Behavioral Health Commissioners Summit

Thursday, September 10th, 2020

2:00-3:30pm E.T.

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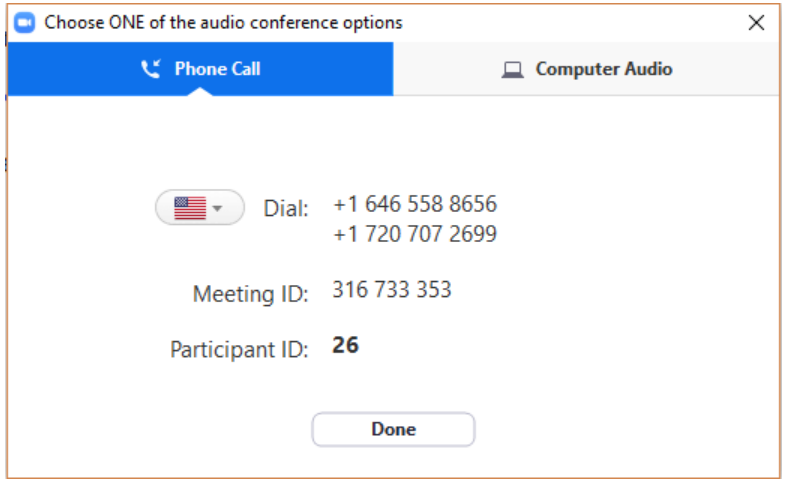
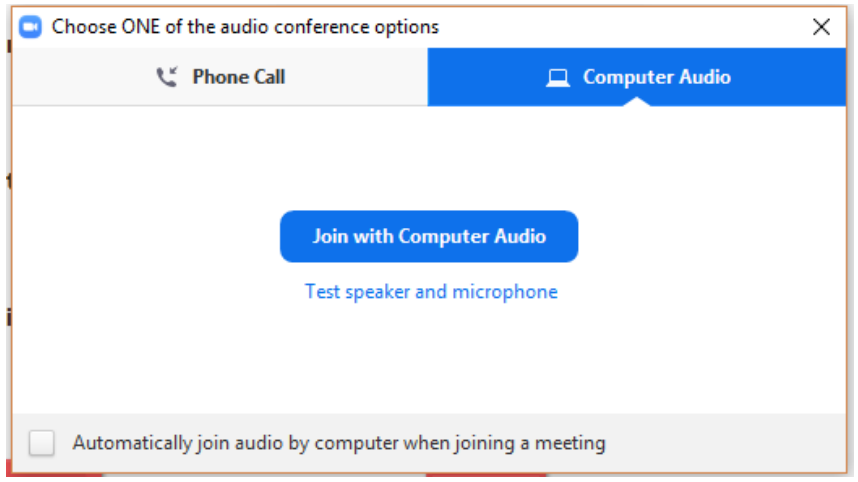
60 YEARS

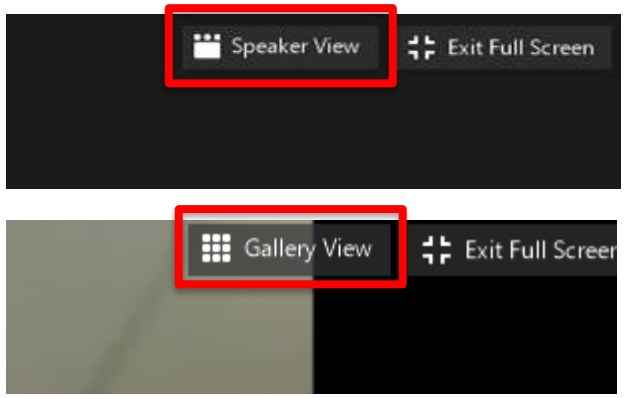
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

Zoom Logistics

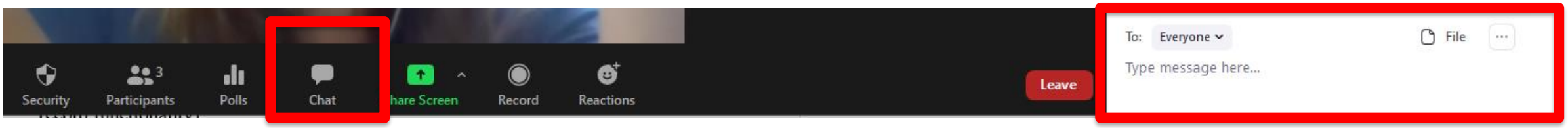
- Call in on your telephone, or use your computer audio option
- If you are on the phone, remember to enter your Audio PIN so your audio and computer logins are linked
- You may select “Gallery View” on the top right control panel to allow visibility of more attendees







How to Share a Question or Comment



Type in the chat box located at the bottom of your screen.

You can choose who to send a chat to.

Welcome Remarks

Chuck Ingoglia, MSW
President and CEO,
National Council for Behavioral Health

Brian Hepburn, MD
Executive Director,
NASMHPD

Rebecca Farley David, MPH
Senior Advisor, Public Policy and Special Initiatives
National Council for Behavioral Health

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Agenda and Overview

- **Welcome and overview**
- **Forecasting of behavioral health trends and data**
  - Kana Enomoto, Senior Expert at McKinsey & Company
- **State official perspectives**
  - Sonja Gaines, MBA, Deputy Executive Commissioner, IDD and Behavioral Health Services, State of Texas
  - Ann Sullivan, MD, Commissioner, Office of Mental Health, State of New York
  - Stephanie Woodard, PsyD, Senior Advisor on Behavioral Health, Department of Health and Human Services, State of Nevada
- **Questions and discussion**

