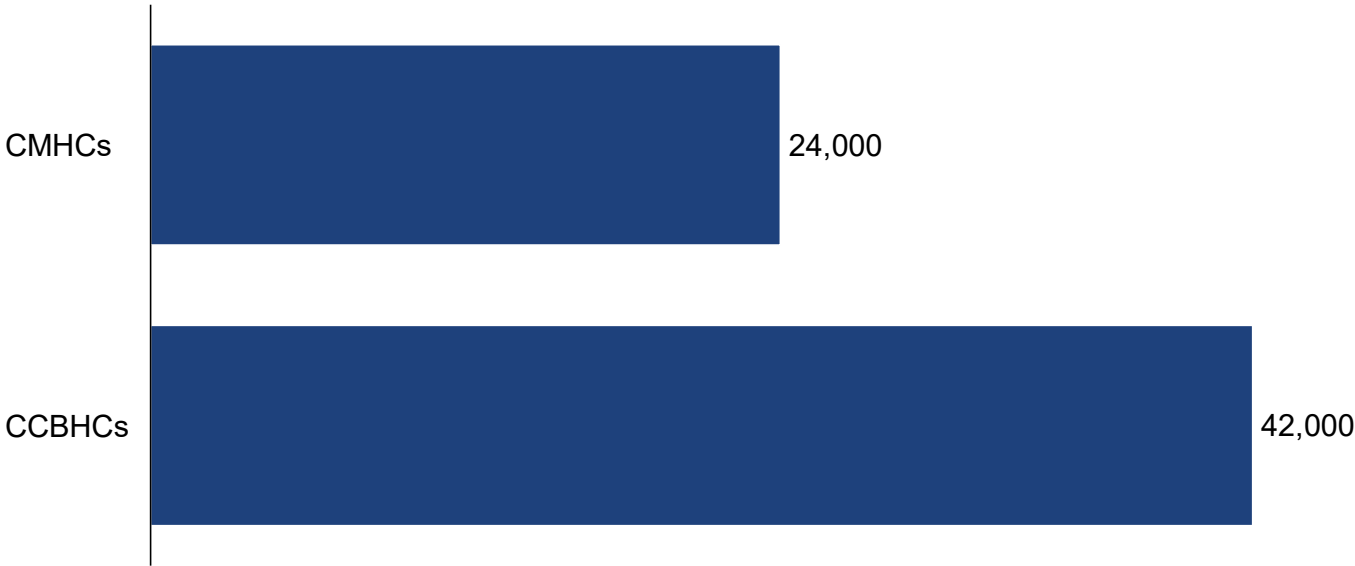
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# Access to care increases with CCBHCs

HIGHLY PRELIMINARY

Annual number of visits to clinics in pre-CCBHC and CCBHC scenarios (2025 projected)



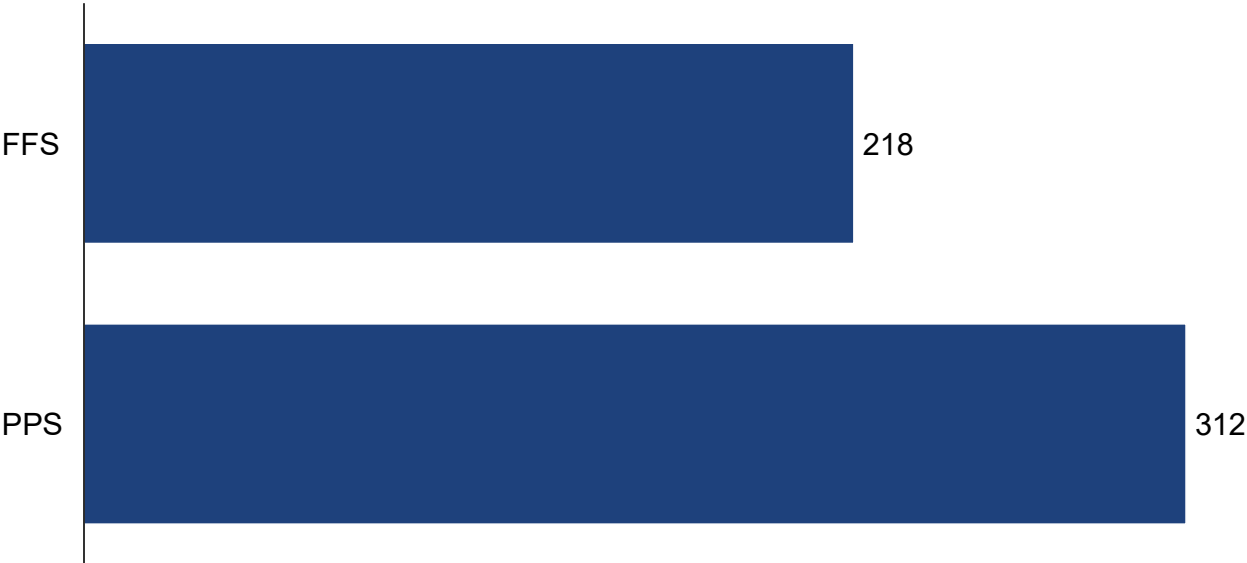
**~75% increase in access to care with CCBHCs compared to CMHCs only**

