



May 2021

MEDICAID

HHS's Preliminary Analyses Offer Incomplete Picture of Behavioral Health Demonstration's Effectiveness



A Century of Non-Partisan Fact-Based Work

GAO@100 Highlights

Highlights of [GAO-21-394](#), a report to congressional requesters

Why GAO Did This Study

Behavioral health conditions—mental health issues and substance use disorders—affect millions of people. HHS estimates that 61 million adults had at least one behavioral health condition in 2019—41 million of whom did not receive any related treatment in the prior year.

Many individuals with behavioral health conditions rely on community mental health centers for treatment, but the scope and quality of these services vary. To improve community-based behavioral health services, PAMA created the CCBHC demonstration and provided HHS with \$25 million to support its implementation.

PAMA directed HHS to assess the demonstration and to provide recommendations for its continuation, modification, or termination. To date, HHS has issued three annual reports assessing the initial demonstration period, which ran from 2017 to 2019. HHS plans to issue a fourth annual report and a final report by December 2021.

This report describes HHS's assessment of the demonstration regarding access, costs, and quality. Under the CARES Act, GAO is to issue another report on states' experiences by September 2021.

GAO reviewed federal laws and regulations; HHS guidance; and HHS's assessments of the demonstration, including three issued reports, interim reports, and the analysis plan for future reports. GAO also interviewed HHS officials and officials from organizations familiar with community health clinics.

HHS provided technical comments, which GAO incorporated as appropriate

View [GAO-21-394](#). For more information, contact Carolyn L. Yocom (202) 512-7114 or yocomc@gao.gov

May 2021

MEDICAID

HHS's Preliminary Analyses Offer Incomplete Picture of Behavioral Health Demonstration's Effectiveness

What GAO Found

The Protecting Access to Medicare Act of 2014 (PAMA) established the Certified Community Behavioral Health Clinics (CCBHC) demonstration and tasked the Department of Health and Human Services (HHS) with its implementation. CCBHCs aim to improve the behavioral health services they provide, particularly for Medicaid beneficiaries. Initially established for a 2-year period, the demonstration has been extended by law a number of times; most recently, it was extended to September 2023. States participating in the demonstration can receive Medicaid payments, consistent with federal requirements, for CCBHC services provided to beneficiaries.

PAMA also required HHS to assess the effect of the demonstration on service access, costs, and quality. HHS's preliminary assessments of the demonstration in eight states, with 66 participating CCBHCs, found the following:

- **Access.** CCBHCs commonly added services related to mental and behavioral health, such as medication-assisted treatment, and took actions to provide services outside the clinic setting, such as through telehealth.
- **Costs.** States' average payments to CCBHCs typically exceeded CCBHC costs for the first 2 years of the demonstration. CCBHC payments and costs were more closely aligned in the second year for most states, better reflecting the payment methods prescribed under the demonstration.
- **Quality.** States and CCBHCs took steps, such as implementing electronic health records systems, to report performance on 21 quality measures.

GAO found data limitations complicated—and will continue to affect—HHS's efforts to assess the effectiveness of the demonstration. For example:

- **Lack of baseline data.** PAMA requires HHS to assess the quality of services provided by CCBHCs compared with non-participating areas or states. The demonstration marked the first time these clinics reported performance on quality measures, so no historical baseline data exist. HHS officials noted that with time, additional data may provide insight on the quality of services.
- **Lack of comparison groups.** PAMA requires HHS to compare CCBHCs' efforts to increase access and improve quality with non-participating clinics and states. HHS was unable to identify comparable clinics or states due to significant differences among the communities.
- **Lack of detail on Medicaid encounters.** PAMA requires HHS to assess the effect of the demonstration on federal and state costs and on Medicaid beneficiaries' access to services. HHS plans to use Medicaid claims and encounter data to assess such changes. However, GAO has previously identified concerns with the accuracy and completeness of Medicaid data and has made numerous recommendations aimed at improving their quality.

HHS's decisions in implementing the demonstration also complicated its assessment efforts. HHS allowed states to identify different program goals and target populations, and to cover different services. HHS also did not require states to use standard billing codes and billing code modifiers it developed. The lack of standardization across states limited HHS's ability to assess changes in a uniform way.

Contents

Letter		1
	Background	3
	HHS's Preliminary Assessments of the Certified Community Behavioral Health Clinic Demonstration Provide an Incomplete Picture of the Program's Effectiveness	8
	Agency Comments	17
Appendix I	Quality Measures Required by the Department of Health and Human Services	20
Appendix II	GAO Contact and Staff Acknowledgments	21
Tables		
	Table 1: Examples of Services Added by Certified Community Behavioral Health Clinics (CCBHC), by Service Category, in the First Year of the Demonstration	9
	Table 2: Quality Measures Required by HHS for the Certified Community Behavioral Health Clinics Demonstration	20
Figures		
	Figure 1: Timeline of HHS's Program Implementation and Reporting of Certified Community Behavioral Health Clinics (CCBHC) Demonstration	7
	Figure 2. Percentage Difference between Certified Community Behavioral Health Clinics (CCBHC) Average Payment Rates and Costs in Daily Payment States, Demonstration Years One and Two	13

Abbreviations

ASPE	Assistant Secretary of Planning and Evaluation
CCBHC	certified community behavioral health clinic
CMS	Centers for Medicare & Medicaid Services
EHR	electronic health record
HHS	Department of Health and Human Services
MAT	medication-assisted treatment
PAMA	Protecting Access to Medicare Act of 2014
SAMHSA	Substance Abuse and Mental Health Services Administration

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

May 17, 2021

Congressional Requesters

Behavioral health conditions—including substance use disorders and mental health conditions—affect millions of adults and adolescents. In 2019, approximately 61.2 million adults in the United States had at least one behavioral health condition; however, an estimated 40.9 million of these adults did not receive any behavioral health treatment in the prior year.¹ Left untreated, behavioral health conditions may lead to worsening health, increased medical costs, and negative effects on employment.