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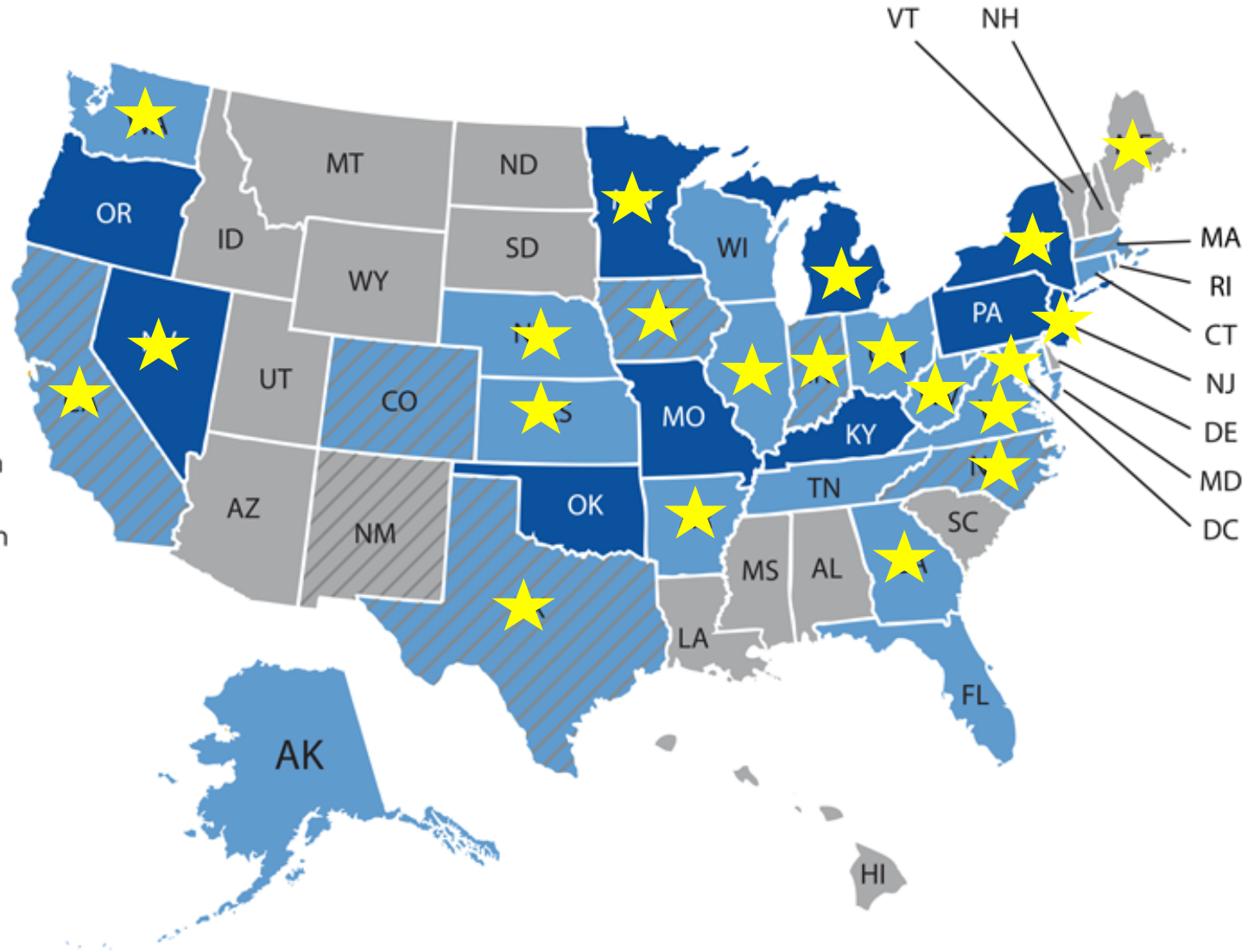
Status of Participation in the CCBHC Model

States selected for the CCBHC demonstration

States where clinics have received expansion grants

States eligible for participation in the demonstration under the Excellence in Mental Health and Addiction Treatment Expansion Act

There are **226 CCBHCs** in the U.S.



The CCBHC Perspective from State Officials

Sonja Gaines, MBA, *Deputy Executive Commissioner, IDD and Behavioral Health Services,* State of Texas

Ann Sullivan, MD, *Commissioner, Office of Mental Health,* State of New York

Stephanie Woodard, PsyD, *Senior Advisor on Behavioral Health, Department of Health and Human Services,* State of Nevada

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Perspective from Texas

Sonja Gaines, MBA
Deputy Executive Commissioner,
IDD and Behavioral Health Services
State of Texas

