Behavioral Health Commissioners Summit

Thursday, September 10th, 2020

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

NASMHPD

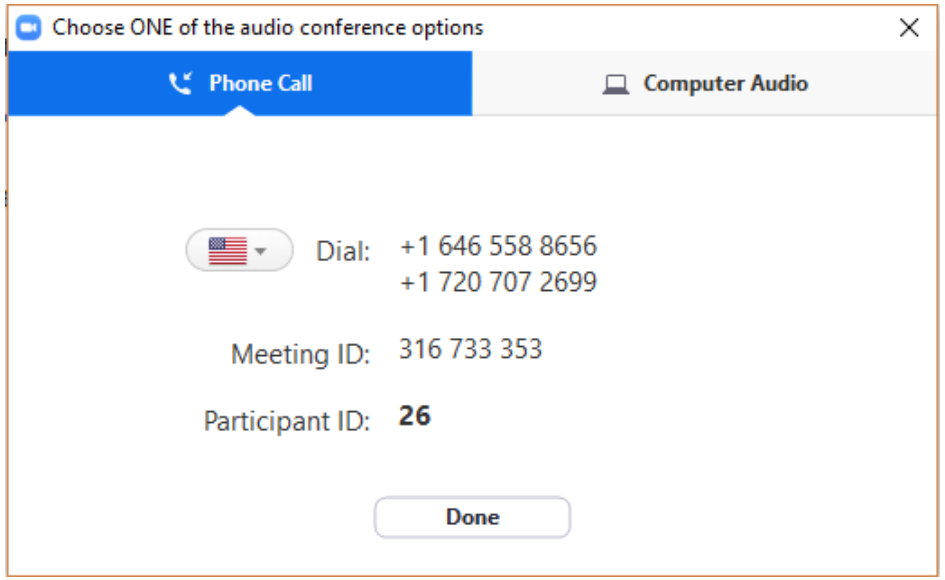
Supporting Excellence in Behavioral Health

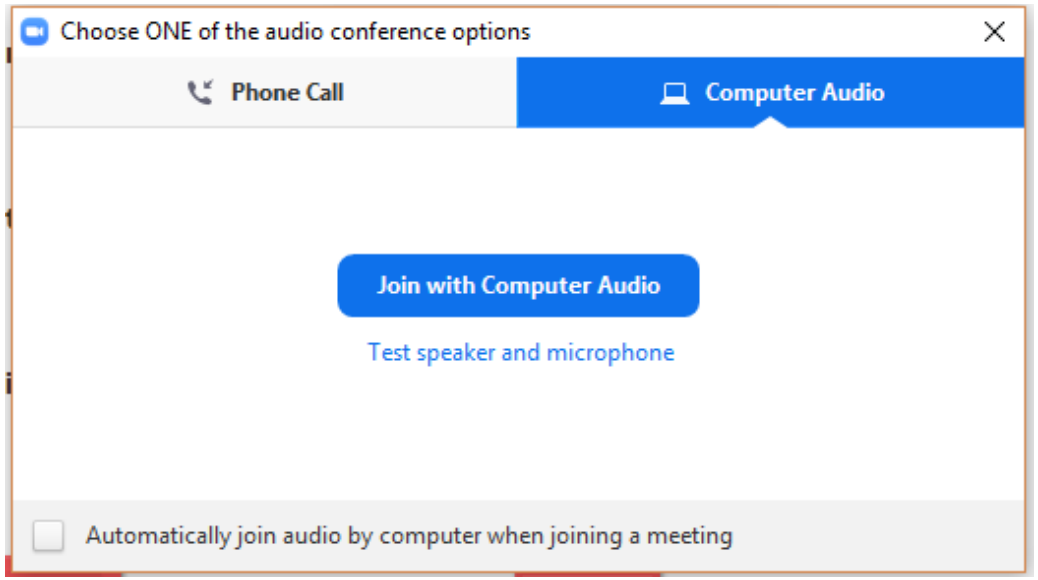
60 YEARS

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

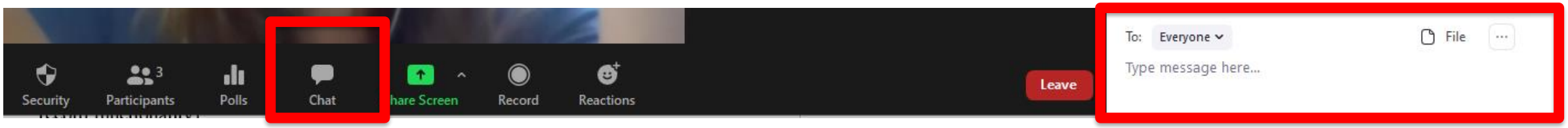
Zoom Logistics

- Call in on your telephone, or use your computer audio option
- If you are on the phone, remember to enter your Audio PIN so your audio and computer logins are linked