Source: CCBHC value analysis model, interviews with Kansas CCBHC leaders, Kansas Medicaid claims via TMSIS, KDADS CCBHC Program Information sheet, Missouri's Impact Report (Year 5): Improving Outcomes & Access to Care, KFF Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier (FY2025), KFF Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP (FY2025), Statista: Arrest rate for all offenses in the United States from 1990 to 2022; National Council for Mental Wellbeing: CCBHC Impact Report: Leading A Bold Shift in Mental Health & Substance Use Care

# CCBHCs transform the payment model – from fee-for-service (FFS) to value-based prospective payment system (PPS)

HIGHLY PRELIMINARY

CCBHC payment rates in FFS and PPS scenarios, \$



**~40% increase in rates** from FFS to PPS

Increased rates have potential to increase workforce retention, quality of care, and access to services

Source: CCBHC value analysis model, interviews with Kansas CCBHC leaders, Kansas Medicaid claims via TMSIS, KDADS CCBHC Program Information sheet, Missouri's Impact Report (Year 5): Improving Outcomes & Access to Care, KFF Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier (FY2025), KFF Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP (FY2025), Statista: Arrest rate for all offenses in the United States from 1990 to 2022, National Council for Mental Wellbeing: CCBHC Impact Report: Leading A Bold Shift in Mental Health & Substance Use Care

# By participating in the federal demonstration, there is enhanced federal funding (e.g., enhanced FMAP)

HIGHLY PRELIMINARY

Federal match (e.g., FMAP) rates within and outside of the federal demonstration, %



**+11pp increase in FMAP rates** when participating in federal demonstration program

Source: CCBHC value analysis model, interviews with Kansas CCBHC leaders, Kansas Medicaid claims via TMSIS, KDADS CCBHC Program Information sheet, Missouri's Impact Report (Year 5): Improving Outcomes & Access to Care, KFF Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier (FY2025), KFF Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP (FY2025), Statista: Arrest rate for all offenses in the United States from 1990 to 2022, National Council for Mental Wellbeing: CCBHC Impact Report: Leading A Bold Shift in Mental Health & Substance Use Care

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# Prospective Payment System (PPS) methodology: PPS-1

HIGHLY PRELIMINARY ILLUSTRATIVE

## CC PPS-1: Methodology

1 **Standard Base PPS Rate** = 
$$\frac{\text{Total annual allowable CCBHC costs}^1}{\text{Total number of CCBHC daily visits per year}}$$

2 **CC PPS-1 Quality Bonus Payments (QBPs):** Under the CC PPS-1 rate methodology, a state may elect to offer QBPs

## CC PPS-1: Illustrative sample rate calculation

Person	Number of Daily Visits in a Year	Trended Annual Costs, \$	CC PPS-1 Payment Per Daily Visit, \$	CC PP-1 Payment, \$
A	25	2,250	100	2,500
B	15	450	100	1,500
C	10	600	100	1,000
D	5	750	100	500
E	35	2,350	100	3,500
F	8	3,000	100	800
G	2	600	100	200
<b>Total</b>	<b>100</b>	<b>10,000</b>	<b>700</b>	<b>10,000</b>

1. For DY1, the total annual allowable CCBHC costs collected during the Demonstration planning phase must be trended forward by the MEI to reflect changes due to inflation; 2. Annual costs may be determined for each person; 3. CC PPS-1 Payment Per Daily Visit = Annual Costs (\$10,000) / Number of Daily Visits in a Year (100) = \$100; 4. CC PPS-1 Payment = Number of Daily Visits in a Year \* CC PPS-1 Payment Per Daily Visit (\$100)

# Prospective Payment System (PPS) methodology: PPS-2

HIGHLY PRELIMINARY ILLUSTRATIVE

## CC PPS-2: Methodology

$$\text{Standard Base PPS Rate} = \frac{\text{Total annual allowable CCBHC costs}^1 \text{ excluding costs for services provided to persons with certain conditions}}{\text{Total number of CCBHC unduplicated monthly visits per year excluding visits of people with certain conditions}}$$

$$\text{Monthly PPS for special populations} = \frac{\text{Total annual allowable CCBHC costs}^1 \text{ including only services provided to persons with certain conditions excluding outlier payments}}{\text{Total number of CCBHC monthly visits per year including only visits of persons with certain conditions}}$$

*Step 2 would be repeated to calculate the PPS rate for each SP that the state has elected to include in their PPS-2 methodology*

**Determine the outlier payment:** Outlier payments are commonly calculated by setting a threshold above which a certain percentage of costs should be kept in reserve to account for anticipated outlier costs during the Demonstration. This threshold should be set based on statistically by studying the distribution of costs at the facility level.

