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

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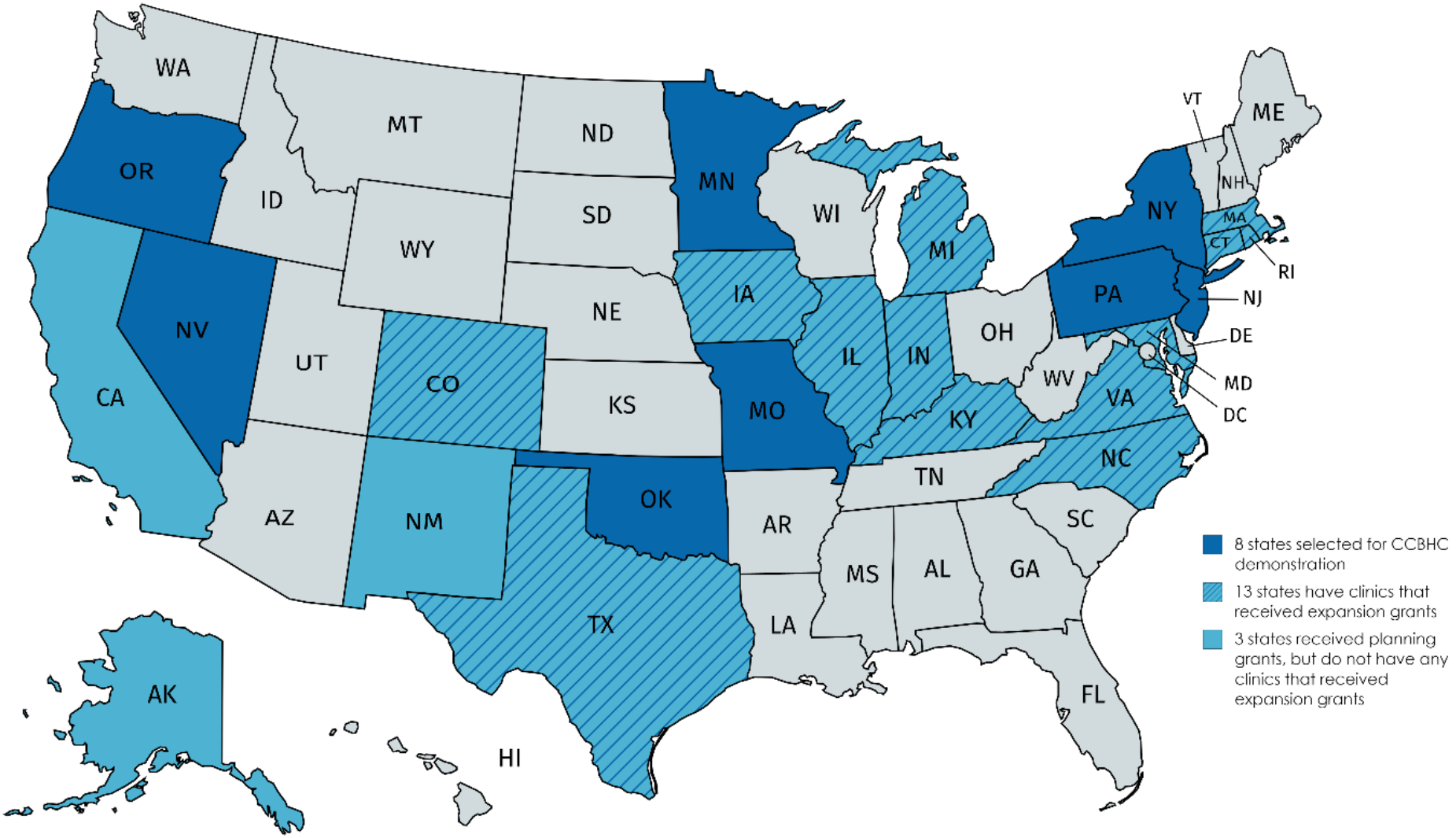
Enacted in 2014 as Section 223 of the Protecting Access to Medicare Act