How to Share a Question or Comment

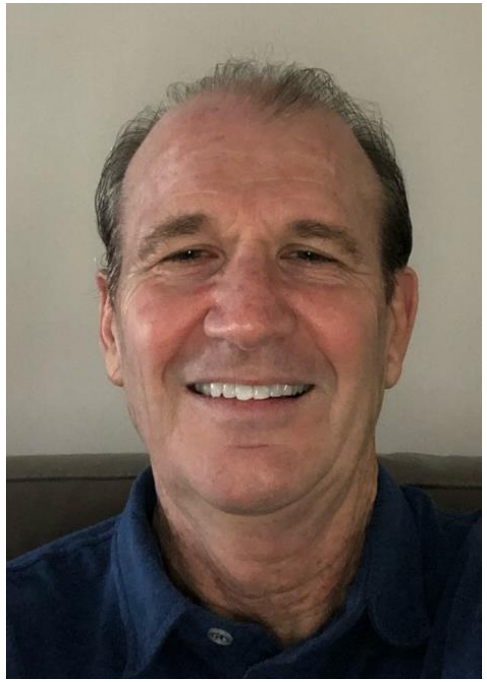


Type in the chat box located at the bottom of your screen.

You can choose who to send a chat to.

Welcome Remarks: Chuck Ingoglia and Brian Hepburn

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



Brian Hepburn, MD
Executive Director,
NASMHPD

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Today's Facilitator

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

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Agenda and Overview

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

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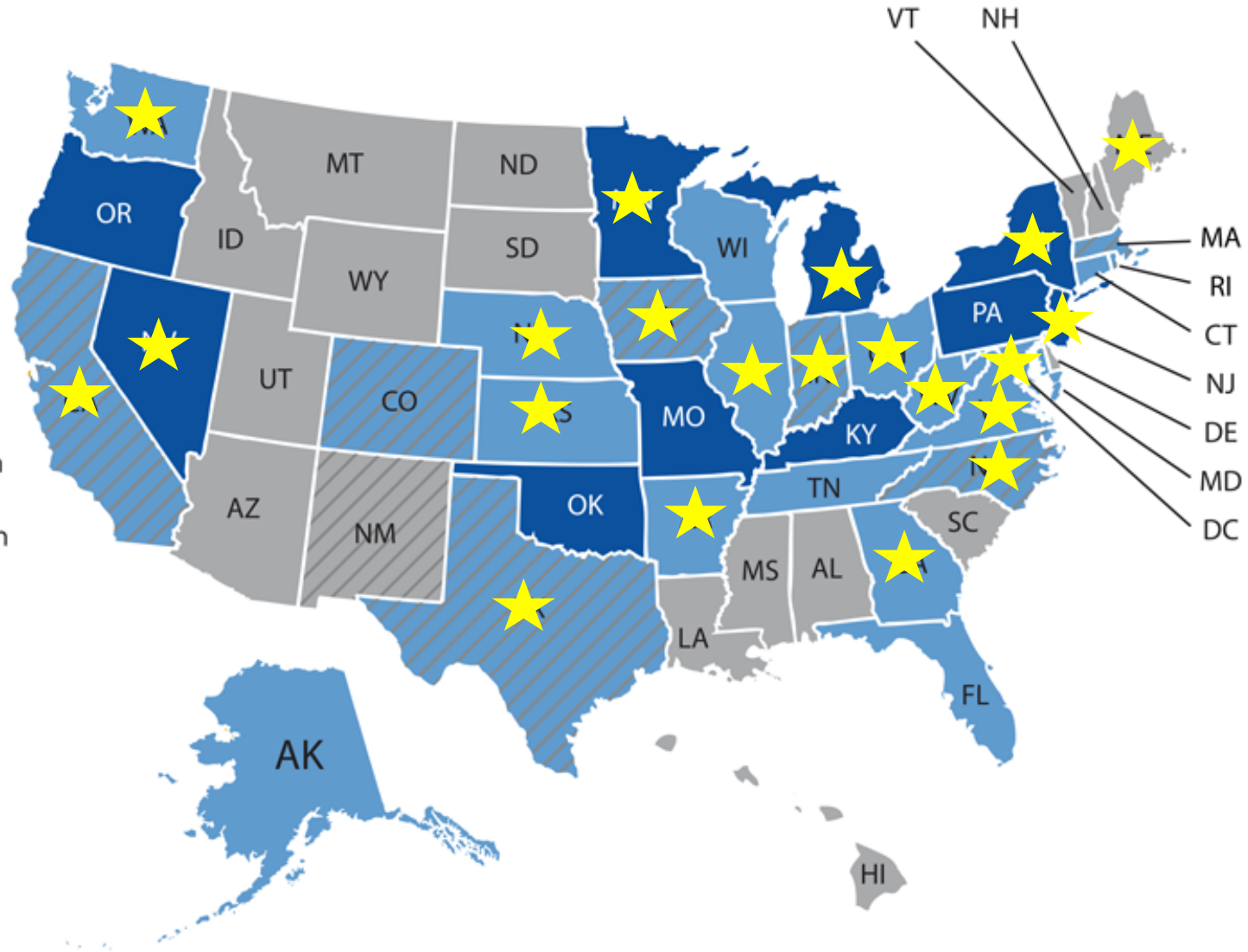
Status of Participation in the CCBHC Model