**CC PPS-2 Quality Bonus Payments (QBPs):** Under the CC PPS-2 rate methodology, a state may elect to offer QBPs

## CC PPS-2: Illustrative sample rate calculation

Person	Month	Outlier	Visit Type	Visit Months	Trended Allowed Monthly Costs, \$	Non-outlier Payment Portion	Outlier Payment Reserve <sup>2</sup>	Payment Per Monthly Visit, \$	
<b>Standard Population</b>									
A	Jan		Standard	1	50	50		250	
A	Feb		Standard	1	150	150		250	
A	Mar	Yes	Standard	1	1,250	1,050	200	250	
B	June		Standard	1	50	50		250	
C	Aug		Standard	1	100	100		250	
D	Sept		Standard	1	100	100		250	
<b>Standard Population Subtotal</b>				<b>Standard</b>	<b>6</b>	<b>1,700</b>	<b>1,500</b>	<b>200</b>	<b>1,500</b>
<b>Special Population A</b>									
E	Nov		Special Population A	1	300	300		700	
E	Dec	Yes	Special Population A	1	1,500	1,100	400	700	
<b>Special Population A Subtotal</b>				<b>Special Population A</b>	<b>2</b>	<b>1,800</b>	<b>1,400</b>	<b>400</b>	<b>1,400</b>
<b>Special Population B</b>									
F	Apr	Yes	Special Population B	1	2,000	1,200	800	900	
G	Aug		Special Population B	1	600	600		900	
<b>Special Population B Subtotal</b>				<b>Special Population B</b>	<b>2</b>	<b>2,600</b>	<b>1,800</b>	<b>800</b>	<b>1,800</b>
<b>Total</b>				<b>Total</b>	<b>10</b>	<b>6,100</b>	<b>4,700</b>	<b>1,400</b>	<b>4,700</b>

1. For DY1, the total annual allowable CCBHC costs collected during the Demonstration planning phase must be trended forward by the MEI to reflect changes due to inflation; 2. For this facility, the monthly outlier threshold is set at \$1,000, with a reserve of 80 percent of costs in excess of that threshold. Therefore, in the rate setting period, 80 percent of the anticipated costs above the \$1,000 threshold would be held in reserve to make outlier payments during the Demonstration period. People A, E, and F each experience 1 month with costs that exceed the established threshold. Therefore, in addition to the applicable PPS rate for each person type, the facility will be paid a varying additional outlier payment

# Prospective Payment System (PPS) methodology: PPS-3

HIGHLY PRELIMINARY ILLUSTRATIVE

## CC PPS-3: Methodology

$$\text{Standard Base PPS Rate} = \frac{\text{Total annual allowable CCBHC costs}^1 \text{ excluding costs for crisis services included under SCS services}}{\text{Total number of CCBHC daily visits per year excluding crisis services visits included under SCS services}}$$

$$\text{PPS rates for each category of special crisis services}^2 = \frac{\text{Total annual allowable CCBHC costs}^1 \text{ including only those for one of the three categories of SCS services}}{\text{Total number of CCBHC daily visits per year including only those for same category of SCS services used in the numerator}}$$

Step 2 would be repeated to calculate a PPS rate for each category of SCS services a state has elected to include in their PPS-3 methodology

3 **PPS-3 Quality Bonus Payments (QBPs):** Under the CC PPS-3 rate methodology, a state may elect to offer QBPs

## CC PPS-3: Illustrative sample rate calculation

Person	Visit Type	Number of Daily Visits in a Year	Trended Annual Costs <sup>3</sup> , \$	CC PP-3 Payment Per Daily Visit <sup>4</sup> , \$	CC PPS-3 Payment <sup>5</sup> , \$
<b>Standard Visits</b>					
A	Standard	21	2,550	100	2,100
B	Standard	19	1,700	100	1,900
C	Standard	7	850	100	700
D	Standard	15	1,000	100	1,500
E	Standard	5	650	100	500
F	Standard	15	1,250	100	1,500
G	Standard	3	500	100	300
<b>Standard Visit Total</b>		<b>85</b>	<b>8,500</b>		<b>8,500</b>
<b>Special Crisis Services- ARP 9813 Mobile Crisis SCS Visit</b>					
A	9813 Mobile Crisis SCS	2	1,250	585	1,170
D	9814 Mobile Crisis SCS	3	1,500	585	1,755
E	9815 Mobile Crisis SCS	4	2,450	585	2,340
F	9816 Mobile Crisis SCS	1	650	585	585
<b>ARP 9813 Mobile Crisis SCS Visit Total</b>		<b>10</b>	<b>5,850</b>		<b>5,850</b>
<b>Special Crisis Services- On Site Crisis Stabilization Visits</b>					
A	On Site Crisis Stabilization SCS	1	325	300	300
F	On Site Crisis Stabilization SCS	2	600	300	600
G	On Site Crisis Stabilization SCS	2	575	300	600
<b>On Site Crisis Stabilization SCS Visit Total</b>		<b>5</b>	<b>1,500</b>		<b>1,500</b>
<b>Total for ALL CCBHC Services</b>		<b>100</b>	<b>15,850</b>	-	<b>15,850</b>