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

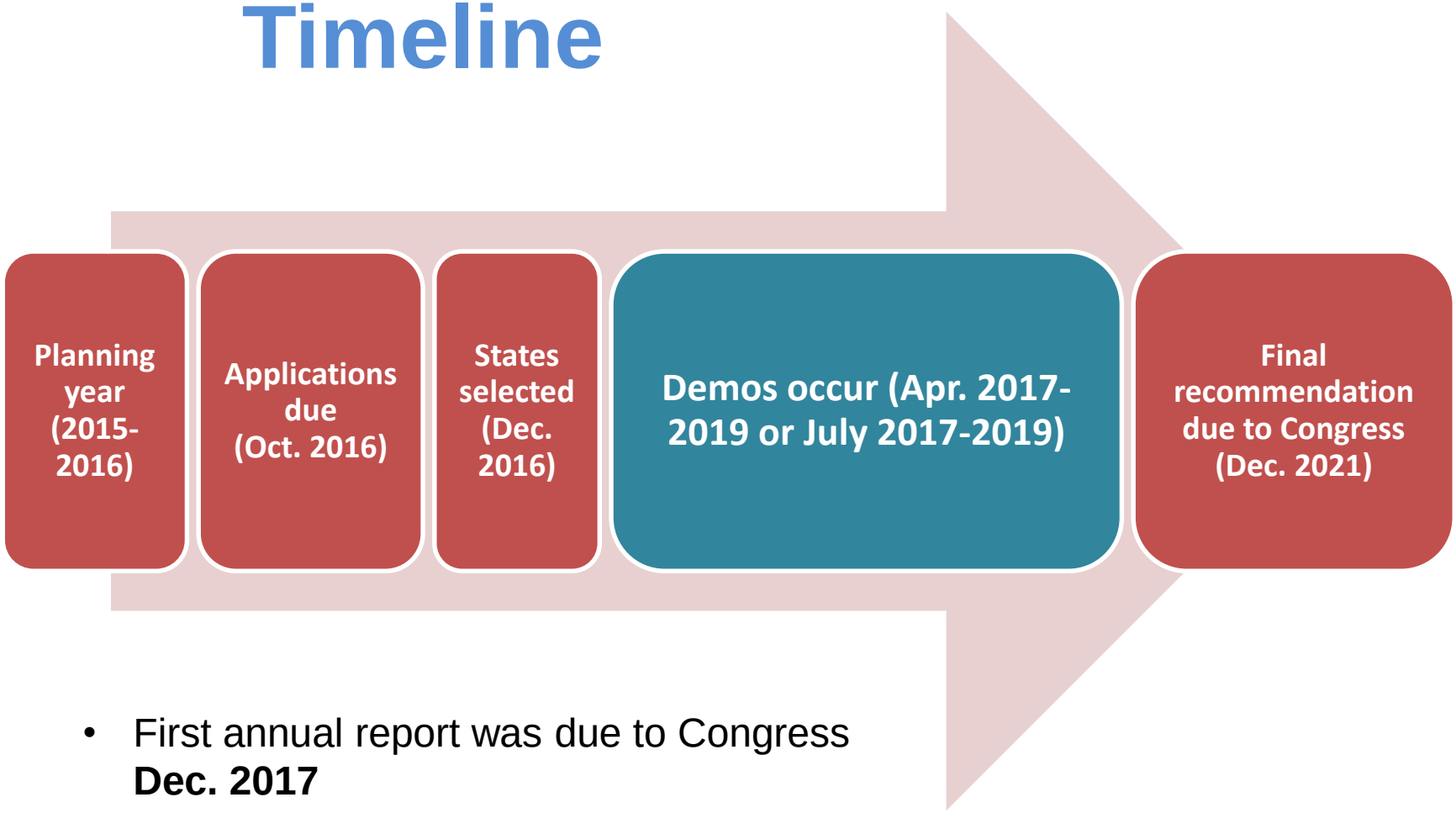
CCBHCs: A New Model

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…

Timeline



- 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

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

90% of CCBHCs have a psychiatrist on staff with an addiction specialty/focus

Within the first year:

398 **new** staff with an addiction specialty or focus

Key staff expansions

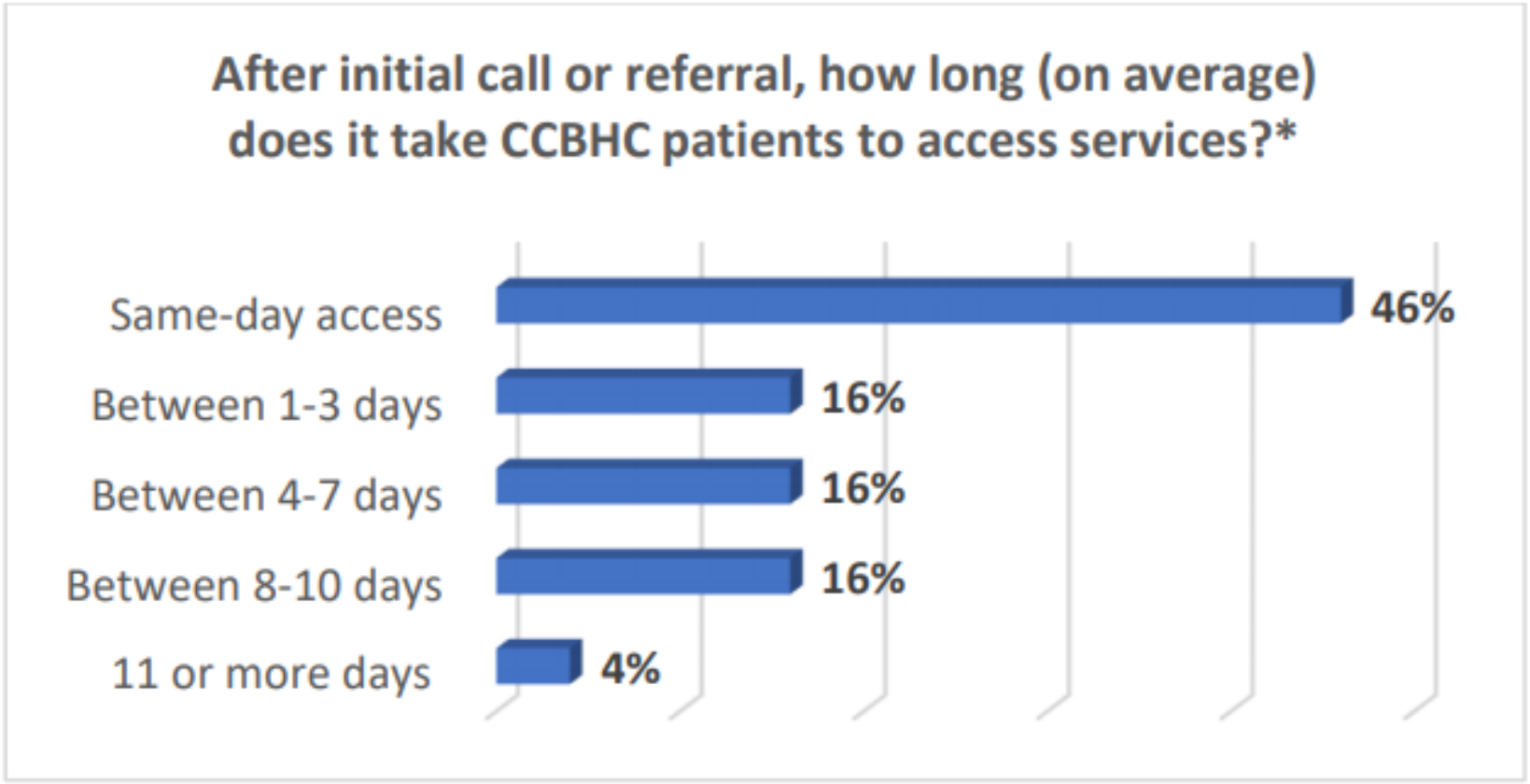
CCBHC status has helped clinics expand access to medication-assisted treatment via expanded training and hiring: 92% of CCBHCs have trained or hired clinicians who can prescribe buprenorphine