States selected for the CCBHC demonstration

States where clinics have received expansion grants

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

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



Forecasting of Behavioral Health Trends and Data

Kana Enomoto, MA
Senior Expert,
McKinsey & Company

McKinsey & Company

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Contents

Even before COVID-19, behavioral health conditions directly accounted for

~17%

of years lost to poor health and premature death in the US

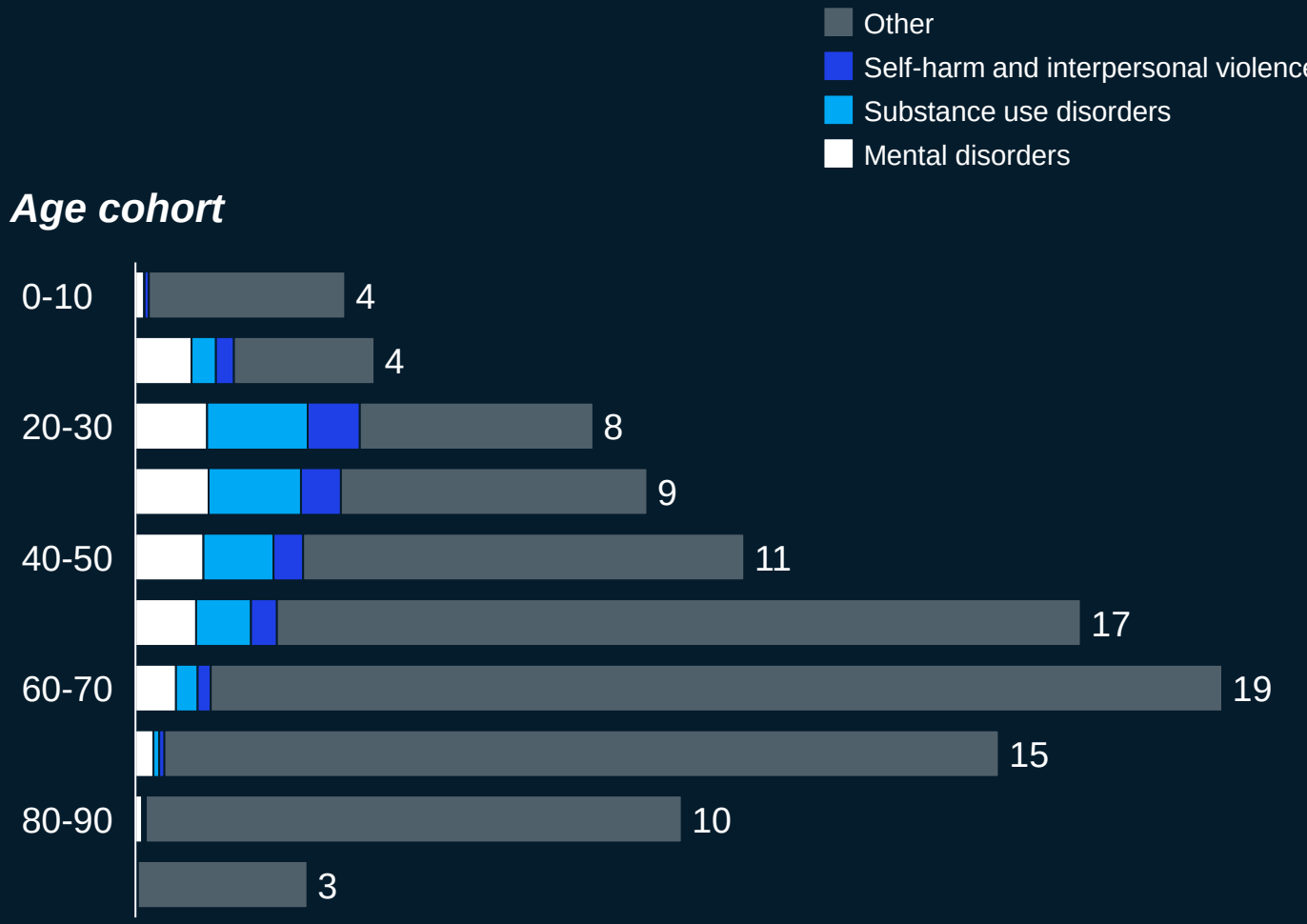
The cost to the US economy is

~$900B

annually[1]

Years lost to poor health and premature death in US in 2017[2]

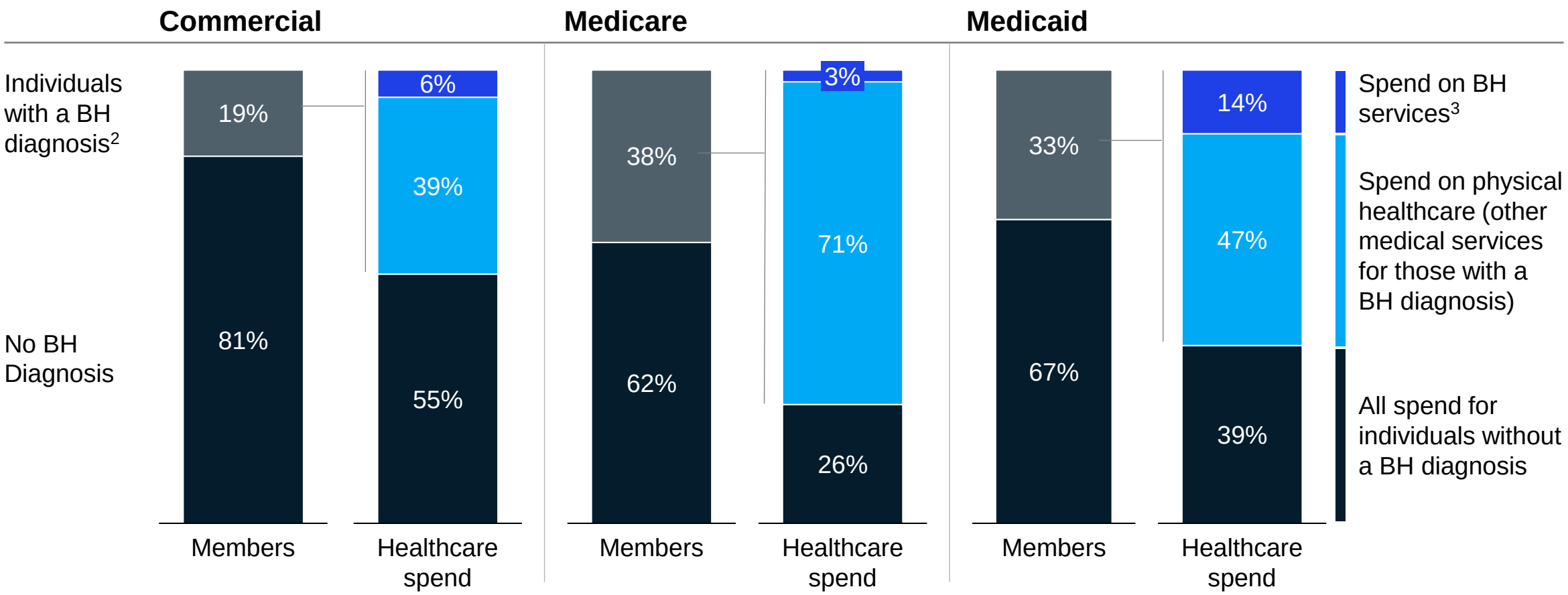
Million



1. Calculated for 2017; includes cost from loss of labor supply from early deaths in 2017, poor health, and loss of productivity
2. Years lost to poor health is the sum of years lived with disability and years of life lost in 2017 due to premature death

Source: US Disease Burden Database, IHME; World Bank; McKinsey Global Institute analysis