1. For DY1, the total annual allowable CCBHC costs collected during the Demonstration planning phase must be trended forward by the MEI to reflect changes due to inflation; 2. The three categories of SCS services are: 1) mobile crisis services meeting the requirements of section 9813 of ARP, 3) CCBHC mobile crisis services that do not meet the ARP section 9813 requirements, and on-site CCBHC crisis stabilization services; 3. Annual costs may be determined for each person; 4. CC PPS-3 Payment Per Standard Daily Visit = Annual Costs (\$8,500) / Number of Daily Visits in a Year (85) = \$100; CC PPS-3 Payment Per ARP 9813 CCBHC Mobile Crisis SCS Daily Visit = Annual Costs (\$5,850) / Number of Daily Visits in a Year (10) = \$585; CC PPS-3 Payment Per CCBHC On Site Crisis Stabilization SCS Daily Visit = Annual Costs (\$1,500) / Number of Daily Visits in a Year (5) = \$300; 5. CC PPS-3 Standard Payment = Number of Standard Daily Visits in a Year \* CC PPS-3 Payment Per Standard Daily Visit (\$100); CC PPS-3 ARP 9813 CCBHC Mobile Crisis SCS Payment = Number of Daily ARP 9813 CCBHC Mobile Crisis SCS Visits in a Year \* CC PPS-3 ARP 9813 CCBHC Mobile Crisis SCS Payment Per Daily Visit (\$585); CC PPS-3 CCBHC On Site Crisis Stabilization SCS Visit Payment = Number of Daily CCBHC On Site Crisis Stabilization SCS Visits in a Year \* CC PPS-3 Payment Per CCBHC On Site Crisis Stabilization SCS Daily Visit (\$300)

# Prospective Payment System (PPS) methodology: PPS-4 (1/2)

HIGHLY PRELIMINARY ILLUSTRATIVE

## CC PPS-4: Methodology

1	<b>Standard Base PPS Rate</b>	=	$\frac{\text{Total annual allowable CCBHC costs}^1 \text{ excluding costs for crisis services included under SCS services}}{\text{Total number of CCBHC daily visits per year excluding crisis services visits included under SCS services}}$
2	<b>Monthly PPS for special crisis services<sup>2</sup></b>	=	$\frac{\text{Total annual allowable CCBHC costs}^1 \text{ including only those costs associated with one of the three categories of SCS services and excluding the costs for services provided to the standard population, persons with certain conditions, costs for crisis services included under the other two SCS services categories.}}{\text{Total number of CCBHC unduplicated monthly visits per year including only visits for the same category of SCS services used in the numerator and excluding the visits for the standard population, persons with certain conditions, and visits for crisis services included under the other two SCS services categories}}$ <p>Step 2 would be repeated to calculate the PPS rate for each SP that the state has elected to include in their PPS-4 methodology</p>
3	<b>Monthly PPS for special populations</b>	=	$\frac{\text{Total annual allowable CCBHC costs}^1 \text{ including only the costs for services to persons with certain conditions and excluding costs for the standard population, crisis services included under SCS services and outlier payments}}{\text{Total number of CCBHC unduplicated monthly visits per year including only the visits for services to persons with certain conditions and excluding visits for the standard population and crisis services included under SCS services}}$ <p>Step 2 would be repeated to calculate the PPS rate for each SP that the state has elected to include in their PPS-4 methodology</p>
4	<b>Determine the outlier payment:</b> Outlier payments are commonly calculated by setting a threshold above which a certain percentage of costs should be kept in reserve to account for anticipated outlier costs during the Demonstration. This threshold should be set based on statistically by studying the distribution of costs at the facility level		
5	<b>CC PPS-4 Quality Bonus Payments (QBPs):</b> Under the CC PPS-4 rate methodology, a state may elect to offer QBPs		

1. For DY1, the total annual allowable CCBHC costs collected during the Demonstration planning phase must be trended forward by the MEI to reflect changes due to inflation; 2. The three categories of SCS services are: 1) mobile crisis services meeting the requirements of section 9813 of ARP, 3 2) CCBHC mobile crisis services that do not meet the ARP section 9813 requirements, 3) and on-site CCBHC crisis stabilization services