TEXAS
Health and Human Services

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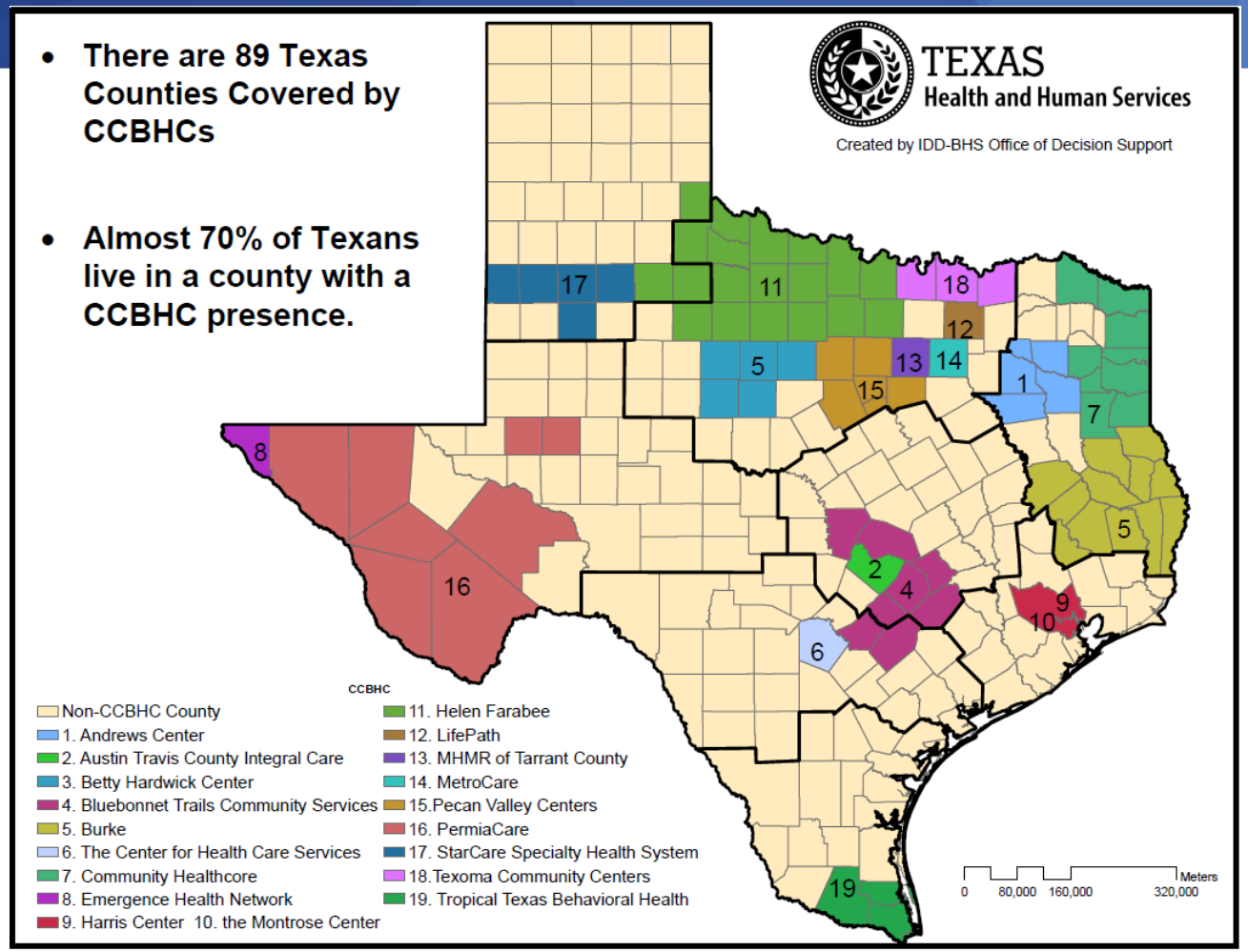
Building a Presence

TEXAS
Health and Human Services

- There are 89 Texas Counties Covered by CCBHCs
- Almost 70% of Texans live in a county with a CCBHC presence.



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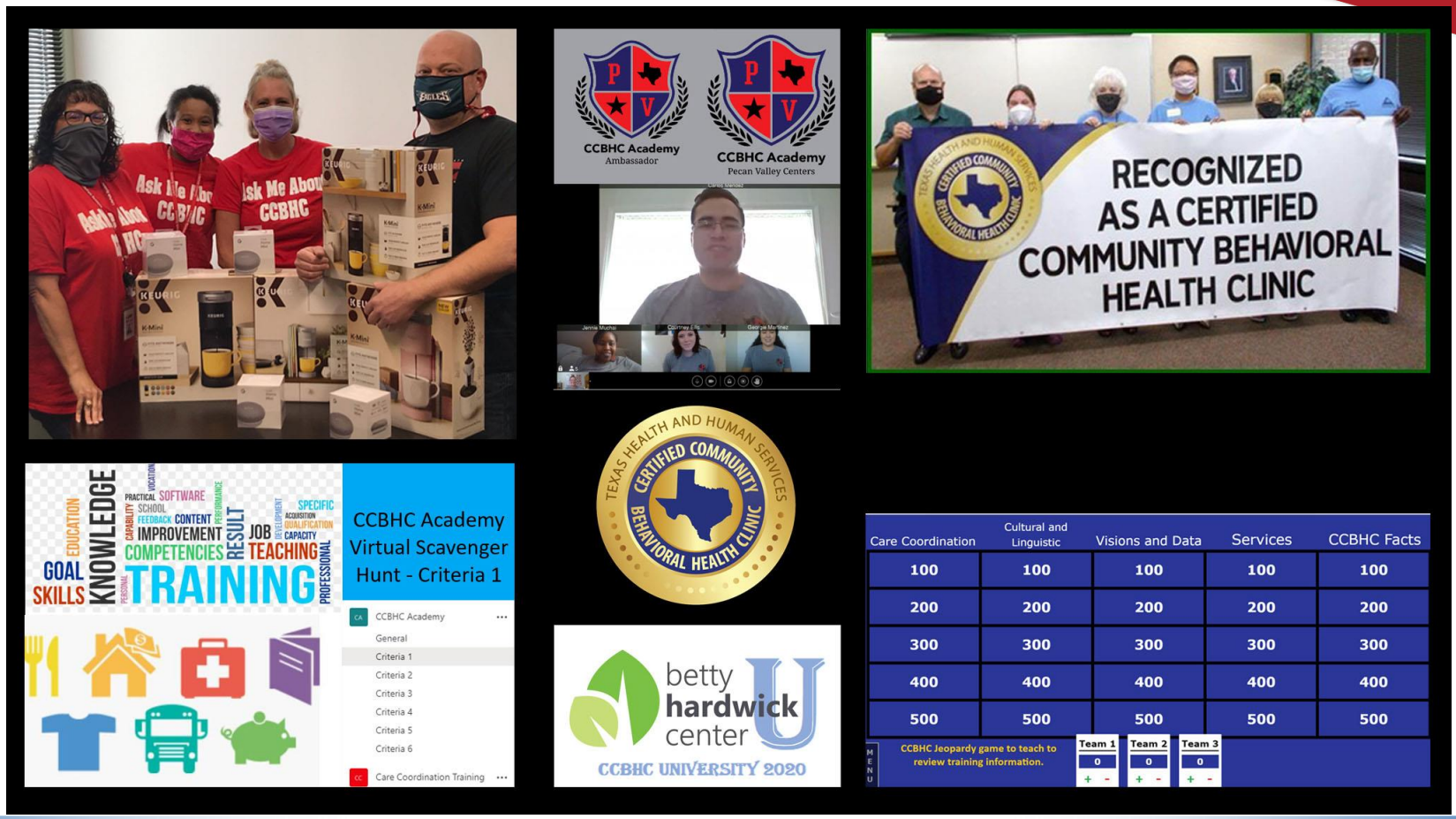
Building a Brand

