CCBHCs: Key Factors for Success

Rebecca Farley David
National Council for Behavioral Health
Where are we now?

Year 1 was about getting up and running...

Year 2 is about showing IMPACT
Our Targets

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?
Support our advocacy & education efforts:

Complete the CCBHC Addiction Treatment Impact Survey!

[https://www.surveymonkey.com/r/H6M2FDS](https://www.surveymonkey.com/r/H6M2FDS)

Your responses will help us highlight CCBHCs’ successes to date and make the case for expansion/extension.
Translating Data into Clinical & Operational Change
Trends we’re seeing: Data

Successes
• Expanding ability to collect and report on data
• Growing sophistication in ways that will help with participation in other value-based models

Challenges
• Collecting data across care settings
• Technical specs for metrics not always a comfortable “fit”
• Lag time in data provided by state
• Tracking state-reported quality measures
• Making change “stick”
Emerging Best Practice:

CCBHCs monitoring performance on state-reported quality metrics

- Identify available data sources, even if imperfect
  - State claims database?
  - HIE?
  - Data from EHR? (Workflow (re)design needed?)
  - Direct relationships/data sharing with hospitals?
  - We will brainstorm ideas with you!

- Integrate data collection/analysis into daily workflows and care pathways
Example: Inpatient and ED utilization

Use care pathways built on best practices for care transitions

• CCBHCs establishing clinical and operational protocols to support the transition from hospitalization to community
  – Discharge planning
  – Care coordination
  – Outreach/engagement to ensure treatment plan follow through

• CQI and PDSA support rapid cycle change
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)
What if things aren’t going as planned?

- Root cause analysis is a process for identifying the **underlying causes** of a problem.
- **Purpose:** Understand **what** happened, **why** it happened, and determine **how** it can be avoided in the future (what changes need to be made).
- When to utilize root cause analysis:
  - When designing an intervention, project or program
  - To analyze adverse events or individual patient cases
  - When projects or interventions aren’t going as planned
Determining the Root Cause

- Tool: Fishbone Diagram
- Process: The 5 Whys
  1. Identify the specific problem
  2. Ask why the problem happens (potential causes)
  3. Repeat – continue to ask why until you come to the root cause of the problem
Problem

Common Cause Areas
People
Processes
Materials
Environment
Management

Cause 1
Sub-cause
Sub-cause

Cause 2
Sub-cause

Cause 3

Cause 4

Problem (Effect)
Common CCBHC challenges identified during root cause analysis

- **Patient level**: Particular groups of patients not receiving screen/service?
  - Examine intake process, revisit workflows for patient subpopulations to ensure data collection is built in, other?
- **Clinic level**: Particular sites doing less well?
  - Connect with clinic leadership, explore
- **Clinician level**: Lack of knowledge/reluctance among some providers?
  - Connect with supervisor, explore the “why” from clinician’s perspective
- **Metric level**: some issue with how we’re collecting the data?
Prioritize next steps

Not all potential actions & objectives are created equal

- Some have greater impact on the sustainability of the CCBHC model…
- Some are more amenable to change…
- Some can see results in short vs. long term…
- Where do you want to invest your resources in the remaining demo year?
Recommended areas of focus

• **Interventions to reduce high-cost items** (e.g. hospitalization, ED, polypharmacy)
  – No savings in the short term for reducing BMI, etc.
  – Focus on transitions of care, crisis and pre-crisis services, wait times → basically, being available so that people come to you instead of to the ED or jail

• **Measurable increases in patient access**

• **Demonstrated quality improvements**

• **The value equation**
Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Langley GL, Nolan, KM, Nolan, TW, Norman, CL & Provost, LP, 1999
Dashboards

Serve as objective visual representations that help agencies evaluate how well they’re doing.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target Goal</th>
<th>Numerator (as of 10/17)</th>
<th>Denominator (as of 10/17)</th>
<th>Actual</th>
<th>Change needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 30-day hospital readmission, MH dx</td>
<td>8%</td>
<td>68</td>
<td>925</td>
<td>7%</td>
<td>1%</td>
</tr>
<tr>
<td>2. Follow up after hosp for mental illness w/in 7 days</td>
<td>10</td>
<td>47</td>
<td>765</td>
<td>10%</td>
<td>0</td>
</tr>
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</table>

ACT clients with a documented primary care visit in the last year

Cases with documentation completed within 24 hrs of appt

# of days without dirty dishes left in breakroom
Stakeholders need answers to these questions:

1. What evidence is there that this change is for real?
2. Ok, it is for real, then is this good for me?
3. Is this good for my patient/healthcare provider?
4. What do I stop doing?
5. What do I keep doing the same?
6. What do I do differently?
Make Data... Fun! Creative! Intriguing!

