Without mental health, there is no health.

Without access to addiction treatment, recovery is out of reach for many.

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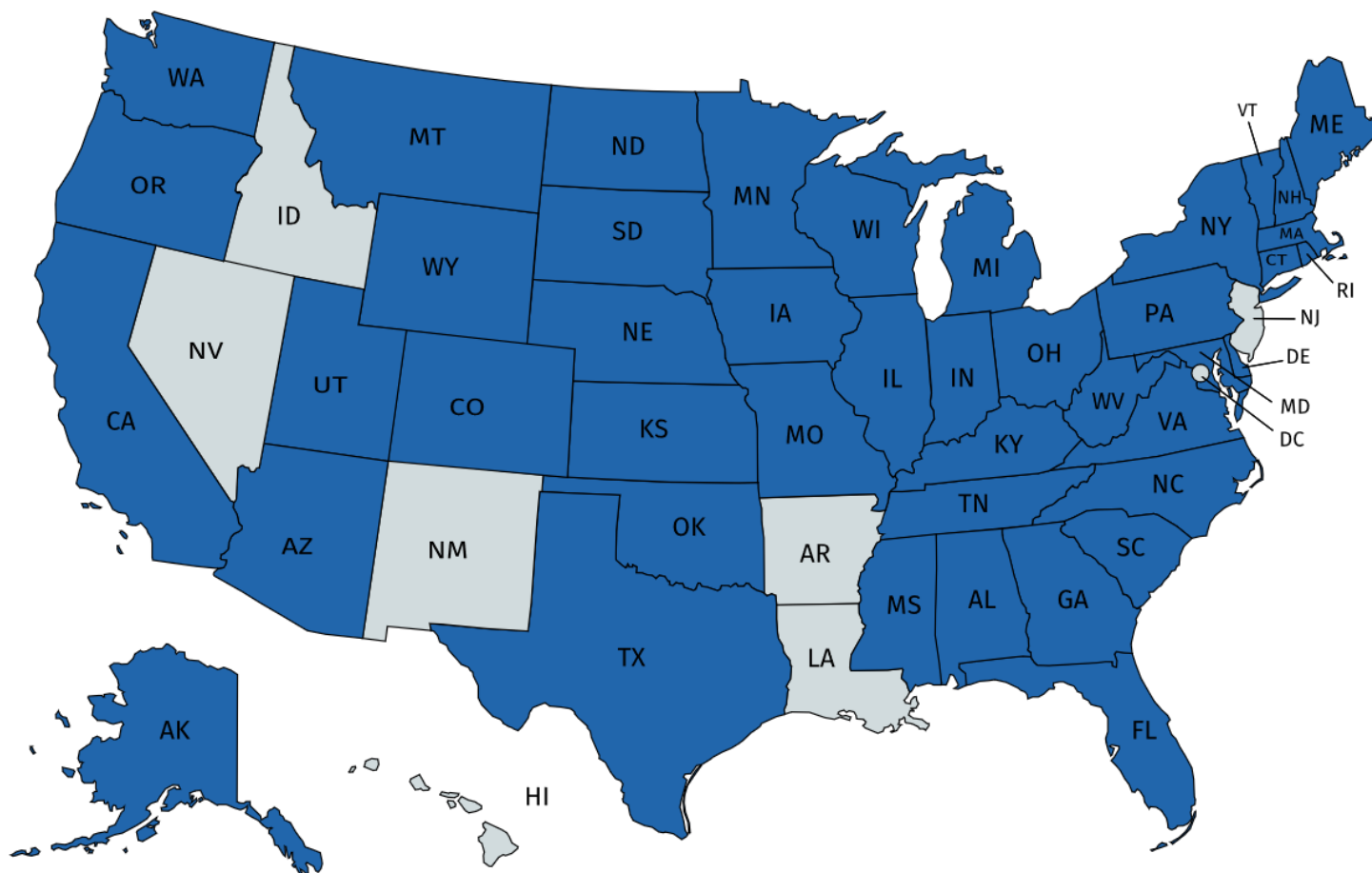
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October 2019

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MH and SUD Care Underfunded and Undervalued

Only 12% of Americans with SUD get specialty treatment in any given year

Only 43% of people living with MI receive treatment - 67% for SMI

1 in 4 Americans have to choose between getting MH treatment and paying for daily necessities

And Yet, Progress Achieved

More people seeking treatment

Reducing stigma and expanding access to care …

But our work is not finished

Challenges Remain

Access challenge: underinvestment in "safety net" services

20 million Americans living with addiction

BH care professionals can only meet 26% of need for services nationwide

Despite parity law, people still being denied treatment

Priorities

CCBHCs

Respond to addiction crisis

Workforce development

Parity

Mental Health First Aid

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CCBHCs

Participation in Certified Community Behavioral Health Clinic Demonstration

— CCBHC Status Report —

● **8 states** selected for CCBHC demonstration

⊘ **13 states** with clinics that received expansion grants

● **3 states** that received planning grants, but do not have clinics that received expansion grants

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Bold shift underway

Integrated physical and mental health care

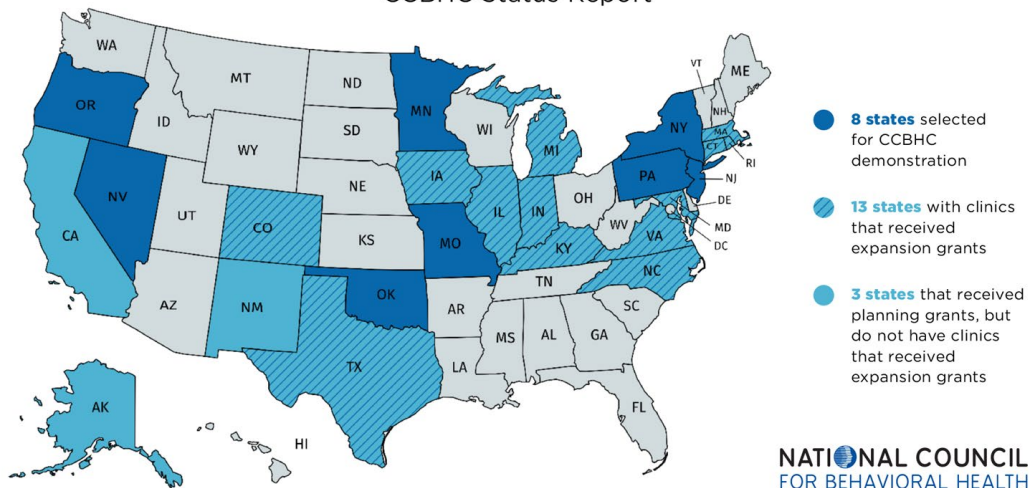**Address social determinants of health**