TEXAS
Health and Human Services



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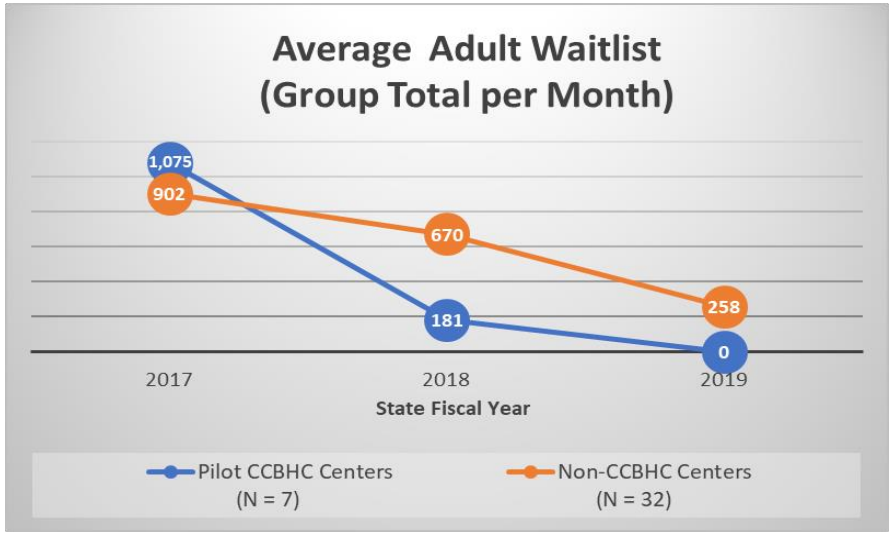
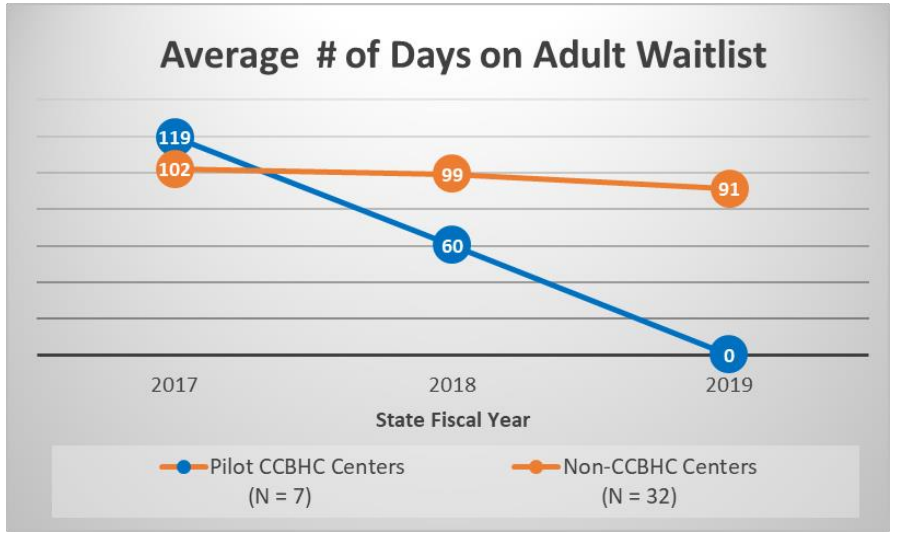
Early Outcomes

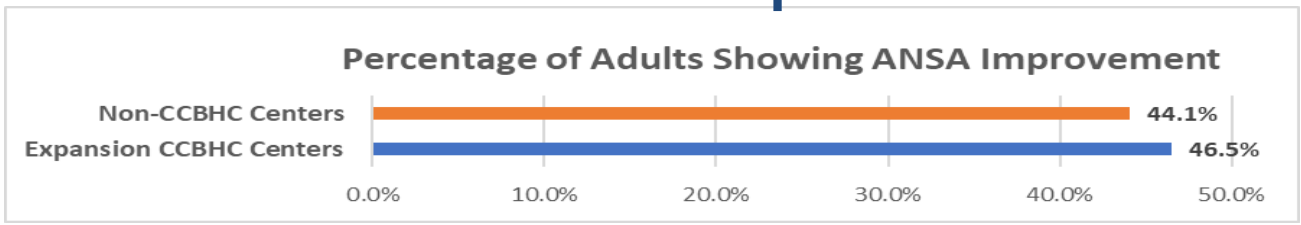
TEXAS Health and Human Services

Eliminated Adult Waitlists in Seven Pilot Sites





Adult Functional Improvement



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Guiding Principle

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In Texas, CCBHCs are built on a philosophy that emphasizes consistent quality, care coordination, and the best outcomes for our clients.

