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Improving access to Treatment Services for Mental Illness and Substance Use Disorders

Certified Community Behavioral Health Centers (CCBHC)

Drivers of Poor Access

- Low reimbursement rates from state Medicaid programs and Medicaid-contracted managed care payers
- Federal and state cuts to grants and contracts for public programs serving individuals with severe and persistent mental illnesses
- Cycle of rate-setting based on baseline inadequate payments
- Inefficiency due to lack of investment in IT and data analytic structure
  - Lack of clear definition of
  - Criteria for good access
- Criteria for what services there should be access to
- Overly restrictive utilization management by MCOs (Wit Decision)

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Outpatient Reimbursement

More than **75%** of the National Council's state association members lost $$ on psychiatry

- 3 year losses increased from $481,000 in 2013 to more than $550,000
- Must earn surplus of **15%** or more to balance budget

Lower staff salaries in general decreases staff retention and is an obstacle to recruitment

- Staff vacancies reduce access
- Staff turnover increases cost and decreases quality

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Consequences

- Lower staff salaries in general decreases staff retention and is an obstacle to recruitment
    - Staff vacancies reduce access
    - Staff turnover increases cost and decreases quality
- Inadequate workforce has limited ability to deliver safe and effective care
- Absence of children's behavioral health services
- Rationing services to most severe illnesses, limiting access for patients milder conditions
- Limited opportunities for innovation
- Less supervision and collaboration

Extended Outpatient Wait Times

Common in all settings

Increases need for Crisis services

Increased ER utilization

Can lead to medication non-adherence with more ED visits and hospitalizations

Prescriptions refilled without monitoring for side-effects

2 out of 3 referring primary care physicians reported difficulty accessing psychiatric services

Consumer Experience

Low patient satisfaction in community mental health centers due to:

- Quality of patient-clinician interaction
- Time limit (often 15 minutes)

Brief appointments with patients with chronic mental health disorders

Lack of timely access to collateral clinical information

Less time to talk with patient's family or other caregivers

Negative impact on clinician-patient relationship

"Compressed time with patients may lead to cold environments and an over-focus on deficits or weaknesses that may disempower or frustrate individuals" – Depression and Bipolar Support Alliance (DBSA)

CCBHCs: Supporting the Clinical Model with Effective Financing

Standard definition	→	**Raises the bar for service delivery**
Evidence-based care	→	**Guarantees the most effective clinical care for consumers and families**
Quality reporting	→	**Ensures accountability**
Prospective payment system (PPS)	→	**Covers anticipated CCBHC costs**

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PPS vs. FFS

Implications of PPS compared to fee-for-service (FFS) model

- Rate is clinic-specific; accounts for varying costs in varying regions
- Payment is the same regardless of intensity or quantity of services received during encounter period (month or day)
- Does not prioritize higher-margin services over services that may better fit patient need
- No financial incentive to provide lots of units of service when fewer services would be as effective
- Does not require that all services be translated into units (i.e., supports nonbillable activities)

CCBHC Accountability Mechanisms

- All CCBHCs must complete standardize cost reports detailed financial information
  - Benchmarking over time
  - Benchmarking across the individual CCBHCs
- 21 mandatory performance measures
  - Benchmarking over time
  - Benchmarking across the individual CCBHCs
- Participation requires state certification of meeting required criteria
  - 114 SAMHSA certification criteria
  - State can add it's own additional certification criteria

Quality Reporting: 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

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Quality Reporting: 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

