ADMH
Alabama Department
of Mental Health
connecting mind and wellness

Certified Community Behavioral Health Clinics

The New Landscape for BH in Alabama

Part 1

TODAY'S AGENDA

- Part 1
  - What are CCBHCs?
  - How CCBHCs are different
  - Q&A
- Part 2
  - CCBHC Requirements
    - Federal
    - State
  - Alabama Vision for CCBHCs
  - Case Scenarios
  - Q&A

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QUESTIONS AND ANSWERS

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- We will answer as many as possible during the webinar and post a recording of the session on the ADMH website.
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POLL

Take a moment and rank your understanding of the CCBHC model on a scale of 1-5

STATE OF BEHAVIORAL HEALTH IN ALABAMA

Rates of SMI/ SED/ SUD higher than national avg

Fragmented Care

Few resources for physical health + SDOH

Youth Mental Health Crisis

Rural areas face significant barriers to accessing care

No coordination btwn MH, SUD, PH

BH Workforce Crisis

Large disparities in care & OUD ED use for African Americans

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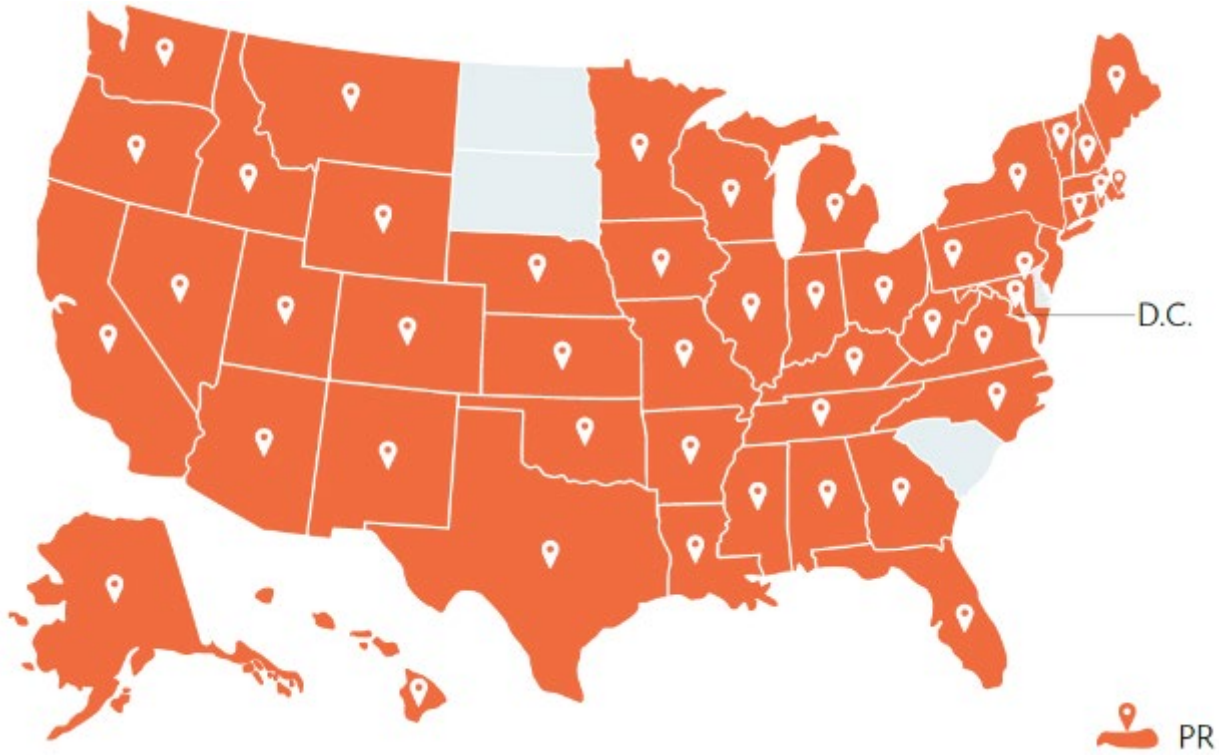
GOALS OF THE CCBHC INITIATIVE

- Expand Community-Based Services
- Enhance care coordination
- Improve Integration with Medical Care
- Expand use of Evidence Based Practice
- Improve Access to High-Quality Care
- Improve Data Collection
- Target people with SMI, SED, and significant SUD while serving the whole community
- Track and reduce disparities
- Involve the community, including those experiencing disparities, to be part of program design

NATIONAL IMPACT – RAISING STANDARDS OF BH CARE

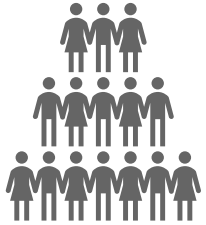
- Today, there are 495 CCBHCs in 46 states, plus Washington, D.C. and Puerto Rico, covering 62% of the nation's population.



https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/

IMPROVED ACCESS TO CARE

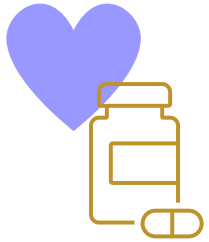
People



33%

Increase in individuals served

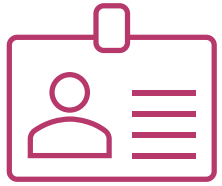
SUD



68%

Report increase in clients engaged in MAT

Workforce



15

New positions hired per clinic (median)

Crisis

29%

Added Mobile Crisis Response

SDOH

81%

Screen for unmet social needs

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https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/