"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



In the first 6 months of implementation:

87%

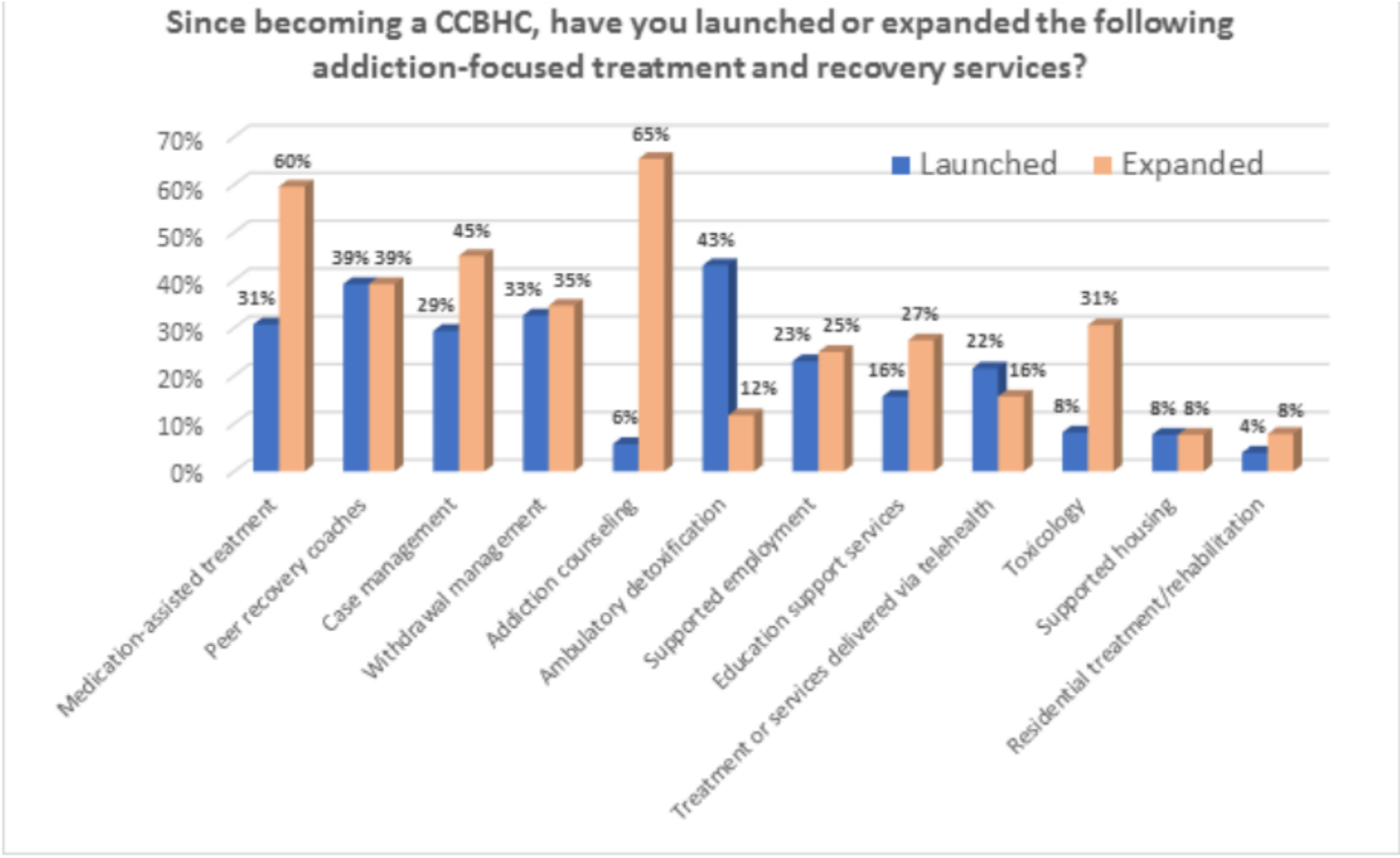
of CCBHCs report an increased number of patients served, representing up to a **25% increase** in total patient caseloads for most clinics

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?"

CCBHCs' expanded service array



"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

Redesigning Care Teams

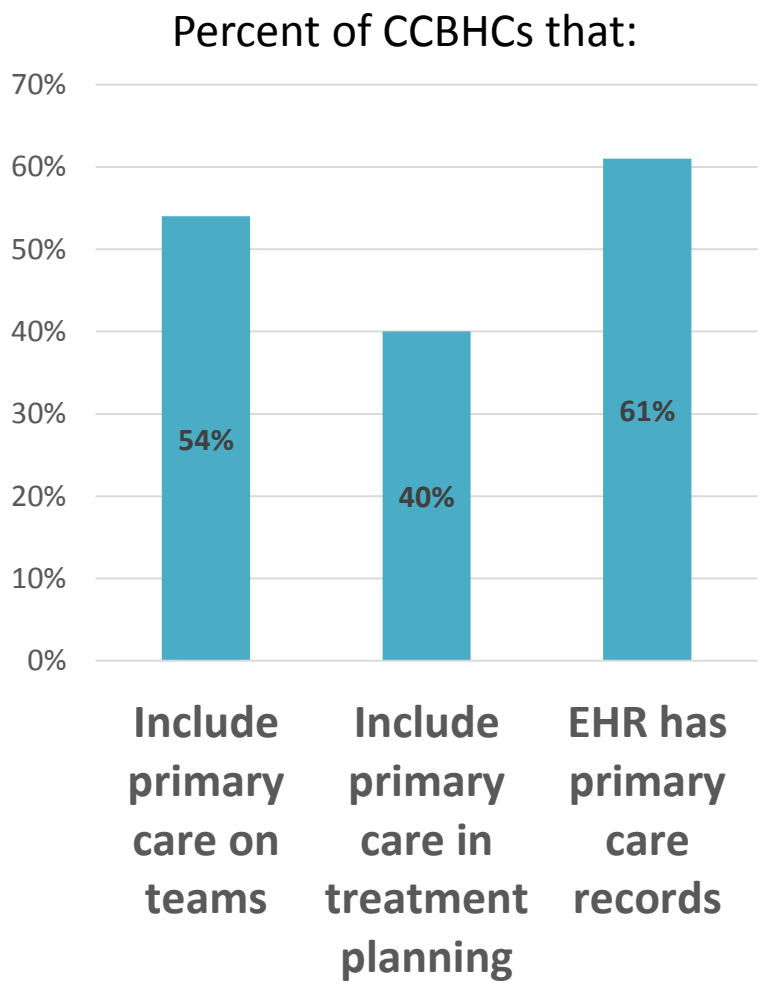
The CCBHC PPS payment model has freed clinics from payment rates tied to units of service.

