Chart the Course: Become a Certified Community Behavioral Health Clinic

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One Day CCBHC Track Intensive

The CCBHC Roadmap
CCBHCs: Quality Matters
Follow the Money
Required CCBHC Services
CCBHC Self-Assessment
Early Responses to the CCBHC Law

Our Response

• CCBHCs are the foundation for…
  – Behavioral Health Centers of Excellence
  – Funding Parity for the Safety Net Delivery System
  – The Good Housekeeping Seal of Approval in all 50 States
A Full Day of Fun Together

1. CCBHC Overview
2. The Front Door
3. CCBHC Services
4. Quality, Quality, Quality
5. Prospective Payment System
6. The Provider Roadmap
   Plus Small Group Work and Discussion Throughout
   Plus Lunch and Breaks

Chapter 1: CCBHC Overview
What is a CCBHC?

THINK but don’t SAY FQBHC

- A Federal Definition
- A Comprehensive Community Behavioral Health Provider Organizations with:
  - Common Scope of Services
  - Common Quality Metrics
  - Paid Actual Costs of Providing Services

Where Did CCBHCs Come From?

- Short Answer:

- Longer Answer:
  - The 2014 Excellence in Mental Health Act
  - $1.1 Billion Investment
  - Key Part of the Law: The CCBHC Demonstration Program
What are CCBHCs Important?

Competition is increasing at the system level

- Disruption—in business models, in policies, in partnerships
- Changing landscape—hospitals are expanding regionally
- Retail health—clinics, over the counter therapies—is gaining a foothold
- And social media means this is happening in public eye

Two Roles of Behavioral Health Providers in the New Health Ecosystem

- Behavioral health inside medical homes—deeply embedded in primary care team, prevention and early intervention, addressing behaviors as well as disorders
- Behavioral health specialty centers of excellence, partnering with medical homes to provide high-value, whole-health care to people with complex conditions

[Images of homes, medical symbols, and people]
The Recipe for Success

• Our organization is known by the entire community as a great place to get care and a great place to work.

• We are an integral part of the health neighborhood, providing (1) rapid access to (2) comprehensive, (3) cost effective care that results in (4) excellent outcomes and (5) high client satisfaction.

Current Timeline

Guidance Released
- CCBHC Criteria
- PPS Guidance
- Planning Grant RFA
  May 2015

State Planning Phase
  Fall 2015-Early 2017

Demonstration States Selected
  Early/Mid-2017

$25 million available
The Guidance (Limbo) Phase

Between January 1 and May 1, 2015

What We Know
- Who can be a CCBHC
- What the *DRAFT* Criteria look like
- 2 Year Demo for 8 States
- CCBHCs will be Paid using a Prospective Payment System (PPS)
- Enhanced FMAP for the Demo States
- Accrediting Organizations are interested (COA, CARF, Joint Commission, etc.)

What We Don’t Know
- The Final CCBHC Criteria
- The Federal CCBHC PPS Regulations
- How many States will apply for a Planning Grant
- How CCBHC Accreditation will unfold
- Whether the Program will be expanded by Congress early
Our Most Important Outstanding Question – What About…

• Organizations that DON’T do everything?
  – Small provider organizations
  – Children’s Providers
  – Adult Providers
  – Special Population Providers
  – Free Standing Substance Use Treatment Clinics
  – Etc.

We will find out soon… In the meantime…

• The National Council has asked SAMHSA to consider the following:
  • CCBHC Services Can Be Provided By:
    – The Legal Entity that is Certified as a CCBHC, and
    – “Designated Partner Organizations” that have formal arrangements with the CCBHC and deliver services under the same requirements as the CCBHC.
The Planning Phase

What the Law Says…

• “Not later than January 1, 2016, the Secretary shall award planning grants to States for the purpose of developing proposals to participate in time-limited demonstration programs.”
Don’t be Tricked…

• The “Planning Phase” is not what you might think.
• This phase should really have been called the:
  – “The State CCBHC Planning and Readiness Preparation Phase.”

