Can You Have it All?
Serve More People, Open New Programs, and Have a Satisfied Staff?

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Enacted in 2014 as Section 223 of the Protecting Access to Medicare Act

Senators Roy Blunt and Debbie Stabenow

Representatives Leonard Lance and Doris Matsui

Excellence in Mental Health and Addiction Act
Status of Participation in Certified Community Behavioral Health Clinic (CCBHC) Demonstration

Note: Demonstration ends on March 31, 2019 in OR & OK, and on June 30, 2019 in the remaining 6 demonstration states.
Opportunities for Other States…

- Future program expansion
  - Medicaid demonstration expansion?
  - CCBHC Expansion Grants?
- Medicaid waiver
- Participation in alternative payment models

But first…
How did we get here?
Crisis in the safety net: access to care

Only **65%** of people with a serious mental illness receive treatment each year.

Only **10%** of people with an addiction receive treatment.

Where do the others go?
Crisis in the safety net: workforce

“We’re competing with grocery stores and fast food for our staff.”

- Psychiatrists particularly hard to recruit/afford
- Chronic staff shortages at every level
- High turnover
Crisis in the safety net: financing

- Low payment rates = unsustainable
- Funding cuts year after year
- No support for key, non-billable activities that improve health
- Behavioral health providers excluded from critical health care & funding bills
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…

- First annual report was due to Congress Dec. 2017
- **Substantial gap** between end of demo and deadline for HHS’ recommendation to Congress on the program’s continuation
Opportunities Supported by CCBHC Status/PPS

CCBHC Status
• PPS = cost-based 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
CCBHC Scope of Services

- Pt. Centered Treatment Planning
- Outpatient MH/SA
- Psychiatric Rehab
- Peer Support
- Screening, Assessment, Diagnosis
- Crisis Services
  - Mobil Emergency
  - Crisis Stabilization

Targeted Case Management

Primary Health Screening & Monitoring

Armed Forces and Veteran’s Services

- Must be delivered directly by CCBHC
- Delivered by CCBHC or a Designated Collaborating Organization (DCO)
Add’l requirements

- Staffing
- Staff training
- Evidence-based practices
- Care coordination
- Timeliness and ease of access
- Quality reporting
- Organizational authority and governance
Why pursue CCBHC status?

For many organizations, CCBHC status offers an improvement over the status quo:

- Payment **based on anticipated costs** supports hiring new staff, filling vacancies, expanding service lines.

- Ability to fund **services outside the four walls** and include expenses not traditionally billable (like EHRs, care coordination, outreach).

- **Coverage for services** not otherwise in the Medicaid state plan (e.g., peer services).
In the first 6 months of implementation…

CCBHCs added **1160+** 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.”
Key staff expansions

Within the first 6 months, CCBHCs hired:

- **72** psychiatrists
- **64%** hired peer recovery specialists

Within the first year:

- **398** new staff with an addiction specialty or focus
- **90%** of CCBHCs have a psychiatrist on staff with an addiction specialty/focus
Key staff expansions

CCBHC status has helped clinics expand access to medication-assisted treatment via expanded training and hiring: 92% of CCBHCs have trained or hired clinicians who can prescribe buprenorphine.

“Our [addiction] treatment staff are now better-trained to identify mental health concerns. Becoming a CCBHC allowed us to hire a second Medical Director who serves as Medical Director for medication-assisted treatment (MAT). This has increased availability of psychiatric care, MAT, and utilization of MAT in our center. This doctor is also interested in leading a group for MAT patients. In the [pre-CCBHC] land we were in before, that would never have been financially sustainable. Having an opportunity for consumers to address questions in a group format about MAT with a doctor will increase our overall MAT utilization.”

Family Guidance Center for Behavioral Healthcare (MO)
By end of Year 1:

68% of CCBHCs have decreased patient wait times

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%
In the first 6 months of implementation:

87% of CCBHCs report an increased number of patients served, representing up to a 25% increase in total patient caseloads for most clinics.
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?”
CCBHCs’ expanded service array

Since becoming a CCBHC, have you launched or expanded the following addiction-focused treatment and recovery services?