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?"

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?



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

AMHERST H. WILDER FOUNDATION
Here for good.

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

North Care (OK)

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

northcare

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

Berks Counseling Center (PA)

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

BCC
Berks Counseling Center
A Certified Community Behavioral Health Clinic

Key Data Points
20% drop in no-show rate from intake to 1st appointment
50% reduction in crisis contacts

RAND/Mathematica Study Results

Big Picture Takeaways:

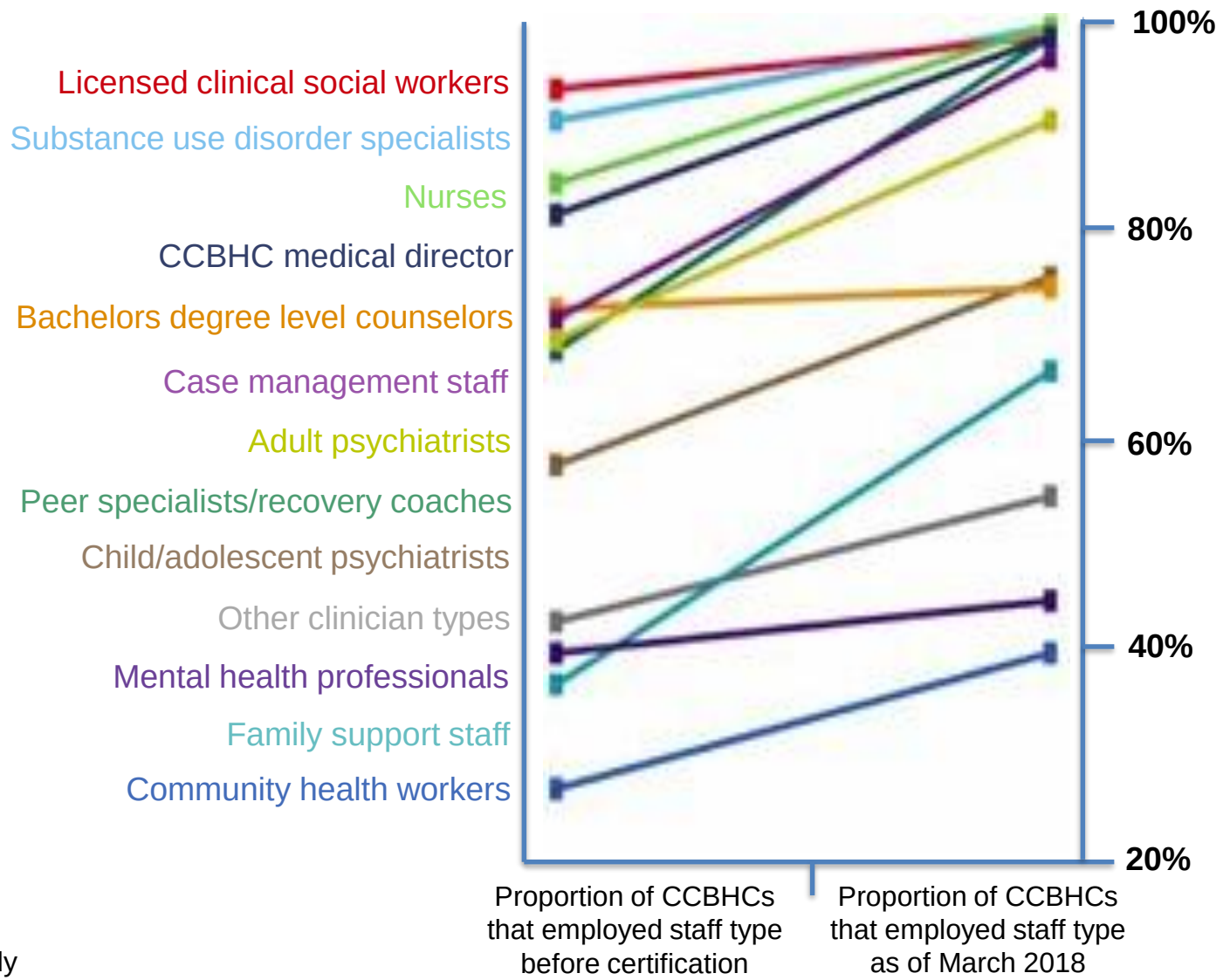
- States and CCBHCs have focused on increasing access to care and maintaining the required staffing and scope of services
- **Staffing and adoption of new services were among the most common early implementation challenges**; state officials report that these challenges have been addressed