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Texas CCBHC Contacts

TEXAS Health and Human Services

Sonja Gaines, Deputy Executive Commissioner, IDD-BHS
idd-bhsdecoffice@hhsc.state.tx.us

mentalhealthtx.org

Jay Todd, Director, IDD-BHS Innovation & Engagement
jay.todd@hhsc.state.tx.us

Texas CCBHC Initiative
TexasCCBHCInitiative@hhsc.state.tx.us

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CCBHC Perspective from New York

Ann Sullivan, MD
Commissioner, Office of Mental Health
State of New York

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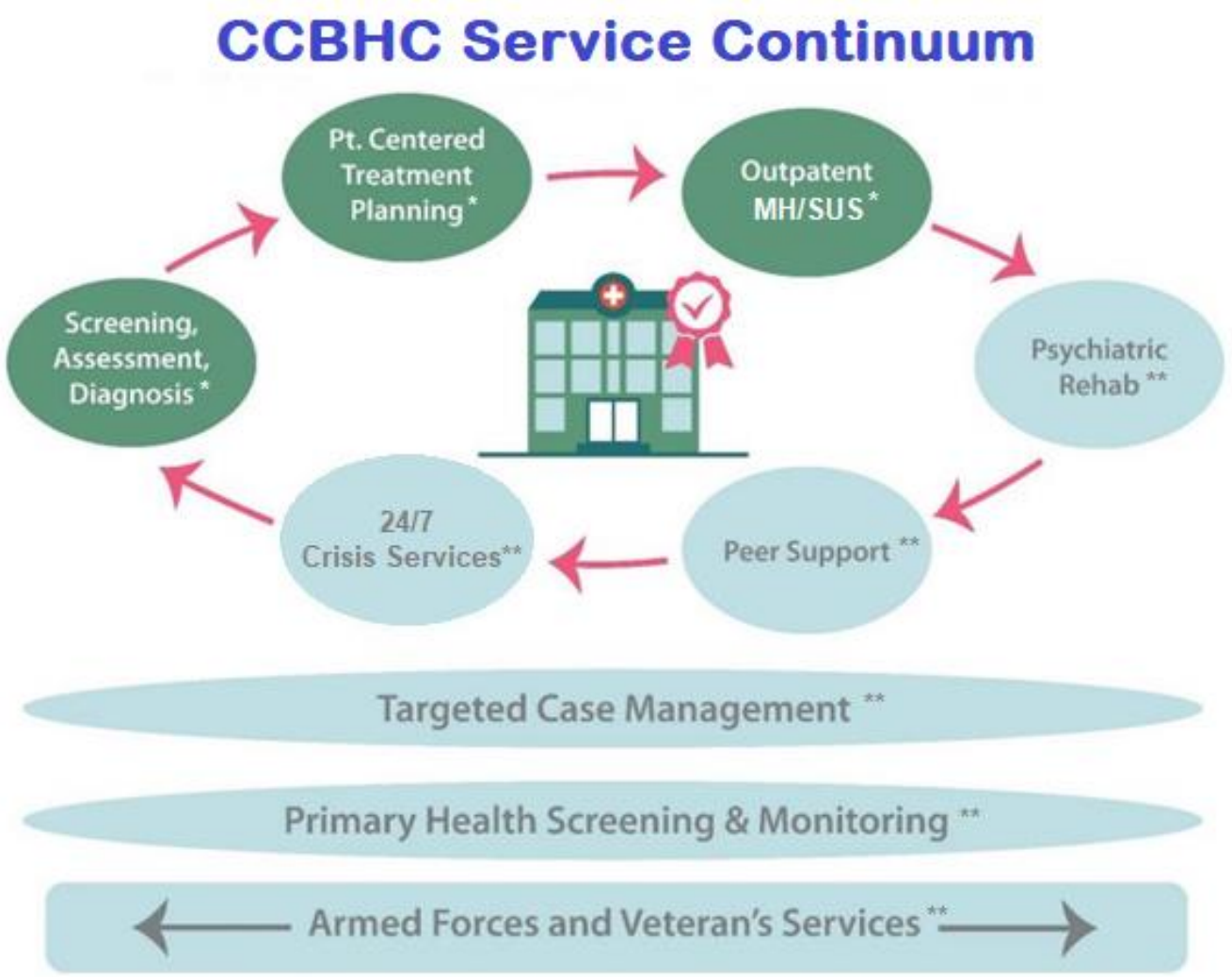
In NYS there are:

- 13 CCBHC programs as a part of the original demonstration; *and*
- 30 CCBHC Expansion Grantees



**CCBHC must directly provide*
***May be provided by Designated Collaborating Organization*

CCBHC Insights & Year 1 Outcomes: Access

- **Open access and immediate availability of services has virtually eliminated wait lists** and increased the number of individuals served by **21%**

- **Growth in the provision of children's and adolescents' services:**
  - 24% of all individuals receiving services were under age 22
  - Increase iOutreach and engagement of unserved/underserved populations increased
  - In home-based, school-based and crisis services for youth
  - 24% of individuals had not received a BH service in the previous year

- **CCBHCs are resourced to hire staff at a competitive salary** to meet community needs which leads to a more **stable and competent workforce**; especially helpful with children's services

CCBHC Insights & Year 1 Outcomes: Access

- Individuals receiving CCHBC services have **shown a reduction in the utilization of more costly inpatient and emergency services**
  - BH inpatient services show a 27% decrease in monthly cost
  - BH ER services show a 26% decrease in monthly cost
- **Physical Health Screening and active connection to primary care is critical**
  - Inpatient health services decreased 20% in monthly cost
  - ER health services decreased 30% in monthly cost