Provide 24/7 crisis care

Collaborate with law enforcement, schools

Coordinate with hospitals to reduce ER visits and readmissions

Goal: extend to all 50 states

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Respond to Addiction Crisis

Build capacity

Remove barriers to MAT

Advocate for additional federal funding

Help state & local governments expand treatment, prevention and recovery efforts

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Workforce Development

Incentivize people to pursue careers in MH and addiction treatment

Competitive wages

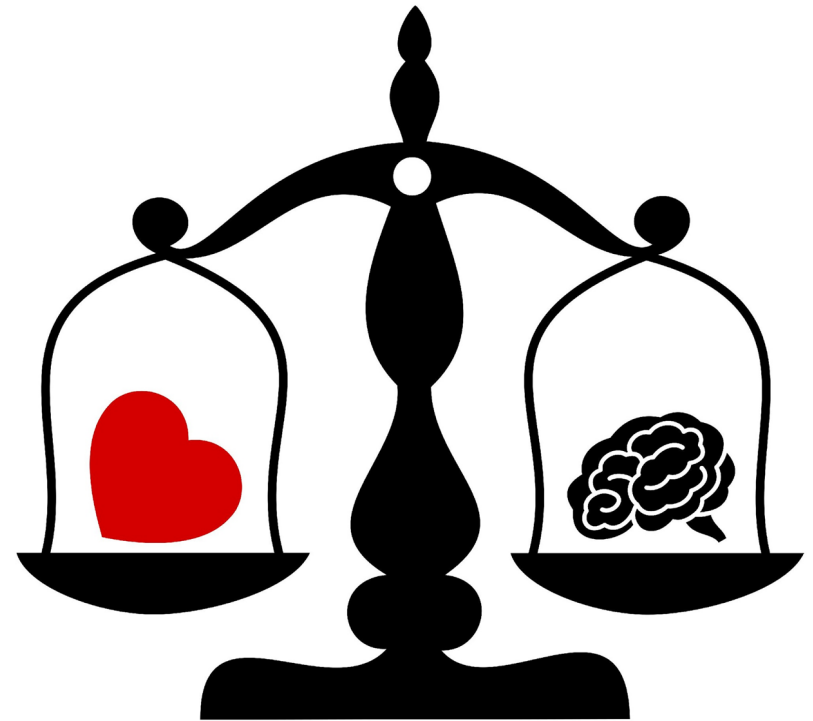**Enhanced reimbursement policies**

Loan repayment programs

Build on Parity Law

Ensure full implementation in all 50 states

Where the law is not sufficient, work with advocates to change federal and state laws

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Expand MHFA

2 million trained

Advocate for additional state and federal funding

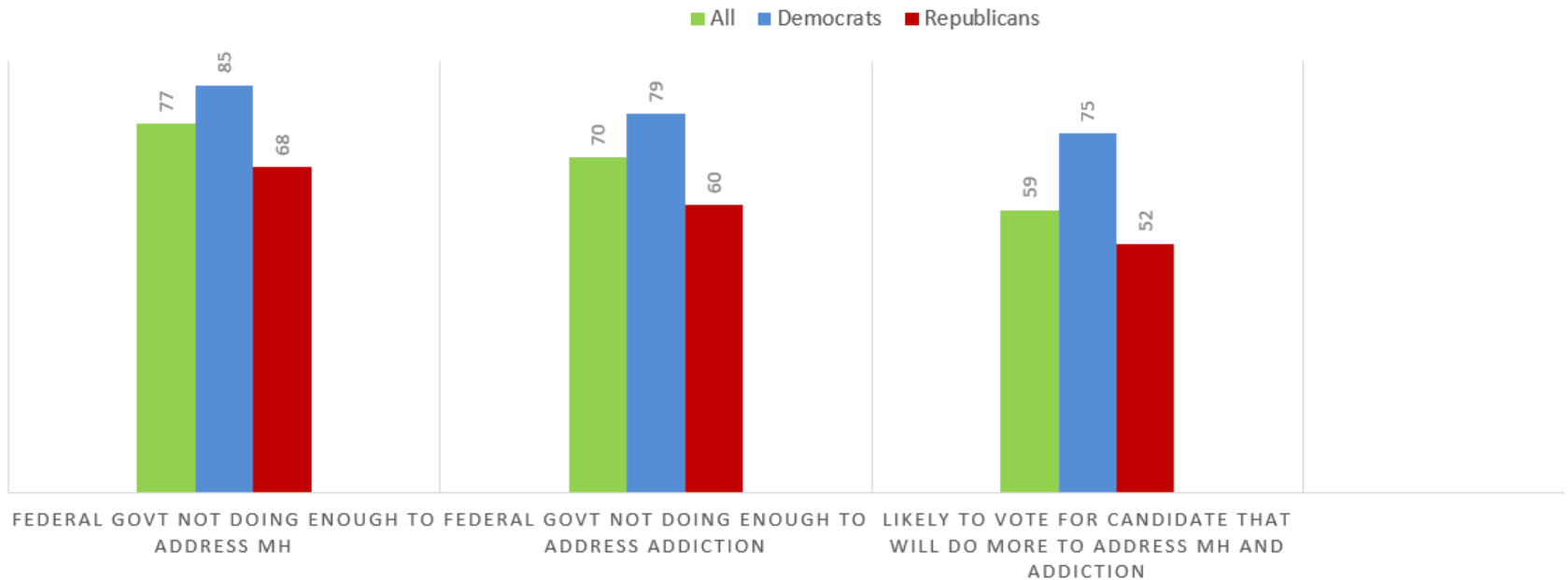**Ensure MHFA training is available to police officers, teachers, other critical audiences in every community**

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National Council for Behavioral Health

We are fighting for a nation that values the mental health of all its people

3,326 member organizations in all 50 states; +750,000 professionals serving +10M people

Let's get to work ... let's make a difference, together

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CCBHCs: A New Model

Built on the concept that the way to expand care is to pay for it

- **National definition** re: scope of services, timeliness of access, etc.
- Standardized **data and quality reporting**
- **Payment rate** that covers the real cost of opening access to new patients and new services…
  - …including non -billable activities like outreach, care coordination, and more…

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CCBHCs provide a financial foundation to…

Participate in VBP

- Data infrastructure
- EHR/HIE
- Assertive care coordination
- Population health management
- Sophisticated management of clinic finances