The **top drugs** that led clients to seek treatment were:

- Alcohol: 32%
- Amphetamines: 23%
- Cannabis: 23%
- Heroin: 6%

Almost half of clients received treatment for more than one drug.
Year 2 Cost Report and Financial Monitoring
Successes

• CCBHCs are getting paid!
• Some CCBHCs incorporating financial reports/forecasts into regular quality and data tracking

Challenges

• Challenges reported in some states with MCO pass-through of PPS rate
• Continued need to increase understanding about billing & financial monitoring in a PPS world
• Delicate balance between revenue optimization and driving down your PPS rate during re-basing
Living within the PPS Rate

- If the PPS rate will be rebased in Year 2
  - Analyze current costs and volume versus the base year cost report
  - Project cost and volume for the balance of Year 1
  - Project Year 2 performance
  - Estimate re-basing of the PPS rate and additional concerns
    - Timing of anticipated costs
    - Adjustments to Year 1 cost report to annualize expenses incurred mid-Year 1
Living within the PPS Rate

• Key drivers of success in an all-inclusive PPS rate model:
  – Salary levels, benefit packages and staffing mix
  – Support staff ratios (direct care versus patient support)
  – Amount of enabling and ancillary services
  – Administrative/overhead infrastructure
  – Provider productivity/clinician capacity

• Remember, CCBHCs have flexibility to design their care delivery model as long as it is managed within the PPS rate system!
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*
Managing Performance

• Managing the cost per visit
• Bottom-line
  – Manage provider productivity to improve the bottom-line
  – Monitor patient utilization – measure patient demand
  – Scheduling – improve productivity (double booking, no show rates, scheduling template) and increase volume
More resources on Year 2 projections & financial monitoring

- **Webinar:** Cracking the Code on Managing Costs and Forecasting Revenue in a PPS Environment [https://register.gotowebinar.com/recording/7148521415648564227?assets=true](https://register.gotowebinar.com/recording/7148521415648564227?assets=true)

- **NatCon18 workshop:** Ensuring Fiscal Health for CCBHCs in a PPS World: Strategies and Considerations for Year 2 (Tues, April 24 10:00-11:00 am)
Sustainability Planning for CCBHCs
Sustainability planning for CCBHCs

- Federal Legislation
- State Medicaid options
- Private payers & APMs
Latest news from Capitol Hill

$100 million for CCBHCs and/or planning grant states

• Unknown:
  – What activities will the grant $ fund?
  – Who will be eligible?
  – Over what time period will the grants be disbursed?

• The good news: an indication of support for the CCBHC model
  – More work ahead to expand the demonstration via Medicaid!
Excellence Act Expansion

Sens. Roy Blunt and Debbie Stabenow

Reps. Leonard Lance and Doris Matsui
# Expansion Act Cosponsors

<table>
<thead>
<tr>
<th>House</th>
<th>House (cont.)</th>
<th>Senate</th>
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</thead>
<tbody>
<tr>
<td>Doris Matsui (CA-6), Original Author</td>
<td>Elise Stefanik (NY-21)</td>
<td>Roy Blunt (MO), Original Author</td>
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<tr>
<td>Andre Carson (IN-7)</td>
<td>John Katko (NY-24)</td>
<td>Debbie Stabenow (MI), Original Author</td>
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<tr>
<td>Lynn Jenkins (KS-2)</td>
<td>Suzanne Bonamici (OR-1)</td>
<td>Joni Ernst (IA)</td>
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<td>James McGovern (MA-2)</td>
<td>Earl Blumenauer (OR-3)</td>
<td>Sheldon Whitehouse (RI)</td>
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<td>Joseph Kennedy (MA-4)</td>
<td>Peter DeFazio (OR-4)</td>
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<td>Seth Moulton (MA-6)</td>
<td>Mark Pocan (WI-2)</td>
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<td>Collin Peterson (MN-7)</td>
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<td>William Lacy Clay (MO-1)</td>
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<td>Carol Shea-Porter (NH-1)</td>
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<td>Leonard Lance (NJ-7), Original Author</td>
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<td>Bill Pascrell (NJ-9)</td>
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<td>Rodney Frelinghuysen (NJ-11)</td>
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<td>Peter King (NY-2)</td>
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<td>Paul Tonko (NY-20)</td>
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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