IMPROVED COORDINATION & COLLABORATION

Primary Care

>20%

Increase in primary care referrals

Criminal Justice

98%

Partnering with criminal justice agencies

Children & Families

83%

Provide on-site school services

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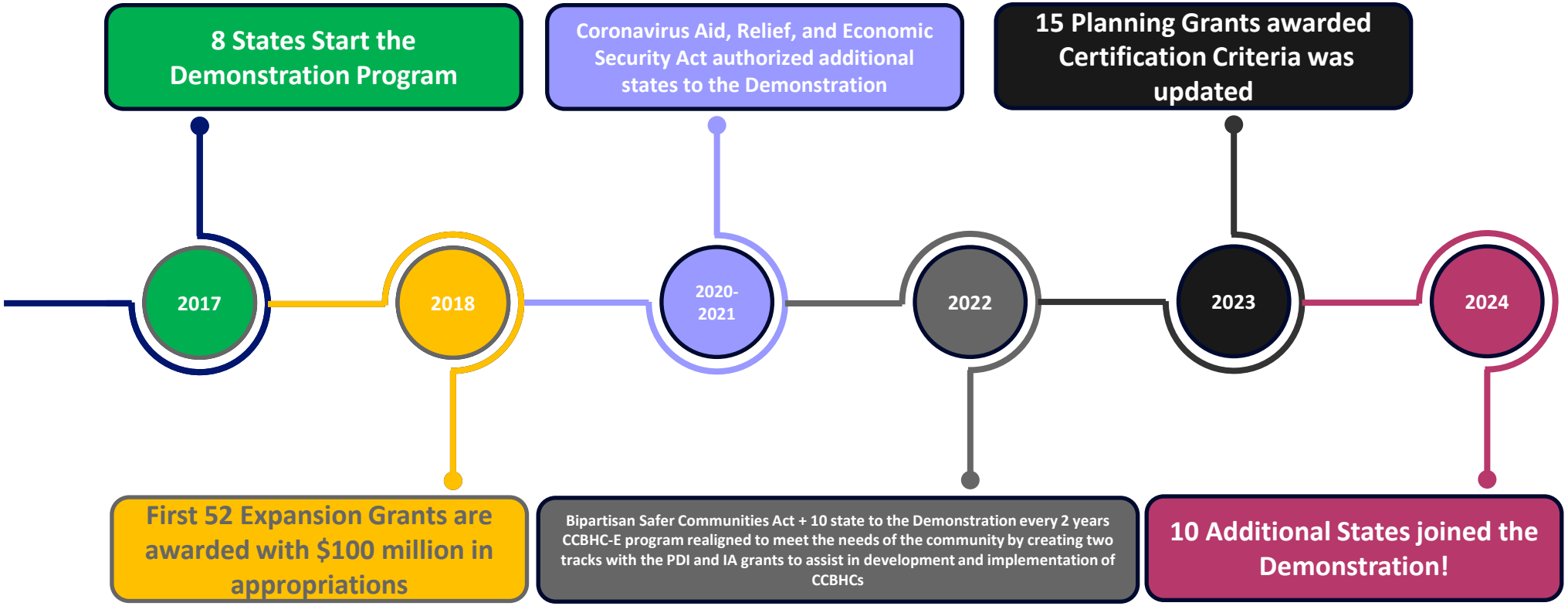
https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/

THE MODEL KEEPS GROWING



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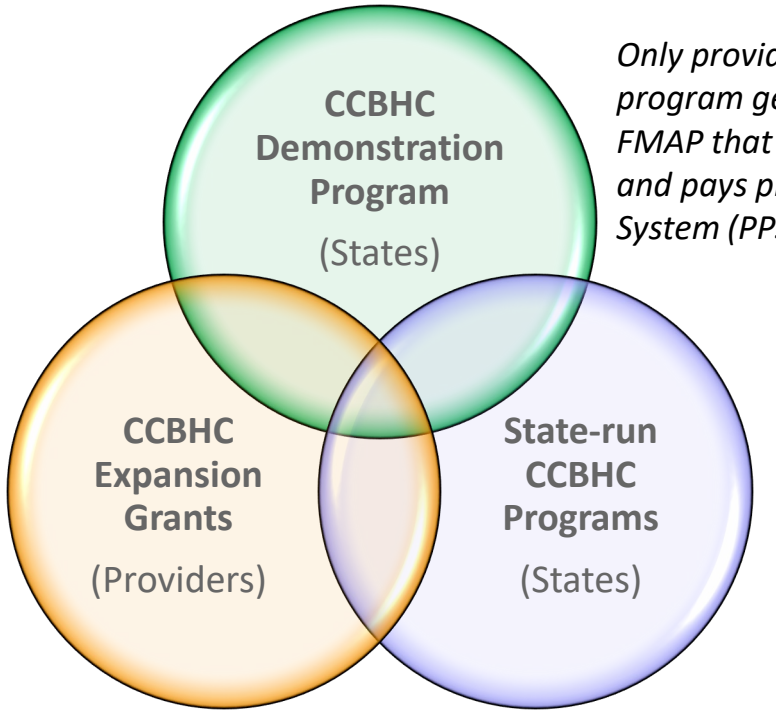
CCBHC STRUCTURE: THE FEDERAL MODEL WITH FEDERAL REQUIREMENTS

TYPES OF CCBHC PROGRAMS

*Our Nation's Biggest Investment Ever in Expanding **and** Sustaining Mental Health and Substance Use Care*



Only providers in the CCBHC Demonstration program generate the enhanced Medicaid FMAP that the State Medicaid agency receives and pays providers via a Prospective Payment System (PPS) rate

CCBHC-Expansion Grantees rely on discretionary grant funding to deliver CCBHC services

States use Medicaid state plan or 1115 demonstration authority

All use (and build on) the same national CCBHC Criteria, with some distinctions.