RAND/Mathematica results, cont'd

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



Source: RAND/Mathematica Study

CCBHC Staffing: Challenges

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

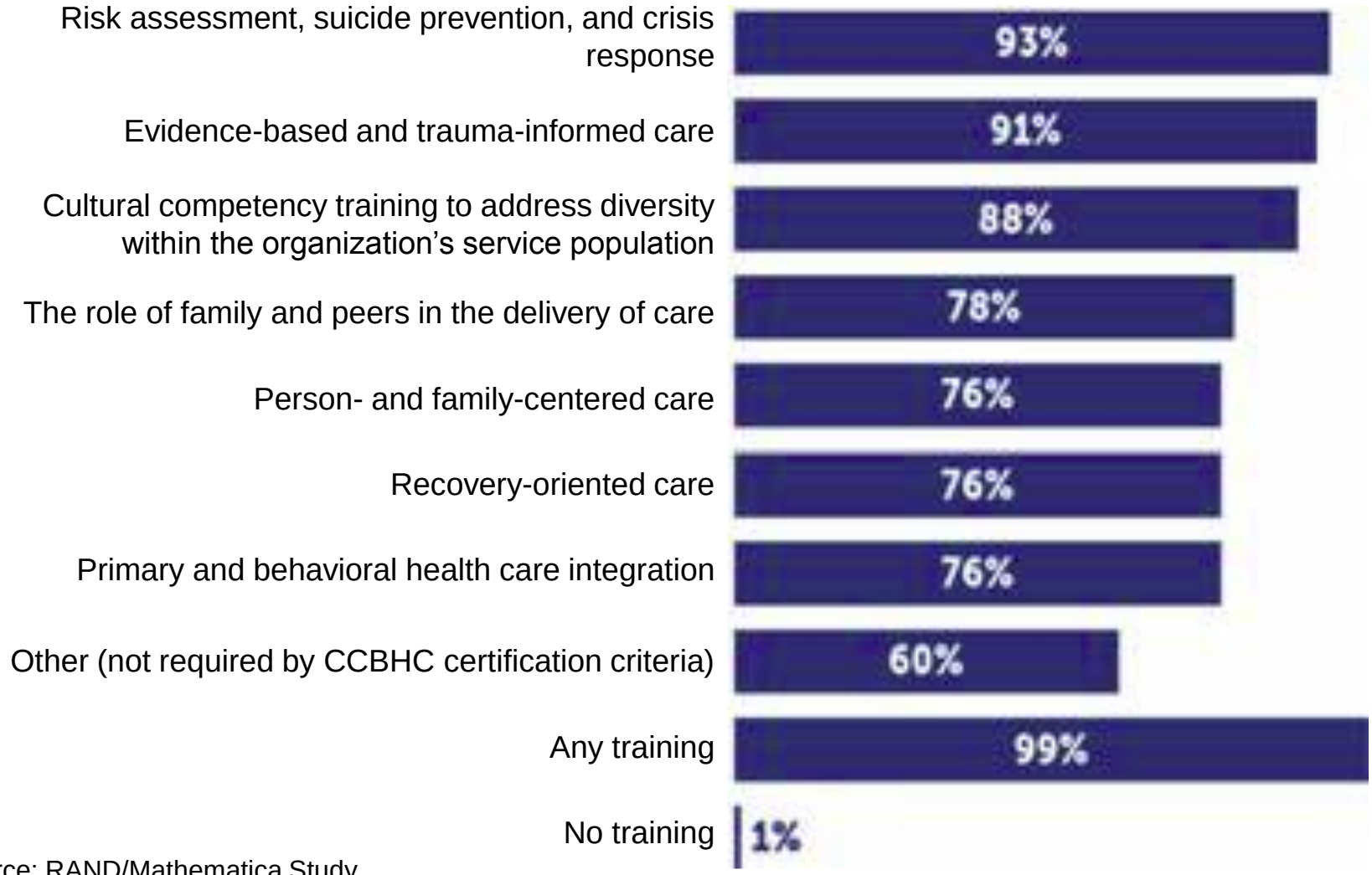
State officials most often reported difficulty hiring psychiatrists, peer staff, substance use disorder (SUD) treatment providers, and licensed clinical social workers