Alleviate the crisis in access

- Workforce expansion
- Access supported by technology
- Increased service capacity
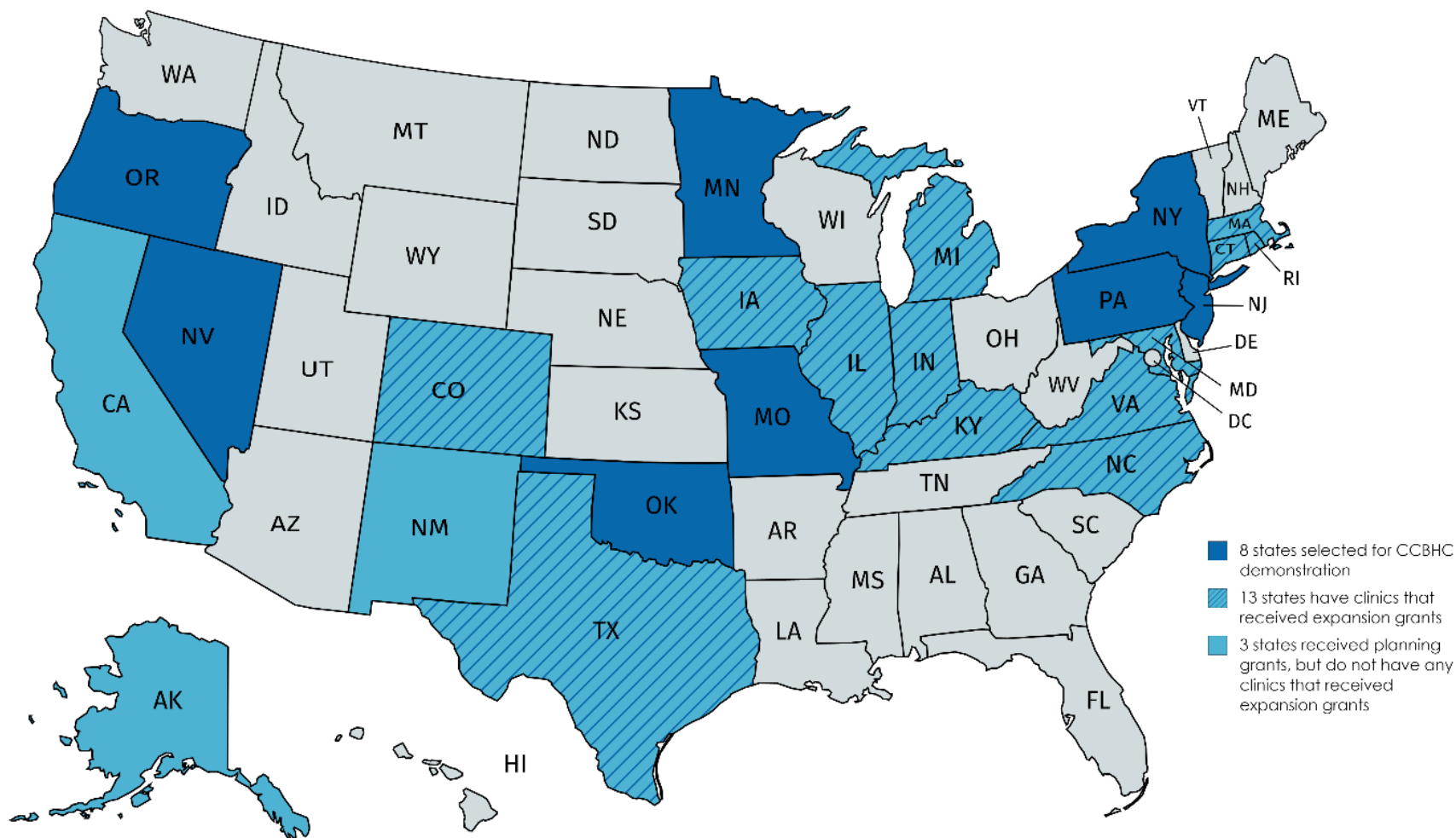- Evidence-based, non -billable activities

The CCBHC Landscape

Two funding tracks, plus state options

- Medicaid demonstration
- Federal grant funding
- Some states (e.g. Texas) moving forward with their own CCBHC adoption

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Status of States' Participation

Legend:
- 8 states selected for CCBHC demonstration
- 13 states have clinics that received expansion grants
- 3 states received planning grants, but do not have any clinics that received expansion grants

CCBHC Criteria

Organizational authority & governance

Scope of services

Staffing

Access & availability

Care coordination

Quality & data reporting

An important caveat:

States had significant flexibility

- States certified CCBHCs and finalized the certification criteria
  - Done within framework set by SAMHSA
- Often variation among states re: specific required services, definition of an "encounter," more
  - E.g. "comprehensive outpatient mental health and addiction services" can look slightly different in different states
- Unknown if/how this approach would change if the program is extended to add'l states

CCBHC Scope of Services
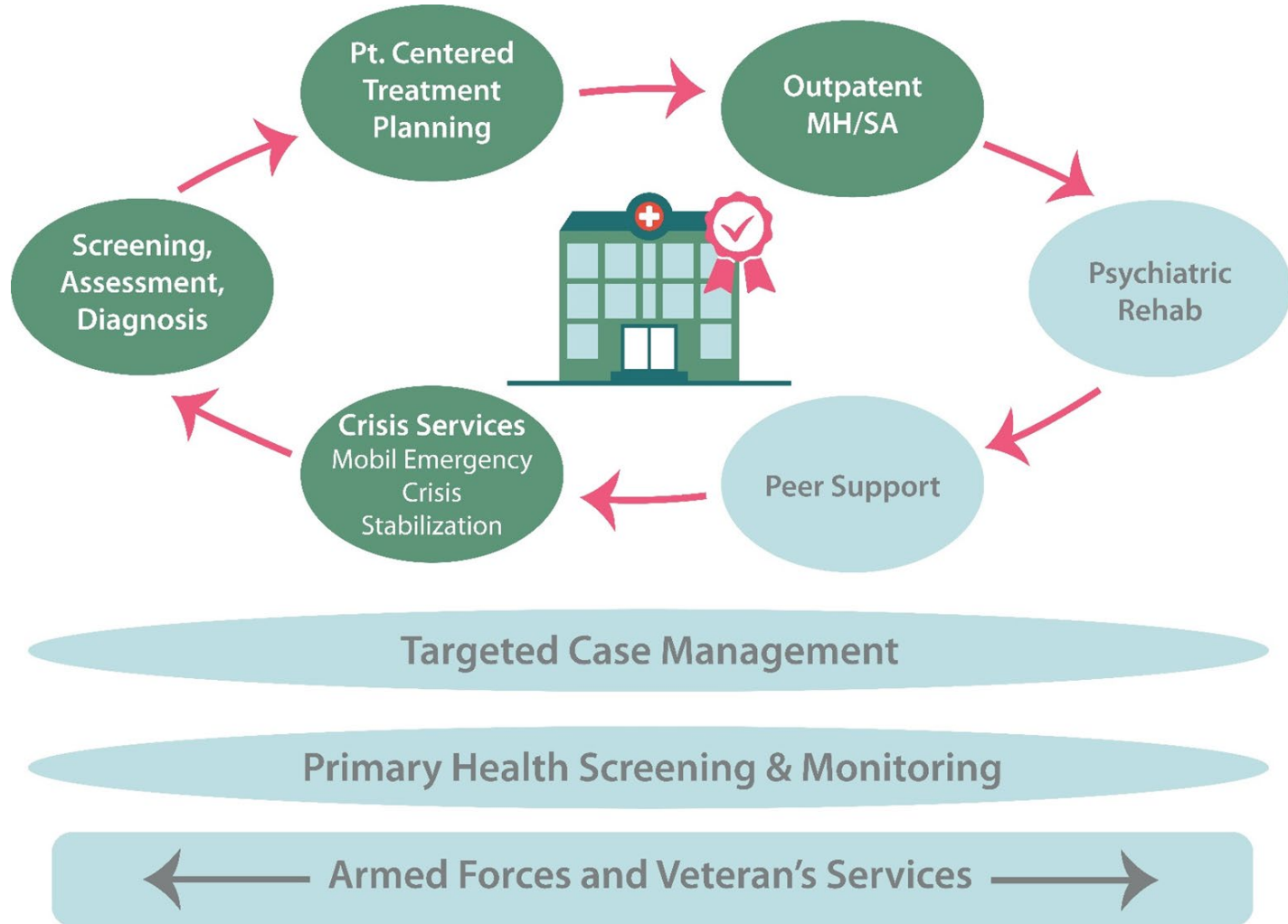
Must be delivered directly by CCBHC
Delivered by CCBHC or a Designated Collaborating Organization (DCO)