Required Planning/Readiness Activities

1. Solicit Input from Patients, Providers, Other Stakeholders
2. Identify the Target Medicaid Population to be Served
3. Design the scope of CCBHC Medicaid Services
4. Certify the Clinics that will be Pilot CCBHCs
5. Establish the CCBHC PPS
6. Verify the State has agreed to Pay the PPS Rates
7. Develop and Provide Other Info to the Feds

• When the state submits it’s proposal to be one of the 8 pilot states, it has to be ready to start the program!
The Demonstration Phase

We Anticipate “Two Tracks” in this Phase

The 8 States
- More Money
- New Billing Processes
- Focused BH Center of Excellence Work
- Improved Outcomes Tracking
- Improved Outcomes
- Standardized Data Reporting
- Comparative Study of CCBHCs and Non-CCBHCs in each State

The Rest of the States
- Centers becoming certified as CCBHCs by the Accrediting Organizations
- Focused BH Center of Excellence Work
- Improved Outcomes Tracking
- Improved Outcomes
- The potential to do Comparative Studies of CCBHC versus Non-CCBHC states
CCBHC Certification in Non-Pilot States

Consider the following

• Medical providers are understanding the importance of addressing the BH needs of their patients.
• Medicare, Medicaid Health Plans, and Commercial Health and Behavioral Health Plans are understanding the importance of BH to their bottom lines.
• All of the above are building high performing networks that include BH providers.

Matched with the following

• Community BH Organization CEOs are leading major efforts to be seen as Centers of Excellence.
• Accrediting Organizations are willing and able to review and certify CBHOs if they meet the certification criteria.

Chapter 3: CCBHC Services
The “Big Nine” Required Services

Required Services

Crisis Services (if needed)
Screening, assessment, diagnosis
Pt. Centered treatment planning
Outpatient MH/SA
Targeted case management
Primary Health Screening & Monitoring
Peer support
Psychiatric Rehab
Armed Forces and Veteran’s Services
The Excellence in Mental Health Act has identified nine required services that must be provided by every Certified Community Behavioral Health Clinic (CCBHC) in the United States.

1. Crisis Services: 24 hour mobile, crisis intervention and stabilization
2. Screening assessment and diagnosis including risk assessment
3. Patient centered treatment planning
4. Outpatient mental health and substance abuse services
5. Targeted Case Management
6. Psychiatric Rehab Services
7. Peer support and family support
8. Care for members of armed forces and veterans
9. Outpatient clinic primary care screening and monitoring

Our Most Important Outstanding Question – What About…

- Organizations that DON’T do everything?
  - Small provider organizations
  - Children’s Providers
  - Adult Providers
  - Special Population Providers
  - Free Standing Substance Use Treatment Clinics
  - Etc.
We will find out soon… In the meantime…

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Let’s Dive into the Required Services Together

- For each of the nine we will give you a chance to read the slide, we will add some editorial comments, and then work together to answer the following questions:
  1. What percentage of the specialty behavioral health providers in your state or community currently do this work (less than 1/3; 1/3 to 2/3; over 2/3)?
  2. How much work will it take for your organization to meet the requirements for the service area?
1. Crisis mental health services

Directly provide the following three crisis mental health services:

• **24-hour mobile crisis teams** includes rapid crisis response to consumers and families and assessment, brief intervention and linkage/referral and collaboration with other crisis and behavioral health services.

• **Emergency crisis intervention** services include psychiatric emergency and crisis teams and ambulatory detox. In addition, emergency crisis teams may integrate crisis hotlines and peer crisis services into their responses.

• **Crisis stabilization services** provide short-term, intensive, community-based services to avoid the need for inpatient hospitalization such as 23 hour crisis stabilization beds, crisis stabilization units, and crisis respite and crisis residential services. Crisis stabilization services may follow emergency room visits and psychiatric hospitalizations.