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

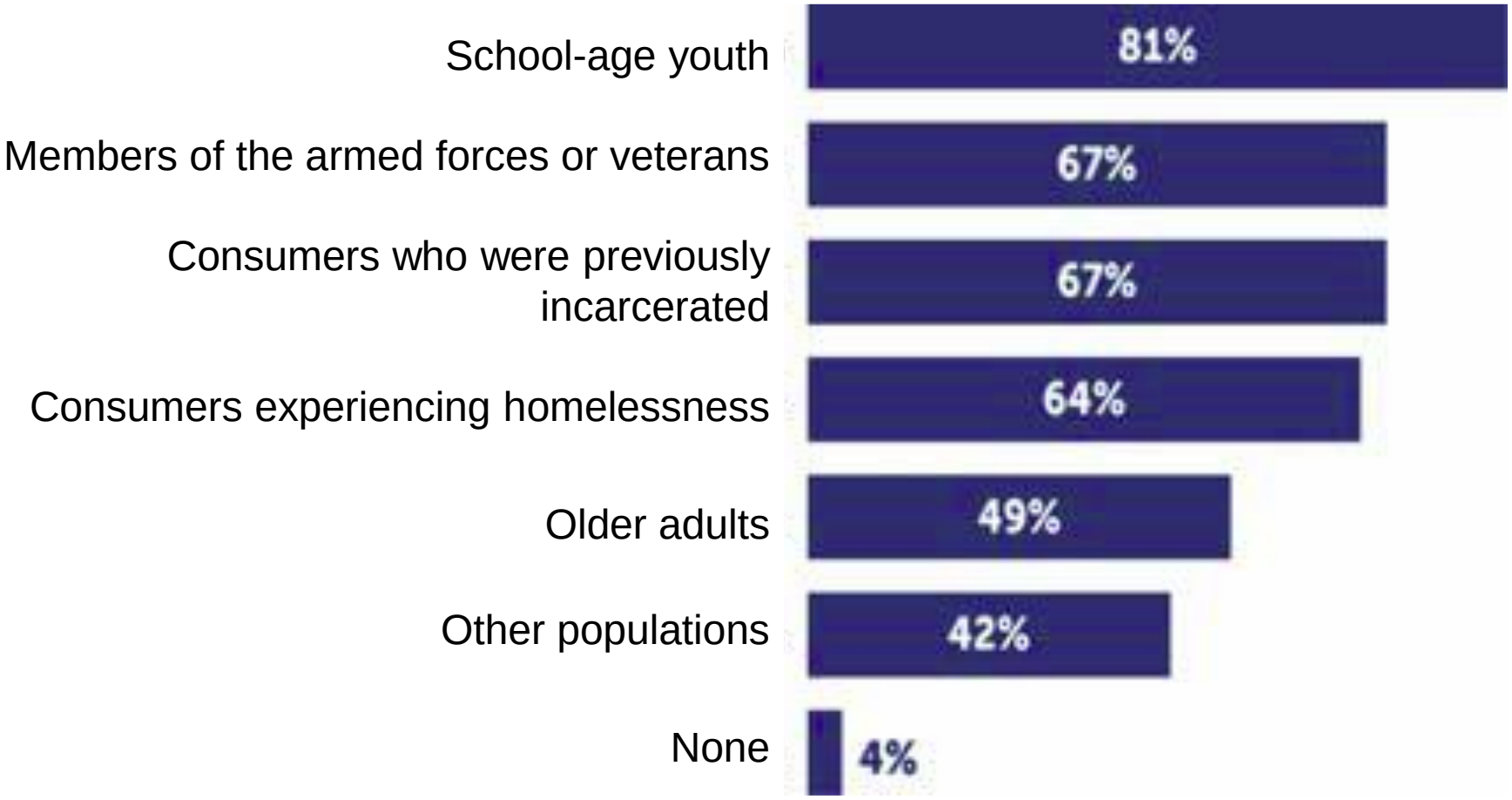
Source: RAND/Mathematica Study

CCBHC Staff Training



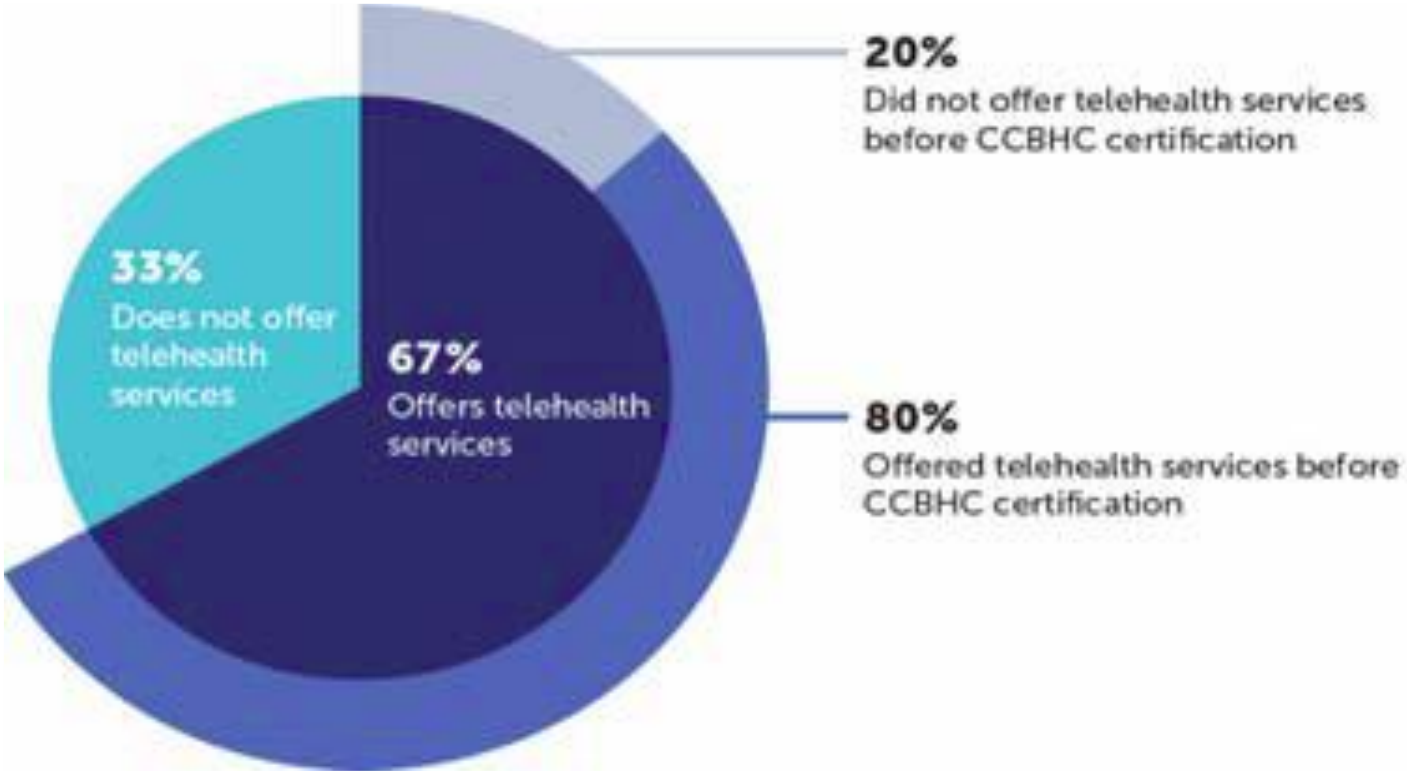
Source: RAND/Mathematica Study

Access to Care: Outreach



Source: RAND/Mathematica Study

Access to Care: Telehealth

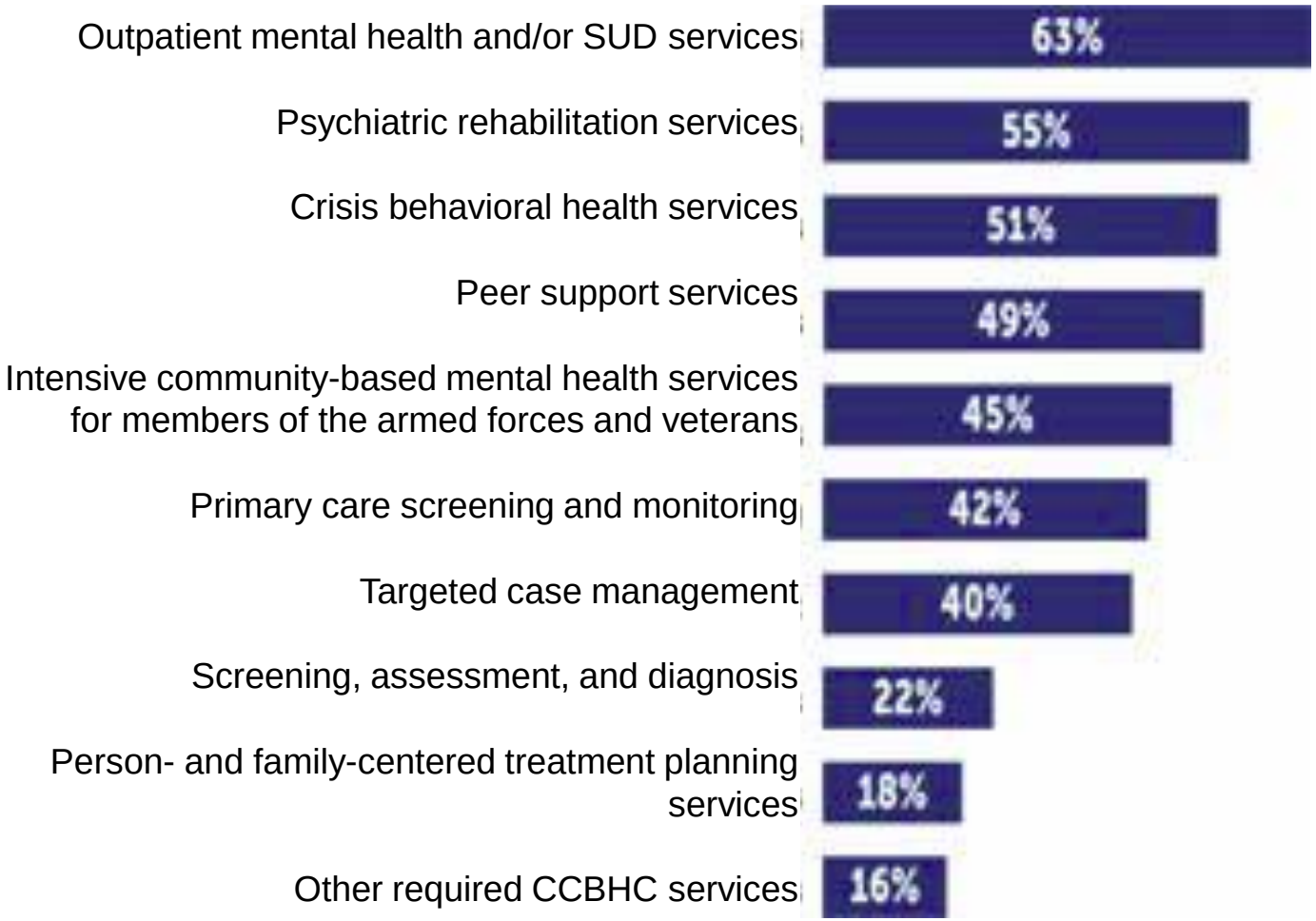


Source: RAND/Mathematica Study

Services Added for Certification