Breaking through old limitations…

Services are not confined to delivery within the 4 walls of a clinic

Think creatively!

- In-home services for newly placed foster youth
- Post-booking assessment in jails
- Outreach to homeless populations

Availability & Accessibility Standards

- Access required at times and places convenient for those served
- Prompt intake and engagement in services
- **Access regardless of ability to pay** and place of residence
  - Sliding fee scales used for clients without ability to pay
- Crisis management services available 24 hours per day

Care Coordination: *The "Linchpin" of CCBHC*

- Partnerships or care coordination agreements required with:
  - FQHCs/rural health clinics
  - Inpatient psychiatry and detoxification
  - Post-detoxification step -down services
  - Residential programs
  - Other social services providers, including
    - Schools
    - Child welfare agencies
    - Juvenile and criminal justice agencies and facilities
    - Indian Health Service youth regional treatment centers
    - Child placing agencies for therapeutic foster care service
  - Department of Veterans Affairs facilities
  - Inpatient acute care hospitals and hospital outpatient clinics
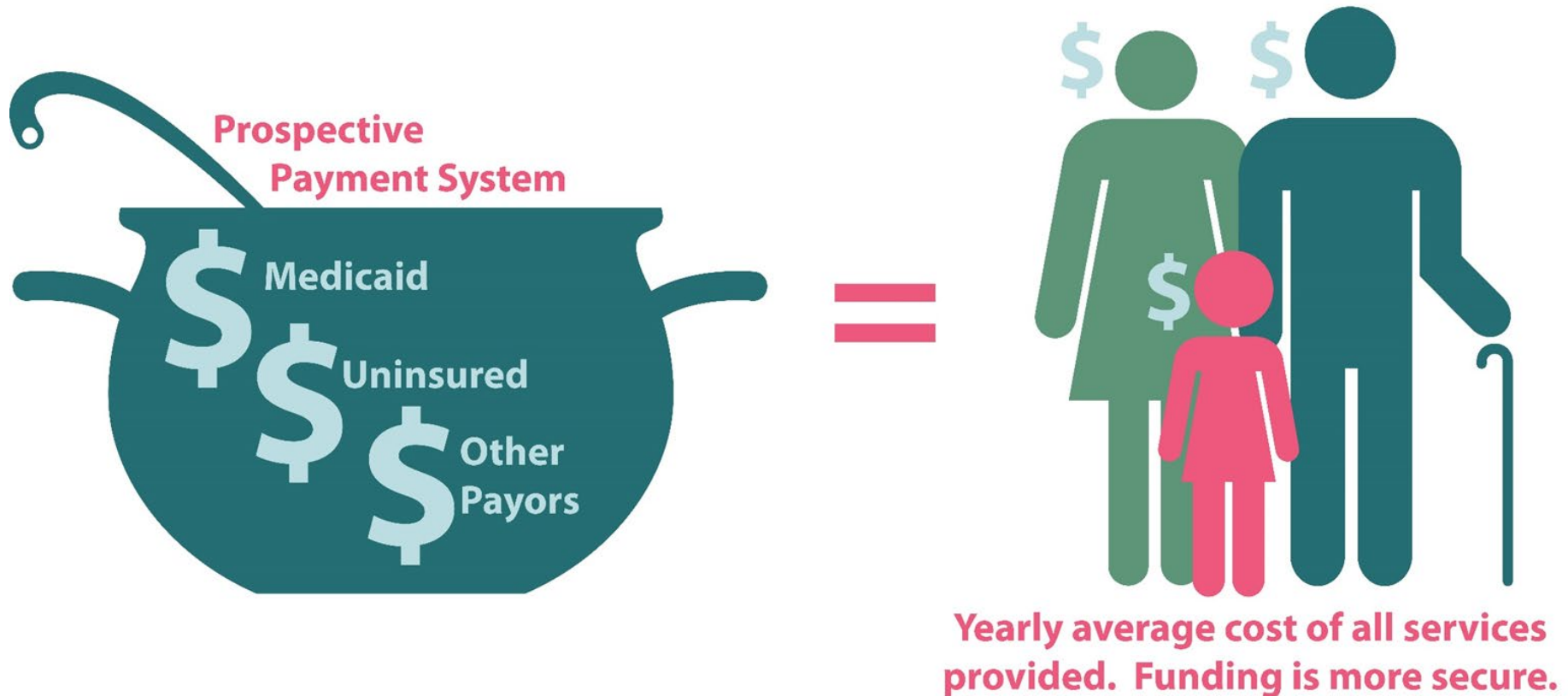
CCBHC Reported Measures (9)

Potential Source of Data	Measure or Other Reporting Requirement	NQF Endorsed
EHR, Patient records, Electronic scheduler	Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients	N/A
EHR, Patient records	Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up	0421
EHR, Encounter data	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (see Medicaid Child Core Set)	0024
EHR, Encounter data	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	0028
EHR, Patient records	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	2152
EHR, Patient records	Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment (see Medicaid Child Core Set)	1365
EHR, Patient records	Adult major depressive disorder (MDD): Suicide risk assessment (use EHR Incentive Program version of measure)	0104
EHR, Patient records	Screening for Clinical Depression and Follow-Up Plan (see Medicaid Adult Core Set)	0418
EHR, Patient records	Consumer follow-up with standardized measure (PHQ-9) Depression Remission at 12 months	0710