In New Jersey to date:

3 of 12 Reps are cosponsors
0 of 2 Senators are cosponsors
Double your impact
Invite your legislators for a site visit

- Upcoming Congressional recesses:
  - **Senate:** May 26-June 3, Aug. 4-Sept. 3
  - **House:** May 25-June 4, July 27-Sept. 3

- 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!
Support our advocacy & education efforts:

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https://www.surveymonkey.com/r/H6M2FDS

Your responses will help us highlight CCBHCs’ successes to date and make the case for expansion/extension.
# Options for states post-2019

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<th>Section 1115 Waiver</th>
<th>State Plan Amendment</th>
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<tbody>
<tr>
<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 certify additional CCBHCs to meet statewideness requirements</td>
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<tr>
<td>With CMS approval, offers opportunity to continue PPS</td>
<td>Subject to CMS approval process; consider timing of request</td>
</tr>
<tr>
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MN plans to continue supporting its 6 CCBHCs after the federal demo ends through an 1115 waiver

The proposed waiver would:

- Target improving the substance use disorder treatment delivery system
- Support CCBHCs from July 2019 - June 2023
- Continue the Prospective Payment System
- Continue all quality measures and formal evaluations
The counter-arguments

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

This is a demonstration program, right? We really shouldn’t expand it until we see the formal evaluation results.
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
1. Know your audience: WHO

- Medicaid managed care plan?
- Medicare Advantage?
- VA, Tricare, other veteran-serving payer/partner?
- Commercial insurance?
- ACO or other alternative payment model?

*Different payers face strikingly different pressures and needs.*
2. Know your audience: WHAT

- What are their sources of funding?
  - What reporting or quality metrics are they responsible for?
- What do they want to accomplish?
  - What is holding them back from their desired accomplishments?
- What other pain points do they have?
- What do they already know about the role of behavioral health in whole health?
  - What do they need to know?
  - What are their past experiences with your organization (or behavioral health clinics generally?)
- What pilot projects has your payer funded/contracted for in the past?
3. Know your audience: WHEN

- When will they be making decisions?
- When should you weigh in?
Value in Value-Based Payments

Value = Quality / Cost
Value Proposition

• A positioning statement that explains **what benefit** you provide **for who** and **how you do it uniquely** well

• It describes your target buyer, the problem you solve and why you are distinctly better than the alternative

• Should show relevancy, quantified value, and unique differentiation
Value proposition should answer the following questions:

- What population(s) is your organization serving?
- What is the (quantifiable) benefit of your services to the community?
- What makes your services unique and different?
- How does this solve a problem for your payer?

Remember: your value proposition should be in the language of your payer!
What population is your organization serving?

• Analysis through risk stratification

• Development of care pathways

• Costing your services

• Systemized approach to treating high, medium and low risk patient populations
What is the benefit of your services to the community?

- Identify the gaps in the system of care in your community
- Identify your partners in your community
- Assess for your primary referral sources (and their relationship to the payer in question)
What makes your services unique and different?

• Benchmark progress toward improved clinical outcomes

• Benchmark progress toward driving down costs

• Incorporate a lean approach to operations

• Accessibility

• Responsiveness to social determinants of health
How does this solve a problem for your payer?

- How would your payer describe the major problems they face or goals they want to accomplish?
  - Your value proposition should be in the language of your payer.

- Assess your payer’s pain points.
  - How can **you** make life better for **them**?

- Research pilot projects your payer has contracted in the past.
  - Find out what they’ve already tried, whether it worked, or why it didn’t.
Measurement

A perpetual question...

In Real Life: The Top Three

- Follow Up After Hospitalization for Mental Illness (31.5%)
- Readmission Rates (15%)
- Access (15%)
- Others
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Be Heard. NATCON 18
Questions?

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