2. Screening, assessment, and diagnosis, including risk assessment

• The Draft Criteria Say…
  – CCBHC directly provides screening, assessment, and diagnosis, including risk assessment, for behavioral health conditions.
  – Specialized screening services such as neurological testing can be provided through “formal arrangement”.
3. Patient-centered treatment planning

- **Includes** the consumer, the family/caregiver of child consumers, the adult consumer’s family to the extent the consumer wishes and any other person the consumer chooses.
- As part of care coordination, the CCBHC ensures that care and services provided by the CCBHC and its partnering providers are provided in accordance with the active treatment plan.

4. Outpatient mental health and substance use services include:

1. **Evidence-based individual, group and family therapies** including Cognitive Behavioral individual and group therapies (CBT), Dialectical Behavior Therapy (DBT), first episode early intervention for psychosis, Multisystemic Therapy, specialty clinical interventions to treat mental health and substance use disorders experienced by youth including youth in Therapeutic Foster Care, and Motivational Interviewing;
2. **Evidence-based medication evaluation and management** (including but not limited to medications for psychiatric conditions, medication assisted treatment for alcohol and opioid substance use disorders (e.g., buprenorphine, methadone, naltrexone (injection and oral), acamprosate, naloxone), prescription long-acting injectable medications for both mental health and substance use disorders, and smoking cessation medications);
3. **Evidence-based intensive services** such as intensive outpatient substance abuse services and intensive psychiatric outpatient services; and
4. **Prevention services**.
Other Outpatient MH and SA requirements

The following services must be available when needed:

- Follow-up care after hospitalization
- Emergency department use or crisis services use;
- Evidence-based suicide safety and treatment services;
- Smoking cessation therapy;
- Evidence-based co-occurring mental and substance use treatment;
- Evidence-based trauma informed treatments;
- Evidence-based treatment for youth and children, older adults, people with co-occurring developmental disabilities, and;
- Neurological consultation.

5. Case management and targeted case management

The CCBHC will directly provide case management and/or targeted case management:

- Case management is defined as: “…diagnosis, treatment and ongoing patient management (e.g., arranging referrals, follow-up, reminders, patient education) by an individual other than the primary care clinician”. It includes:
  - Referral to indicated community services;
  - Follow-up supports to persons deemed at higher risk of suicide, particularly during times of transitions such as from an emergency department or psychiatric hospitalization;
  - Assertive community treatment (ACT);
  - Targeted case management for specific groups; and
  - Community wrap-around services for youth and children
6. Psychiatric rehabilitation services

- Directly or through formal arrangement provide evidence-based psychiatric rehabilitation services, including:
  - medication education;
  - self-management;
  - training in personal care skills;
  - individual and family/caregiver psycho-education;
  - community integration services;
  - recovery support services including Illness Management & Recovery;
  - financial management;
  - dietary and wellness education
  - supported housing;
  - supported employment; and
  - supported education

7. Peer support and counselor services and family supports

- CCBHC directly provides these peer and recovery support services
- Family/caregiver support services include: family/caregiver psycho-education, parent training and family-to family/caregiver support services
- Specialized peer crisis, bridger and other consumer operated services can be delivered through formal arrangement
8. Services for members of armed forces and veterans

- Assistance in coordinating services with TRICARE for current members of armed forces. Veterans will be offered assistance to enroll in VHA
- Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA
- Adherence to National Consensus Statement on Mental Health Recovery, SAMHSA’s 10 guiding principles, and VHA additional principals of privacy, security and honor
- Additional guidelines for training in military culture and treatment planning

9. Primary Care Screening and Monitoring of Key Health Indicators and Health Risk

- CCBHC directly collects physical health information on each consumer through self-report, provider observation, and measurement of BMI and blood pressure, at intake and at least annually thereafter.
- The CCBHC also directly or through formal arrangement provides more in-depth screening and monitoring of key health indicators and health risks.
- CCBHC refers to primary care, assures that key screening steps are followed (e.g. Diabetes and blood pressure screenings, weight) and follow up. Children’s primary care services include assessment of learning disabilities, family/caregiver functioning, and trauma screening
Required 9 Services (recap)