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



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**
  - 97% adapted existing EHR or HIT systems
  - 33% adopted new systems

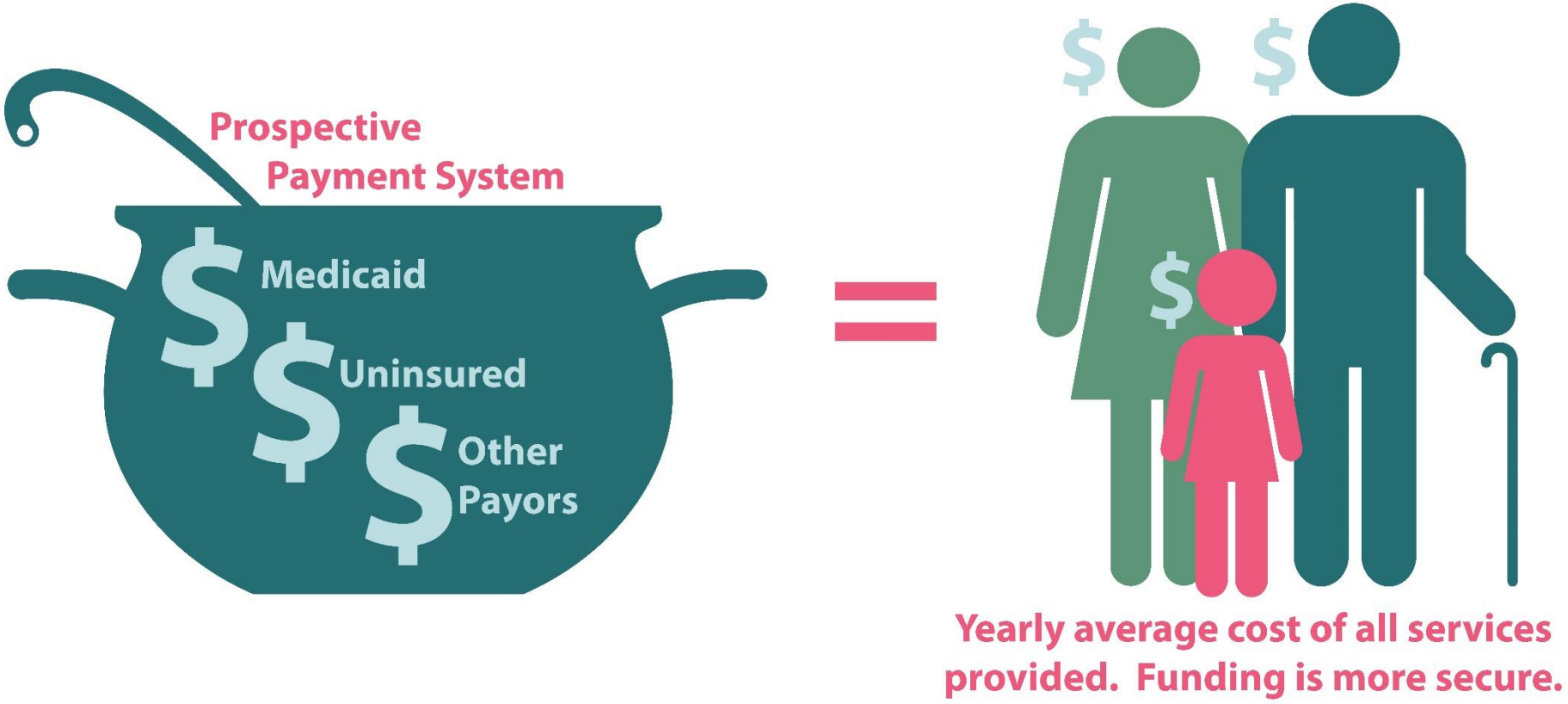
- **CCBHCs most often reported changing their EHRs to:**
  - Facilitate reporting the required quality measures
  - Exchange clinical information with DCOs or other external providers
  - Add clinical decision support features