Community mental health centers can provide some treatment for these conditions, but the scope and quality of services offered can vary across states and across clinics. Medicaid, a joint federal-state program that financed health care coverage for 77 million low-income and medically needy individuals in 2020, often pays for services provided to beneficiaries in these centers.

To improve the availability and quality of services provided in community mental health centers, Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA) created a 2-year demonstration program for up to eight states, and tasked the Department of Health and Human Services (HHS) with its implementation.² The demonstration has been extended by

¹See Substance Abuse and Mental Health Services Administration (SAMHSA), *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).

²Pub. L. No. 113-93, § 223, 128 Stat. 1040, 1077-83. PAMA provided HHS with \$25 million to support states to prepare to participate in the demonstration. HHS awarded planning grants to 24 states, from which it selected eight states for participation in the demonstration: Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania. The demonstration initially included 67 CCBHCs. In March 2018, one CCBHC withdrew from the demonstration after Nevada revoked its certification. Pennsylvania opted out of the demonstration at the end of the initial 2 years. The demonstration was initially set to end on June 30, 2019.

law a number of times; most recently, the demonstration was extended through September 30, 2023.³

In implementing the demonstration, HHS created criteria for states to certify community mental health centers or other behavioral health facilities; these criteria provided flexibility for states to implement activities that aligned with their respective Medicaid programs and community needs. HHS then selected eight states to participate in the demonstration in 2017; these states, in turn, designated 66 community mental health centers as certified community behavioral health clinics (CCBHC). Among other goals, CCBHCs are to offer individuals a broader array of mental health and substance use services, and to focus on care coordination and improved quality.

PAMA also established multiple reporting requirements for HHS regarding CCBHCs. For instance, PAMA required HHS to assess the effectiveness of the CCBHC demonstration during its initial 2 years, which spanned from 2017 to 2019. Specifically, HHS was to assess the demonstration's effectiveness on service access, the impact of federal and state costs of providing mental health services, and the quality and scope of services, and to issue annual reports summarizing its findings. In addition to the annual reports, PAMA required HHS to issue a final report with recommendations for the continuation, expansion, modification, or termination of the demonstration by December 2021. As of March 2021, HHS had published three of four planned annual reports, which include information on activities to implement the demonstration and preliminary information on the demonstration's effects.⁴

You asked that we provide information on HHS's evaluations of the CCBHC demonstration. This report describes HHS's assessment of the CCBHC demonstration's effect on access, costs, and quality.

³For example, the CARES Act extended the demonstration through November 30, 2020, and expanded the demonstration to include two additional states (Kentucky and Michigan). Pub. L. No. 116-136, § 3814, 134 Stat. 281, 430. More recently, the Consolidated Appropriations Act, 2021 extended the demonstration through September 30, 2023. Pub. L. No. 116-260, div. CC, tit. II, § 206, 134 Stat. 1181, 2984. These legislative extensions allowed states to continue to receive Medicaid payments, consistent with federal requirements, for CCBHC services provided to beneficiaries. The extensions did not include additional HHS reporting requirements.

⁴HHS published these three reports in August 2018, September 2019, and September 2020.

To describe HHS's assessment of the CCBHC demonstration's effect on access, costs, and quality, we reviewed federal laws and regulations, and HHS guidance for implementing the demonstration. We reviewed the three HHS annual reports that were publicly available in March 2021, the month we completed our analysis. We also reviewed other HHS documents, including interim reports, which provide detailed information on CCBHC cost reports and CCBHC efforts to implement the demonstration, and HHS's analysis plan for its full evaluation, which includes information on the scope and content of its fourth annual report and its final report. We interviewed officials from the three HHS agencies with CCBHC-related responsibilities: the Office of the Assistant Secretary for Planning and Evaluation (ASPE), the Centers for Medicare & Medicaid Services (CMS), and the Substance Abuse and Mental Health Services Administration (SAMHSA).⁵ We also interviewed the HHS contractors that conducted the evaluations—Mathematica and RAND—to obtain information on the methods used to assess the demonstration's effect; officials from the National Quality Forum to understand behavioral health quality measures endorsed by the organization; and officials with the National Council for Behavioral Health.

We conducted this performance audit from June 2020 to May 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.

Background

PAMA directed HHS to establish specific requirements for CCBHCs, participating states, and HHS with respect to access, costs, and quality.

Access. PAMA required CCBHCs to provide coordinated care and to offer access to a comprehensive range of services to all individuals. Specifically, PAMA identified nine specific categories of services that CCBHCs were to provide. In implementing the demonstration, HHS developed criteria that offered states flexibility in determining specific services CCBHCs were to provide within each of those categories. For example, one category of service was outpatient treatment for mental

⁵The three HHS agencies collaborated to implement the demonstration. SAMHSA developed the criteria for states to certify existing community mental health centers as CCBHCs; CMS prepared guidance to states to establish a prospective payment system; and ASPE directed the evaluation of the program.

health and substance use disorders. Within this category, states could select among specific services, such as motivational interviewing to engage with individuals experiencing substance use disorders, or provide medication-assisted treatment (MAT) to treat substance use disorders, such as opioid use. States also had flexibility in other areas, such as determining program goals and target populations; the types of staff most appropriate to provide CCBHC services; and activities to increase CCBHC access for clients, including extending hours of service and providing services in settings outside the clinic.⁶

