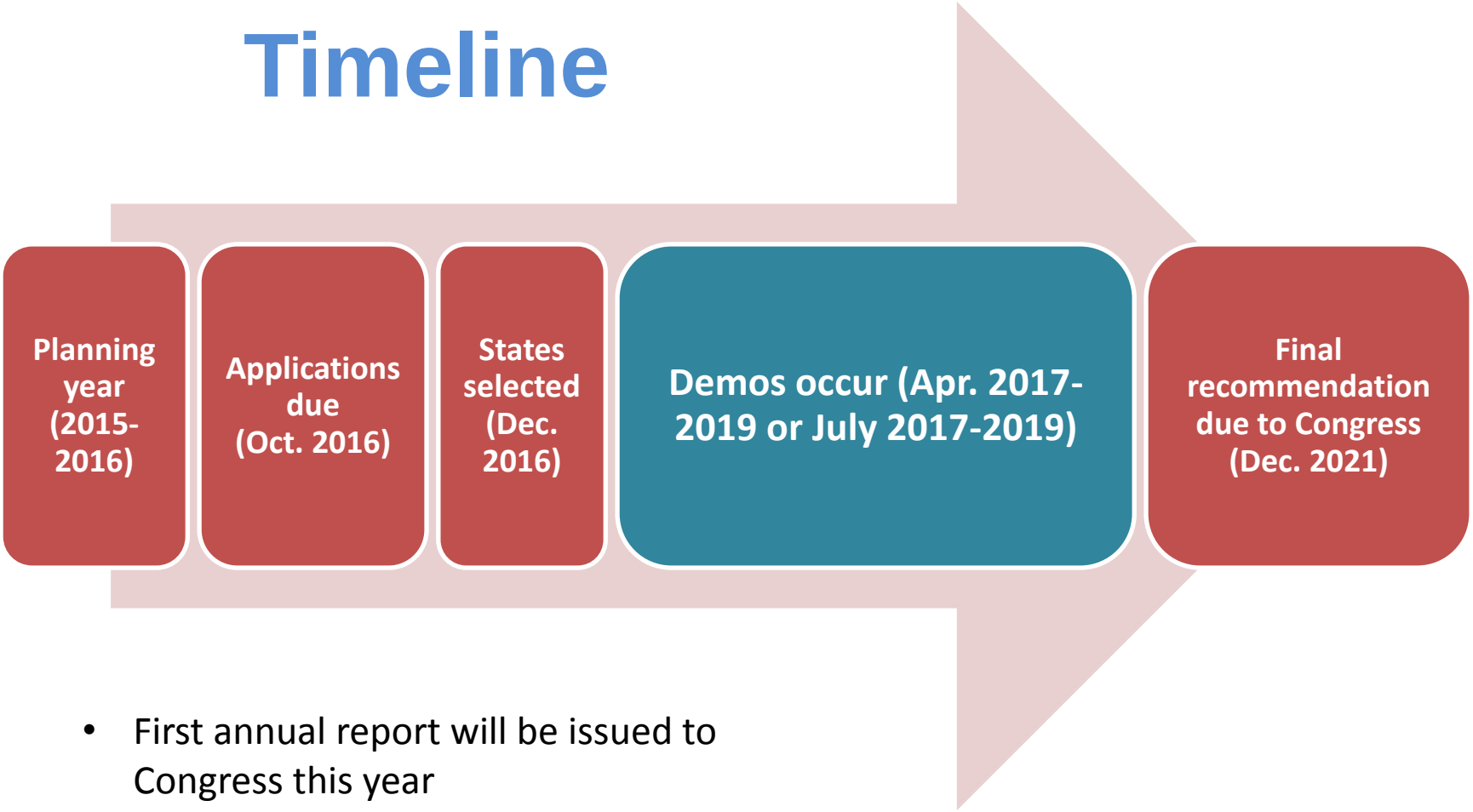
CCBHCs: Where Are We, and What's Ahead?

Rebecca Farley David

National Council for Behavioral Health

Timeline



- First annual report will be issued to Congress this year
- **Substantial gap** between end of demo and deadline for HHS' recommendation to Congress on the program's continuation

CCBHC Successes to Date

The following data reflects responses from 47 of 67 CCBHCs, a 70% response rate. Responses were collected in Nov. 2017.