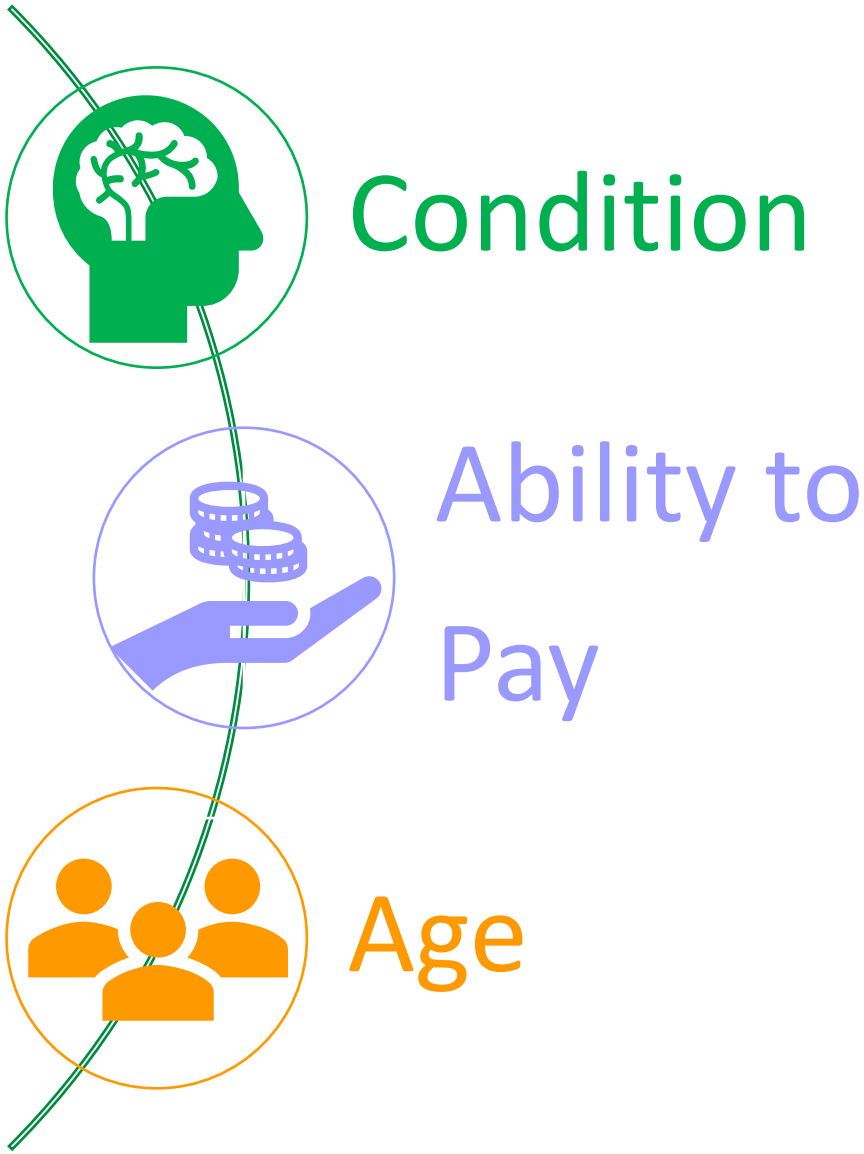
DEMONSTRATION VS. EXPANSION

National model with federal accountability

	Demonstration	Expansion
Reimbursement	Prospective Payment System Enhanced Federal Match for States Provider Accountability for Medicaid $	Grant Funding
Authority	State Government with Federal authority & accountability	Federal Government
Quality	Clinic Collected and State Collected Quality Measures Quality Bonus Program*	National Outcomes Measures (NOMs) SPARS Clinic Collected Quality Measures*
Certification	State Certification Process	Self Certification
Oversight	State Mental Health Authority	SAMHSA Grant Program Office
Standards	113 Standards + Any Applicable State Certification Requirements	113 Standards

CCBHCS ARE FOR EVERYONE WHO NEEDS THEM

CCBHCs must provide services to anyone seeking help for a mental health or substance use condition **regardless of:**

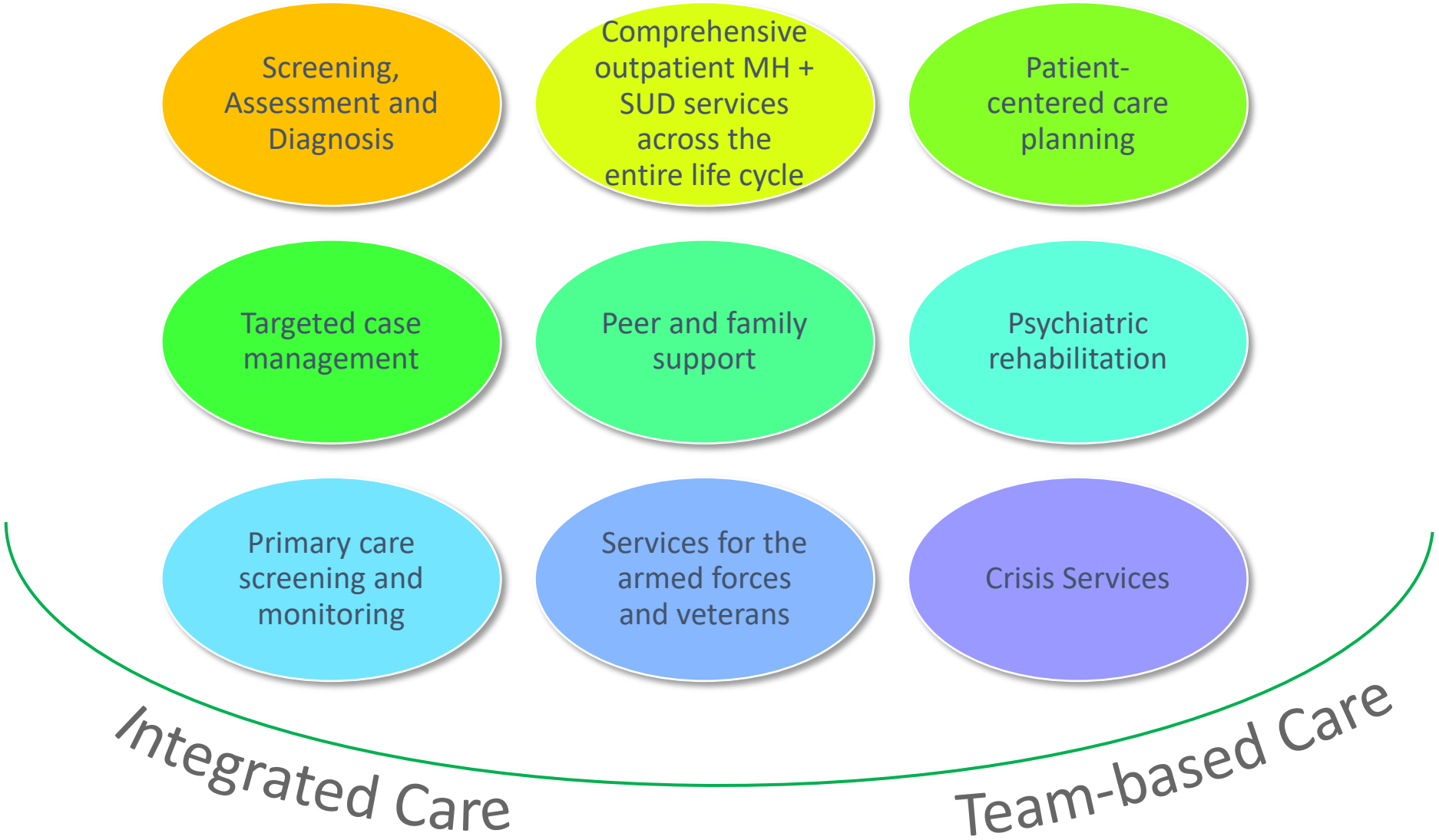


MINIMUM STANDARDS

The Federal Protecting Access to Medicare Act (PAMA) establishes 113 standards in six areas that an organization must meet to achieve CCBHC designation:

- Staffing
- Accountability
- Care Coordination
- Service Scope
- Quality/Reporting
- Organizational Authority

NINE REQUIRED SERVICES WITH REQUIRED APPROACHES



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DESIGNATED COLLABORATING ORGANIZATION (DCO)

- A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers core services under the same requirements as the CCBHC

- A CCBHC can use a Designated Collaborating Organization (DCO) to provide up to 49% of the required service encounters

POLL

Which of the following CCBHC services or care approaches does your organization need the most support to implement effectively?

(check all that apply)

PROSPECTIVE PAYMENT SYSTEM (PPS) RATE EQUATION

$$\frac{\text{Total allowable CCBHC costs of providing services to all patients each year}}{\text{Total number of CCBHC daily visits each year}} = \boxed{\text{Medicaid payment rate for each daily visit}}$$

This calculation results in the same payment amount each day, regardless of the intensity or type of services that are provided that day

ADMH has selected PPS-1: Single **daily** "threshold" rate based on encounters that pays for the "cost" of all CCBHC services.

HOW THE PPS RATE CAN CHANGE SERVICE DELIVERY

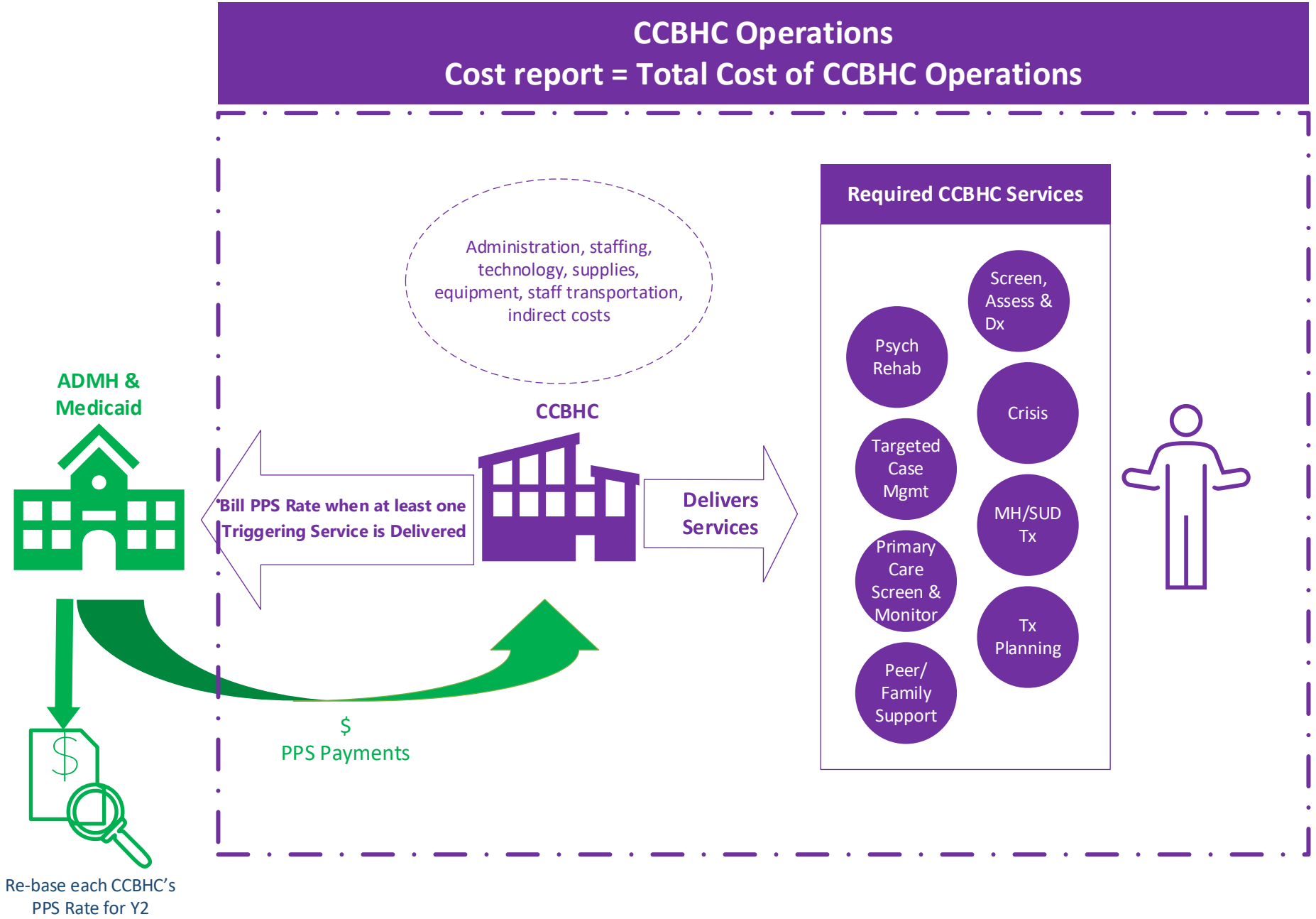
"Allowable CCBHC Costs" include:

- Direct costs related to anticipated CCBHC services and activities (e.g., staff salaries, care coordination activities, costs of services provided under agreement/contract, medical supplies, professional liability insurance, etc.)
- Allocation of overhead, indirect costs
- Costs paid to DCOs to deliver CCBHC services
- Additional anticipated costs to serve increased # of individuals