Costs. PAMA directed HHS to establish a prospective payment system to pay CCBHCs for services provided to Medicaid beneficiaries. States selected one of two payment models established by HHS and developed CCBHC-specific rates based on each clinic's historical costs and changes in scope of services provided.⁷ Six participating states—Minnesota, Missouri, Nevada, New York, Oregon, and Pennsylvania—selected a daily rate model: a fixed amount for each day that a Medicaid beneficiary receives CCBHC services, regardless of the type or volume of services received. The two remaining states—New Jersey and Oklahoma—selected a monthly payment model, which also provides a fixed payment regardless of the type or volume of services, but includes variable payment rates to account for special populations or conditions, as well as outlier payments to account for high cost beneficiaries.⁸

Quality. PAMA required CCBHCs and states participating in the demonstration to report quality data. Quality 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. CCBHCs and states are to report performance for 21 quality measures (12 reported by states and nine reported by CCBHCs), selected by HHS from existing programs, such as its Medicaid

⁶For this report, we generally refer to individuals seeking care in CCBHCs as clients.

⁷The payment methods prescribed by HHS aimed to improve the alignment between states' payments to CCBHCs and CCBHCs' total projected costs. The prospective payment rate only applies to CCBHC services provided to Medicaid beneficiaries. For Medicaid beneficiaries, states previously paid these clinics on a fee-for-service basis or paid managed care organizations a fixed amount per beneficiary per month for a specific set of services.

⁸States selecting this option can also provide bonus payments to CCBHCs that meet state-specified performance requirements on quality measures and all states but New York and Oregon chose to do so.

and Children's Health Insurance Programs Child and Adult Core Sets (hereafter, the Child and Adult Core Sets).⁹ State-reported measures, such as the extent to which CCBHCs are providing medication management for antidepressants, often derive from claims and encounter data, while CCBHC-reported measures, such as screening for clinical depression, typically derive from clinical data.

PAMA also required HHS to assess the effectiveness of the 2-year CCBHC demonstration on service access, costs, and quality, and to issue annual reports summarizing its findings. Specifically, PAMA required HHS to assess

- access to community-based mental health services under the Medicaid program in participating areas of the state compared with non-participating areas;
- the impact of the demonstration on the federal and state costs of covering a full range of mental health services; and
- the quality and scope of mental health services CCBHCs provided compared with non-participating areas in the state, as well as with non-participating states.

HHS focused its assessment of the demonstration on the initial 2 years of the demonstration, 2017 to 2019. As of March 2021, HHS had issued three annual reports to Congress, each of which assessed different aspects of the demonstration. For example:

- First annual report (August 2018): HHS described its demonstration implementation efforts, including the planning grant offered to states and the selection of participating states.
- Second annual report (September 2019): HHS described CCBHC efforts to meet demonstration criteria, including new services added, and described the prospective payment systems implemented by participating states.
- Third annual report (September 2020): HHS described the estimated costs of providing services during the first year of the demonstration,

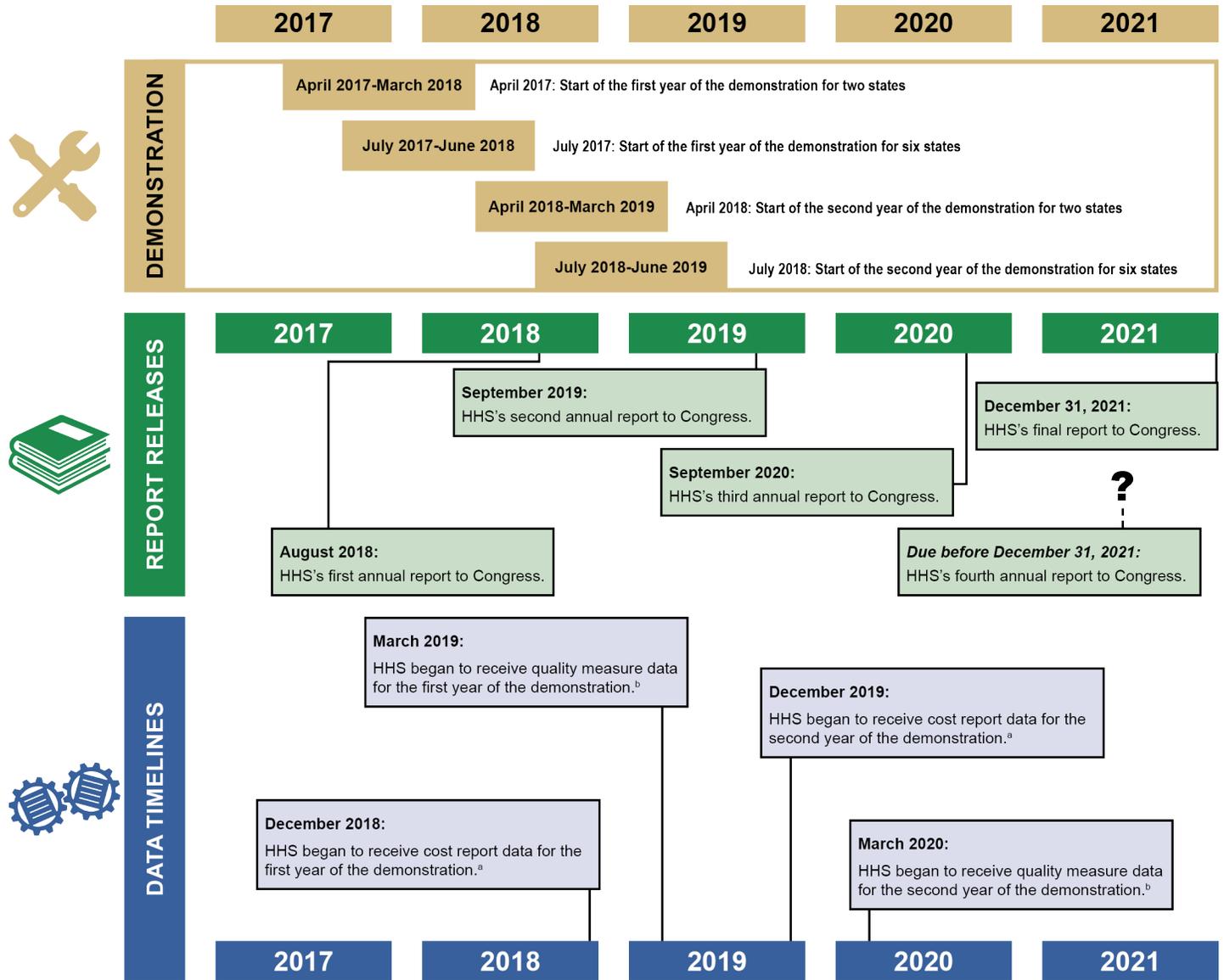
⁹HHS also relied on quality measures identified by the National Quality Forum, a nonprofit organization that evaluates and determines which measures to recognize as the best available for a given aspect of care. HHS adapted the quality measures for the demonstration so that individual CCBHCs could report performance on quality measures.