- Medication-assisted treatment: 31% launched, 60% expanded
- Peer recovery coaches: 39% launched, 39% expanded
- Case management: 29% launched, 45% expanded
- Withdrawal management: 33% launched, 35% expanded
- Addiction counseling: 65% launched
- Ambulatory detoxification: 43% launched
- Supported employment: 12% launched, 23% expanded
- Education support services: 25% launched, 16% expanded
- Treatment or services delivered via telehealth: 8% launched, 22% expanded
- Toxicology: 31% launched
- Supported housing: 8% launched, 8% expanded
- Residential treatment/rehabilitation: 4% launched, 8% expanded
“Our biggest impact to date as a CCBHC is that we are providing higher quality, evidence-based services to our patients. We have been able to reduce our waiting times for patients due to the increase in staff. Our patients can often times be seen on the same day or scheduled within a couple of days.”

“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.”
CCBHC Criteria
Staffing
Staffing Standards

- Medicaid-enrolled providers
- Credentialed, certified, and licensed professionals
- Individuals with expertise in addressing the needs of children and adolescents
- Liability/malpractice insurance must be maintained, adequate for the staffing and scope of services provided
- Peer providers must be included in treatment plans (with peers either on staff or as DCOs)
- Culturally and linguistically competent and appropriate
  - Including for Veterans and members of the Armed Services
- Management team:
  - Chief Executive Officer or Executive Director/Project Director
  - Psychiatrist as Medical Director
- Positions
  - States will specify disciplines required for certification, but must include:
    - Medically trained BH provider able to prescribe and manage meds (i.e., opioid and alcohol treatment)
    - Peers
    - Credentialed substance abuse specialists
    - Individuals with trauma expertise
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?”
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 on teams: 54%
- Include primary care in treatment planning: 40%
- EHR has primary care records: 61%
Amherst H. Wilder (MN)

“Who we employ is equally as important as who we serve.”

- Implemented a Clinical Training Institute to build their workforce
- Introduced additional disciplines
  - Peer specialists, psychiatric rehabilitation staff, care coordinators,
- Culture change around “qualifications” and “fit”
- Institutionalizing racial equity/health equity
- How do we measure impact?
  - Staff: quarterly dashboards;
  - Clients: impact measures; client satisfaction data

Since April 2017, they’ve hired 38 new staff within CCBHC services; 88% of whom are from communities of color – a similar percentage to their client population
Proactive focus on staff communication, onboarding, & team structure improves staff retention

• Extensive overhaul of onboarding process
• Increased number of direct care & management staff to support system transformation
• Implemented staff feedback surveys, listening sessions
• Implemented training & clinical development opportunities (e.g. “nursing college”)
• LGBTQ+ workgroup improves staff retention & consumer inclusion

North Care (OK)

100% Retention of Advanced Practice providers at 1-year mark
Northern Pines (MN)

Integrated pharmacists into care teams to reduce negative polypharmacy

- Partnership between community pharmacy, CCBHC, University of MN
- Clinical pharmacist & pharmacy resident integrated into care teams
  - Bridge gaps between multiple providers
  - Identify and resolve drug interactions/adverse reactions
  - Provide medication adherence counseling & medication education
- Integrated postdoctoral pharmacy residency training program into the CCBHC
Leveraging redesigned treatment teams & data collection to reduce no-shows, increase client engagement

• PPS rate supports coordination, staffing of multidisciplinary treatment teams
  – Teams expanded to include housing, wellness, other services to meet clients’ whole needs
• DCO relationships with crisis and psychiatric rehab providers bring add’l coordination and clients
• Data analytics support coordination across teams and partners
  – e.g., better knowledge of who is using crisis services, ability to provide alternate clinical supports

Key Data Points

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<td>20% drop in no-show rate</td>
<td>from intake to 1st</td>
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<td></td>
<td>appointment</td>
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<tr>
<td>50% reduction in crisis</td>
<td>contacts</td>
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Berks Counseling Center (PA)
States and CCBHCs have focused on increasing access to care and maintaining the required staffing and scope of services.