"Total Number of CCBHC Visit Days" include:

- All visit days for CCBHC services (not just those covered by Medicaid)
- Visits provided directly by CCBHC staff and from DCOs
- Projected increase in number of individuals served/service days (if applicable)

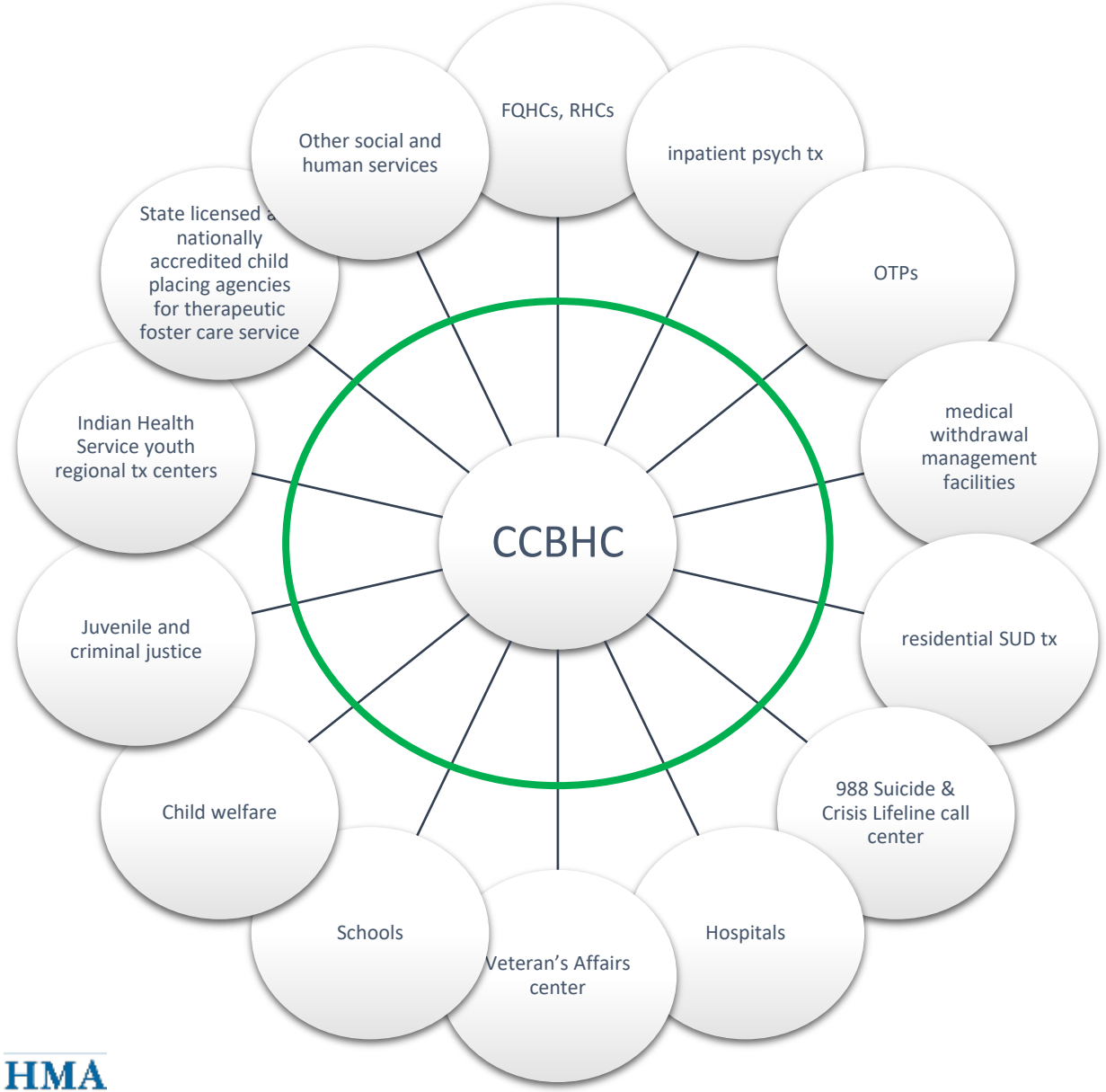
PPS creates incentives for care efficiency, quality, and comprehensive service delivery.


CCBHC Operations
Cost report = Total Cost of CCBHC Operations
Administration, staffing, technology, supplies, equipment, staff transportation, indirect costs
Required CCBHC Services
Screen, Assess & Dx
Psych Rehab
Crisis
Targeted Case Mgmt
MH/SUD Tx
Primary Care Screen & Monitor
Tx Planning
Peer/ Family Support
ADMH & Medicaid
CCBHC
*Bill PPS Rate when at least one Triggering Service is Delivered
Delivers Services
$
PPS Payments
Re-base each CCBHC's PPS Rate for Y2

STRENGTHENING COMMUNITY PARTNERSHIPS THROUGH CCBHCS

Required Partners	Community Providers & Supports, i.e.,	Partners based on needs of population served &/or experiencing disparities, i.e.,
• FQHCs, RHCs • Inpatient & residential SUD programs, OTPs, detox • Dept of Veteran's affairs centers & clinics • EDs, inpatient acute care hospitals, outpatient clinics	• Schools • Child Welfare, foster care agencies • 988, Crisis Lifeline • Juvenile, Criminal Justice • Other social & human services	• Specialty providers for MAT • Homeless shelters • Housing agencies • Employment services • Aging & disability resource centers