Since implementation began…

CCBHCs have added

1160

new positions to their staff

including:

72

psychiatrists

212 staff with an addiction specialty or focus

Oklahoma's CCBHCs have hired more than the national average.

189 new staff positions have been added by CCBHCs in Oklahoma.

Oklahoma's 3 CCBHCs represent 3% of survey respondents but have hired 16% of all new staff.

From…

*"We're competing **with grocery stores and fast food** for our staff."*

To…

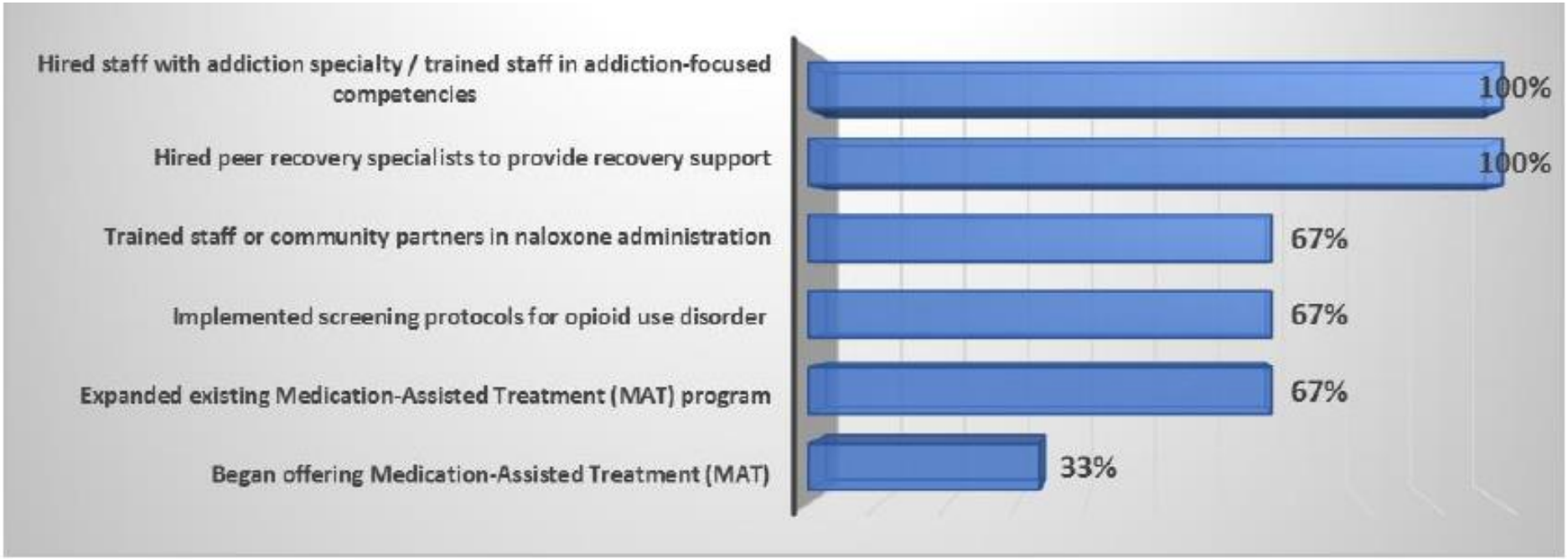
*"CCBHC status has allowed us to court and hire more highly qualified candidates, **because we can now offer more competitive salaries."***

Since implementation began…

100%

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

Oklahoma CCBHCs' activities to expand opioid treatment capacity



New partnerships with law enforcement

Law Enforcement Center Liaison
Family Guidance Center, MO

CCBHC PPS supported creation of a new staff position, "Law Enforcement Center Liaison"

- An LPC hired on full time
- Directly coordinating with local jails to plan release and pick-up
- Assists in finding housing
- Helps to enroll eligible individuals in Medicaid
- Coordinates care and will take them to their initial appointments if needed

0% Re-arrest Rate
Grand Lake Mental Health, OK

CCBHC PPS supported creation of Intensive Outpatient Program for high-risk individuals who cycle between hospitalization and jail.