State Reported Measures (12)

Potential Source of Data	Measure or Other Reporting Requirement	NQF Endorsed
URS	Housing Status (Residential Status at Admission or Start of the Reporting Period Compared to Residential Status at Discharge or End of the Reporting Period)	N/A
Claims data/ encounter data	Follow-Up After Emergency Department for Mental Health	2605
Claims data/ encounter data	Follow-Up After Emergency Department for Alcohol or Other Dependence	2605
Claims data/ encounter data	Plan All-Cause Readmission Rate (PCR-AD) (see Medicaid Adult Core Set)	1768
Claims data/ encounter data	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications	1932
Claims data/ encounter data	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (see Medicaid Adult Core Set)	N/A
Claims data/ encounter data	Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (see Medicaid Adult Core Set)	0576
Claims data/ encounter data	Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (see Medicaid Child Core Set)	0576
Claims data/ encounter data	Follow-up care for children prescribed ADHD medication (see Medicaid Child Core Set)	0108
Claims data/ encounter data	Antidepressant Medication Management (see Medicaid Adult Core Set)	0105
EHR, Patient records	Initiation and engagement of alcohol and other drug dependence treatment (see Medicaid Adult Core Set)	0004
MHSIP Survey	Patient experience of care survey; Family experience of care survey	N/A

CCBHC Payment

Establishment of a Prospective Payment System

Prospective Payment System

$ Medicaid

$ Uninsured

$ Other Payors

=

Yearly average cost of all services provided. Funding is more secure.

PPS-1 Guidelines (Daily Encounter Payment)

- CCBHCs receive a fixed daily reimbursement per visit
  - Based on the FQHC PPS approach used nationally
- Payment is the same regardless of intensity of services

$$\frac{\text{Total allowable costs of providing services per year}}{\text{Total number of daily visits per year}} = \text{Daily per-visit rate}$$

PPS-1

- **Pros**
  - Methodology and requirements familiar from the FQHC experience
  - Completion & review of cost report less complex
  - Implementation of one payment rate per CCBHC less complex
  - Data/system requirements may be more likely to be currently available at CMHCs
  - Option to include quality bonus payments to CCBHCs
- **Cons**
  - One payment rate per visit
    - Does not account for matching payment to disparate consumer conditions
    - Errors in predicting patient mix more problematic

PPS-2 Guidelines (Monthly Encounter Payment)

- CCBHCs receive a fixed monthly reimbursement for every individual who has at least one visit in the month

- Payment is the same regardless of number of visits per month or intensity of services

- CCBHCs do NOT get paid in months when the patient does not receive any services

- Allows CCBHCs to establish separate reimbursement rates for distinct populations in addition to a base rate

PPS-2

- **Pros**
  - Includes a process to address outlier costs
  - Allows for more ability to match payment to patient condition
  - Requires quality bonus payments to CCBHCs
- **Cons**
  - Completion of cost report more complex
  - Data/system requirements are complex to produce required cost report elements by condition level
  - Difficult for State to review and validate payment rates
  - Administratively more complex for State to make payments to CCBHCs when factoring in condition level, outliers and quality bonus payments

CCBHC payment in managed care: 2 options

- Option 1: PPS pass-through via MCOs
  - MCO capitation rate is adjusted by state to account for PPS
  - MCOs pass PPS rate through to providers
  - Administratively simpler but requires trust/oversight regarding payment, network panels, and routing of clients to providers
- Option 2: PPS wraparound payment
  - MCOs contract with and pay providers per usual
  - Providers report on actual payments received; state calculates what the payment would have been under a PPS and provides periodic wraparound payments to make up the difference
  - Administratively more complex, but guarantees full PPS for all CCBHCs

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What's happening in states that are using each PPS model?

- Universal view among clinics that PPS is an improvement
  - No apparent advantage between PPS1 vs. PPS2
- Adequacy of rate depends on whether clinic accurately estimated patient encounters and costs
  - Vast majority of clinics did well at this
  - Some clinics had **greater costs** or **fewer encounters** than expected (PPS rate insufficient to cover costs; states working with clinics on outlier payments or rate adjustments)
  - Some clinics had **lower costs** or **more encounters** than expected (PPS rate produces higher margin for clinic than state is comfortable with; rebasing will bring PPS rate down)

"Now that we've seen what service delivery can be like, it would be impossible to go back."

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Role of commercial insurance

- PPS not available; not all CCBHC services covered
- Planning for your unique payer mix is critical for success

PAYER MIX

Legend: ■ Medicaid ■ Uninsured ■ Commercial ■ Medicare ■ Tricare/VA ■

Left pie: Medicaid 71%, Uninsured 18%, Commercial 7%, Medicare 3%, Tricare/VA 3%

Right pie: Medicaid 38%, Uninsured 18%, Commercial 29%, Medicare 12%, Tricare/VA 3%
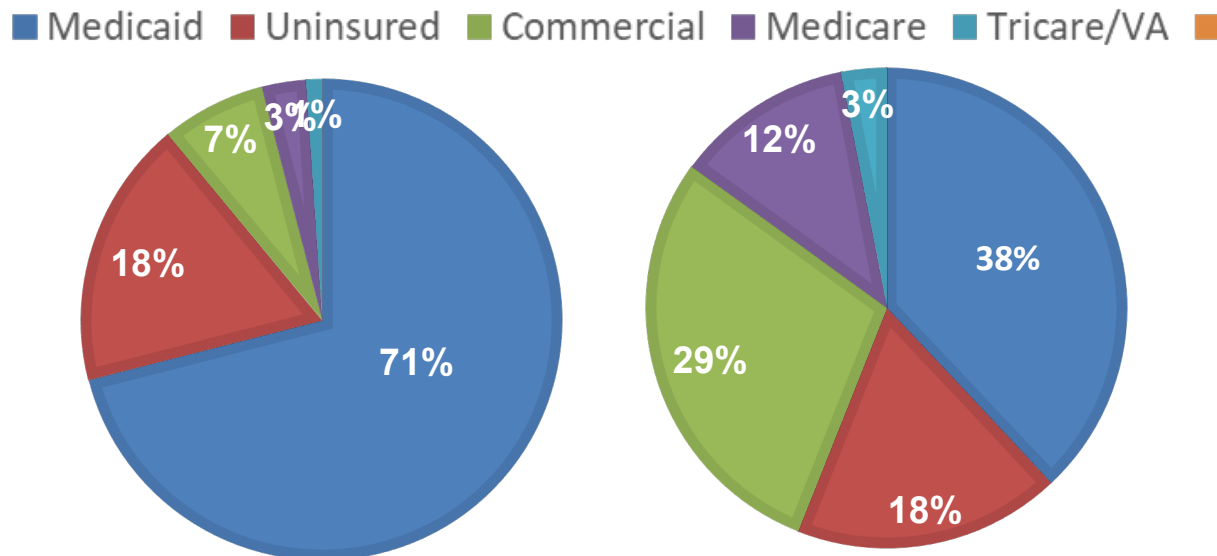
Alternative payment models (APMs) shifting pay from volume to value