as well as the experiences of states and CCBHCs reporting required quality measures.

In some cases, these three reports reflect preliminary information, as complete data were not always available from states or CCBHCs at the time of issuance. For example, in the second annual report, HHS did not include information on the actual cost of providing CCBHC services, because states had not yet submitted cost report data. Similarly, for the third annual report, states and CCBHCs did not submit data needed to assess performance on the quality measures in time to be included in the report.¹⁰ For its fourth annual report, HHS officials said they may update findings from these three reports as additional data are reviewed. HHS also plans to issue its final report by December 2021 with recommendations for the continuation, expansion, modification, or termination of the demonstration, as outlined by PAMA. (See fig.1.)

¹⁰Therefore, HHS's discussion of CCBHC performance on identified quality measures was a description of states' and CCBHCs' activities to collect these data.

Figure 1: Timeline of HHS’s Program Implementation and Reporting of Certified Community Behavioral Health Clinics (CCBHC) Demonstration



Legend: HHS=Department of Health and Human Services.

Source: GAO analysis of HHS data. | GAO-21-394

^aData are submitted 9 months after the end of the demonstration year for the participating state.

^bData are submitted 12 months after the end of the demonstration year for the participating state.

HHS's Preliminary Assessments of the Certified Community Behavioral Health Clinic Demonstration Provide an Incomplete Picture of the Program's Effectiveness

In assessing the effect of the demonstration, HHS describes participating clinics' efforts to expand access across states and to report on specified quality measures, as well as compares state payments with CCBHC costs. However, data limitations have complicated—and will continue to affect—HHS's assessments of the effectiveness of the demonstration on service access, federal and state costs, and quality.

HHS Identified Some Changes to Access, Costs, and Quality

Access

HHS reported that CCBHCs added a broad range of services, including services in all nine categories required by PAMA.¹¹ CCBHCs most commonly added services in categories related to mental and behavioral health, such as the outpatient mental health and substance use or psychiatric rehabilitation categories. Less commonly, CCBHCs added services in categories related to screening and assessments, and person-centered treatment planning. (See table 1.)

¹¹CCBHCs added these services as a result of certification. In developing the criteria for clinic certification, HHS described services that CCBHCs could provide in each of the nine categories. To be certified as a CCBHC, a clinic had to provide some services in each of these categories, they are not required to provide all services described by HHS.

Table 1: Examples of Services Added by Certified Community Behavioral Health Clinics (CCBHC), by Service Category, in the First Year of the Demonstration

Service category	Examples of services	Number of CCBHCs that added at least one new service ^a
Outpatient mental health and substance use	<ul style="list-style-type: none"> Medication-assisted treatment for alcohol and opioid use Cognitive behavioral therapies 	42
Psychiatric rehabilitation	<ul style="list-style-type: none"> Supported employment Financial management 	37
Crisis behavioral health	<ul style="list-style-type: none"> 24-hour mobile crisis teams Emergency crisis intervention services 	34
Peer and family support	<ul style="list-style-type: none"> Peer-run drop-in centers Parent training 	33
Intensive mental health services for veterans and armed service members	<ul style="list-style-type: none"> HHS does not describe specific services, but lists standards for any mental health care provided to this group, including Care is consistent with minimum clinical guidelines established by the Veterans' Health Administration Each veteran is assigned a Principal Behavioral Health Provider 	30
Primary care screening and monitoring	<ul style="list-style-type: none"> Body mass index screening Diabetes screening 	28
Targeted case management	<ul style="list-style-type: none"> Targeted case management 	27
Screening, assessment, and diagnosis	<ul style="list-style-type: none"> Mental screening and diagnostic services Substance use disorder screening and diagnostic services 	15
Person-centered treatment planning	<ul style="list-style-type: none"> Person-centered treatment planning, including risk assessment and crisis planning 	12

SOURCE: GAO analysis of the Department of Health and Human Services data. | GAO-21-394

NOTE: The Protecting Access to Medicare Act of 2014 (PAMA) 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.

