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Bridging the Addiction Treatment Gap: Certified Community Behavioral Health Clinics

Despite the surging opioid crisis, **only one in 10 Americans with an addiction receives treatment in any given year**.[1] Meanwhile, decades of funding cuts have left treatment providers struggling to hire staff and expand programs to meet the needs in their communities. Recent influxes of federal grant funding for some opioid-related activities have provided critical support but have not enabled the comprehensive, long-term expansions in treatment capacity required to address the whole health needs of people living with addiction. Certified Community Behavioral Health Clinics (CCBHCs) were enacted in 2014 to fill the gaps in unmet need for addiction and mental health care and expand access to comprehensive, community-based treatment. Sixty-six CCBHCs launched in eight states in 2017. Early results[2] from the two-year program demonstrate how CCBHCs are advancing access to opioid and other addiction care. **As the nation considers what steps should be taken to address the ongoing opioid epidemic, the CCBHC model deserves to be expanded so that more communities can transform their capacity to serve people living with addiction.**

What is a CCBHC?

Section 223 of the Protecting Access to Medicare Act of 2014 established a federal definition and criteria for Certified Community Behavioral Health Clinics (CCBHCs). These entities, a new provider type in Medicaid, must provide a **comprehensive range of addiction and mental health services** to vulnerable individuals while meeting additional requirements related to staffing, governance, data and quality reporting, and more.

In return, CCBHCs receive a Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations. CCBHCs are currently in operation in eight states selected for participation in this initiative (also known as the CCBHC model or the Excellence in Mental Health and Addiction Act): **Minnesota**, **Missouri**, **Nevada**, **New Jersey**, **New York**, **Oklahoma**, **Oregon** and **Pennsylvania**.

Filling the Gap in Unmet Need for Addiction Care

CCBHCs are making critical inroads in filling the addiction treatment gap that leaves 90 percent of those in need without access to care. Historically, dismally low reimbursement rates and lack of coverage for a full continuum of addiction care have prevented clinics from serving new clients, opening new service lines or hiring sufficient staff to care for all community members living with addiction. The CCBHC model eliminates this barrier by establishing a Medicaid payment rate that is inclusive of the full costs of expanding service lines to meet the needs of increased patient caseloads, while requiring CCBHCs to serve all individuals regardless of their ability to pay. As a result, **nearly all CCBHCs (94 percent) have**

94%

of CCBHCs report an increase in the number of patients treated for addiction.

17%

of CCBHCs have seen a >50% increase in their number of *new* patients with addiction.

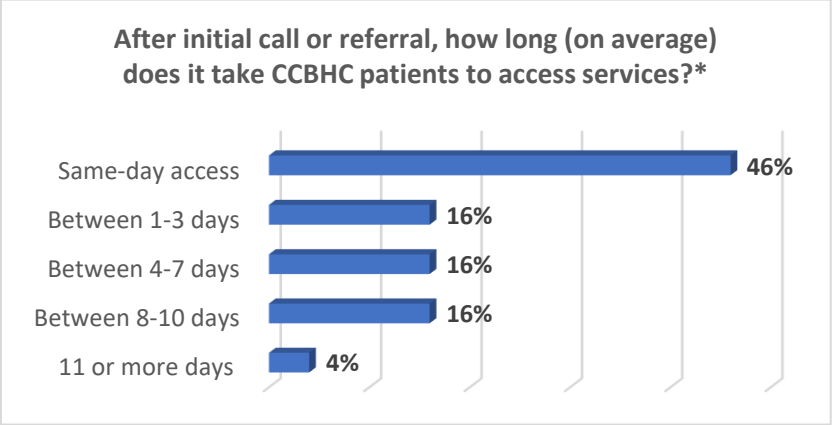
68%

of CCBHCs report a decrease in patient wait times, with nearly half providing same-day access to care.

increased the number of patients with addiction they serve, either by taking on new patients, improving screening protocols to newly identify addiction among existing patients, or both.

Reducing Wait Times for Addiction Care

Lengthy wait times for services reduce the likelihood that patients will initiate and fully engage in care; long wait times also increase the risk of a deadly event such as overdose. CCBHCs have invested heavily in reducing wait times, and their efforts have succeeded: since becoming a CCBHC, **68 percent** of clinics have seen a *decrease* in patient wait times, while **30 percent** have seen wait times remain steady despite increases in patient caseloads across most CCBHCs. After an initial call or referral, **78 percent** of CCBHCs can offer an appointment within a week or less.