Value

Capitation

Shared Savings

Episodic Bundles

Pay for Performance

CCBHCs capture elements of P4P and bundled pay (nearly approaching capitation in states w/ monthly PPS)

Volume (FFS)
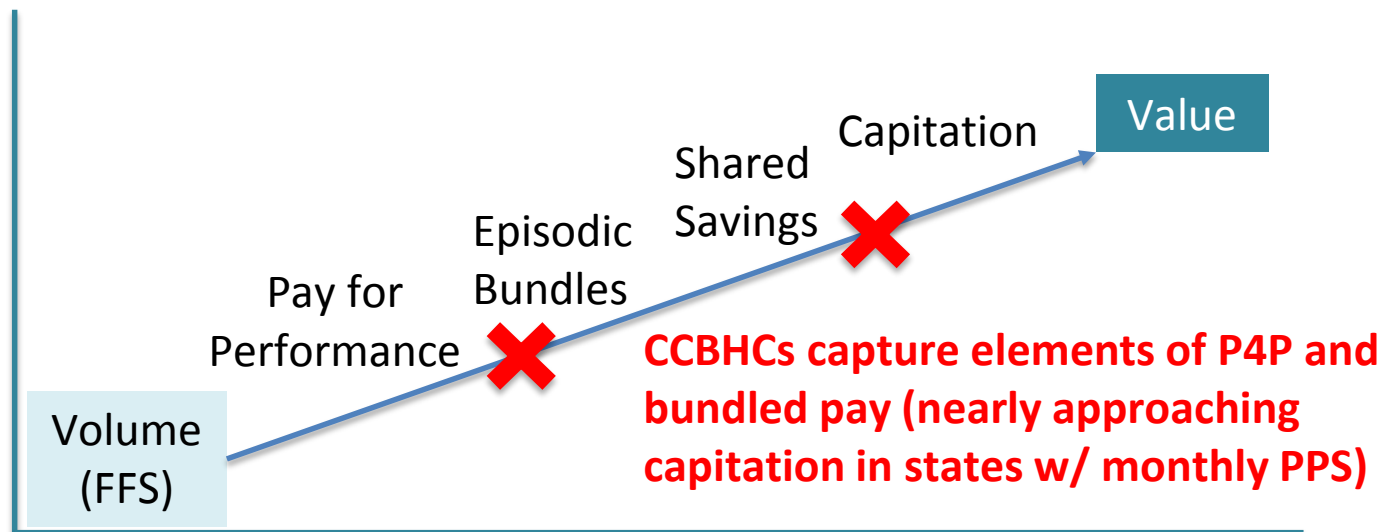
"Value" can mean may things, but commonly:

- Improve clinical outcomes & reduce cost of care for complex, chronically ill populations
- Prevent unnecessary readmissions and other costly outcomes

CCBHC Status/PPS: Driving Value

CCBHC Status

- $PPS = cost$-related reimbursement

Enhanced Operations

- New staff & service lines
- Redesigned access & staffing
- Technology
- Data tracking & analytics
- Internal communications/change mgmt.
- Partnership development

Better client care

- More clients served
- Population health management
- Outcome -driven

CCBHCs' Successes, 2.5 Years In

- Increased hiring / recruitment
- Greater staff satisfaction & retention
- Redesigning care teams
- Improved access to care
  - More clients served
  - Clients accessing greater scope of services (e.g. addiction care)
- Launch of new service lines to meet community need
- Deploying outreach, chronic health management outside the four walls of the clinic
- Improved partnerships with schools, primary care, law enforcement, hospitals
- Outcome -driven treatment

Trends we're seeing: Workforce

Successes

- Filling staff vacancies
- Hiring for new functions
- Shift to multidisciplinary, team-based care

Challenges

- Hiring/recruitment in the face of nationwide workforce shortage
- Onboarding many new staff at once

In the first year of implementation…

CCBHCs added

3000+

new positions to their staff…
and mass hiring continues!

*"CCBHC status has allowed us to court and hire more highly qualified candidates, **because we can now offer more competitive salaries.**"*

Access to Care

The CCBHC model has enabled clinics to increase access across two dimensions:

- Reduced wait times
- Increased numbers of individuals served

Clinics are leveraging **technology** and **data** to support enhanced access initiatives.

Challenges include maintaining timeliness of access in the face of increased caseloads and a workforce shortage.

After initial call or referral, how long (on average) does it take CCBHC patients to access services?*

Same-day access	46%
Between 1-3 days	16%
Between 4-7 days	16%
Between 8-10 days	16%
11 or more days	4%
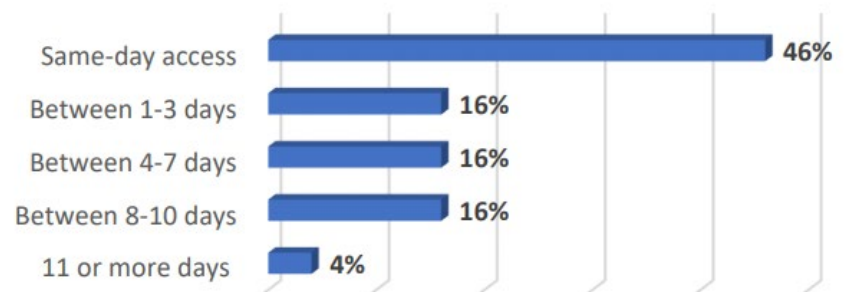
Spectrum Behavioral Health (NY)

Focus on rapid initiation into SUD treatment, data tracking results in increased engagement in treatment

Spectrum Health & Human Services

- Redesigned intake process for faster access, incorporating motivational interviewing
- Implemented team review of no-show cases followed by community outreach
- Trained ER providers on MAT; administration can now take place before client leaves hospital or by community provider w/in 24 -48 hrs
- Developed specific treatment track for clients with OUD based on severity of need

Key Data Points
Sharp reduction in 1st assessment visit **no-show rate from 50% to 25%**
95% of individuals receive 1st clinical session **within 10 business days**
Rapid initiation of SUD treatment (clinical session within 14 days of initial diagnosis) = **77%**
Retention in SUD treatment (2 additional visits within 34 days of initiation) = **97%**

Outcome -driven Treatment

The CCBHC model has supported clinics in bringing on **new technologies** and **staff** to collect and measure data on clients' progress, outcomes and goals.