^aTotal reflects the number of CCBHCs that reported adding at least one new service as a result of certification in the first year of the demonstration (2017-2018). While a number of CCBHCs added additional services in the second year of the demonstration (2018-2019), HHS's preliminary reports did not aggregate data by service category for that year.

In HHS's issued reports, HHS also described mental and behavioral health services commonly added by CCBHCs. For example:

- Thirty-one CCBHCs began offering MAT services. MAT involves the use of medications approved by the Food and Drug Administration in combination with counseling to treat substance use disorders. In January 2020, we reported that MAT could be effective in reducing opioid use and engaging individuals in their recovery compared with

abstinence-based treatment.¹² HHS has also identified expanding access to MAT as a priority for reducing opioid use disorders.¹³

- Eighteen CCBHCs began offering supported employment, which involves helping individuals with mental illness find and maintain employment. In February 2019, we reported that supportive services, such as housing and employment, could help individuals initiate and continue behavioral health treatment.¹⁴ HHS also reported in 2009 that individuals participating in supportive employment were more successful at obtaining work and earned more than individuals in other vocational services, and that obtaining employment may be associated with improvements in symptoms and self-esteem.¹⁵

According to HHS's reports, CCBHCs also took actions to expand access by providing services to clients outside the clinic setting. For example:

- Eleven CCBHCs began offering services in locations outside the clinic, including in schools or in clients' homes. HHS reported in 2019 that providing services in schools can increase identification of individuals needing treatment, increase access to care, and decrease stigma when seeking treatment.¹⁶
- Ten CCBHCs began offering telehealth services. Research has found that telehealth, which is the delivery of clinical services remotely using telecommunication technologies, may reduce hospitalization and lower health care costs by facilitating frequent and ongoing

¹²See GAO, *Opioid Use Disorder: Barriers to Medicaid Beneficiaries' Access to Treatment Medications*, [GAO-20-233](#) (Washington, D.C.: Jan. 24, 2020).

¹³See GAO, *Opioid Use Disorders: HHS Needs Measures to Assess the Effectiveness of Efforts to Expand Access to Medication-Assisted Treatment*, [GAO-18-44](#) (Washington, D.C.: Oct. 31, 2017). At the end of the initial 2 years of the demonstration, 61 of the 66 CCBHCs provided MAT services.

¹⁴See GAO, *Behavioral Health: Research on Health Care Costs of Untreated Conditions is Limited*, [GAO-19-274](#) (Washington, D.C.: Feb. 28, 2019).

¹⁵See Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Supported Employment: Training Frontline Staff*. Pub. No. SMA-08-4364 (Rockville, Md.: 2009). At the end of the initial 2 years of the demonstration, 54 of the 66 CCBHCs provided supported employment services.

¹⁶See Centers for Medicare & Medicaid Services and Substance Abuse and Mental Health Services Administration, *Joint Informational Bulletin: Guidance to States and Schools Systems on Addressing Mental Health and Substance Use Issues in Schools* (July 1, 2019). Also see [GAO-19-274](#). At the end of the initial 2 years of the demonstration, 64 of the 66 CCBHCs provided services in locations outside the clinic.

treatment.¹⁷ Additionally, we reported in July 2017, that telehealth might increase access to services in rural areas and areas with provider shortages.¹⁸

HHS's issued reports do not provide information on the effect of the demonstration on Medicaid beneficiaries' access to services, including comparing service access in CCBHCs with access in non-participating areas, as required by PAMA.¹⁹ According to the analysis plan for its December 2021 report, HHS intends to compare changes in service utilization by Medicaid beneficiaries served by CCBHCs with Medicaid beneficiaries not served by CCBHCs, including any changes in the use of hospital, emergency department, and outpatient services.

Costs

In analyzing CCBHC costs, HHS found that states' average payments to CCBHCs typically exceeded average CCBHC costs for both years of the demonstration, and that CCBHC payments and costs were more closely aligned in the second year of the demonstration in states using the daily payment model.²⁰ HHS reported factors that may have contributed to the higher discrepancy between costs and payments during the first year. For example, many CCBHCs had difficulty hiring and retaining staff, which may have resulted in lower than expected costs. The closer alignment

¹⁷See [GAO-19-274](#).

¹⁸See GAO, *Telehealth; Use in Medicare and Medicaid*, [GAO-17-760T](#) (Washington, D.C.: July 20, 2017). At the end of the initial 2 years of the demonstration, 46 of the 66 CCBHCs provided telehealth services.

¹⁹HHS noted that information included in its issued reports, such as an analysis of the number of Medicaid beneficiaries served versus those projected and evidence from interviews with organizations representing consumers and families, suggest that CCBHCs have improved access.

²⁰HHS's reports define CCBHC costs as the amount CCBHCs reported spending during a given demonstration year, as reflected in annual cost reports submitted to their respective state. For 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 March 2021.