**Note*: One clinic (2%) responded that they do not know how long it takes CCBHC patients to access services after initial call or referral.

Bikur Cholim (NY)

Prior to becoming a CCBHC, Bikur Cholim had a waitlist of 140 patients. By hiring new staff, expanding treatment programs and implementing rapid access protocols, Bikur Cholim has completely eliminated its waitlist while simultaneously expanding its total patient caseload.

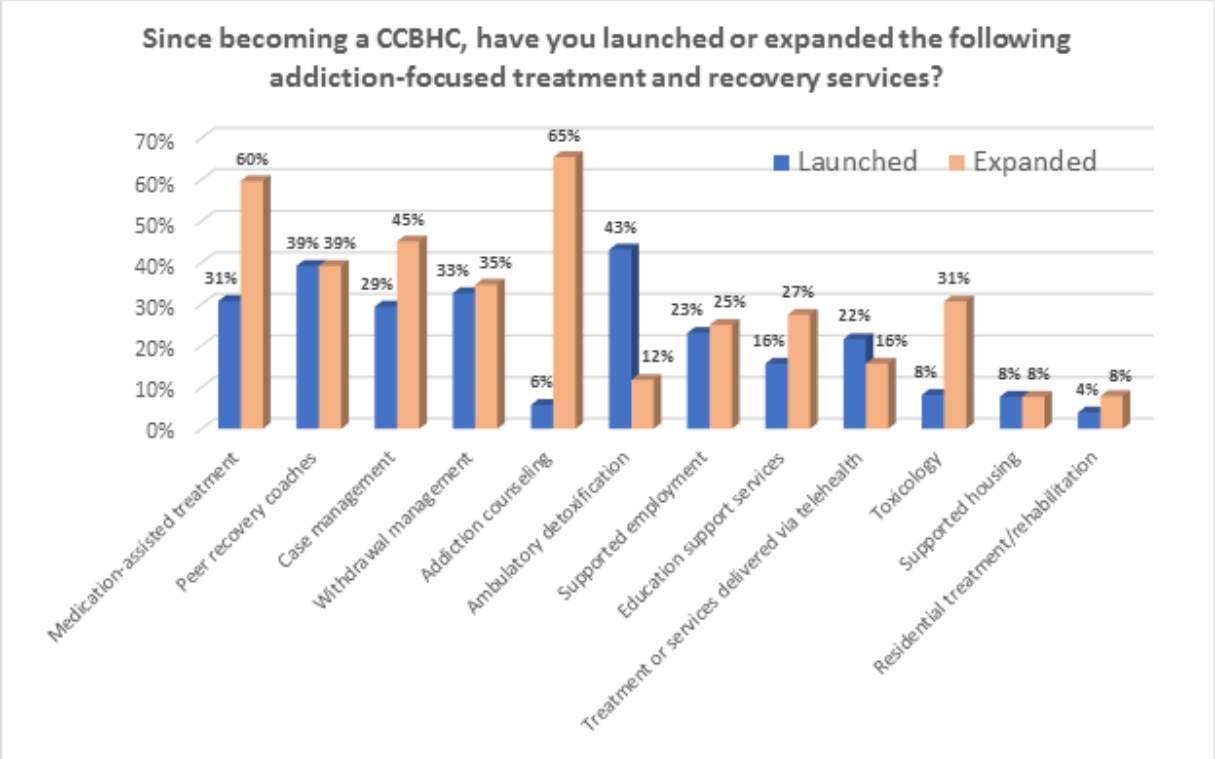
CCBHCs Advancing the Continuum of Addiction Care

Acknowledging that people in many communities lack access to the full continuum of medically necessary substance use care, the CCBHC model requires a robust array of addiction treatment and recovery activities. In contrast to the current patchwork of available services, **consumers and families in every community with a CCBHC know they will have access to a guaranteed set of high-quality services fully coordinated with other health care providers.** Unlike current reimbursement models, which are typically too low to support the actual costs of care delivery, the CCBHC model provides sustainable funding for these capacity expansions.

Required CCBHC Addiction Treatment Services
Crisis care: 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization
Evidence-based outpatient substance use services (e.g., addiction counseling, medication-assisted treatment, addiction technologies, assertive community treatment, cognitive behavioral therapy)
Ambulatory and medical detoxification
Treatment for co-occurring addiction and mental illness
Screening, assessment and diagnosis, including risk assessment for substance use
Brief intervention and referral to treatment for problematic substance use identified during screening
Peer recovery support and family support services
Treatment planning, including risk assessment and crisis planning
Referral to outside providers for specialized substance use services outside the expertise of the CCBHC
Targeted case management

Launching and Expanding Addiction Service Lines

One-hundred percent of CCBHCs report leveraging their CCBHC status to expand the scope of their addiction treatment services. For many, these activities represent the first time such services have been available in their communities.