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

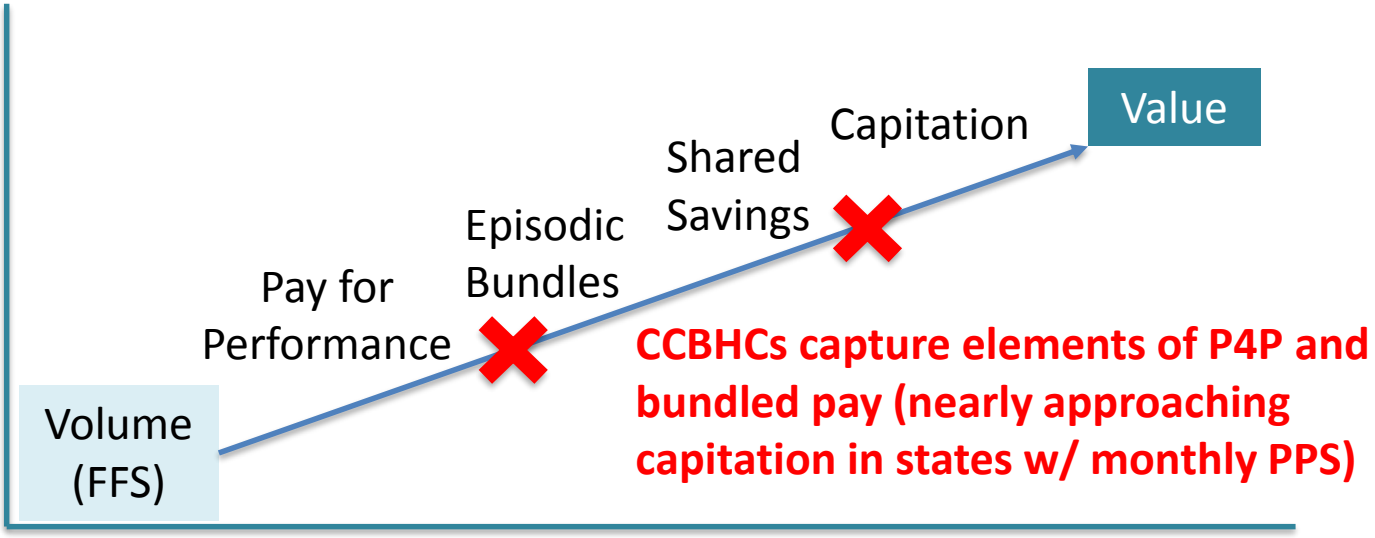
Establishment of a Prospective Payment System (PPS)



PPS vs. FFS

FFS	PPS
Low payment rates don't cover cost of doing business	Reimbursement covers anticipated cost of care for Medicaid services
Latest evidence-based practices may not be covered in a rigid FFS	Cost-based reimbursement allows flexibility and payment for innovative service delivery
FFS payment drives staffing mix instead of clinical staff mix being driven by needs of patients	Appropriate staffing mix covered on a cost-basis
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)	Cost-based reimburses incentivizes clinics to take a nuanced look at the extent to which infrastructure impacts patient outcomes

Alternative payment models (APMs) shifting pay from volume to value



Incentives for health system investment in behavioral health care

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

- 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**!

Randy Tate, National Council Board Member and CEO of NorthCare in Oklahoma City

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

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

115TH CONGRESS
1ST SESSION

S. 1905

To increase the number of States that may conduct Medicaid demonstration programs to improve access to community mental health services.

IN THE SENATE OF THE UNITED STATES

OCTOBER 2, 2017

Ms. STABENOW (for herself and Mr. BLUNT) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To increase the number of States that may conduct Medicaid demonstration programs to improve access to community mental health services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Excellence in Mental Health and Addiction Treatment Expansion Act".

SEC. 2. COMMUNITY MENTAL HEALTH SERVICES DEMONSTRATION PROGRAM.

Section 223(d) of the Protecting Access to Medicare Act of 2014 (42 U.S.C. 1396a note) is amended—

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

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

Minnesota Medicaid 1115 Waiver

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

<u>The proposed waiver would:</u>

- ✓ 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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