- Currently 18 individuals in the program for 9 months.
- 1 rehospitalization
- 0 re-arrests.
- Local law enforcement has been counting their saved driving hours, mileage and gas costs.

Other trends we're seeing

- **Workforce**
  - Filling staff vacancies
  - Hiring for new functions
  - Challenge: onboarding so many new staff at once

- **Data**
  - Expanding ability to collect and report on data
  - Growing sophistication in ways that will help with participation in other value-based models
  - Challenge: Collecting data across care settings, developing workflows and parameters for data collection

Other trends we're seeing (cont.)

- **Technology**
  - Adopting new tools, upgrading old tools
  - Tech tools that support non-4-walls approach
  - Challenge: braiding funding to support non-allowable costs
- **Integration**
  - New clinical and operational norm
  - Clear movement toward an increasingly sophisticated workforce capable of providing whole-person care
  - Challenge: MH/SUD integration/culture change

Our work is not over

Mathematica/RAND evaluation holds the keys to sustaining & expanding CCBHCs

1. **Access to care:** How has access increased?
2. **Scope of services:** Are CCBHCs able to fully implement the scope of services?
3. **Quality:** what is the quality of care provided to CCBHC clients?
4. **Costs:** Do the PPS rates cover the full cost of care for the CCBHCs?
5. **Savings:** What is CCBHCs' impact on inpatient, emergency, and ambulatory service utilization rates as well as state and federal Medicaid costs?

Are CCBHCs <u>really</u> improving access to services, or are we just paying more for business as usual?

Key areas of focus for the next 17 months

- Interventions to reduce high-cost items (e.g. hospitalization, ED, polypharmacy)
- Measurable increases in patient access
- Demonstrated quality improvements on the 21 CCBHC quality indicators
- The value equation

Inpatient and ED utilization

Use care pathways built on best practices for care transitions

- Establish clinical and operational protocols to support the transition from hospitalization to community
  - Discharge planning
  - Care coordination
  - Outreach/engagement to ensure treatment plan follow through
- Use CQI and PDSA!

To demonstrate success, CCBHCs must:

Monitor your performance on follow-up after hospitalization and hospital readmission

- Identify available data sources, <u>even if imperfect</u>
  - State claims database?
  - HIE?
  - Direct relationships/data sharing with hospitals?
  - We will brainstorm ideas with you!
- Integrate data collection/analysis into daily workflows and care pathways

Use data to understand client risk and intervene early

- Use data to identify key risk factors that drive rehospitalization…
  - …and to spot your clients who are at high risk of being hospitalized for the first time
- Build workflows to address high risk individuals early and assertively

Did you know: Data from CMMI evaluations indicates the greatest savings to date are from reduced hospitalizations (vs. reduced ED visits)

Keep score

Data can win over initially resistant partners

- Track progress and report back to hospitals on the value of your services/partnership
  - Number of days of hospital stay avoided?
  - Timeliness of access to community services post-hospitalization?
  - Other quality or access indicators they care most about?
- Be persistent in your efforts to build relationships with hospitals – they will pay off!

Why focus on outreach & engagement?

Because it's better for clients	Because it's required	Because it affects the bottom line
• Improves client experience of care • Increases engagement with care • Allows us to serve more people!	• Standards of timeliness in CCBHC certification criteria • Quality reporting requirements	• Anticipated vs. actual visits • No-shows have a greater impact on total yearly revenue under PPS vs. FFS • Need sufficient #s of Medicaid patients