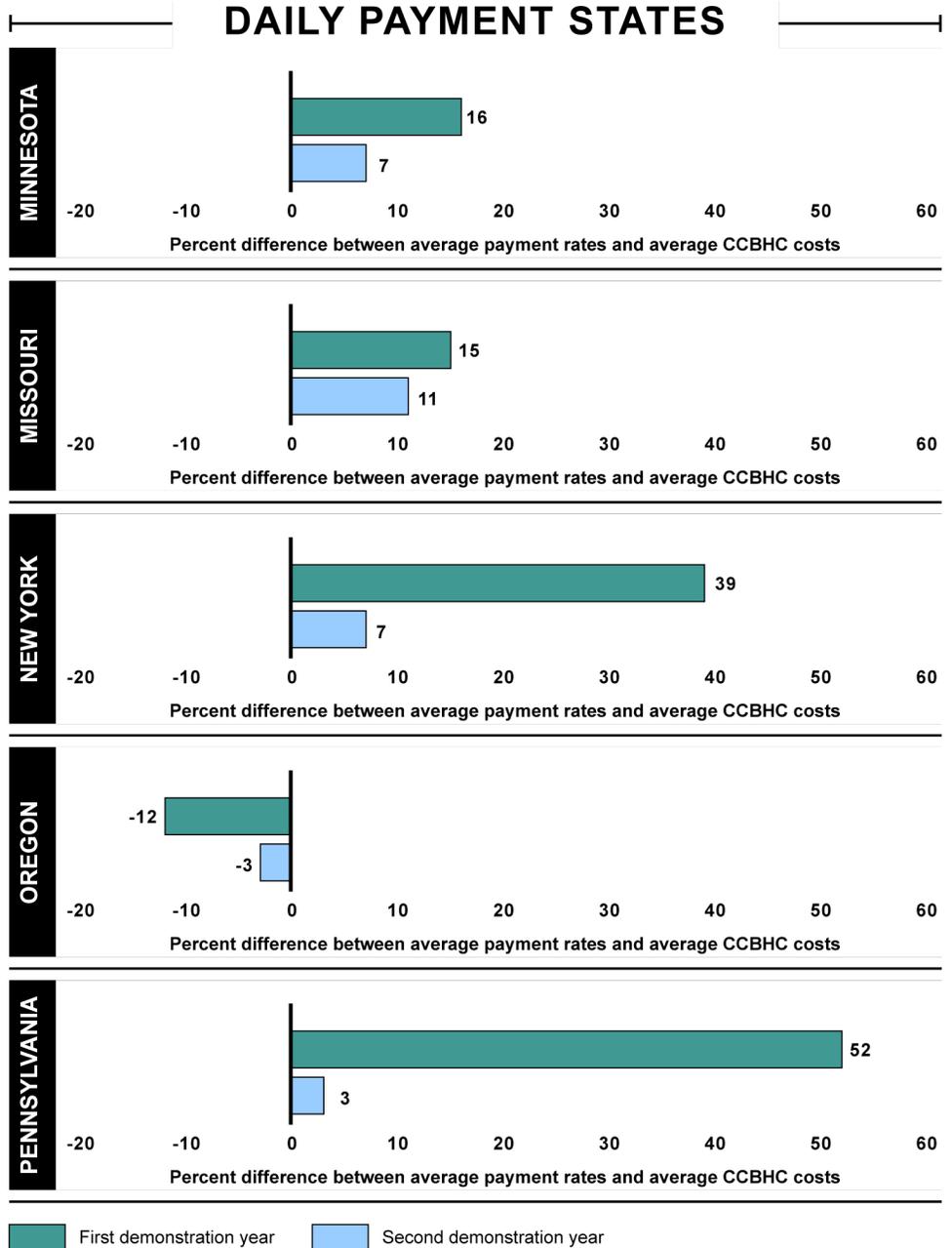
between costs and payments in the second year of the demonstration in these states was consistent with HHS expectations.²¹

- **States using the daily payment model.** Under the CCBHC demonstration, six participating states chose a daily payment model. HHS found that for four of these six states, average payments to CCBHCs were higher than average costs in the first year of the demonstration, ranging from 15 percent higher in Missouri to 52 percent higher in Pennsylvania. For the remaining state, Oregon, average payments to CCBHCs were 12 percent lower than actual costs in the first year of the demonstration.²² HHS also found that for the second year of the demonstration, states' average payments to CCBHCs more closely aligned with average CCBHC costs, ranging from 3 percent below average costs in Oregon to 11 percent above average costs in Missouri. (See fig. 2.)
- **States using the monthly payment model.** Under the CCBHC demonstration, two of the participating states chose the monthly payment model, New Jersey and Oklahoma. New Jersey reported projected costs instead of actual costs for both demonstration years; therefore, HHS limited this analysis to Oklahoma. HHS found that average payments to CCBHCs in the first year of the demonstration were 2 percent below costs in Oklahoma. In contrast to states using the daily payment model, the difference between payment rates and CCBHC costs in Oklahoma increased in the second year of the demonstration, with payments growing to 18 percent above costs.

²¹The demonstration marks the first time that CCBHCs in seven of the eight states completed cost reports. HHS did not verify information included in these reports. In some cases, HHS identified instances that could indicate some CCBHCs did not always report costs correctly, including one CCBHC that did not report any indirect costs.

²²HHS excluded Nevada from this analysis due to data limitations, including that the state did not submit cost reports for the second demonstration year in time to be included.

Figure 2. Percentage Difference between Certified Community Behavioral Health Clinics (CCBHC) Average Payment Rates and Costs in Daily Payment States, Demonstration Years One and Two



Source: GAO analysis of Department of Health and Human Services (HHS) data. | GAO-21-394

Notes: A positive percentage indicates how much the state average rate was greater than the state average CCBHC costs and a negative percentage indicates how much the rate was less than the

costs. Daily payment states pay CCBHCs a fixed amount for each day that a Medicaid beneficiary receives CCBHC services, regardless of the type or volume of services received. Nevada is also a daily payment state but did not submit cost data for the second demonstration year in time to be included in this analysis. The first demonstration year ran from 2017 to 2018; the second demonstration year ran from 2018 to 2019.