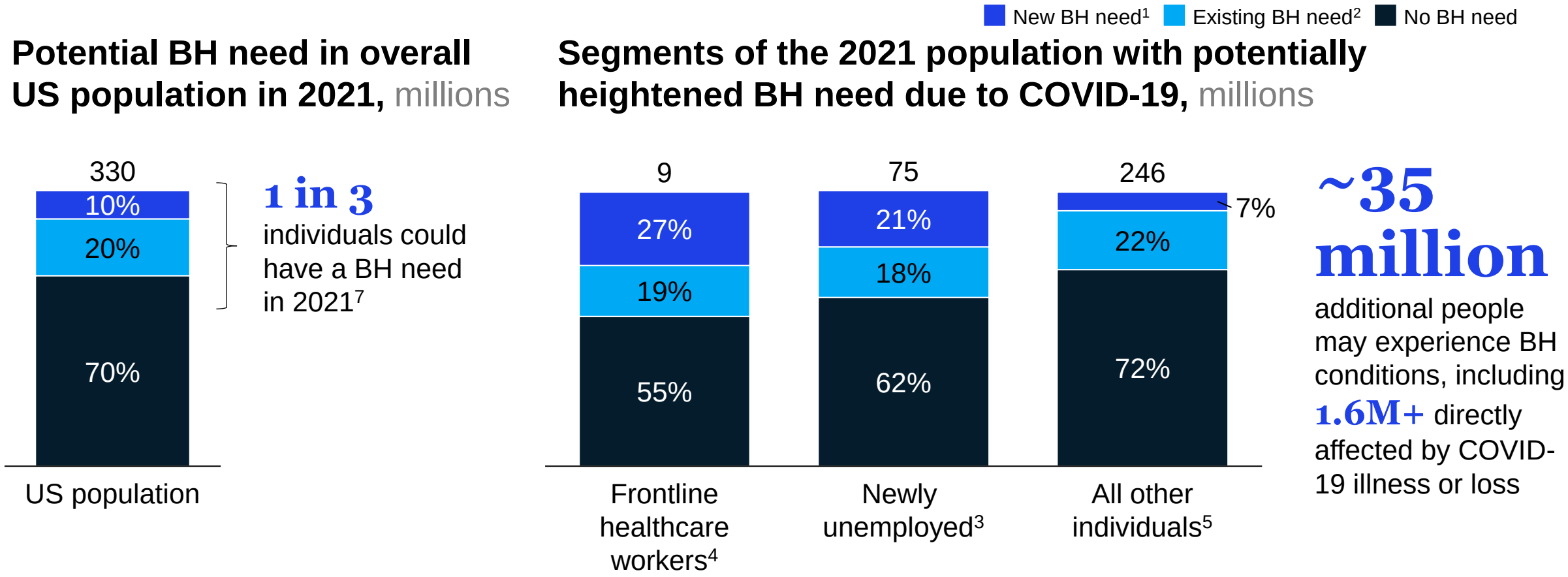
Across lines of business, individuals with behavioral health conditions account for significant healthcare spend1



1. Amount paid by payers on medical and pharmacy claims (excludes copays, deductibles, and out-of-pocket payments) | 2. One or more medical claims with a primary or secondary diagnosis of any behavioral health condition | 3.Includes claims with a primary diagnosis of a BH condition, as well as CPT, HCPCS, and NDC codes specific to behavioral health

Source: 2017 data from Medicare FFS Limited Data Set, de-identified Medicaid data, IBM's Truven MarketScan Commercial Database (any analysis, interpretation, or conclusion based on these data is solely that of the authors and not International Business Machines Corporation)

The COVID-19 pandemic could lead to a ~50% increase in the prevalence of behavioral health conditions