- Crisis Services (if needed)
- Screening, assessment, diagnosis
- Pt. Centered treatment planning
- Outpatient MH/SA
- Psychiatric Rehab
- Peer support
- Targeted case management
- Primary Health Screening & Monitoring
- Armed Forces and Veteran’s Services

Care Coordination Makes 10?
Care Coordination
Agency for Healthcare Research and Quality (2014) defines care coordination as:
“deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care… needs… are known ahead of time and communicated at the right time to the right people…”

- CCBHC care coordination activities can include:
  - Appointment scheduling and follow-up; Use of electronic health records system and consumer registries; Shared, person centered treatment plans addressing consumer needs and preferences
  - Interagency coordination with FQHC’s, inpatient, detox, VA facilities and others is essential: data exchange, referrals, etc.

CCBHS service processes: Reframed
Levels of care: Algorithms or protocols to coordinate treatment

Chapter 4: Quality, Quality, Quality
Did You Know…

• The FQHC System has…

Welcome to the HRSA Data Warehouse
The HRSA Data Warehouse (HDW) serves as the enterprise repository for HRSA data. The data are updated frequently and are integrated with external information and data sources, enabling users to gather relevant and meaningful information about health care programs and the populations they serve.

Did You Know…

• The Behavioral Health System in the U.S. is moving from a 50 states… 50 sets of rules…

• To a national quality framework for behavioral health?

National Behavioral Health Quality Framework
Table of Contents

- Substance Abuse and Mental Health Services Administration National Behavioral Health Quality Framework — Overview
- Examples of Recommended Measures and Identified Gaps
- Next Steps for the National Behavioral Health Quality Framework
- Exhibit I: Recommended and Future Measures
- Appendix: Additional Measures for Consideration

#NatCon15
Did You Know…

- Affordable Care Act requires
  - National Quality Strategy (NQS)
  - SAMHSA’s National Behavioral Health Quality Framework:
    1. Effective
    2. Person-Centered
    3. Coordinated
    4. Healthy Living
    5. Safe
    6. Affordable/Accessible

Did You Know…

- There are a zillion quality measures relevant to persons with BH Disorders?
  - 116 in the draft NBHQF
  - 64 in the Meaningful Use set
  - 44 in the Physician Quality Reporting System
  - 37 in the SAMHSA State URS set
  - 28 in the FQHC UDS set
Did You Know…

- The CCBHC Program is one of the key vehicles for this national BH quality effort?
- Focusing on two areas:
  - Quality Improvement Program
  - Quality Measurement

Deconstructing FQHC UDS
The FQHC UDS

- Uniform Data System
  - National Reporting System for FQHCs and RHCs
  - Annual Reporting Model (February 15th Deadline)
  - 12 Tables
- CCBHC Reporting System modeled after UDS

### UDS Table Examples

#### Exhibit 1: Patients by Zip Code

<table>
<thead>
<tr>
<th>Zip Code (a)</th>
<th>None Uninsured (b)</th>
<th>Medicaid/SCHIP Other Public (c)</th>
<th>Medicare (d)</th>
<th>Private (e)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Other ZIP Codes
Unknown Residence
TOTAL

#### Exhibit 3: Patients by Race and Ethnicity and Language

<table>
<thead>
<tr>
<th>PATIENTS BY RACE</th>
<th>PATIENTS BY HISPANIC OR LATINO ETHNICITY</th>
<th>Patients Not Hispanic/Latino (a)</th>
<th>Patients Hispanic/Latino (b)</th>
<th>Patients Unreported/Refused to Report (c)</th>
<th>TOTAL (d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>2a. Native Hawaiian</td>
<td></td>
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<td></td>
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<tr>
<td>2b. Other Pacific Islander</td>
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<tr>
<td>3. Total Hawaiian/Pacific Islander (Sum Line 2a + 2b)</td>
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<tr>
<td>3. Black/African American</td>
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<tr>
<td>4. American Indian/Alaska Native</td>
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<tr>
<td>5. White</td>
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<tr>
<td>6. More than one race</td>
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<tr>
<td>7. Unreported/Refused to report</td>
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<tr>
<td>TOTAL: Patients Hispanic/Latino (Sum: Line 3 + 4 + 5 + 6 + 7)</td>
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</tr>
<tr>
<td>TOTAL: Patients Not Hispanic/Latino + Patients Hispanic/Latino + Patients Unreported/Refused to Report (Sum: Line 3 + 4 + 5 + 6 + 7)</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