Staffing and adoption of new services were among the most common early implementation challenges; state officials report that these challenges have been addressed.

**Big Picture Takeaways:**

- States and CCBHCs have focused on increasing access to care and maintaining the required staffing and scope of services.
- Staffing and adoption of new services were among the most common early implementation challenges; state officials report that these challenges have been addressed.
Nearly all CCBHCs employ the staff required or suggested in the criteria.

Proportion of CCBHCs that employed case managers, peer staff, psychiatrists, and family support staff increased due to certification.

Medical director is a psychiatrist in 91% of CCBHCs; others have psychiatric nurse practitioners.

Proportion of CCBHCs that employed staff type before certification vs. as of March 2018:
- Licensed clinical social workers
- Substance use disorder specialists
- Nurses
- CCBHC medical director
- Bachelors degree level counselors
- Case management staff
- Adult psychiatrists
- Peer specialists/recovery coaches
- Child/adolescent psychiatrists
- Other clinician types
- Mental health professionals
- Family support staff
- Community health workers

Source: RAND/Mathematica Study
72% of CCBHCs reported that at least one required or suggested staff position was vacant for at least two months since the start of the demonstration.

State officials most often reported difficulty hiring psychiatrists, peer staff, substance use disorder (SUD) treatment providers, and licensed clinical social workers.

Reasons were not unique to CCBHCs: (1) rural or remote CCBHC locations, (2) high salary expectations from potential staff, and (3) regional and state workforce shortages.

Solutions: offering higher salaries at CCBHCs and leveraging professional networks within the state to advertise CCBHC positions.

Source: RAND/Mathematica Study
CCBHC Staff Training

- Risk assessment, suicide prevention, and crisis response: 93%
- Evidence-based and trauma-informed care: 91%
- Cultural competency training to address diversity within the organization’s service population: 88%
- The role of family and peers in the delivery of care: 78%
- Person- and family-centered care: 76%
- Recovery-oriented care: 76%
- Primary and behavioral health care integration: 76%
- Other (not required by CCBHC certification criteria): 60%
- Any training: 99%
- No training: 1%

Source: RAND/Mathematica Study
Access to Care: Outreach

- School-age youth: 81%
- Members of the armed forces or veterans: 67%
- Consumers who were previously incarcerated: 67%
- Consumers experiencing homelessness: 64%
- Older adults: 49%
- Other populations: 42%
- None: 4%

Source: RAND/Mathematica Study
Access to Care: Telehealth

- 20% Did not offer telehealth services before CCBHC certification
- 80% Offered telehealth services before CCBHC certification
- 33% Does not offer telehealth services
- 67% Offers telehealth services

Source: RAND/Mathematica Study
84% of CCBHCs added services or expanded their service array in the required categories to meet certification requirements.

Services added most commonly in the outpatient mental health and/or SUD, psychiatric rehab, crisis behavioral health, and peer support categories:

- Outpatient mental health and/or SUD services (63%)
- Psychiatric rehabilitation services (55%)
- Crisis behavioral health services (51%)
- Peer support services (49%)
- Intensive community-based mental health services for members of the armed forces and veterans (45%)
- Primary care screening and monitoring (42%)
- Targeted case management (40%)
- Screening, assessment, and diagnosis (22%)
- Person- and family-centered treatment planning services (18%)
- Other required CCBHC services (16%)

Source: RAND/Mathematica Study
Quality Improvement: EHR/HIT Systems

• CCBHCs made changes to health information technology (HIT) or EHR systems to facilitate participation in the demonstration
  o 97% adapted existing EHR or HIT systems
  o 33% adopted new systems

• CCBHCs most often reported changing their EHRs to:
  o Facilitate reporting the required quality measures
  o Exchange clinical information with DCOs or other external providers
  o Add clinical decision support features
Quality Improvement: Using Data

- CCBHCs are in the early stages of using information from the quality measures to improve care
- 79% reported using the quality measure data to change clinical practice during the past 12 months
  - Increased screening for suicide risk
  - Increased screening and follow-up for depression
  - Reduced time between consumer intake and assessment
  - More frequent “dashboard” reports of changes in quality measures over time
CCBHC Payment