# Prospective Payment System (PPS) methodology: PPS-4 (2/2)

HIGHLY PRELIMINARY ILLUSTRATIVE

## CC PPS-4: Illustrative sample rate calculation

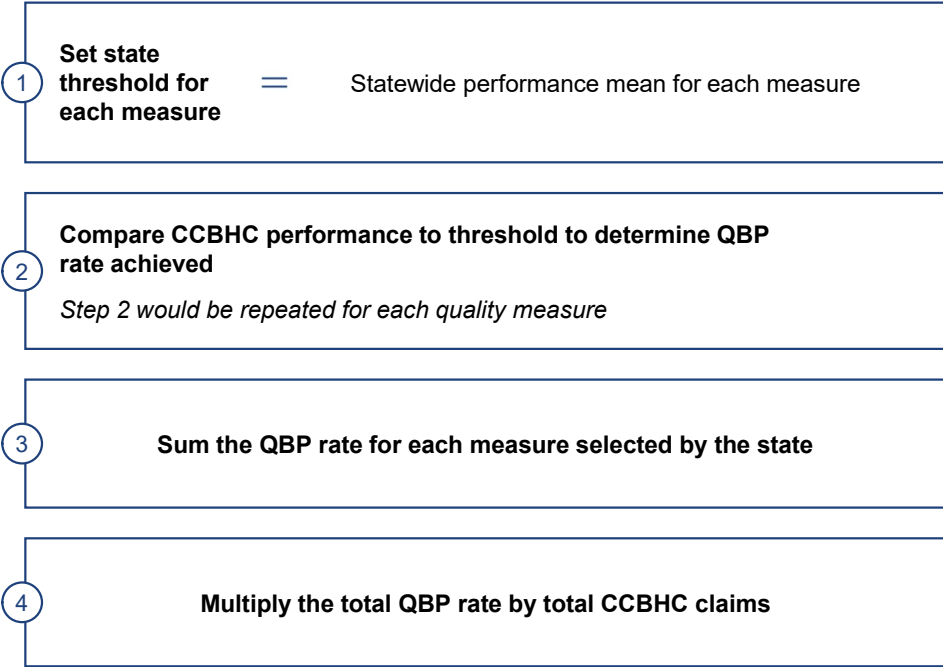
Person	Month	Outlier	Population Type	Visit Months	SCS?	Trended Allowed Monthly Costs, \$	Non-outlier Payment Portion <sup>1</sup>	Outlier Payment Reserve	Payment Per Monthly Visit, \$
<b>Standard Population</b>									
A	Jan		Standard	1	No	50	50		225
A	May		Standard	1	No	75	75		225
B	Mar		Standard	1	No	150	150		225
C	June		Standard	1	No	50	50		225
C	Aug	Yes	Standard	1	No	950	910	40	225
D	Sept		Standard	1	No	115	115		225
<b>Standard Population Subtotal</b>			<b>Standard</b>	<b>6</b>		<b>1,390</b>	<b>1,350</b>	<b>40</b>	<b>1,350</b>
<b>Special Population A</b>									
E	Apr	Yes	Special Population A	1	No	1,200	960	240	805
E	Dec		Special Population A	1	No	650	650		805
<b>Special Population A Subtotal</b>			<b>Special Population A</b>	<b>2</b>		<b>1,850</b>	<b>1,610</b>	<b>240</b>	<b>1,610</b>
<b>Special Population B</b>									
F	May	Yes	Special Population B	1	No	975	915	60	620
G	Oct		Special Population B	1	No	325	325		620
<b>Special Population B Subtotal</b>			<b>Special Population B</b>	<b>2</b>		<b>1,300</b>	<b>1,240</b>	<b>60</b>	<b>1,240</b>
<b>Special Crisis Services- 9813 Mobile Crisis Services</b>									
C	Aug	N/A	All	1	Yes	600	600		450
E	Nov	N/A	All	1	Yes	300	300		450
<b>Special Crisis Services- 9813 Mobile Crisis Services Subtotal</b>			<b>All</b>	<b>2</b>		<b>900</b>	<b>900</b>		<b>900</b>
<b>Total</b>			<b>Total</b>	<b>12</b>		<b>5,440</b>	<b>5,100</b>	<b>340</b>	<b>5,100</b>

1. For this facility, the monthly outlier threshold is set at \$900, with a reserve of 80 percent of costs in excess of that threshold. Therefore, in the rate setting period, 80 percent of the costs above the \$900 threshold would be held in reserve to make outlier payments during the Demonstration period. People C, E, and F each experience 1 month with costs that exceed the established threshold. Therefore, in addition to the PPS rate for each person type, the facility will be paid a varying additional outlier payment.