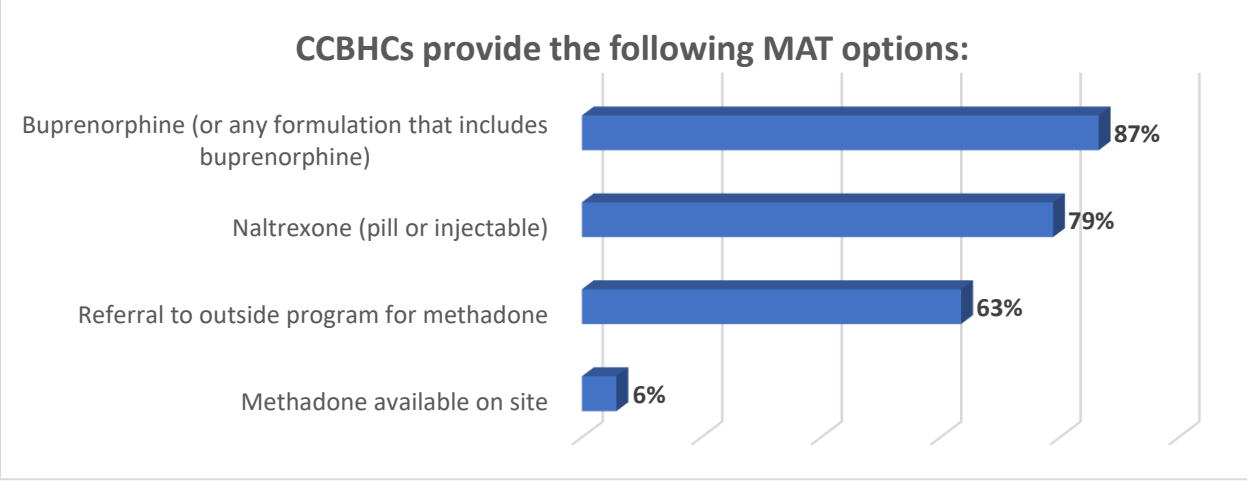
Catholic Charities of Trenton (NJ)
"Until now, our inner-city community has had no integrated treatment for addicted pregnant women or ambulatory detox treatment for Medicaid enrollees. Through CCBHC, we have been able to develop services to treat these vulnerable populations."

Facilitating Adoption of Medication-assisted Treatment

Medication-assisted treatment, or MAT, is a highly effective addiction treatment method that combines the use of medications with cognitive and behavioral therapies. MAT is the gold standard for opioid addiction treatment with medications such as methadone, buprenorphine and extended-release naltrexone consistently demonstrating positive patient outcomes. These results include: reduced drug use, fewer overdose incidents, reduced transmission of infectious disease though injection drug use and reduced criminal justice involvement. Despite its proven effectiveness, fewer than 10 percent of patients with opioid addiction receive MAT. Further, more than two-thirds of U.S. addiction clinics and treatment centers still do not offer MAT medications. Limited and inadequate insurance reimbursement, shortages of qualified treatment professionals and biases against MAT in favor of abstinence-based treatments have all contributed to the lack of available medication-assisted treatment programs nationwide.

The CCBHC model has spurred near-universal adoption of medication-assisted treatment as a complement to the full array of other outpatient services available. Ninety-two percent of CCBHCs offer at least one type of FDA-approved medication-assisted treatment, either on-site or via referral to an outside program.

CCBHC status has helped clinics expand access to medication-assisted treatment via expanded training and hiring: 92 percent of CCBHCs have trained or hired clinicians who can prescribe buprenorphine: **48** respondents reported that **168** of their providers have DATA 2000 waivers which are required to prescribe buprenorphine—an average of **3.5** per CCBHC.