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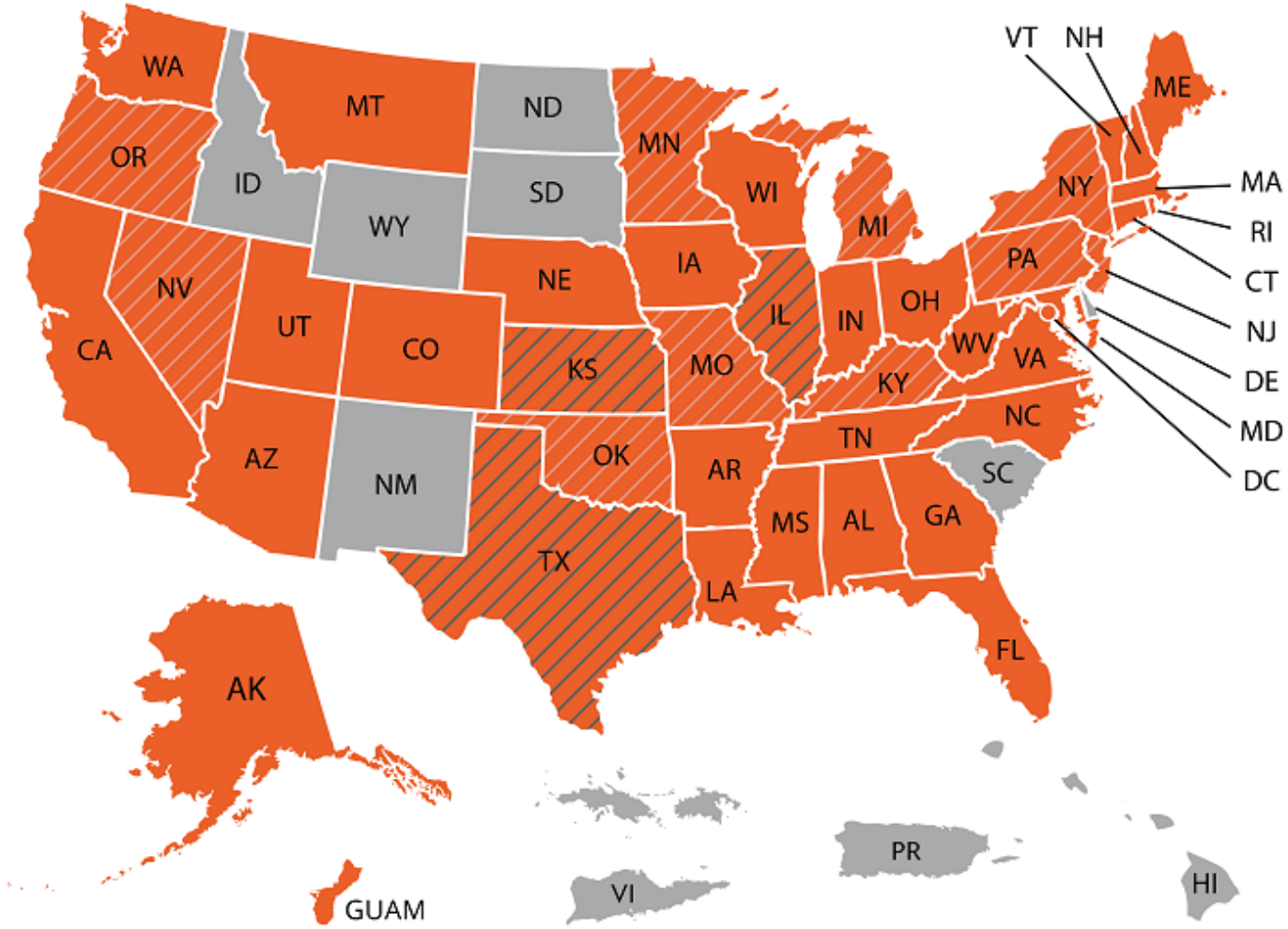
Status of Participation in the CCBHC Model

- States where clinics have received expansion grants
- States selected for the CCBHC demonstration
- Independent statewide implementation
- No CCBHCs

There are **431 CCBHCs** in the U.S., across 42 states, Guam and Washington, D.C.



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CCBHCs' State Impact Over Time

Missouri

- Hospitalizations **dropped 20%** after 3 years, ED visits **dropped 36%**
- Overall access to BH services **increased 23% in 3 years,** with veteran services **increasing 19%**
- **In 1 year, 20% decrease** in cholesterol; **1.48-point Hgb A1c decrease**
- Justice involvement with BH populations **decreased 55%** in 1 year

Texas

- The CCBHC model in Texas is projected to save **$10 billion by 2030**
- In 2 years, there were **no wait lists** at any CCBHC clinic
- **40% of clients** treated for cooccurring SUD and SMI needs, compared to 25% of other clinics