#### Exhibit 5: Patients by Language

<table>
<thead>
<tr>
<th>PATIENTS BY LANGUAGE</th>
<th>NUMBER (a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Patients Best Served in a Language Other Than English</td>
<td></td>
</tr>
</tbody>
</table>
**UDS Table Examples**

Exhibit 5: Staffing and Utilization

<table>
<thead>
<tr>
<th>Personnel by Major Service Category</th>
<th>FTEs (A)</th>
<th>Clinic Visits (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family Physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. General Practitioners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Interns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Obstetric/Gynecologists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Pediatricians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Other Specialty Physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Total Physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Nurse Practitioners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9a. Physician Assistants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10a. Certified Nurse Midwives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11a. Nurses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Exhibit 7: Selected Diagnoses and Services

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Applicable ICD-9-CM Code</th>
<th>Number of Visits by Diagnosis regardless of priority (A)</th>
<th>Number of Patients with Diagnosis regardless of priority (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Symptomatic HIV</td>
<td>042, 079.53, V08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Tuberculosis</td>
<td>019.xx – 019.xx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Syphilis and other sexually transmitted infections</td>
<td>099.xx – 099.xx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Hepatitis B</td>
<td>070.26, 070.22, 070.39, 070.32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Hepatitis C</td>
<td>070.41, 070.44, 070.51, 072.54, 070.70, 070.71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Asthma</td>
<td>493.xx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Chronic bronchitis and emphysema</td>
<td>499.xx – 492.xx</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CCBHC Reporting Structure**

- Will likely include standardized data elements like the ones on the previous slides
- Plus CLINICAL MEASURES
- Draft CCBHC Criteria:
  - Table 4: Access
  - Table 5: Care Coordination
  - Table 6: Process of Care
  - Table 7: Outcomes
  - Table 8: Screening and Prevention
Digging into Potential CCBHC Measures

Chapter 5 – Potential Clinical Quality Measures - Access

- Access to services –
  - Rationale – delays in access results in one or more of the following: no care, more acute care, higher cost care, care designed for more serious conditions. CCBHCs will need to develop “no wrong door” approaches that are effective at engaging consumers at the appropriate time and level of care.
- Measures of wait times for routine visits and timeliness of visits for all ambulatory services including psychiatric care.
Potential Clinical Quality Measures – Care Coordination

• Care Coordination services –
  – Rationale – care coordination in varying degrees of intensity has shown to improve clinical outcomes by engaging and linking consumers to appropriate care and transitions from one level to another.
  • Measures include post-discharge follow-up following residential/inpatient/emergency department visits; co-occurring MH/SUD treatment, coordination of primary and behavioral healthcare, and the initiation and engagement of persons in SUD treatment.

Potential Clinical Quality Measures – Appropriateness of Services

• Appropriateness of services –
  – Rationale – The right service at the right time and the use of services that are evidenced-based producing more predictable results. Use of dynamic treatment plans where treatment and interventions are modified as measured by progress. Use of functional assessment tools that supply the data to measure outcomes. Standards of care and clinical practice guidelines.
  • Measures include progress toward treatment goals and using population health outcomes as the metrics.
Chapter 5 – Potential Clinical Quality Measures - Access

• Access to services –
  – Rationale – delays in access results in one or more of the following: no care, more acute care, higher cost care, care designed for more serious conditions. CCBHCs will need to develop “no wrong door” approaches that are effective at engaging consumers at the appropriate time and level of care.
• Measures of wait times for routine visits and timeliness of visits for all ambulatory services including psychiatric care.