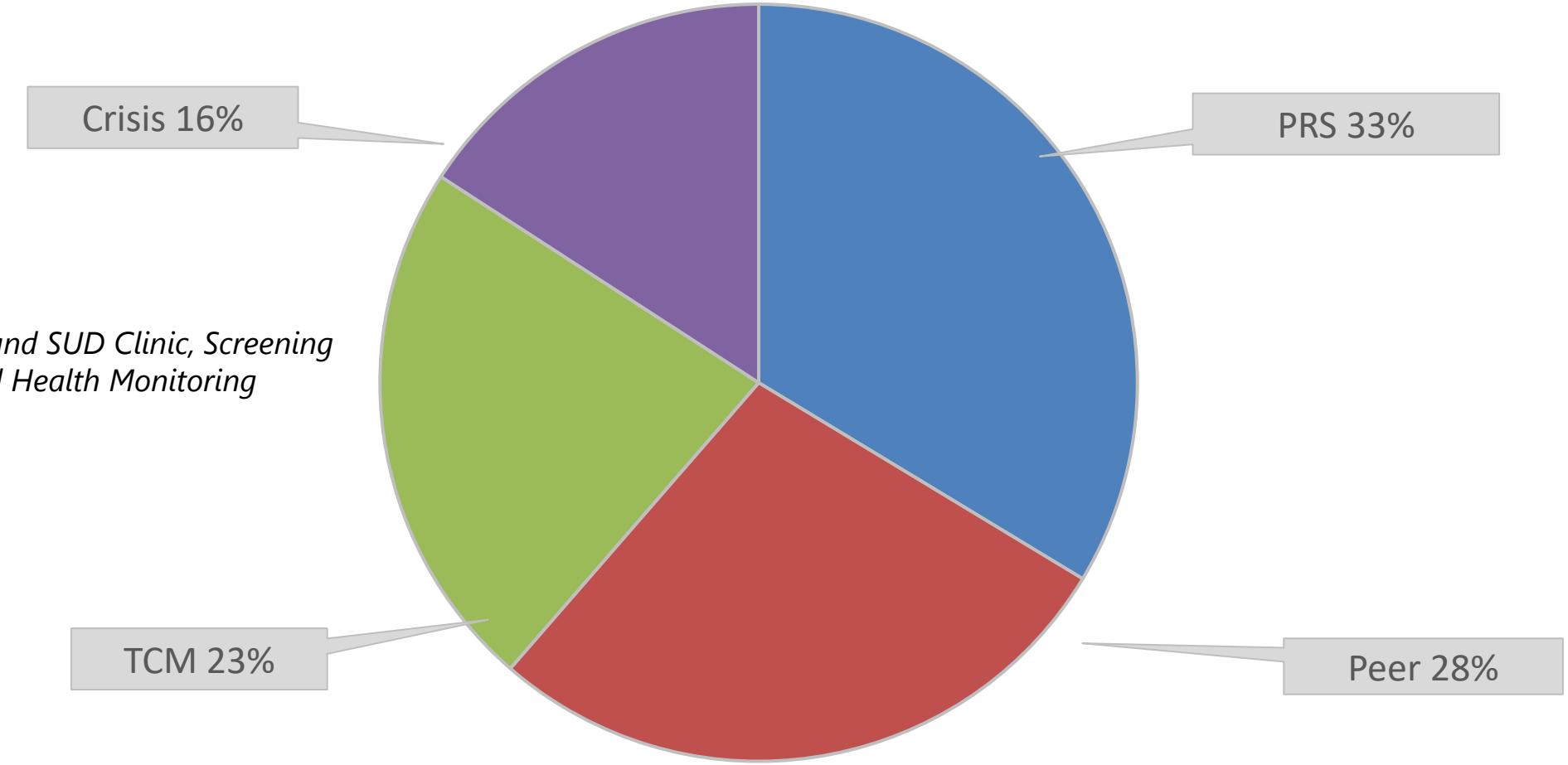
CCBHC Integrated Care

- In CCBHCs, 62% of individuals served were living with SMI, and 66% had a co-occurring substance use diagnosis
- Critical that programs have robust MH and SUD integration
  - To ensure this standard we assessed the degree of MH/SUD integration using SAMHSA's validated tool called the DDCMHT.
  - CCBHCs scored 4.26 out of 5 across 7 domains of integration. Non-integrated MH or SUD clinics would only score a 1 out of 5
- Improved care transitions and connections from increased access to care coordination
  - 81% of individuals received care coordination primarily to facilitate care transitions from inpatient departments, ERs, primary care and other community providers

CCBHC Insights: Engagement

- BH plan all-cause readmission rate dropped from **24% to 8% after the first year of CCBHC participation** (a 54% decrease)
- Crisis outreach and treatment re-engagement is provided by clinicians familiar with the individuals who were disengaged from treatment
- Several CCBHCs **developed significant coordinated efforts with police and judicial services** to engage justice-involved individuals and divert patients from ERs and inpatient units
- Peer and family support are integrated as a critical part of the person-centered and recovery-focused design of CCBHC program, introduced to everyone at intake, and can be received at any point during a treatment episode without the need for additional screening
- Care Coordination in person, active, going where the client is e.g. inpatient or ER or community to facilitate critical transitions in care