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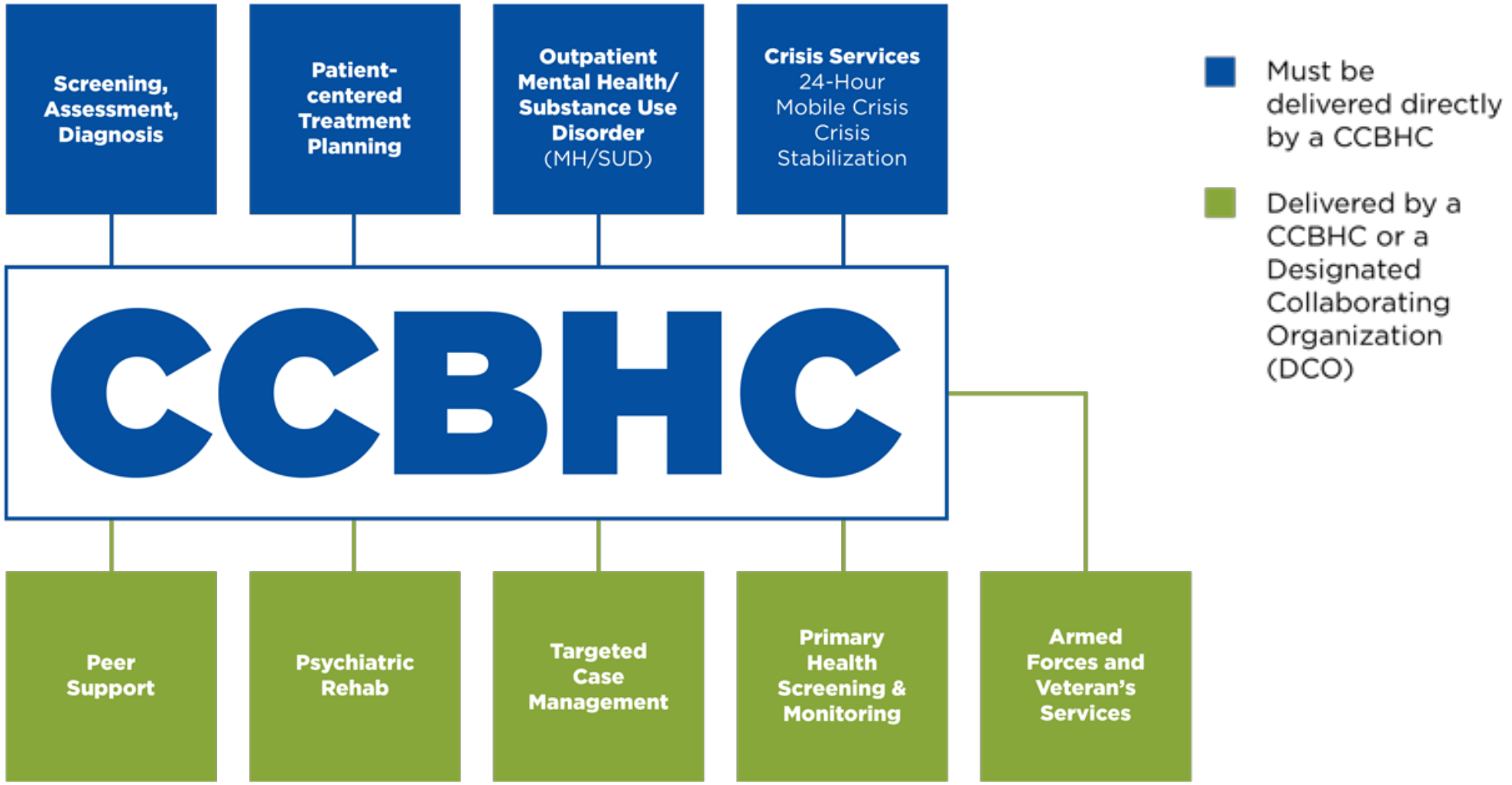
Timely Access Requirements

- If a crisis need is identified, care must be provided immediately or within 3 hours at the latest.
- If an urgent need is identified, clinical services must be provided within 1 business day.
- If routine needs are identified, services must be provided within 10 business days.
- Evening and weekend clinic times must be available
- Subject to more stringent state standards, all new consumers must receive a person-centered diagnostic and treatment planning evaluation within 60 days of their first request for services.