CCBHC CARE COORDINATION



Not just referral relationships…

Required Partnerships

Formal Agreements

Health Information Exchange

Protocols for Care Transitions

Active post-discharge follow-up

Interdisciplinary treatment team

Includes person/family caregiver

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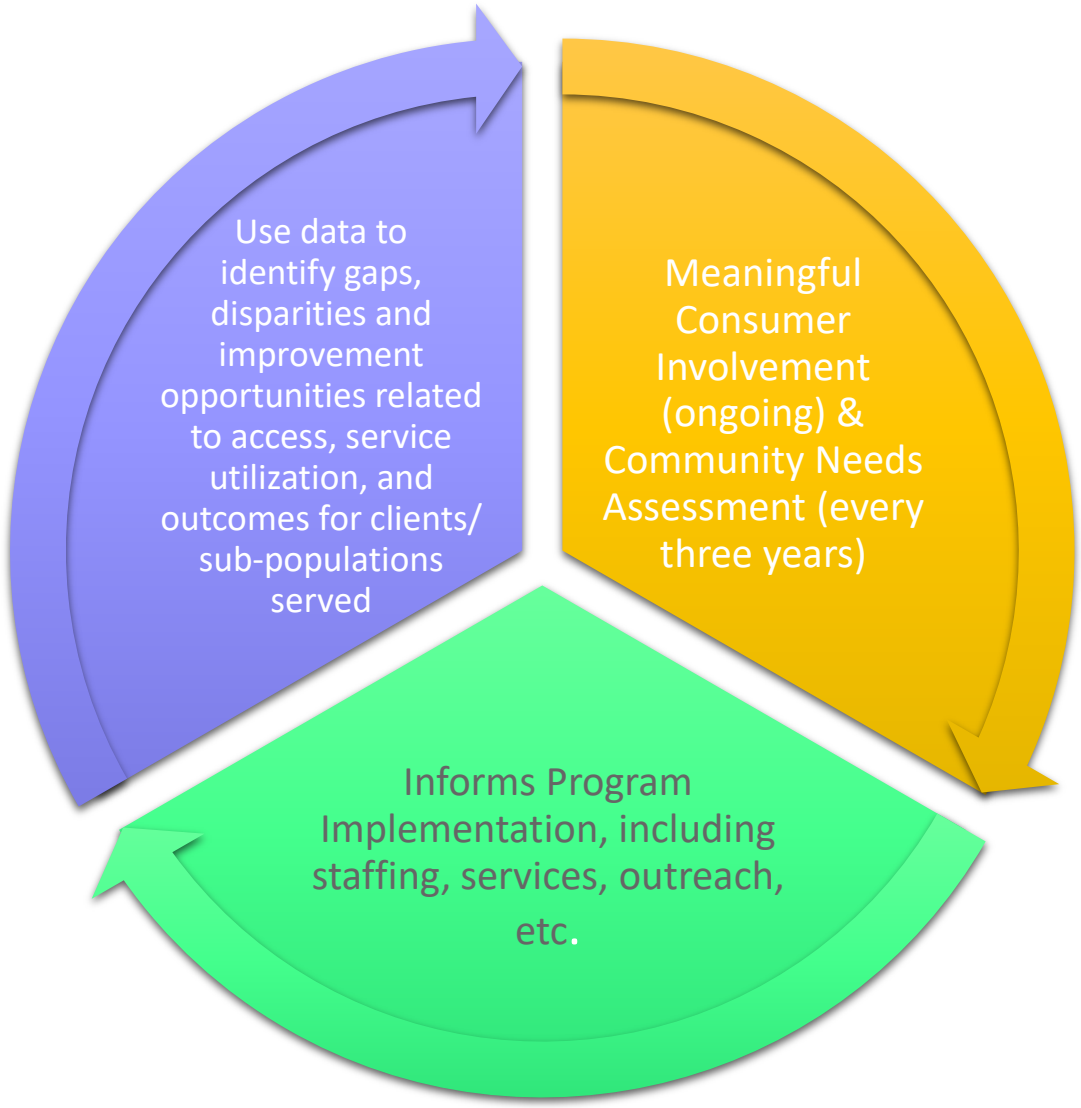
Continuous Quality Improvement:

CCBHCs rely on consumer input, needs assessment, and program data to continuously improve



DISPARITY REDUCTION

- Disparity reduction is a primary focus of the CCBHC model
- CQI regarding disparity reduction is **required**

» "The **CQI plan includes an explicit focus on populations experiencing health disparities** (including racial and ethnic groups and sexual and gender minorities) and addresses how the CCBHC uses disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health disparities." (5.b.3)

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CMS HEALTH EQUITY FRAMEWORK IN PRACTICE

DISPARITIES

How does your organization disaggregate data to understand the unique experiences and outcomes for subpopulations?

LANGUAGE/CULTURE

Has your organization embraced CLAS standards for service accessibility and delivery of culturally sensitive and responsive services?

DATA

How timely is your transfer of EHR and patient claims data?

How do you document Race, Ethnicity, language, or disability (REL-D) - and guarantee data integrity? How will you collect Sexual Orientation and Gender Identity (SOGI) data?

CAPACITY

How does your organization build capacity in the organization, its workforce, and partners to address racial disparities?

ACCESSIBILITY

How can you make care and connections to coverage more accessible for your patients?

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CLAS: CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

National Standards:

- **Quality:** Care and Services that are Responsive to the Diverse cultures in US communities
- **Reduction of Disparities:** Reducing persistent health disparities experienced by racial, ethnic, linguistic, sexual and gender minorities
- **Respect and Responsiveness:** Respect the whole individual and Respond to the individual's health needs and preferences

WHY CLAS MATTERS:
INFLUENCE ON HOW AN INDIVIDUAL SEEKS TREATMENT

- **Distinctions** (or lack thereof) between mental and physical health
- **Symptom presentation**, e.g. somatic vs cognitive
- **Timeliness of Care/Acuity** of need at time of presentation
- Shame, **stigma**, "loss of face," fear of revisiting events
- **Collective/Historical/Inter-generational trauma**
  - Includes mistrust of providers
- Differences in **coping and resiliency**

- **Social constructs** (i.e., gender, race, and ethnicity) impact individuals psychologically.
- Having **multiple identities** leads to an individual experience and may lead to unique types of oppression (code switching)
- **Therapeutic alliances** may be improved when staff/clinicians acknowledge and understand patient experiences and the impact of co-occurring characteristics of identity
- **Cultural awareness** will help staff and clinicians identify the most sustainable approach, modality, and engagement strategies for patients and their collateral supports

POLL

Take a moment and rank your understanding of the CCBHC model on a scale of 1-5

QUESTIONS

ADDITIONAL TUESDAY TA SESSIONS

- Orientation Part 2
- Primary Care Screening & Monitoring and Best Practices for Integration
- Care coordination & Case Management
- CCBHC Billing & Service Activities, incl Triggering Events
- Certification Process and Timeline
- Quality and Reporting