National Better Practice Performance Standards

• Access to Treatment Performance Standards:
  – Primary Access – Time to provide client face to face initial intake/assessment after call for help – Same Day/Open Access Model
  – Secondary Access – Time to provide client face to face service with his/her treating clinician following intake/assessment date – 3 to 5 days but not later than 8 days after same day assessment provided
  – Tertiary Access – Time to first face to face service with Psychiatrist/APRN following the intake/assessment date - 3 to 5 days but no later than 8 days after the same day assessment provided
National Better Practice Performance Standards

• **Access to Treatment Cost Performance Standards:**
  (From initial contact by client to completion of the treatment plan process costs)
  • Number of Access to Treatment processes within each center:
    – Gold Standard – One Standardized Process for the center – all ages and all clients served regardless of diagnostic group
  • Number of staff hours needed from first call for routine help to treatment plan completion range from 2 hours to 2.5 hours which will require staff to use collaborative documentation process
    – Diagnostic Assessment process target is one hour using CSR support
    – Diagnostic Assessment and Initial Treatment Plan target is one hour and twenty minutes using CSR support
  • Target Cost of total process from first contact to treatment plan completion is a range from $150 to $200

National Better Practice Performance Standards

• **National Standard for Appointment Types:**
  – Appointment Kept
  – No Show (less than 36 to 24 hrs notice)
  – Appointment Canceled by Client (36 to 24 hrs or more notice)
  – Appointment Canceled by Staff
  • **NOTE:** No Show/Cancellations Clarification:
    • No Show definition is not based solely on clients behavior as much as the impact of this behavior on service capacity of each direct care staff that day (i.e., Late cancellation results in a potential no show to schedule)
    • Cancellations count as No Shows IF the team is not backfilling 90% of pre-cancelled appointments – Therefore, no shows and cancellations carry the same weight of reduced service capacity if the backfilling process is not happening
National Better Practice Performance Standards

- **National No Show/Late Cancelled Performance Standards:**
  - Initial Intake/Diagnostic Assessment Services = 0% No Show/Cancel rate based on Same Day access models
  - Ongoing Therapy Services = 8% - 12% No Show/Late Cancelled
  - Initial Psychiatric Evaluations = 12% to 15% No Show/Late Cancelled
  - Ongoing Medication Follow Up Services – 5% - 8% No Show/Late Cancelled - NOTE: Medications provided by phone to clients that missed their appointments will have to be addressed to positively impact ongoing no show rates.

- **Annual Direct Service/Billable Hour Performance Standards for Outpatient Services:**
  - Full Time MDs/DOs/APRNs: 1,450 direct service hours per year
  - Part Time MDs/DOs/APRNs: 80% of employed time
  - Full Time Therapists and Nurses: 1,350 direct service hours per year
  - Part Time Therapists and Nurses: 65% of employed time
  - Full Time Community Support Staff: 1,250 direct service hours per year
- Part Time Community Support Staff: 60% of employed time
National Better Practice Performance Standards

• **Utilization Management Performance Standards:**
  – 98% compliance rate for monthly authorization and re-authorization utilization management requirements
  – 95% compliance with quantitative and qualitative chart review compliance standards

• **Documentation Submission Compliance Standards:**
  – Initial Diagnostic Assessment completed within 15 minutes after one hour face to face appointment 98% of the time
  – Initial Service/Treatment Plan completed within 24 hours after the initial diagnostic assessment has been completed 98% of the time
  – Progress Notes completed at the end of the session with client present using collaborative documentation model 98% of the time

National Better Practice Performance Standards

• **Positive Outcomes Performance Standards:**
  – Attainment of an outcome rating level of 90% showing improvement in the last annual treatment planning or survey period.
  – Attainment of a positive consumer satisfaction rating level of 95% regarding their opinions about services provided and level of attainment/recovery reached.