CCBHC Scope of Services



CCBHCs' Role in the Crisis Continuum

Prevention	Crisis Response	Post-crisis care
• Early engagement in care • Crisis prevention planning • Outreach & support outside the clinic	• 24/7 mobile teams • Crisis stabilization • Suicide prevention • Detoxification • Coordination with law enforcement & hospitals	• Discharge/release planning, support & coordination • Comprehensive outpatient MH & SUD care

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CCBHC Increases the Availability of Crisis Response

100% of CCBHCs offer crisis response services, with **51%** of them having newly added crisis services as a result of certification.

Required crisis activities: 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization

Common crisis response activities include:

- Partners with 911 to have relevant 911 calls screened and routed to CCBHC staff (17%)
- Mobile behavioral health team responds to relevant 911 calls instead of police/EMS (e.g. CAHOOTS or similar model) (19%)
- Behavioral health provider co-responds with police/EMS (e.g. clinician or peer embedded with first responders) (38%)
- Operates a crisis drop-in center or similar non-hospital facility for crisis stabilization (e.g. 23-hour observation) (36%)
- Coordinates with hospitals/emergency departments to support diversion from EDs and inpatient (78%)

Workforce recruitment data

CCBHCs participating in the demonstration program **hired an average of 117 new staff positions each, with a median of 43.***

The most commonly added staff include adult and child psychiatrists, licensed clinical social workers, nurses, counselors, case managers, and peer specialists/recovery coaches.**

State officials cited expansion of staff as one of the biggest system improvements resulting from the CCBHC demonstration.**

CCBHCs' ability to hire additional staff is **"one big win for the [CCBHC prospective payment] rate."** –Nevada state official

*Source: https://www.thenationalcouncil.org/wp-content/uploads/2021/05/052421_CCBHC_ImpactReport_2021_Final.pdf

**Source: https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//196051/CCBHCImpFind.pdf

Data highlights: increased care access

Nevada: **250% increase** in individuals served from year 1 to year 3 (from 903 patients to 2,270)

Missouri: 27% increase in access to client care from baseline to the fourth year of the program, increasing the total number of individuals served to 150,578.

Texas: In 2 years, there were no wait lists at any CCBHC clinic

Oregon: 17% increase in number of individuals with serious mental illness served (double non-CCBHCs' increase)

New York: 21% increase in individuals served in first year, **with one-quarter having not received a BH service in the prior 3 years**

Reduced ED/inpatient visits data

Oklahoma: CCBHCs reduced the proportion of their clients seen in emergency departments by 18-47% (rates varied by clinic) and those admitted to inpatient care by 20-69% over the first four years of the program, compared to baseline.

Missouri: **20% decrease** in all cause hospitalization and **36% decrease** in all cause ER visits

New York: 54% decrease in the number of CCBHC clients using behavioral health inpatient care, translating to a 27% decrease in associated monthly costs in year 1

New Jersey: decline the in all-cause acute readmission rates from the year 1 to year 2

Other Positive Impacts

- Increased use of Medication assisted treatment (MAT) for substance use disorder
  - **Missouri: 122% increase in MAT over 3 years**
  - **Oklahoma had very few individuals receiving MAT prior to the CCBHC demonstration reported a 700% growth over 4 years.**
- Missouri: Of those engaged in care who had some type of prior law enforcement involvement, nearly 70% had no further law enforcement involvement at six months.
- Texas: 40% of CCBHC clients treated for cooccurring SUD and SMI needs, compared to 25% of other clinics

Spotlight On: Diversion Crisis Support

Grand Lake Mental Health (Oklahoma) developed an intensive outpatient urgent care facility as a place for police officers to bring individuals who are in crisis and need behavioral health treatment, rather than booking them in jail or taking them to a psychiatric hospital. The drop-in center provides crisis stabilization and support services from trained mental health professionals and links individuals to ongoing outpatient treatment and health management support. In its first three years, the program produced a 99% reduction in emergency psychiatric hospitalizations, producing an estimated $14.9 million in savings.

36% of CCBHCs operate a crisis drop-in facility, contributing to jail and hospital diversion.

Spotlight On: Community Re-entry

Family Guidance Center (Missouri) created a Law Enforcement Center Liaison, a full-time position located in their local jail, to work as a discharge planner with individuals who are set to be released from incarceration. The Liaison also completes assessments, connects individuals to needed behavioral health treatment and provides crisis services or mental health services on site at the correctional facility.

