Program	Directed Payment Program for Behavioral Health Services (DPP BHS)
Target Beneficiaries	Adults and children enrolled in STAR, STAR+PLUS, and STAR Kids

Intended Quality Outcomes

1. Continue successful DSRIP innovations by CMHCs to promote and improve access to behavioral health services, care coordination, and successful care transitions.
2. Incentivize continuation of services provided to Medicaid managed care members aligned with the Certified Community Behavioral Health Clinic (CCBHC) model of care.

Program Overview

- This new DPP continues to support the state's transition to the CCBHC model of care.
- CCBHCs provide a comprehensive range of evidence-based mental health and substance use disorder services, with an emphasis on the provision of 24-hour crisis care, care coordination with local primary care and hospital providers, and integration with physical health care.
- Component 1 is a uniform dollar increase issued in monthly payments to entities participating in the program. As a condition of participation, providers will report on progress made toward certification or maintenance of CCBHC status. Enrolled providers will also be required to report on the implementation status of activities foundational to quality improvement, such as telehealth services, collaborative care, integration of physical and behavioral health, and improved data exchange.
- Component 2 is a uniform percent increase on certain CCBHC services. As a condition of participation, providers are required to report on metrics that align with CCBHC measures and goals. Providers that have CCBHC certification are eligible for a higher rate enhancement.
- To align with the incentive to achieve CCBHC certification, Component 2 rate increases will be applied to the following codes: H2014, T1017, H2017, 99214, H2011, 99213, 90837, 90792, 90791, H0034, 90834, H0020, 99215, 96372, H0005.
- Eligibility for the program is determined through an application process.

Reporting Requirements

- All measures must be reported semiannually as a condition of participation in the program. Component 1 includes structure measures, and Component 2 includes process and outcome measures.
- Semiannual reporting is planned to take place during Reporting Period 1 (Dec 2021) and Reporting Period 2 (Apr 2022).
    - Reporting Period 1 (Dec 2021): The data measurement period for reported measures will be January 1, 2021 through June 30, 2021.
    - Reporting Period 2 (Apr 2022): The data measurement period for reported measures will be January 1, 2021 through December 31, 2021.

- For Component 2 outcome and process measures, CMHCs must report rates stratified by the following payer types: Medicaid Managed Care**, Other Medicaid, Uninsured, and All Payer.

Program Component	Measure ID	Measure Name	Measure Type	NQF #	Measure Steward
B1 - Dollar Increase	B1-145	Certified Community Behavioral Health Clinic (CCBHC) Certification Status	Structure	NA	NA
	B1-146	Provide patients with services by using remote technology including audio/video, client portals and apps for the provision of services such as telehealth, assessment collection and remote health monitoring/screening	Structure	NA	NA
	B1-147	Provide integrated physical and behavioral health care services to children and adults with serious mental illness	Structure	NA	NA
	B1-148	Participate in electronic exchange of clinical data with other healthcare providers/entities	Structure	NA	NA
B2 – Rate Enhancement	B2-149	Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Process	2152	PCPI
	B2-150	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	1365	PCPI
	B2-151	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	0104	PCPI
	B2-152	Follow-Up After Hospitalization for Mental Illness 7-Day (discharges from state hospital)	Outcome	0576	NCQA
	B2-153	Follow-Up after Hospitalization for Mental Illness 30-Day (discharges from state hospital)	Outcome	0576	NCQA
	B2-154	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Process	0421	CMS

** In the reporting template, providers will indicate whether the provider's system can report the required reporting payer type of "Medicaid Managed Care" as outlined above to include STAR, STAR+PLUS, and STAR Kids. If provider's system cannot report "Medicaid Managed Care" as outlined above, then the provider may alternatively report the "Medicaid Managed Care" payer type as "Medicaid" (includes all Medicaid Managed Care programs and Medicaid FFS). This alternative will only be available during Year 1 of the DPP. As a result of using this alternative, the required reporting payer types would be: Medicaid, Uninsured, and All Payer.