Distribution of Non-Clinic CCBHC Services



**Excludes MH and SUD Clinic, Screening Procedures and Health Monitoring*

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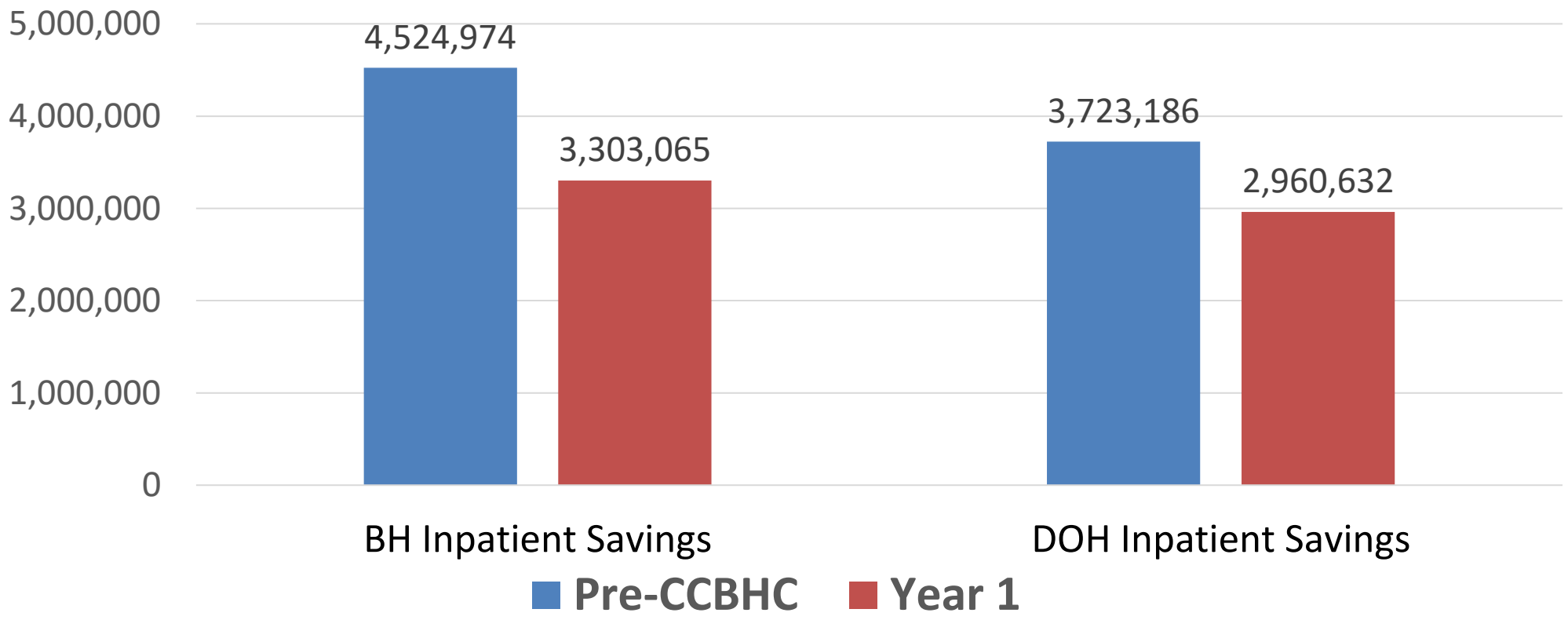
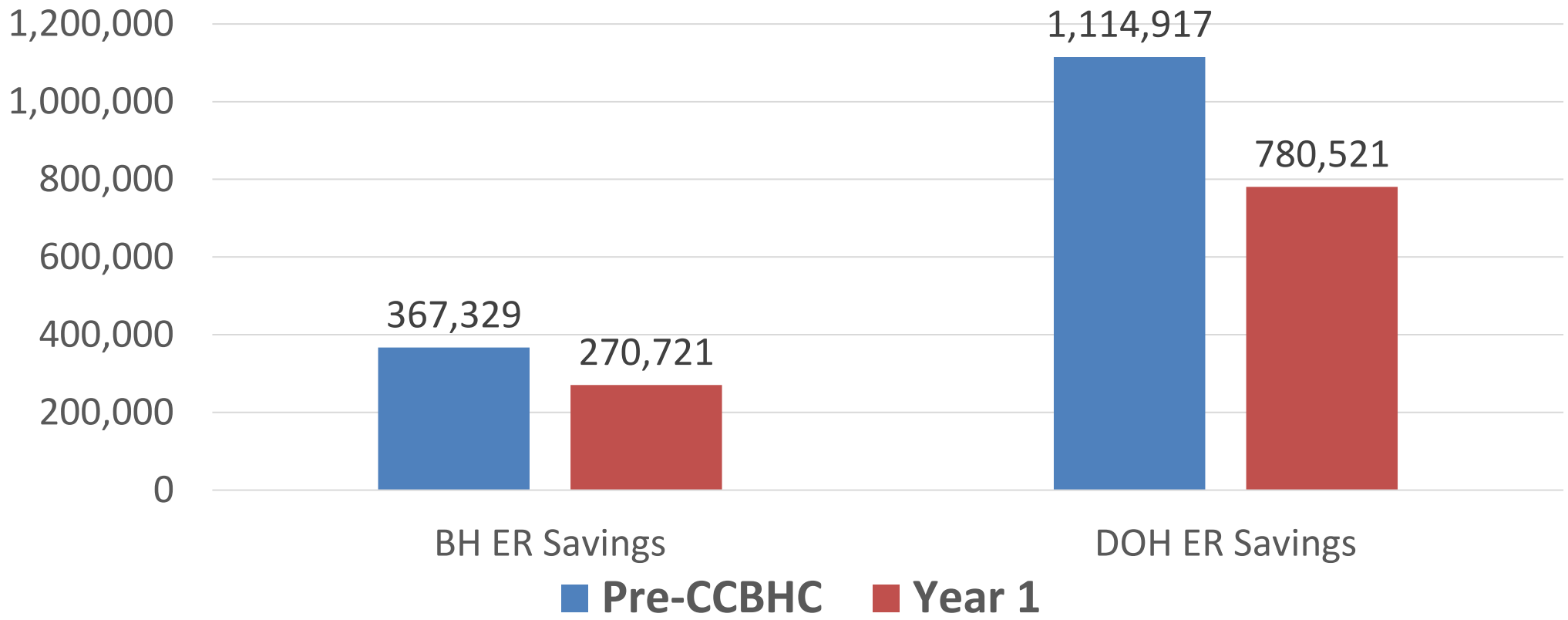
CCBHC Monthly IP Savings in First Year (in dollars)