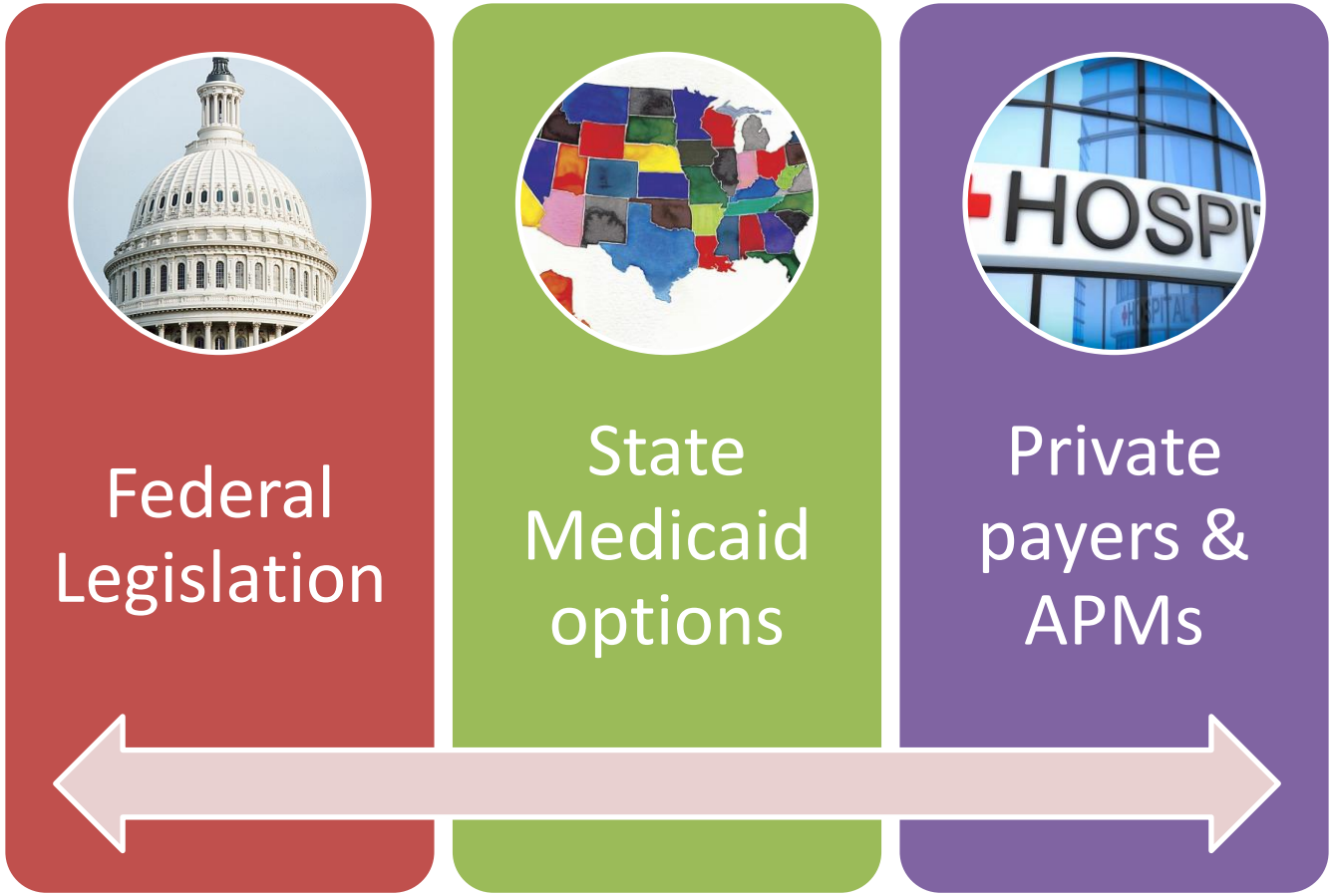
Evaluating your payer mix

- How many Medicaid encounters do you need to make the PPS math work?
  - Are Medicaid patients getting the right service mix at the right intensity each month? *Step patients down to lower levels of service if higher-intensity care is no longer needed.*
- What is the gap between your needed and actual number of Medicaid encounters… and why?
  - Are Medicaid patients not showing up for visits? *Focus on outreach, engagement, transportation, other identified reasons for no-shows*
  - Do you not have enough Medicaid patients in your case mix? *Focus on outreach, enrollment, partnerships with other places/sites where potential clients are seen*