• **Customer Service Performance Standards:**
  – Answering the Phone and Telephonic Standards:
    • Answer by the second ring
    • Do not leave a person on hold more than 30 seconds without re-empowering them
    • Voice mail protocols to ensure responsive customer service instead of a customer service dumping ground
  – Acknowledging Arrival of Client/families at the front check in desk within 10 seconds
Chapter 5: The Prospective Payment System

Prospective Payment Systems (PPS)

• Medicare or Medicaid Payments based on a predetermined fixed amount

• Currently relates to:
  – Inpatient Hospitals
  – Long Term Care Hospitals
  – Home Health
  – Hospice
  – Skilled Nursing Facilities
  – Hospital Outpatient Services
  – Inpatient Psych
  – Inpatient Rehab
  – FQHCs and RHCs
A Tale of 2 Sibling

This session is partially a story of 2 siblings separated childhood: CHCs and CMHCs

FQHCs – Five Decades of Unfolding

1960s  Migrant Health Act of 1962 for farm workers/families
       Economic Opportunity Act of 1964 funds CHCs

1970s  Section 330 of the Public Health Services Act
       - Community Health Center Program – Section 330(e)
       - Migrant Health Center Program – Section 330(g)
       National Health Service Corps begins

1980s  Health Care for the Homeless Program – Section 330(h)
       The 3 Types of CHCs become known as FQHCs
       FQHC Cost-Based Payments for Medicare & Medicaid

1990s  Free Federal Tort Protection (Malpractice Insurance)
       Public Housing Primary Care Program – Section 330(i)

2000s  Prospective Payment System
       States Required to Cover Difference between Rates & PPS
       Expansion of Funding and Capacity, adding BH Services
The Five FQHC PPS Standards

1. PPS pays a single per-visit rate.
2. PPS is based on the average cost of all allowed services provided by all allowable providers.
3. PPS supports comprehensive FQHC/RHC services.
4. PPS rates are determined separately for each individual FQHC or RHC.
5. States using Medicaid managed care organizations (MCOs) must make up the difference between what the MCO pays and the PPS rate.

Digging into FQHC PPS
Medicaid PPS

- Payment methodologies and reimbursement varies by state

- In the beginning…
  - Public Health Service Act included a provision to ensure FQHC’s were reimbursed for 100% of their reasonable costs associated with furnishing these services

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**Medicaid PPS**

- **The Math Problem:**
  - Baseline rate established in Year 1
  - PPS payment rate increased each year by a standard medical inflation factor or Medicare Economic Index (MEI)

- **Two Options:**
  - State Medicaid Agencies pay PPS per-visit rate, or
  - Alternative Payment Methodology (APM) for each face to face visit
PPS Medicaid Payments and Medicare

- Some states adopt the Medicare PPS payment
  - Must equal center’s reasonable cost
- Problem:
  - Medicare covers a much narrower set of services than state Medicaid systems

PPS Payments - CCBHCs Need to Get it Right the First Time

- Be aware of cost ceilings:
  - Not allowed if it excludes reasonable and related costs
- Baseline PPS rates:
  - Improperly calculated the first time will never catch up to your actual cost even with inflation factors in place
Medicaid PPS Payment Restrictions

• We Don’t Know What CCBHC PPS will look like yet, but here’s what to watch out for:
  – Visit Limits
  – Carve Outs
    • Offsite services
  – Bundled services
    • i.e. individual therapy and med management on the same day

“Wraparound” Payments

• Payments that are required to make up the difference between MCO payments and the PPS or APM rate
• States are required to make the payments at least every 4 months
Impact of Wraparound Payments

- Not being made within the 4 month time frame impacting cash flow
- Significant delay for Out of Network patients

Alternative Payment Methodologies
Alternative Payment Methodologies

- States may pay above the PPS rate
- Congress allows for APM’s
- Payment must be equal or greater than the PPS
- At last count 21 states are using some form of an APM

Oregon is Figuring This Out

- Moving FQHCs from Prospective Payment
- To Primary Care Subcapitation
- With agreed upon Performance Measures
- Oregon is one of the Early Adopters
- 3 Centers went live March 1, 2013
Community Health Centers and Primary Care Capitation

- States can implement Alternative Payment Methods for CHCs, as long as the amounts going to the centers is NO LESS than under the PPS.
- Moving to Capitation means that the Encounter is no the Payment Unit of Measure.
- Centers are able to use the money in a much more flexible manner (who, what, where, when).
- Centers are still tracking and reporting encounters, but “Patient Touches” is a more relevant tracking unit (phone calls, non-licensed staff visits, etc).
- Minimum Performance Measures are being added.