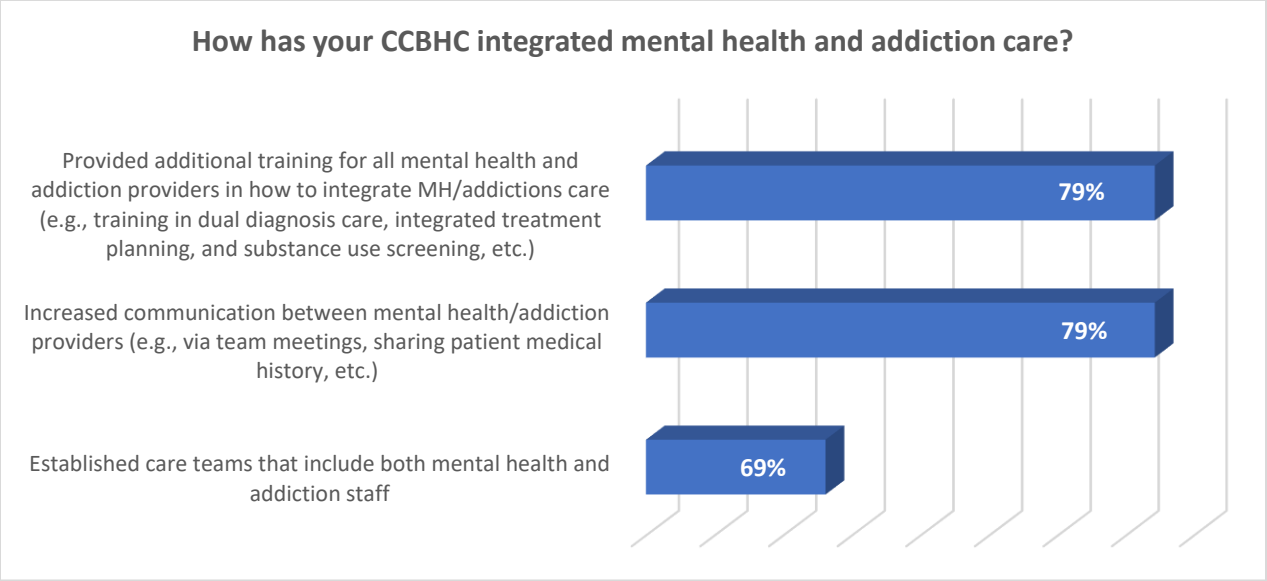


Family Guidance Center for Behavioral Healthcare (MO)
"Our [addiction] treatment staff are now better-trained to identify mental health concerns. Becoming a CCBHC allowed us to hire a second medical director who serves as medical director for medication-assisted treatment (MAT). This has increased availability of psychiatric care, MAT and utilization of MAT in our center… In the land we were in before [pre-CCBHC], that would never have been financially sustainable."

Advancing the Integration of Addiction Care

For an industry that has historically operated in a silo apart from the rest of health care, the CCBHC model represents a critical advance in coordinating and integrating addiction care. People living with addiction are at higher risk for co-occurring chronic physical health conditions such as hepatitis or HIV/AIDS. In many cases a mental health condition may underlie or exacerbate an addiction and addiction cannot be adequately addressed without also addressing physical and mental health issues.

CCBHCs serve a population with an especially high prevalence of co-occurring disorders: the majority of CCBHCs (**85 percent**) noted that more than half of their patients with an addiction have a co-occurring mental health condition such as schizophrenia or post-traumatic stress disorder. **One-hundred percent of CCBHCs have integrated mental health/addiction care by leveraging their payment rate to support staff hiring, training, care coordination and/or establishing referral relationships with other providers.**



Wallowa Valley Center for Wellness (OR)

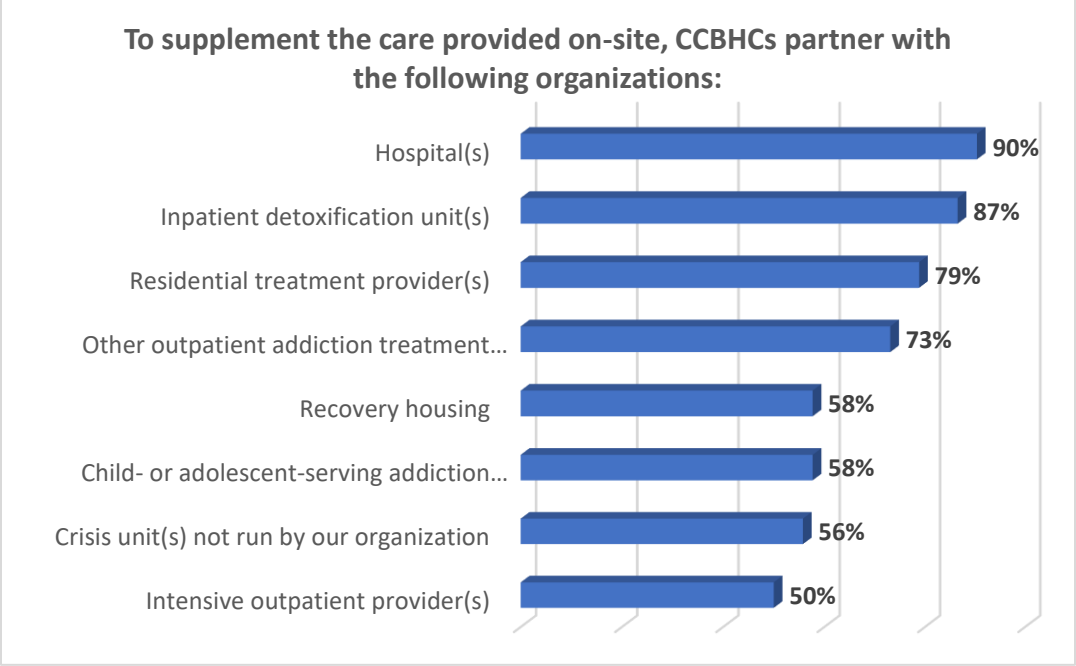
"Due to a fully integrated electronic health record with our federally-qualified health center (FQHC), we are better able to identify comorbidities in all clients served, and care coordination with primary care providers is seamless."