Sample CCBHC outreach & engagement activities

- **All states:** same-day/next-day access is the new standard.
- **Missouri:** Partnering with or opening school-based health clinics to reach children and parents where they go daily
- **Oregon:** Dedicated outreach workers for homeless individuals, aimed at managing chronic health conditions
- **Minnesota:** using telemedicine to provide access to non-physician clinicians
- **Oregon:** outreach worker stationed in jail, provides assessment, discharge planning, Medicaid enrollment
- **Pennsylvania**: data highlighted service disruption as risk factor for suicide; outreach workers use service utilization reports to spot gaps in care and provide assertive follow-up outside the 4 walls of the clinic

Sustainability planning for CCBHCs



Excellence Act Expansion

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—

Expansion Act Cosponsors

House

- Leonard Lance (NJ-7), Original Author
- Doris Matsui (CA-6), Original Author
- Andre Carson (IN-7)
- William Lacy Clay (MO-1)
- Carol Shea-Porter (NH-1)
- Peter DeFazio (OR-4)
- James McGovern (MA-2)
- Early Blumenauer (OR-3)
- Lynn Jenkins (KS-2)
- Collin Peterson (MN-7)
- Rodney Frelinghuysen (NJ-11)
- Joseph Kennedy (MA-4)
- Bill Pascrell (NJ-9)

Senate

- Roy Blunt (MO), Original Author
- Debbie Stabenow (MI), Original Author

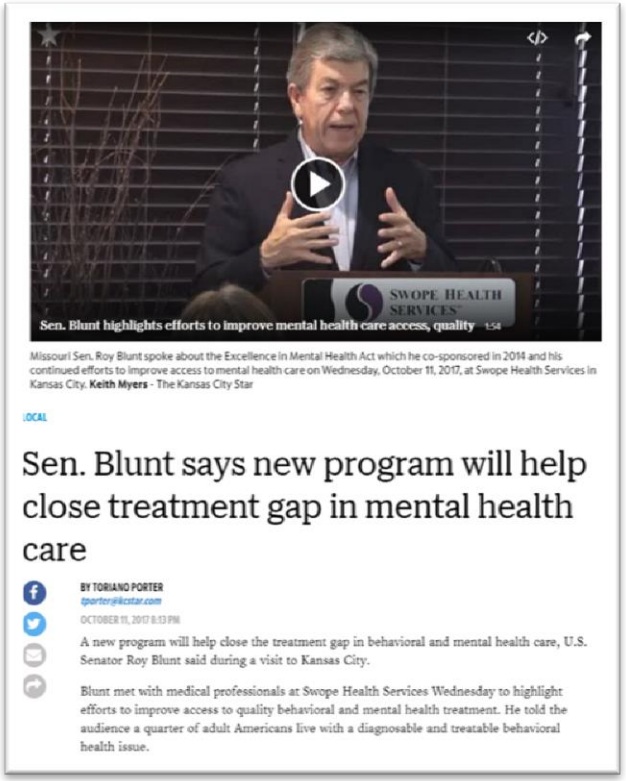
Take Action! Ask your legislators to cosponsor the Excellence Expansion Act…

…and follow up again in 6 months with any additional data, stories, or news coverage