Oregon’s CHC Alternative Payment Method Metrics

- Tobacco Screening
- Depression Screening
- Diabetes Control
- Cervical Can Screening
- Weight Control: Adults
- Weight Control: Kids
- HTN Control
- Childhood Immunizations
- Patient Experience
- Continuity with Team
- Patients Assigned vs. Seen
- Patient Touches
- Total Patient Costs and Utilization
Chapter 6: The Provider Roadmap

Major Strategic Initiative

- Preparing to become a CCBHC is an exciting way to focus the energy of everyone in your organization.
- Drawing on a high level of planning, staff engagement and change management skills.
At-A-Glance

Phase 1: Internal Education

Phase 2: State Level Organizing and Advocacy

Phase 3: Internal and External Readiness Activities

Phase 4: Implementation

A Note to Providers in States NOT Going After a Planning Grant

• Surprisingly, most of the tasks in the 4 Phases are relevant.
• Simply delete or reframe the tasks related to participating in the CCBHC Demonstration.
Phase 1: Internal Education

- Tap into material from the National Council as it comes out (Ongoing)
- Study the final CCBHC Criteria and PPS Guidelines (May)
- Review the CCBHC State Planning Grant Application (May)
- Complete a CCBHC Readiness Assessment and identify areas of strengths and weaknesses (Coming Soon)
- If you think you will meet the CCBHC criteria, identify potential partners to join with you to round out your service offerings (As Soon As You Can)
- If you probably WON’T meet the CCBHC criteria, identify organizations that are likely to qualify and prepare to pitch your organization as a value-added partner (As Soon As You Can)

Phase 2: State Level Organizing and Advocacy

- Organize through your State Provider Association (ASAP)
- Determine how the CCBHC Planning Grant can fit with health reform planning activities already underway in your state (ASAP)
- Develop the “business case” for how the CCBHC program can help achieve the triple aim in your state, with an emphasis on bending the healthcare cost curve (ASAP)
- Pitch the business case to your Governor’s office, Medicaid office, MH/SA office, etc. (ASAP)
- Work with your State’s FQHC Primary Care Association to describe how the program can assist, not compete with, their efforts (ASAP)
- Compel your state, via legislation, to participate including authorization of spending authority (ASAP)
Phase 3: Internal and External Readiness Activities

**Certification**
- Research the potential Certification Organization and identify a preferred organization *(Summer 2015)*
- Weave the certification requirements into an internal and external readiness plan *(Summer 2015)*

**External**
- Participate in State CCBHC Planning Processes *(Beginning Fall 2015)*
- Partnership building with other behavioral health providers *(Beginning Fall 2015)*
- Partnership building with health care providers *(Beginning Fall 2015)*

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Phase 3: Internal and External Readiness Activities

- Staffing Adequacy (Criteria 1)
- Access and Availability (Criteria 2)
- Care Coordination (Criteria 3)
- Scope of Services (Criteria 4)
- Quality and Reporting Infrastructure (Criteria 5)
- Governance and Accreditation (Criteria 6)
- Clinical Practices and Outcomes Based Care (Additional Area 1)
- PPS Readiness (Additional Area 2)
- Business Practices (Additional Area 3)
- Information Technology (Additional Area 4)
Phase 4: Implementation

• The Pilots will likely go live early – mid 2017

• Regardless of your State’s situation (didn’t apply; applied, didn’t win; applied and selected) plan to:
  – Begin acting “as if” you were a CCBHC as soon as possible, fulfilling the requirements in the criteria.
  – Get certified as a CCBHC in 2016 (yes, next year).