HHS's reports do not include information on the effect of the demonstration on federal and state costs of providing a full range of mental health services, as required by PAMA. According to the analysis plan for its December 2021 report, HHS intends to identify federal and state Medicaid costs associated with all services, including emergency and inpatient services, provided to beneficiaries who also obtain services in CCBHCs. HHS plans to compare these costs to the costs associated with similar services provided to Medicaid beneficiaries not served by CCBHCs.

Quality

The Department of Health and Human Services (HHS) Child and Adult Core Sets

HHS established the Child and Adult Core Sets to obtain information on the quality of care provided to individuals enrolled in states' Medicaid and Children's Health Insurance Programs. The measures included in both sets cover a range of physical and behavioral health areas. HHS first reported states' performance data for the Child Core Set in 2012 and for the Adult Core Set in 2015.

HHS publishes performance data on measures reported by at least 25 states that meet HHS's standards for data quality. While state reporting of these data is currently voluntary, HHS reported state performance on 23 of 26 measures in the Child Core Set, and 25 of 33 measures in the Adult Core Set, for federal fiscal year 2019.

Source: GAO. | GAO-21-394

HHS reports also include information on CCBHC performance on quality of care measures during the first year of the demonstration on the 21 quality measures identified by HHS. HHS relied on sources, such as its Child and Adult Core Sets and the National Quality Forum, to identify these quality measures, and directed states and CCBHCs to report performance on these measures for the first time.

HHS-identified quality measures include those directly related to behavioral health, such as rates of depression or substance use screening and treatment, as well as other quality indicators, such as housing status and hospital readmission rates. Most required quality measures relate to processes, including those that assess the extent to which CCBHCs implement clinical practices, such as screening for clinical depression.²³ (See app. I.)

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 (EHR) systems. However, due to data limitations discussed below, these assessments do not compare CCBHC performance on the quality of services with non-participating areas, or with other states, as required by PAMA. According to the analysis plan for its December 2021 report, HHS instead plans to

²³HHS finalized its effort to identify the quality measures in March 2015 and maintained this set of measures as required reporting during the initial demonstration period, 2017-2019.

describe any changes in CCBHC performance on the quality measures between the initial 2 years of the demonstration.

Data Limitations Complicate HHS Assessments of the Demonstration's Effectiveness

In reviewing HHS's assessments, we identified several limitations that have complicated—and will continue to affect—HHS's efforts to evaluate the demonstration.²⁴ For example, the lack of baseline data for identified quality measures and difficulty identifying comparable, nonparticipating clinics, are among the data limitations that complicate HHS's efforts to assess the effectiveness of the demonstration. In addition, HHS's decisions regarding the design of the demonstration and the scope of data to collect also complicate its assessment efforts.

Examples of data limitations that complicate HHS efforts.

- **Lack of baseline data.** PAMA requires HHS to assess the quality and scope of services provided by CCBHCs compared with nonparticipating areas and states. The demonstration marked the first time that CCBHCs had to collect and report performance on the measures identified by HHS.²⁵ As a result, historical baseline data to assess changes in CCBHC's performance on the quality measures do not exist. ²⁶ HHS officials noted that as the program matures, additional data should become available, which could shed light on the quality of services provided across CCBHCs.

²⁴At the time of our review, March 2021, HHS had published three of the four planned annual reports. In addition, the agency is required to issue a final report with recommendations for continuation, expansion, modification, or termination of demonstration projects under Section 223 by December 2021. The CARES Act also includes a provision, for GAO to report on states' experiences with the CCBHC demonstration by September 27, 2021 and, in response, GAO is conducting additional work on the demonstration.

²⁵Evaluations typically rely on comparable sources, such as baseline data or existing benchmarks, to assess performance improvement on quality measures. Many CCBHCs reported challenges retrieving relevant data, including data from newly implemented EHR systems.

²⁶HHS noted that it intends to compare CCBHC performance on quality measures to relevant benchmarks, such as the Child and Adult Core Sets and the Medicare Merit-based Incentive Payment System. While existing benchmarks for the measures in the Child and Adult Medicaid Core Sets could provide context to understand CCBHC performance on certain measures, they are not appropriate for evaluating CCBHC performance due to population differences. For example, the benchmark for the depression remission measure is based on the experience of a statewide population who receive treatment in a range of health care settings, unlike the data reported by CCBHCs, which are limited to individuals treated at the CCBHC.

Prior GAO Findings on Medicaid Encounter Data

Medicaid encounter data can provide a variety of information, including information on the services provided to beneficiaries and their associated costs. Encounter data may also be used to set Medicaid payment rates and to assess quality.

We have frequently found encounter data, particularly for beneficiaries enrolled in managed care organizations, to be incomplete, inaccurate, and untimely. For example,

- In January 2017, we found that managed care data were incomplete or unreliable in 32 states, and states report these data up to 3 years late.
- In January 2021, we reported that managed care inpatient data from 37 states did not meet the Centers for Medicare & Medicaid Services' standards for completeness and consistency.

These and other data limitations have complicated efforts to assess Medicaid costs and to ensure beneficiaries' access to covered services.