72% of CCBHCs provide pre-release screening, referrals, or other activities to ensure continuity of care upon re-entry to the community from jail

Spotlight On: Peer Co-Responders

Monarch (North Carolina) launched an EMS Rapid Opioid Overdose Team, a collaboration between Monarch and Stanly County EMS to administer Suboxone in the field, connect individuals to peer support during the moment of emergency response, and link them to appropriate treatment. Over a 2-year period this team was able to provide support to 120 people in their community who had experienced an overdose. Monarch's Peer Support was utilized as the key engagement piece to build relationships and connect people in the community with the right level of care needed for each individual.

33% of CCBHCs employ a co-responder model, with a peer or clinician embedded with first responders to provide onsite support.

How does the CCBHC financial model support these gains?

CCBHC **Prospective Payment System (PPS)** establishes a Medicaid rate reflective of clinics' costs

Advantages include the ability to:

- Hire new staff and fill vacancies in competitive markets
- Add new service lines
- Have staff number and mix that reflects level of community need, not historically available reimbursement
- Support non-billable activities (e.g. care coordination, outreach)
- Support technology and data costs
- Build partnerships with hospitals, police, and others

The CCBHC Landscape

Three implementation options:

1. Medicaid demonstration (open to 10 states currently)
2. Federal grant funding
3. Independent state implementation via Medicaid SPA or waiver

CCBHC Medicaid Demonstration
Authorized through **Sept. 30, 2023**
8 states entering 5th year of demo in 2021
2 states will begin demo in next 4-5 months

SAMHSA CCBHC Expansion Grants
Yearly funds appropriated since 2018
Grantees in 42 states, DC & Guam
Latest grants awarded July 2021

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States have significant flexibility to craft their CCBHC programs

- States certify CCBHCs and finalize the certification criteria
  - Done within framework set by SAMHSA
- Variation allowed among states
  - specific required services,
  - definition of an “encounter,” more
- States retain authority to implement CCBHCs via waiver/SPA without being part of the federal demonstration

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Reflections on Cost to States

Wide variation in costs, but general consensus that PPS brings substantial value

Multiple sources of variation in total cost

"ROI" is a balance between costs and savings

- States report savings from reduced hospitalization/emergency department utilization…
- …at the same time they report increases to the number of Medicaid clients served

Attainment of cost savings contingent upon fully resourcing CCBHCs' activities designed to reduce costly health service utilization

Participating states perceive value for their investment; some are making additional investments to bring more CCBHCs online

"In a field that has been severely underfunded for years, just increasing access to behavioral health services IS a huge return on investment."

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CCBHC Payment methodology makes your state funds go further

- Prospective payment methodology allows costs for many services in the rate that either
  - Are not billable in FFS Medicaid payment methodology
  - Do not have a standard FFS billing unit available -
- All states that of implemented the CCBHC PPS payment methodology have been able to identify costs that were previously being paid for with 100% state funds that are allowable costs in the CCBHC PPS payment methodology
- Making these 100% state-funded functions part of the CCBHC program allows the state to obtain federal match for the previously unmatched funds.
- Some common examples include: Community outreach, Training, Care by nontraditional providers, Supports and services that are not clinical treatment, Consultation and support the courts and schools

CCBHC Demonstration/PPS: Driving Value

CCBHC Demo

- **Certification** = standardized core requirements
- **PPS** = Medicaid reimbursement that supports costs associated with expanded access & enhanced operations

Enhanced Operations

Expansion of service lines (e.g., crisis response, SUD treatment)

Ability to hire and retain specialty providers (e.g., child psychiatrists, MAT prescribers)

Same-day access to care

High-impact, flexible staffing models targeted to patient need

Technology adoption, electronic health info exchange

Data tracking & analytics

Collaboration/coordination with law enforcement, schools, others

Population health management, data-driven care

Improved Outcomes

- 25% more clients served on average
- Elimination of waitlists
- Reduced hospitalization, ED visits
- Reduced incarceration, recidivism
- Improved physical health

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State officials report that:

The CCBHC model has lowered costs, improved outcomes, and contributed to building critical behavioral health system capacity and infrastructure required to meet rising levels of need for care while integrating services with the rest of the health care system.

State officials credit the CCBHC prospective payment system (PPS) as being instrumental to the success of their CCBHC programs.

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Resources

CCBHC SUCCESS CENTER

https://www.thenationalcouncil.org/ccbhc-success-center/
Email us at: ccbhc@thenationalcouncil.org

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