Clinics are moving to **risk-stratification** as a way to standardize treatment across sites, ensure delivery of care in line with programmatic goals.

"As a result of becoming a CCBHC, we have partnered with a data mining firm to develop dashboards for all CCBHC quality measures. We are able to see **real-time progress toward outcomes** by comparing time frames and can drill down from location-specific data all the way to client- and clinician-specific information to determine **where we are successful and where additional efforts are needed**."

Grand Lake Mental Health (OK)

Population risk-stratification paired with assertive data tracking results in improved outcomes.

- Population stratified into four specialty groups based on severity of need and service utilization, plus standard population
- Data collection/analysis implemented to track whether clients are:
  - experiencing improvements across all dimensions of wellness
  - accessing preventive care
  - living longer, healthier lives
  - invested in their own recovery
- As consumers get better, they require lower levels of care

Grand Lake Mental Health: Outcomes to Date

2,100

Reduction in inpatient days in CY2017

"We must consistently use the data **to determine what is working and what is not.** We must do more of what is working **and be able to prove <u>why</u> it is working**."

12,970

Lbs lost by clients with high BMI in first year as CCBHC

161

Clients quit smoking during first year as a CCBHC

89%

Percent of youth GLMHC serves diverted from out-of-home placement in CY2017

Launch of New Service Lines to Meet Community Needs

The CCBHC model has supported clinics in bringing on new service lines and staff to meet the needs of their communities.

Many of these investments were not financially possible previously.

"Who we employ is equally as important as who we serve. Since April 2017, we've hired 38 new staff within our CCBHC services; **88% of whom are from communities of color—** similar percentages to our client populations."

Improving Staff Satisfaction and Retention

CCBHCs have increased hiring, redesigned teams and improved professional development opportunities for staff, resulting in better satisfaction/retention.

"At a meeting recently, one of our psychiatrists said, 'Who wouldn't want to work in a place like this [CCBHC]? **It's the best gig I've ever had!**' Now, when have you ever heard a psychiatrist say that about working in the public sector before?"

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Redesigning Care Teams

The CCBHC PPS payment model has freed clinics from payment rates tied to units of service.

With anticipated costs of delivering care fully covered in the PPS rate, CCBHCs are re-envisioning how they use staff at different levels as part of multidisciplinary care teams.

"The CCBHC initiative made it possible for us to **look at our whole system with an eye towards what outcomes** we wanted patients to see – what was our workflow process? What was our staffing model?"

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PPS offers _sustainable_ financial flexibility for person-centered service delivery

Grants, philanthropy, public & private insurance payment

Services are time-limited, not uniformly available, often limited to special populations/programs

Comprehensive PPS rate

All services available to all clients, regardless of ability to pay
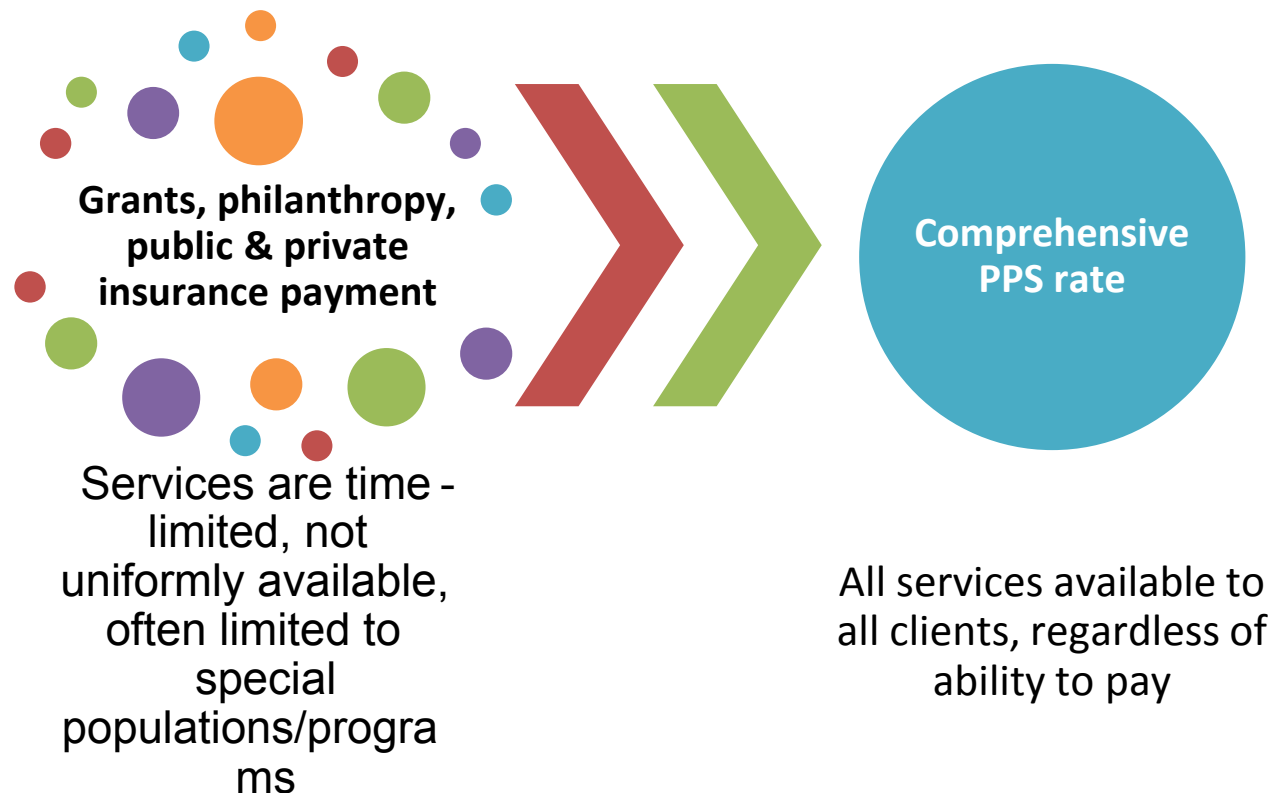
"This model shows that when you're given the financial flexibility to do the right thing, you get results that previously would have been unfathomable."

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Redesigning Teams

- Clinicians no longer tied to the billable hour
- Enables CCBHCs to think creatively about teams
  - Psychiatrists freed up for internal consults?
  - Smaller caseloads?
  - Care coordination partners as team members?
  - Addition of peer specialists, addiction counselors, other staff not previously involved?