# Quality Bonus Payment (QBP) methodology

HIGHLY PRELIMINARY ILLUSTRATIVE

## QBP: Methodology



## Illustrative sample rate calculation

QBP Measure	Threshold (state average)	State QBP Payment	CCBHC Performance by CCBHC	QBP Received
Comparative Measure A	55%	<ul style="list-style-type: none"> <li>55%-65% Achievement: 1% of CCBHC claims</li> <li>&gt;65-75% achievement: 2% of CCBHC claims</li> <li>&gt;75% achievement: 2.5% of CCBHC claims</li> </ul>	55%	1%
Comparative Measure B	75%	<ul style="list-style-type: none"> <li>75%-85% Achievement: 1% of CCBHC claims</li> <li>&gt;85 achievement: 2% of CCBHC claims</li> </ul>	76%	1%
Comparative Measure C	65%	<ul style="list-style-type: none"> <li>65%-70% Achievement: 0.5% of CCBHC claims</li> <li>&gt;70-80% achievement: 0.75% of CCBHC claims</li> <li>&gt;80% achievement: 1% of CCBHC claims</li> </ul>	73%	0.75%
Comparative Measure D	80%	<ul style="list-style-type: none"> <li>80%-85% Achievement: 1% of CCBHC claims</li> <li>&gt;85% achievement: 2% of CCBHC claims</li> </ul>	86%	2%
Comparative Measure E	65%	<ul style="list-style-type: none"> <li>65%-75% Achievement: 0.25% of claims</li> <li>&gt;75-85% achievement: 0.5% of CCBHC claims</li> <li>&gt;85% achievement: 1% of CCBHC claims</li> </ul>	86%	1%
Comparative Measure F	60%	<ul style="list-style-type: none"> <li>60%-75% Achievement: 0.5% of CCBHC claims</li> <li>&gt;75% achievement: 2% of CCBHC claims</li> </ul>	74%	0.50%
Comparative Measure G	90%	<ul style="list-style-type: none"> <li>90%-95% Achievement: 0.5% of CCBHC claims</li> <li>&gt;95% achievement: 2% of CCBHC claims</li> </ul>	96%	2%
Optional QBP Measure WWC-CH	55%	<ul style="list-style-type: none"> <li>55%-65% Achievement: 0.25% of claims</li> <li>&gt;65-75% achievement: 0.5% of CCBHC claims</li> <li>&gt;75% achievement: 1% of CCBHC claims</li> </ul>	54%	0%
State-Developed Quality Measure	70%	<ul style="list-style-type: none"> <li>70%-80% Achievement: 0.5% of CCBHC claims</li> <li>&gt;80-85% achievement: 1% of CCBHC claims</li> <li>&gt;85% achievement: 1.5% of CCBHC claims</li> </ul>	80%	0.50%
			<b>Total QBP (% of CCBHC claims)</b>	<b>8.75%</b>

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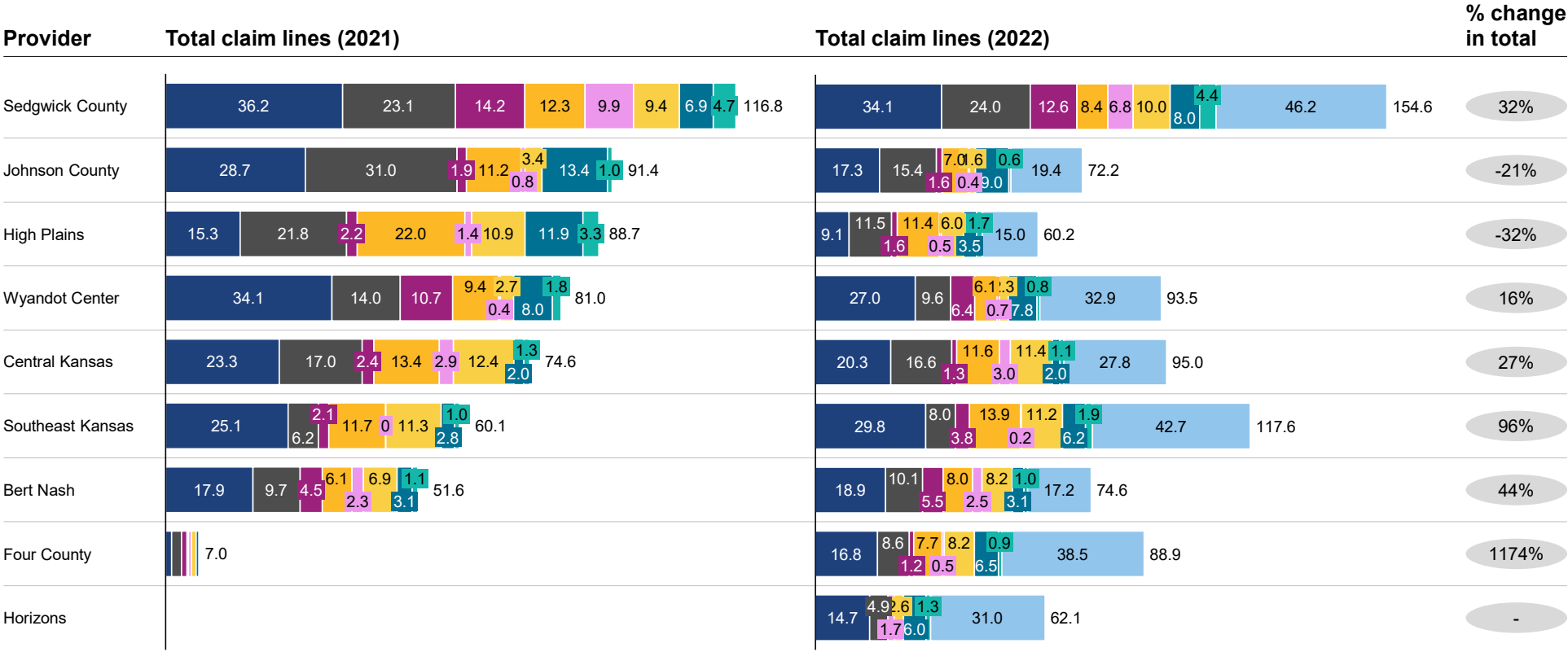
- CCBHC overview
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- **Kansas Medicaid claims output**