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FEDERAL VS. STATE REQUIREMENTS

FEDERAL VS. STATE REQUIREMENTS UNDER DEMONSTRATION

Federal Requirements

113 minimum standards

9 required services

Serving all ages, regardless of condition and/or ability to pay

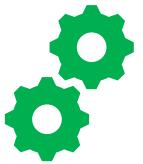
Medicaid Compliance enforcement

State Requirements & Policies

Triggering events codes

Data submission & reporting processes

Oversight & Monitoring processes



CCBHC Policies & Procedures

Program Design

Medicaid compliance accountability

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CCBHCS ARE NOT 'BUSINESS AS USUAL'

- Transitioning from a discreet program to a one-stop hub of integrated care
- Integrated care includes services outside of the clinic's 4 walls
- Care coordination to truly support whole-person care
- Measurable outcomes and disparity reduction
- Meaningful, two-way, community communication and input into program design
- New accountability for Medicaid dollars

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THE PAYOFF

For consumers and families:

Timely access to high quality, comprehensive, data-driven, evidence-based, person-centered, coordinated, and integrated care across the lifespan

For providers:

The payoff for providers engaging in the Demonstration is a sustainable Prospective Payment System (PPS) rate for their services, a Cost+ reimbursement methodology

For States:

Participation in the federal demonstration program enables states to access enhanced Federal Medical Assistance Percentages (FMAPs) for CCBHC services

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ALABAMA VISION FOR CCBHCS

ADMH GOALS FOR CCBHCS

Improve availability of, access to, and participation in services

- Address workforce crisis
- Improve business as usual BH practices
- Help people identify and access the full array of services needed to support their recovery
- Involve the community in the design of BH programs

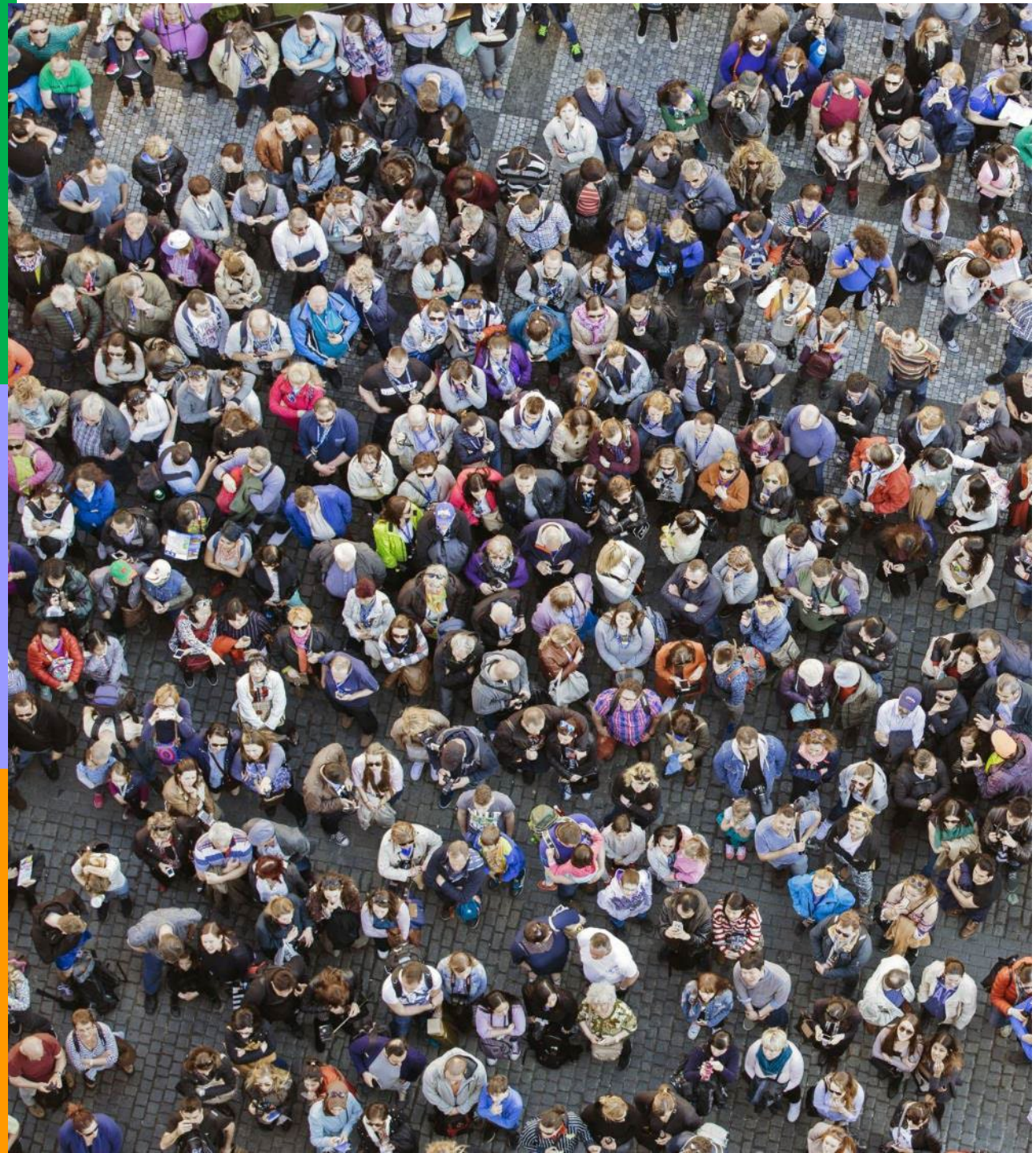
Provide the most complete scope of services required in the CCBHC Criteria

- Leverage telehealth for rural communities
- Expand outpatient SUD services
- Expand mobile crisis services
- Enable reimbursement for psychiatric rehabilitation

Improve quality of Behavioral Health services for whole-person care

- Integrate MH, SUD, physical health care
- Provide services to address social determinants of health
- Strengthen care and outcome monitoring through improved data collection
- Meaningfully track and address disparities

Services & access go beyond clinic 4 walls



ALABAMA'S DEFINED POPULATIONS OF FOCUS

- All ages, races, ethnicities, genders, disability statuses, sexual orientations, and gender identities with SED, SMI, SUD, opioid use disorder (OUD), and co-occurring mental and substance disorders (COD), and those with or at risk of HIV and Hepatitis C due to injection drug use.