Double your impact

Invite your legislators for a site visit

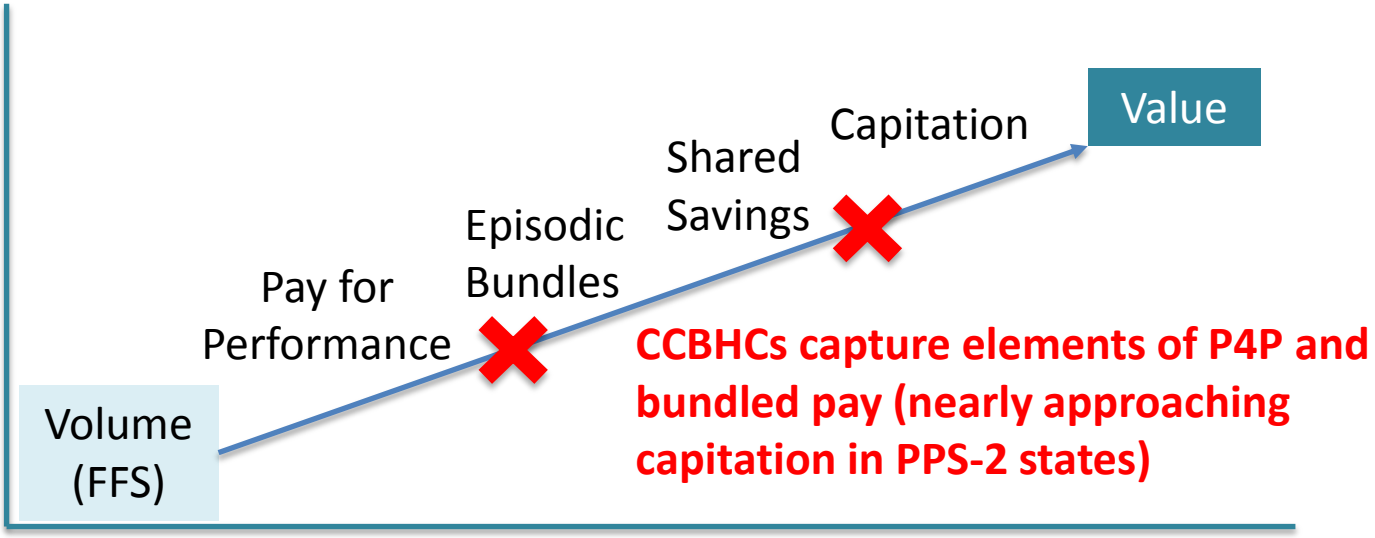
- Upcoming Congressional recesses:
  - **Senate:** Feb. 17-25, Mar. 24-Apr. 8
  - **House:** Feb. 17-25, Mar. 23-Apr. 9
- Suggested activities:
  - Tour of your facility
  - Meet selected staff & clients involved in key CCBHC activities (e.g. opioid treatment, veterans' services, crisis care)
  - Provide a handout & discuss how your CCBHC is expanding access to services
  - Invite local media, make time for photo-ops!



Options for states post-2019

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)	May have to request waiver of statewideness (or 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	

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

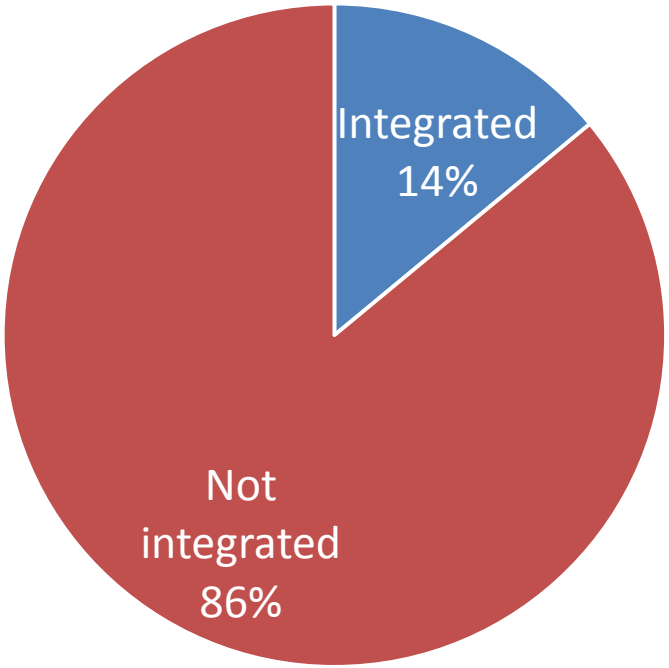
- Prevent unnecessary readmissions
- Improve clinical outcomes & reduce cost of care for complex, chronically ill populations

Despite accountability for behavioral health…

Few ACOs have engaged MH/SUD providers

"We recognize the need to engage with existing behavioral health providers, but we need to know what unique capabilities they bring to the table."

% of ACOs with Integrated BH Services, 2014



Making the business case for your services

What keeps payers/partners up at night?

"People don't care about health care costs. They care about how much it costs ***them***."

Dr. Mark Fendrick
Center for Value-Based Insurance Design

Questions?

Rebecca Farley David
Vice President, Policy and Advocacy
RebeccaD@thenationalcouncil.org