# CCBHC treatment: Services, by provider

HIGHLY PRELIMINARY

■ CPST ■ Other ■ Personal case services ■ Psychotherapy ■ Peer supports ■ PSR ■ TCM ■ Crisis ■ CCBHC services (T1040)

Annual claims (in thousands) for Medicaid-reimbursed CCBHC treatment services, by CCBHC, 2021-2022



Source: Kansas Medicaid claims, via TMSIS

# CCBHC treatment: Change in services, by provider

HIGHLY PRELIMINARY

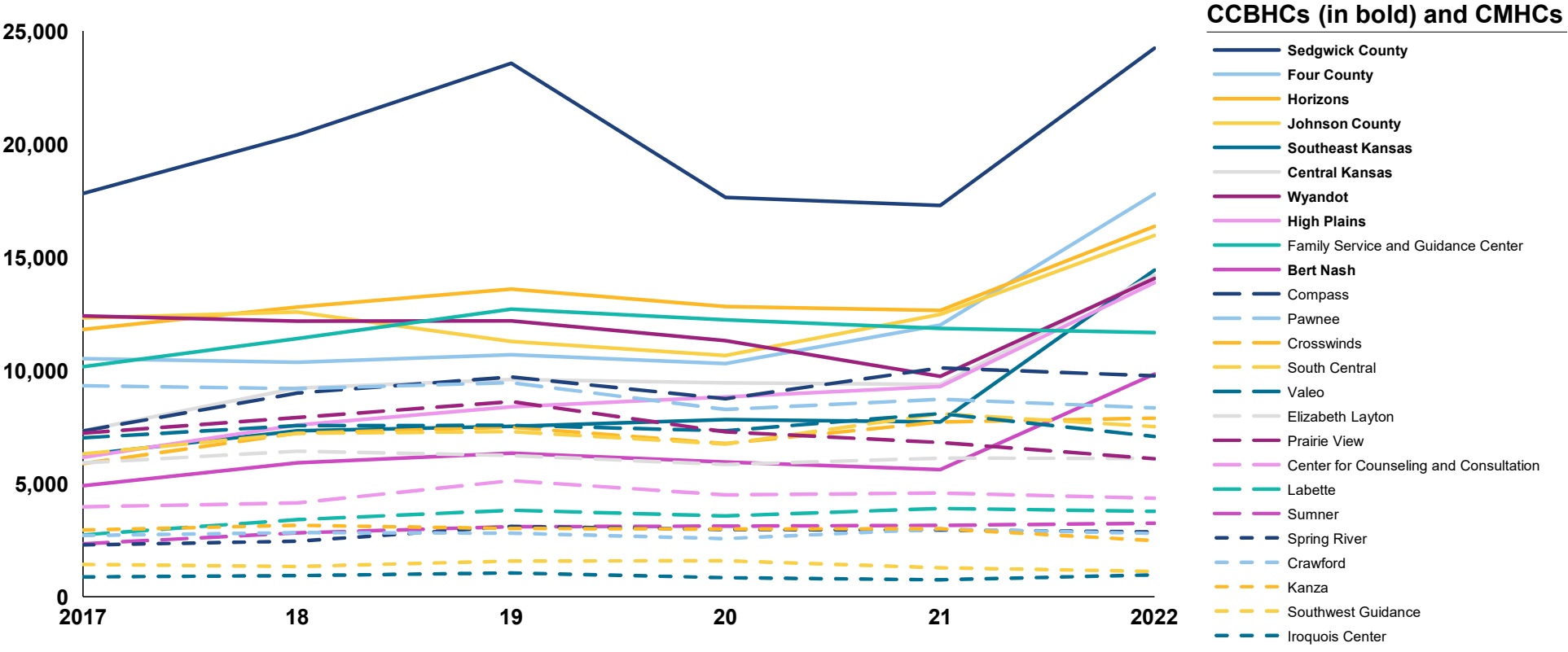
Change in annual claims for Medicaid-reimbursed CCBHC treatment services, by CCBHC, 2021-2022, %

