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

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National Council for Behavioral Health
Timeline

- Planning year (2015-2016)
- Applications due (Oct. 2016)
- States selected (Dec. 2016)
- Demos occur (Apr. 2017-2019 or July 2017-2019)
- Final recommendation due to Congress (Dec. 2021)

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

“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

- Hired staff with addiction specialty or trained staff in addiction-focused competencies: 100%
- Hired peer recovery specialists to provide recovery support: 100%
- Trained staff or community partners in naloxone administration: 67%
- Implemented screening protocols for opioid use disorder: 67%
- Expanded existing Medication-Assisted Treatment (MAT) program: 67%
- Began offering Medication-Assisted Treatment (MAT): 33%
# New partnerships with law enforcement

<table>
<thead>
<tr>
<th>Law Enforcement Center Liaison</th>
<th>0% Re-arrest Rate</th>
</tr>
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<tbody>
<tr>
<td><strong>Family Guidance Center, MO</strong></td>
<td><strong>Grand Lake Mental Health, OK</strong></td>
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<tr>
<td>CCBHC PPS supported creation of a new staff position, “Law Enforcement Center Liaison”</td>
<td>CCBHC PPS supported creation of Intensive Outpatient Program for high-risk individuals who cycle between hospitalization and jail.</td>
</tr>
<tr>
<td>• An LPC hired on full time</td>
<td>• Currently 18 individuals in the program for 9 months.</td>
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<tr>
<td>• Directly coordinating with local jails to plan release and pick-up</td>
<td>• 1 rehospitalization</td>
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<tr>
<td>• Assists in finding housing</td>
<td>• 0 re-arrests.</td>
</tr>
<tr>
<td>• Helps to enroll eligible individuals in Medicaid</td>
<td>• Local law enforcement has been counting their saved driving hours, mileage and gas costs.</td>
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<tr>
<td>• Coordinates care and will take them to their initial appointments if needed</td>
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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 really 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, even if imperfect
  - 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?

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

- Federal Legislation
- State Medicaid options
- Private payers & APMs
Excellence Act Expansion

Sens. Roy Blunt and Debbie Stabenow

Reps. Leonard Lance and Doris Matsui
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

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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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<tr>
<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>May have to request waiver of statewideness (or certify additional CCBHCs)</td>
</tr>
<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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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 capture elements of P4P and bundled pay (nearly approaching capitation in PPS-2 states)
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

- Integrated: 14%
- Not integrated: 86%
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 \textit{them}.”

Dr. Mark Fendrick
Center for Value-Based Insurance Design
Questions?

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