- 27% decrease in BH Inpatient spend
- 20% decrease in DOH Inpatient spend

CCBHC Monthly ER Savings in First Year (in dollars)



- 26% decrease in BH ER spend
- 30% decrease in DOH ER spend

OMH/OASAS CCBHC Oversight

- Site visits to ensure compliance to CCBHC standards
  - Chart audits and staff interviews
  - Reports on results of visits with corrective action plan developed and monitored
- Evaluate compliance with CCBHC standards
- Multiple learning collaboratives
- Focus on facilitating best practices: Integrated Treatment, Psychosocial Rehab, Peer Support
- Medicaid data validation through matching of each provider's EHR data
- Monthly program oversight calls
- Dedicated finance staff to review CCBHC cost reports

CCBHC Financing: 13 Initial CCBHC's Established in Original State Managed Grant

- Key principles: **access to behavioral health care needed to be increased** to address unmet need and the behavioral health system needed comprehensive approach for accessing treatment
- NY State projected an increase from **$40 million spend to $80 million for these 13 sites** which was supported with enhanced federal match of 65% for NY (usually 50%) and projected savings
- Demonstration resulted in **significantly more growth (more than three-fold) at the CCBHC sites driven by unmet community need** and rates were rebased using actual costs which varied significantly
- With rebasing to cost and continuation of enhanced FMAP, NY projects the continuation of the current sites are **affordable as long as clinical and quality metrics are met**

Finance: CCBHC Medicaid Rates

A provider-specific daily rate that is cost-based and paid when an individual receives at least one eligible CCBHC service. The rate affords much flexibility in the delivery of care.

Challenges:

- The rate setting process is labor intensive requiring dedicated staff
- The year 1 rates were budgeted and incorporate both actual and anticipated costs and service volume when calculated
- The year 1 rates create the potential for surpluses or losses if the rates are not reconciled to actual cost and service volume
- Unlike FQHCs the CCBHC rate methodology does not include a mechanism to cover uncompensated care, although CCBHCs must serve all individuals regardless of ability to pay

NYS CCBHC Sustainability Plan If Model is Discontinued

- CCBHC State Plan Amendment: Pending with CMS enables continuity of care should the demo authority expire.
- New York is also using a 1915(b)(4) Selective Contracting Waiver to initially limit the SPA to the 13 original demonstration providers.
- Rate methodology is periodically updated and rebased using actual costs and trended prospectively within specific growth parameters.
- State contribution increases if Federal government discontinues enhanced FMAP adding to the challenge of expansion; future contribution to value-based payment arrangements that include bundled payments or modified risk arrangements would be considered as long as quality and array of services are maintained.

Takeaways of CCBHC Model

- The CCBHC program creates an effective and comprehensive model of care that when properly resourced can produce impressive clinical outcomes.
- Implementing such a robust program model requires constant monitoring and attention to ensure program fidelity
- Attention is needed when setting rates to facilitate economy and efficiency for providers
- Factoring in the enhanced Federal match, the CCBHC model requires increased State spend to address unmet need but real potential exists for future return on investment

Perspective from Nevada

Stephanie Woodard, PsyD
Senior Advisor on Behavioral Health
State of Nevada

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Transforming Nevada's Behavioral Health System

Why did your state pursue the CCBHC model?

- ✓ *Opportunity to increase access to high quality, integrated behavioral healthcare*
- ✓ *Accelerate innovation and maturing of the Nevada Behavioral Healthcare System*
- ✓ *Best practices for outpatient continuum*
- ✓ *Behavioral health/healthcare professional shortage areas*
- ✓ *Financing model, cost-based reimbursement*
- ✓ *Outcome-driven, patient-centered*

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Transforming Nevada's Behavioral Health System

What was your state's vision and how is that being achieved?

Demonstration Program Goal: Improve availability of, access to, and participation in services

- ✓ *Integrated care available in Urban, Rural and Frontier Regions*
- ✓ *Expanded from 3-10 clinics using Community Mental Health Block Grant (CMHS) funding*
- ✓ *Guided by the Readiness Assessments and Dual Diagnosis Capability Toolkits*
- ✓ *Crisis System Essentials*
- ✓ *Evidence-based practices to scale (Safer Suicide Care, ACT, MAT, Peer Recovery Supports, Targeted Case Management, Psychiatric Rehabilitation (BST/PSR)); Technical Assistance/Training*
- ✓ *Expansive target populations*
- ✓ *Emphasis on outcomes and engagement; quality not quantity*

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Transforming Nevada's Behavioral Health System

What process did you choose to pursue CCBHCs (e.g., 1115 waiver, 1915(b) waiver, or a SPA)?

✓ *State Plan Amendment*

Any barriers or facilitators in pursuing it?

✓ *Leadership and a culture of excellence*

✓ *All services were already in the state plan*

✓ *We had expanded from 3-10, statewide access*

✓ *Fee-For-Service, move toward Managed Care*

✓ *Multidisciplinary team approach*

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Transforming Nevada's Behavioral Health System

What data can you share about CCBHC success? Any particular stories?

- ✓ *Increased access to children's behavioral health services, MAT, primary care*
- ✓ *No waitlists for care*
- ✓ *Coordination between law enforcement and centers; reduced transport to ER's and jail*
- ✓ *Increased workforce statewide*

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Transforming Nevada's Behavioral Health System

What advice would you give to other commissioners considering CCBHC implementation?

- ✓ *Build upon your strengths and be bold in addressing your weaknesses*
- ✓ *Ensure you have expertise across your team*
- ✓ *Engage stakeholders including individuals and families with lived experience when considering your design*
- ✓ *Invest in your partnerships*

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Planning and Implementation

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Questions and Discussion

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CCBHC Success Center (link)

Thank You!

Contact us: CCBHC@TheNationalCouncil.org

Please take a moment to share your feedback in the post-session survey.