CCBHC services	Sedgwick County	Johnson County	High Plains	Wyandot Center	Central Kansas	Southeast Kansas	Bert Nash	Four County
CPST	-6%	-40%	-41%	-21%	-13%	19%	5%	1,196%
Other	4%	-50%	-47%	-31%	-3%	30%	4%	336%
Personal case services	-11%	-18%	-28%	-40%	-45%	80%	23%	4%
Psychotherapy	-32%	-37%	-48%	-35%	-14%	19%	31%	2,193%
Peer supports	-31%	-53%	-65%	81%	3%	339%	8%	-8%
PSR	7%	-52%	-45%	-13%	-8%	-1%	19%	739%
TCM	15%	-33%	-70%	-3%	0%	124%	0%	995%
Crisis	-5%	-41%	-49%	-54%	-14%	98%	-9%	830%
CCBHC services (T1040)	No claims for CCBHC services (T1040) in 2021							

# CMHC and CCBHC providers: Members served

HIGHLY PRELIMINARY

### Distinct annual members for CMHCs and CCBHCs, 2017-2022



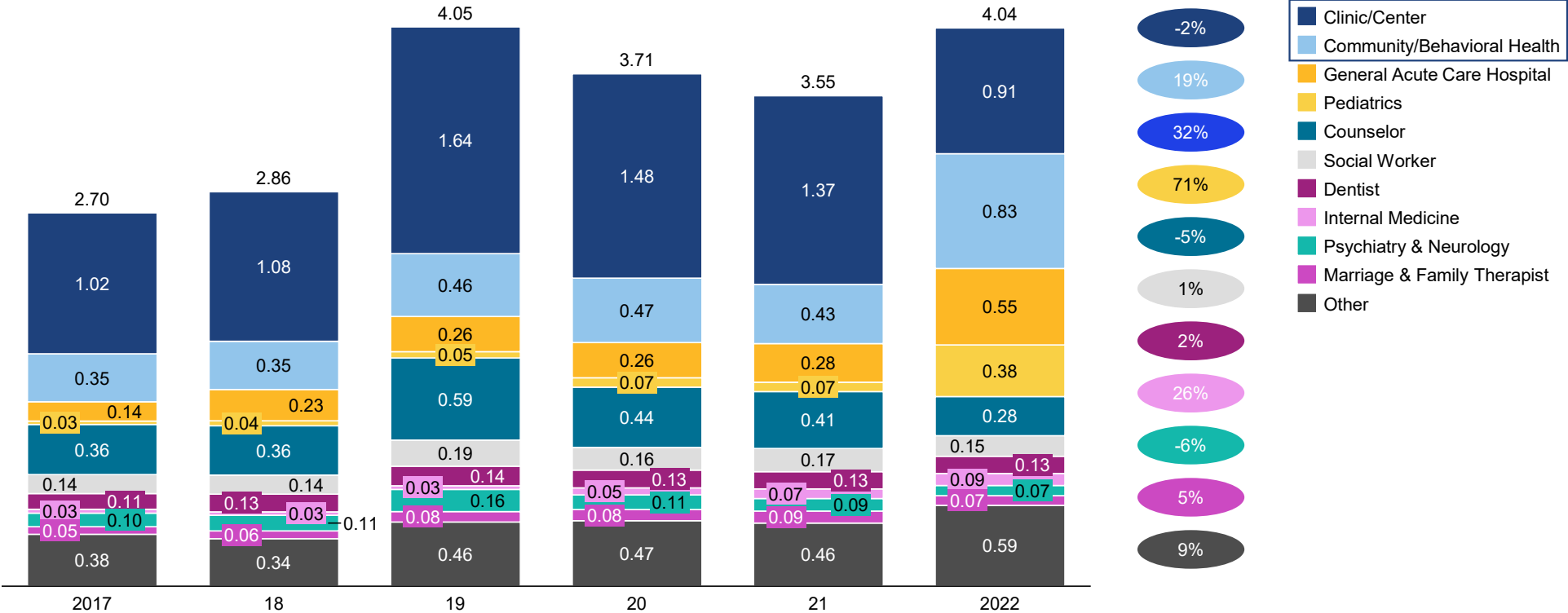
Source: Kansas Medicaid claims, via TMSIS

# BH treatment: Top 10 provider types

HIGHLY PRELIMINARY

Details follow XX CAGR

Annual claims (millions) for Medicaid-reimbursed behavioral health treatment services<sup>1</sup>, by provider taxonomy



1. Behavioral health treatment identified as all claims with a primary diagnosis of a behavioral health condition

# CMHC and CCBHC treatment: Top services

HIGHLY PRELIMINARY

XX CAGR

Annual claims (millions) for Medicaid-reimbursed CCBHC treatment services<sup>1</sup>, by service type



1. Behavioral health treatment identified as all claims with a primary diagnosis of a behavioral health condition and provider taxonomy of "Clinic/Center" or "Community/Behavioral Health"