- Priority Populations & Disparities
  - People with OUD with emphasis on the African-American population
  - Pregnant and Parenting Women (PPW)
  - People experiencing homelessness.

CMHCs

Model of Care Delivery is unique to each CMHC

All ages
All severities

All payers (or none)
All geographies

CMHC

Community Partners

Screening, Evaluation

Those with **crisis** needs are served within 3 hours via BH crisis services, including mobile crisis

MH Treatment

SUD Treatment

Whole Person, Person-Centered

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CCBHCs

Model of Care Delivery is standardized across all CCBHCs, with data reporting and quality monitoring requirements

All ages
All severities
All diagnoses

All payers (or none)
All geographies

Outreach & Engagement

Formal Partnerships for Care Coordination

Designated Collaborating Organizations

CCBHC

Formal Partnerships for Care Coordination

Community Partners

Screening, Evaluation, **Triage**

Those with **crisis** needs are served within 3 hours via BH crisis services, including mobile crisis

Those with **urgent** needs are served within 1 business day usually via Open Access

Those with **routine** needs are served within 10 business days via clinic services

9 core services with specific requirements for Whole Person, Person-Centered, Team Based care

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CASE SCENARIOS

CCBHCS TRANSFORM BH CARE NATIONAL COUNCIL FOR MENTAL WELLBEING

- *Scenario: Mary is hearing voices and doesn't know where to get help, so she turns to opioids to help dull the problem.*

Emergency Response	Mary develops an opioid addiction and overdoses. Emergency responders are called.
Hospital	Mary is revived with naloxone and discharged from the hospital with a referral to a community provider.
Failed MAT attempt	Mary attends the appointment but the provider cannot issue a prescription for MAT and makes a referral to a MAT clinic 2 hours away.
SUD worsens	Mary gets worse and never makes it to the MAT clinic. She resumes opioid use and begins drinking alcohol.
Law Enforcement	Mary causes a public disturbance while intoxicated and experiencing a mental health crisis. The police are called and Mary spends the night in jail detoxing.
Delayed services	Mary is released from jail the next day and referred for substance use disorder (SUD) services, but there is a six-week wait for an appointment.
Crisis cycle	Mary continues a dangerous downward spiral, prompting continued interaction with law enforcement and ED professionals.

Preventive Outreach	**Mary is contacted by a care coordinator working with the hospital and the local CCBHC as part of routine community outreach to opioid users.**
Prompt service access	**Outreach worker schedules a same day appointment for Mary at the CCBHC.**
Transportation	**Mary is transported to the CCBHC where MAT is prescribed and administered immediately.**
Appropriate MH screening	**The CCBHC also conducts a mental health screening, which determines Mary is experiencing a first episode of psychosis.**
Treatment Planning	**A psychiatric treatment plan is developed and a care team is assembled with follow-up plan in place.**
Care coordination	**Mary's outreach manager ensures she has what she needs to attend appointments (transportation, access at convenient times, etc.) and maintain her treatment plan.**
Improved Outcome	**Mary is stabilized and maintains her treatment plan and no longer requires urgent or high intensity services.**

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https://vitalityunlimited.org/wp-content/uploads/2020/06/2020-VU-CCBHC-IMPACT-REPORT.pdf

2024 CCBHC IMPACT REPORT NATIONAL COUNCIL FOR MENTAL WELLBEING

"Since we are considered a frontier community, it has **decreased waiting times, allowed same-day crisis interventions, and provided community-based support …** for the severely mentally ill. It has provided the spectrum of complete behavioral health in a frontier rural community." — Vitality Unlimited, Nevada (Medicaid CCBHC)

"Our previous model did not allow adults seeking services to receive access to medications at the intake appointment. We have been able to alter this process to where those seeking services' initial visit is with a psychiatrist and they are able to **receive prescriptions the same day**." — Starcare Specialty Health System, Texas (Medicaid CCBHC)

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https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/

2024 CCBHC IMPACT REPORT NATIONAL COUNCIL FOR MENTAL WELLBEING

"Being able to provide MAT has promoted access and success for those we serve. The program **has improved communication about individuals transferring from jails and other programs to promote a seamless transition to therapy and MAT care**. **Peer recovery coaches** play an integral role in increasing access as well, by providing supportive transportation alongside support and guidance." — Community Mental Health Authority of Clinton-Eaton-Ingham, Michigan (Medicaid CCBHC)

"We've been able **to offer better salary** that has assisted us in hiring and retaining staff. We've had approximately 20 former staff return to our agency that had previously left due to salary." — Bert Nash Community Mental Health Center, Kansas (Medicaid CCBHC)

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2024 CCBHC IMPACT REPORT NATIONAL COUNCIL FOR MENTAL WELLBEING

"Providing **comprehensive integrated care** — including care coordination — has had a positive effect on our client population. We see increased awareness of physical health needs as a result of added screenings, increased knowledge of resources available at Burke and outside of Burke, and improved ability to navigate the health care system. These all lead to a greater level of follow through for addressing physical health needs and ultimately improved health for our clients." — Burke Center, Texas (Medicaid CCBHC)

"For a small, rural community mental health agency, we have been able as a CCBHC to sustain a **24/7/365 mobile crisis team** that serves all ages, regardless of insurance. As a result, we have then been able to meet the increased need for services through **Same Day Access, increased MOUD services, doubled our staff** to decrease wait times and provide flexible/creative services." — Pines Behavioral Health Services, Michigan (Medicaid CCBHC)

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WORDS MATTER

- What are 1-2 words that describe your feelings about how the CCBHC model will impact the people your organization serves
- https://www.menti.com/alsd533qoav5

WORDS MATTER

Feelings about how the CCBHC model will impact the people my organization serves

POLL

Given what you heard today, what best practices for CCBHCs would you like to learn more about?

- Best Practices in:
  - Integrated BH/PH care
  - Integrated MH/SUD Care
  - Rural access issues
  - Designing compliant mobile crisis services
  - Workflows for centralized intake and triaging, and staffing patterns
  - Content for DCO contracts

QUESTIONS

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