Berks Counseling Center (PA)

"Providing health screenings and assessments is part of our process as is blood work, taking vitals and providing physical health care on-site. We have identified untreated conditions of diabetes, cardio-vascular and other conditions, and referred patients to specialists for care. Better physical health significantly improves the patient's mental health as well as their ability to benefit from addiction treatment."

Ramsey County Mental Health (MN)

"A nursing screen is being done in all programs, including our mental illness/substance use disorder program. Our registered nurse helps connect patients with additional services if needed."



CCBHCs also report partnering with recovery services: **35 percent** partner with recovery community organizations and **8 percent** partner with recovery high schools or collegiate recovery programs.

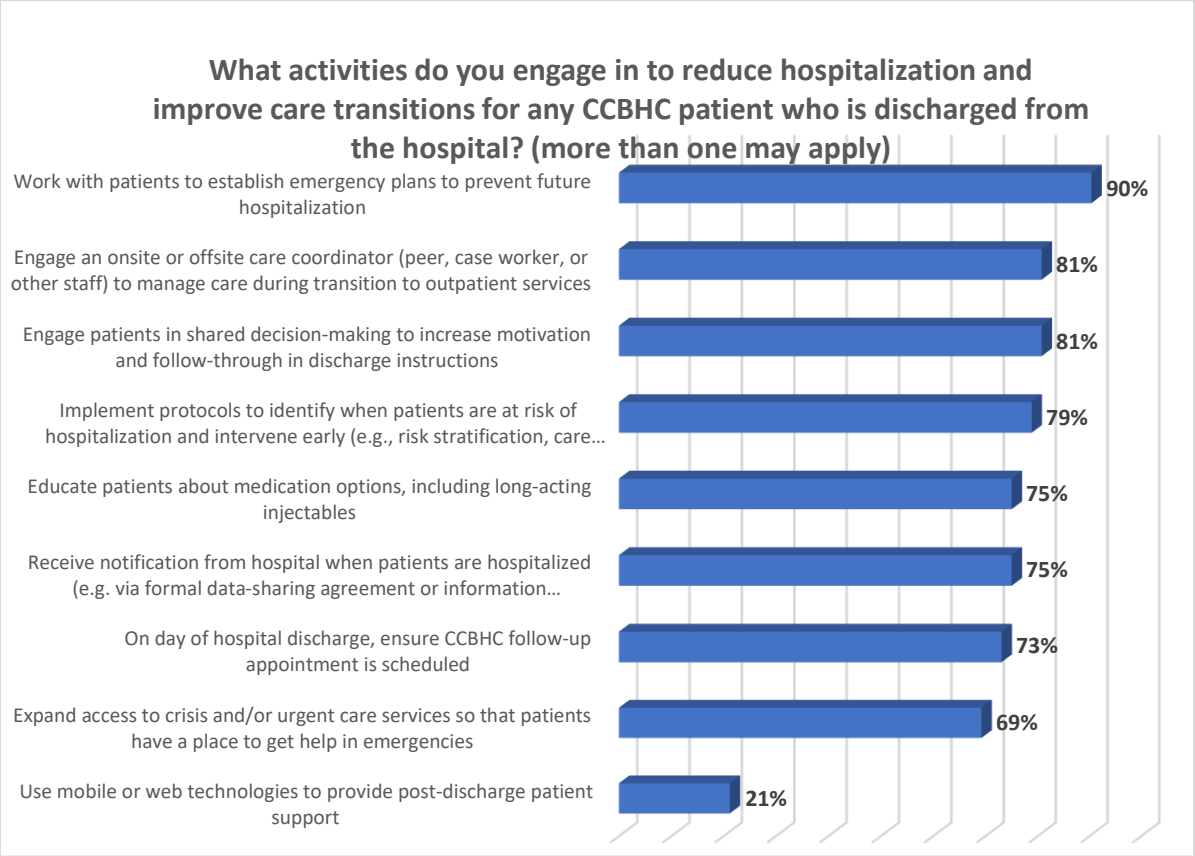
New Frontier Treatment Center (NV)