Percent of CCBHCs that:

Include primary care…	54%
Include primary care in…	40%
EHR has primary care…	61%
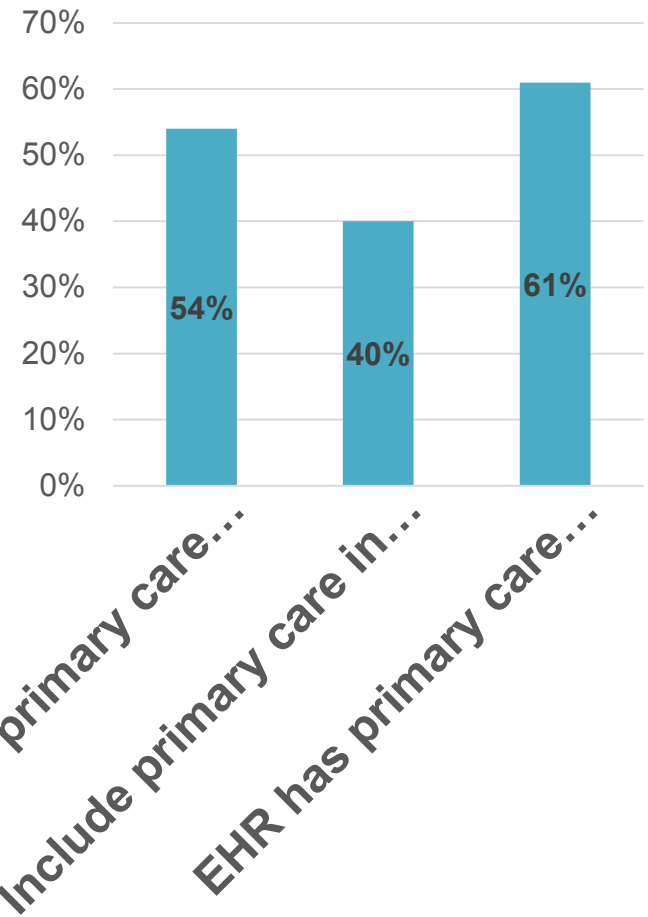
Deploying Community-based Services for Chronic Health Management

CCBHCs are using their funding flexibility to redesign delivery and reach consumers outside the 4 walls of the clinic, with a focus on crisis or pre-crisis intervention and chronic disease management.

"**Our Care Coordinator spends Tuesdays at [the supportive housing unit]** to meet with tenants and staff, and provides updates to resources... [resulting in] increasing client compliance with medical appointment attendance."

Wallowa Valley Center for Wellness (OR)

Mobile unit and community-based teams support clients with health management, wellness

- Frontier location results in high no-show rates, difficulty maintaining adequate service flows
- Implemented data analytics to understand service utilization, redesign workflows
- Staff travel to client homes, other community locations
- Launched "Health on Wheels" van
- Home-based medication management used regularly, has improved BMI & other wellness indicators
- **61%** of clients receive community-based services

Trends we're seeing: Data & quality reporting

Successes

- Expanding ability to collect and report on data

- Developing workflows for data collection & validating collected data

- Growing sophistication in ways that will help with participation in other value-based models

Challenges

- Collecting data across care settings

- Grappling with how to glean information on state-reported quality measures

- Difficulties with specific technical specifications of some metrics

How do CCBHCs enhance an integrated care environment?

- Redesigned teams
- Outreach beyond the 4 walls of a clinic
- Data-driven approaches to care
- Moving from integration to population health
- Good partners to other health system entities in improving health outcomes
  - e.g. working with hospitals to reduce readmissions and streamline care transitions
- Not without its challenges…

Reflections on cost to states

Wide variation in costs but general consensus that the new payment model brings substantial value

- Enhanced federal match as part of demo
- Multiple sources of variation in total costs to states
- Participating states perceive value for their investment; some are making additional investments to bring more CCBHCs online
- Return on investment for states is based on adequately funding full scope of services, quality reporting activities, etc.

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Cost to states

- **In a nutshell: it varies widely!**

- Enhanced match rate from demo helped keep total state expenditures down
  - Particularly for states that were funding CCBHC required activities (e.g. care coordination) with general revenues □ shift expenditures to Medicaid

- General agreement that 2 years is too soon to realize anticipated cost savings

- Legislatures have appropriated additional funds to keep program going as Congress extends it

One state's preliminary cost savings data

BH Inpatient

Cohort	Timeframe	Recipients per Month	Claims Per Month	Claims Per Month Per Person	Avg. Cost Per Month (Adj)
Clinic	Pre July 2017	3,740	5,117	1.4	$ 44,412,726
	Post July 2017	4,241	4,940	1.2	$ 42,187,509
			(177)	(0.2)	$ (2,225,217)
	%		-3%	-15%	-5%
CCBHC	Pre July 2017	405	668	1.6	$ 4,524,974
	Post July 2017	369	439	1.2	$ 3,303,065
			(229)	(0.5)	$ (1,221,909)
	%		-34%	-28%	-27%

Clinic vs CCBHC Demonstration Year 1 Analysis
CCBHC recipient's BH inpatient services show a 27% decrease in average cost per month over the prior period, as compared with non-CCBHC clinics' 5% reduction in average cost per month.

BH ER Services

Cohort	Timeframe	Recipients Per Month	Claims Per Month	Claims Per Month Per Person	Avg. Cost Per Month (Adj)
Clinic	Pre July 2017	3,317	10,922	3.29	$ 2,527,827
	Post July 2017	3,815	11,851	3.11	$ 2,657,829
			929	(0.2)	$ 130,002
	%		9%	-6%	5%
CCBHC	Pre July 2017	351	1,287	3.66	$ 367,329
	Post July 2017	320	982	3.06	$ 270,721
			(305)	$ (0.6)	$ (96,608)
	%		-24%	-16%	-26%

Total savings across BH inpatient & ER plus physical health inpatient & ER in first year of demonstration:

$2.4 million

Next steps for CCBHC model

- Federal expansion legislation
- Federal grant funding
- State-led expansion efforts
  - Medicaid waiver
  - State Plan Amendment

Options for States via Medicaid

Section 1115 Waiver
Enables states to experiment with delivery system reforms
Requires budget neutrality
Must be renewed every 5 years
State must be sure to specify inclusion of selected CCBHC services (some may not otherwise be included in state plan)
With CMS approval, offers opportunity to continue PPS
Subject to CMS approval process; consider timing of request

State Plan Amendment
Enables states to permanently amend Medicaid plans to include CCBHC provider type, scope of services, requirements, etc.
Does not require budget neutrality
With CMS approval, can continue PPS
Cannot waive statewideness, may have to certify additional CCBHCs
Subject to CMS approval process; consider timing of request

Excellence in Mental Health and Addiction Treatment Expansion Act

Sens. Roy Blunt (MO) and Debbie Stabenow (MI)

Reps. Doris Matsui (CA) and Markwayne Mullin (OK)

S. 824/ H.R. 1767

- Extends the original 8 states for 2 more years

- Expands the Medicaid demo to include 11 additional states

Just the first step…

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Discussion & Questions

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