Source: GAO, Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements, [GAO-17-173](#) (Washington, D.C.: Jan. 6, 2017); and Medicaid: Data Completeness and Accuracy Have Improved, Though Not All Standards Have Been Met, [GAO-21-196](#) (Washington, D.C.: Jan. 14, 2021). | GAO-21-394

- **Lack of comparison groups.** PAMA requires HHS to compare the effectiveness of CCBHC efforts to increase access and improve quality with non-participating areas and states. For multiple reasons, HHS was unable to identify comparable clinics or states. For example, in some participating states, most community mental health centers participated in the demonstration; as such, comparison clinics were not available. Similarly, HHS officials noted that significant differences among the communities or case mixes served by CCBHCs and non-participating clinics limited the types of comparisons that could be made. HHS officials also noted that a comparison across states was not appropriate given the amount of state variation in services covered by Medicaid and provided by CCBHCs.
- **Lack of detail on Medicaid encounters.** PAMA requires HHS to assess the effect of the demonstration on federal and state costs of providing a full range of mental health services and on Medicaid beneficiaries' access to services. HHS officials told us they plan to use Medicaid claims and encounter data to analyze costs and service utilization for the December 2021 report.²⁷ HHS officials said that due to resource limitations, its analyses would be limited to three participating states (Missouri, Oklahoma, and Pennsylvania). HHS determined that these states had the most complete data at the time they began their analyses.²⁸ However, in its preliminary analyses of data from these states, HHS identified limitations, including limitations that reflect well-known concerns about encounter data. For example, encounter data frequently do not identify the cost of care or the specific service provided to the Medicaid beneficiary. We also have a large body of work that identifies ongoing concerns with the accuracy and completeness of Medicaid data, particularly encounter data.²⁹ Over the past several years, we have made at least 42

²⁷Claims are records of services delivered to beneficiaries and paid for on a fee-for-service basis, and encounter data are records of services delivered to beneficiaries enrolled in managed care plans, for which states pay a per-member-per-month rate.

²⁸HHS initially identified a fourth state, Oregon, to include in its analyses, but subsequently excluded the state due to data quality concerns.

²⁹For example, see GAO, *Medicaid Managed Care: Additional CMS Actions Needed to Help Ensure Data Reliability*, [GAO-19-10](#) (Washington, D.C.: Oct. 19, 2018); *Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements*, [GAO-17-173](#) (Washington, D.C.: Jan. 6, 2017); *Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures*, [GAO-18-220](#) (Washington D.C.: Jan. 19, 2020), and *Medicaid: Data Completeness and Accuracy Have Improved, Though Not All Standards Have Been Met*, [GAO-21-196](#) (Washington, D.C.: Jan. 14, 2021).

recommendations related to improving Medicaid data, 15 of which were not implemented as of December 2020.

Beyond these data limitations, HHS's decisions related to demonstration design and data reporting also complicated its assessment efforts. For example, HHS officials acknowledged that they did not prescribe specific services CCBHCs should provide within each of the required service categories, noting that states and CCBHCs were best equipped to identify the care needed by their unique populations. As a result, participating states identified different program goals and target populations, and often opted to cover different services. The lack of standardization across participating states limited HHS's ability to assess changes across states in any uniform way.

HHS also did not collect standard data on service utilization across CCBHCs and states. Specifically, HHS did not require states to use standard billing codes and billing code modifiers it developed to identify specific services provided to Medicaid beneficiaries in CCBHCs. Instead, according to HHS officials, HHS allowed states the option to use their state specific billing codes, if doing so was less burdensome.³⁰ As a result, HHS's efforts to track utilization of specific services across CCBHCs and states in a standard way are limited.³¹

Agency Comments

We provided a draft of this report to HHS for review. HHS 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>.

³⁰HHS noted that requiring states to use the standard billing codes and modifiers would have been extremely burdensome, especially given that states and clinics were already required to complete cost reports and to submit clinic-level quality measures for the first time.

³¹According to HHS officials, HHS has not examined the extent to which participating states required CCBHCs to use HHS's billing code modifiers to identify the specific services provided to Medicaid beneficiaries. However, the officials stated that based on a preliminary review of Medicaid claims and encounter data from the three states selected for the costs and service utilization analysis, Missouri is the only selected state that consistently used the billing code modifiers

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 II.

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

List of Requesters

The Honorable Ron Johnson
Ranking Member
Permanent Subcommittee on Investigations
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable James Risch
United States Senate

The Honorable Mike Lee
United States Senate

The Honorable Pat Toomey
United States Senate

The Honorable Ted Cruz
United States Senate

The Honorable Mike Braun
United States Senate

Appendix I: Quality Measures Required by the Department of Health and Human Services

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

Table 2: Quality Measures Required by HHS for the Certified Community Behavioral Health Clinics Demonstration

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

Source: GAO analysis of data from the Department of Health and Human Services (HHS) and the National Quality Forum. | GAO-21-394

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgements

In addition to the contact named above, Susan Anthony (Assistant Director), Kimberly Lloyd Perrault (Analyst-in-Charge), and Taneeka Hansen made key contributions to this report. Also contributing were Sonia Chakrabarty, Terrell Lasane, Hannah Locke, Drew Long, Eric Peterson, and Vikki Porter.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through our website. Each weekday afternoon, GAO posts on its [website](#) newly released reports, testimony, and correspondence. You can also [subscribe](#) to GAO's email updates to receive notification of newly posted products.

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, <https://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on [Facebook](#), [Flickr](#), [Twitter](#), and [YouTube](#).
Subscribe to our [RSS Feeds](#) or [Email Updates](#). Listen to our [Podcasts](#).
Visit GAO on the web at <https://www.gao.gov>.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact FraudNet:

Website: <https://www.gao.gov/about/what-gao-does/fraudnet>

Automated answering system: (800) 424-5454 or (202) 512-7700

Congressional Relations

Orice Williams Brown, Managing Director, WilliamsO@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800 U.S. Government Accountability Office, 441 G Street NW, Room 7149 Washington, DC 20548

Strategic Planning and External Liaison

Stephen J. Sanford, Acting Managing Director, spel@gao.gov, (202) 512-4707 U.S. Government Accountability Office, 441 G Street NW, Room 7814, Washington, DC 20548