Establishment of a Prospective Payment System (PPS)

Prospective Payment System

Medicaid
Uninsured
Other Payors

Yearly average cost of all services provided. Funding is more secure.
## PPS vs. FFS

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<th>FFS</th>
<th>PPS</th>
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<td>Low payment rates don’t cover cost of doing business</td>
<td>Reimbursement covers anticipated cost of care for Medicaid services</td>
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<td>Latest evidence-based practices may not be covered in a rigid FFS</td>
<td>Cost-based reimbursement allows flexibility and payment for innovative service delivery</td>
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<td>FFS payment drives staffing mix instead of clinical staff mix being driven by needs of patients</td>
<td>Appropriate staffing mix covered on a cost-basis</td>
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<td>Lack of required cost reporting means clinics usually lack accurate data of the return on investment of each treatment modality that includes all cost inputs (e.g. infrastructure and IT)</td>
<td>Cost-based reimburses incentivizes clinics to take a nuanced look at the extent to which infrastructure impacts patient outcomes</td>
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Alternative payment models (APMs) shifting pay from volume to value

- Reduce ED overcrowding
- Improve bed availability
- Reduce inpatient length of stay

Incentives for health system investment in behavioral health care

- Prevent unnecessary readmissions
- Improve clinical outcomes & reduce cost of care for complex, chronically ill populations
CCBHCs are moving from integration to population health

- Hiring **dedicated population health** analysts, clinicians, other staff
- Using **data analysis** to understand utilization and risk among client population
- Developing **care pathways** to ensure comprehensive, assertive service delivery to high-risk populations
- Partnering with hospitals to receive **notifications** when patients are discharged
- Assessing for **non-health needs** that are determinants of health (e.g. housing, food, etc.)
- And much, **much more**!
“Now that we’ve seen what service delivery can be like, it would be impossible to go back.”

Randy Tate, National Council Board Member and CEO of NorthCare in Oklahoma City
Next steps for CCBHC model

• Federal expansion legislation
• Federal grant funding
• State-led expansion efforts
  – Medicaid waiver
  – State Plan Amendment
  – State regulation of clinics & investment in services
  – Participation in alternative payment models
Excellence Act Expansion: S. 1905/H.R. 3931

Sens. Roy Blunt and Debbie Stabenow

Reps. Leonard Lance and Doris Matsui
CCBHC Expansion Grants

Funding and Awardees

• Up to **$2 million** per grantee, per year for **2 years** (Total = $4 million)
• Up to **25 clinics** will be selected
• Total available funding ~$100 million
• Grant terms begin Sept 30, 2018 and extend through Sept. 30, 2020
• Grantees do NOT receive PPS (differs from Medicaid demonstration)
## Options for States via Medicaid

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<th>Section 1115 Waiver</th>
<th>State Plan Amendment</th>
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<td>Enables states to experiment with delivery system reforms</td>
<td>Enables states to permanently amend Medicaid plans to include CCBHC provider type, scope of services, requirements, etc.</td>
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<td>Requires budget neutrality</td>
<td>Does not require budget neutrality</td>
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<tr>
<td>Must be renewed every 5 years</td>
<td>With CMS approval, can continue PPS</td>
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<tr>
<td>State must be sure to specify inclusion of selected CCBHC services (some may not otherwise be included in state plan)</td>
<td>Cannot waive statewideness, may have to certify additional CCBHCs</td>
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<tr>
<td>With CMS approval, offers opportunity to continue PPS</td>
<td>Subject to CMS approval process; consider timing of request</td>
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Minnesota Medicaid 1115 Waiver

MN plans to continue supporting its 6 CCBHCs after the federal demo ends through an 1115 waiver

The proposed waiver would:
✓ Target improving the substance use disorder treatment delivery system
✓ Support CCBHCs from July 2019 - June 2023
✓ Continue the Prospective Payment System
✓ Continue all quality measures and formal evaluations
Discussion & Questions

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