"The addition of recovery support services is proving to be an amazing addition to our services; clients are actually seeking out extra help now."

Reducing Hospitalizations by Improving Care Transitions

People living with mental illness or addiction have high rates of hospitalization and emergency room visits. During and post-hospitalization represents a critical intervention period in which an assertive care transition strategy can help patients initiate or re-engage in treatment with the goal of reducing future hospitalizations. Preventable hospitalizations are also a major driver of costs in the health care system. Unfortunately, traditional funding streams provide little support for partnerships, care coordination activities and engagement activities outside the four walls of a clinic that are known to improve outcomes and reduce hospitalizations.

CCBHCs have used their payment model to support activities to reduce hospitalizations and improve care transitions for CCBHC patients who are discharged from the hospital, including improved data collection and analytics to identify patients at high risk for hospitalization or readmission.



Grand Lake Mental Health (OK)

"As a result of becoming a CCBHC, we have partnered with a data mining firm to develop dashboards for all CCBHC quality measures. We are able to see real-time progress toward outcomes by comparing time frames and can drill down from location-specific data all the way to client- and clinician-specific information to determine where we are successful and where additional efforts are needed."

Hiring New Staff to Launch Addiction Services, Meet Demand

The nationwide shortage of addiction and mental health professionals has stymied efforts to respond to the opioid crisis. Meanwhile, inadequate funding hinders community-based providers' efforts to recruit and retain key staff, including physicians and other medical professionals, to serve people living with addiction.

A key goal of the CCBHC initiative was to expand clinics' capacity to serve more people via an expanded workforce**. In the first year of the program, across the CCBHCs surveyed, 398 new staff have been hired with an addiction specialty or focus**—an average of **8.3** addiction clinicians per organization.

An important benefit of the CCBHC payment model is its ability to support hiring of medical staff. As a result, **90 percent** of CCBHCs report having a psychiatrist(s) on staff with an addiction specialty or focus. For many CCBHCs, this is the first time they have been able to hire an addiction-specialty physician.

Future of the CCBHC Initiative: Congressional Action Needed

The CCBHC model advances addiction care by establishing a sound fiscal footing for certified clinics, reimbursing them for the full range of required addiction services and enabling them to expand service lines and patient caseloads to begin to fill the gap in unmet need in their communities. Unfortunately, under current law, the demonstration is limited to eight states over just two years. Despite widespread interest, 11 states that planned to implement CCBHCs have been shut out of the program due to the eight-state limit. **Meanwhile, the two-year timeframe means that current participants will see their progress in expanding access to addiction and mental health care stripped away when the program ends.**

Bipartisan legislation to expand the CCBHC model was introduced as **S. 1905/H.R. 3931** in the 115th Congress. In February, President Trump requested additional support for CCBHCs as part of his Fiscal Year 2019 budget request to Congress. In the FY 2018 omnibus spending package signed into law in March 2018, Congress included $100 million in new funding to supplement the CCBHC model. Despite this new grant funding, additional congressional action is needed to authorize an extension of the scope and length of the initiative. **The National Council for Behavioral Health urges Congress to take quick action to extend the life of this important program.**

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[1] Park-Lee, E. et al. (2017) Receipt of Services for Substance Use and Mental Health Issues among Adults: Results from the 2016 National Survey on Drug Use and Health. Accessed online at https://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FFR2-2016/NSDUH-DR-FFR2-2016.pdf

[2] In April 2018, the National Council for Behavioral Health surveyed CCBHCs about the impact of their addiction services in the program to date. Fifty-two of the 66 participating CCBHCs across the United States provided responses, with representation from each of the eight CCBHC states. This report highlights addiction service impacts of the CCBHC initiative as of April 2018.