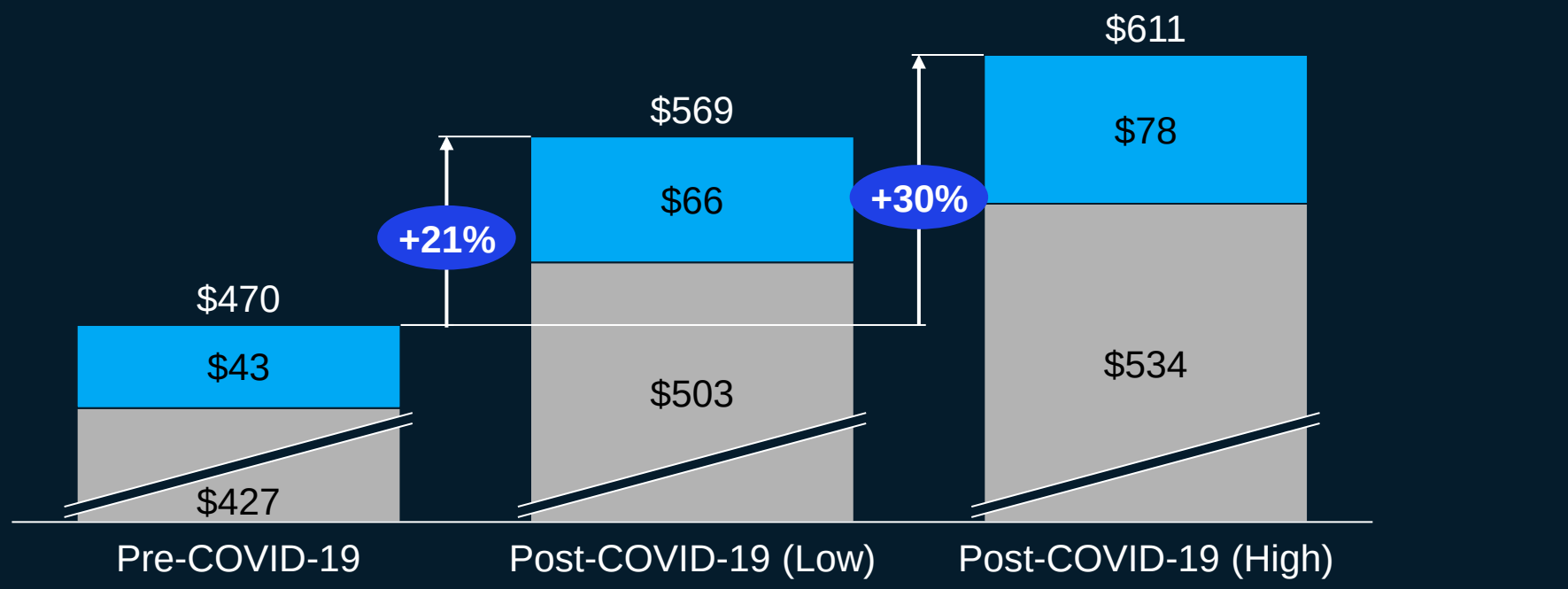
1. Individuals with new onset of a BH condition (~6% increase in BH population) as a result of experiences related to COVID-19 pandemic (e.g., depression, anxiety, PTSD)
2. Existing BH need extrapolated to total US population based upon Medicare LDS, blinded state Medicaid data, and Truven Commercial data. Assumes ~51.1M existing low BH needs, and ~1.7M existing high BH needs
3. Assumes ~24% unemployment rate in 2021 (total unemployment of ~75M) due to economic impact of COVID-19 and ~1.3X increase in BH prevalence for this population
4. Increase in BH condition prevalence (~1.5-1.9X) among hospital and residential care facility healthcare workers primarily driven by PTSD, anxiety, and depression
5. Individuals with existing or new BH needs that are not either newly unemployed or frontline healthcare workers (e.g., individuals and families sheltering in place, essential workers)
6. Includes increased BH prevalence (~1.5-1.9X) among those hospitalized due to COVID-19 or those that had a close family member die from COVID-19
7. Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

Source: Analysis includes claims data from the Medicare FFS Limited Data Set from the Centers for Medicare & Medicaid Services, deidentified Medicaid data, and the International Business Machines Corporation's Truven MarketScan Commercial Database. Any analysis, interpretation, or conclusion based on these data is solely that of the authors and not International Business Machines Corporation

A potential 50% increase in prevalence of BH conditions could lead to ~20-30% (i.e., $100B to $140B) of additional healthcare spend

Approximately **1 in 4** Americans has a BH diagnosis[1], but they account for **60%** of non-consumer healthcare spending[2]

Potential changes in total spend for people with BH needs before and during first year post-COVID-19,[3,4] $ billions



1. This does not include Tricare, Individual market, or uninsured populations
2. Accounts for reduction in spend for people losing employment and not gaining Medicaid coverage
3. One or more medical claims with a primary or secondary diagnosis of any behavioral health condition
4. Payer-paid amount measures on medical and pharmacy claims (excludes copays, deductibles, or out-of-pocket payments)

Source: Analysis includes claims data from the Medicare FFS Limited Data Set from the Centers for Medicare & Medicaid Services, deidentified Medicaid data, and the International Business Machines Corporation's Truven MarketScan Commercial Database. Any analysis, interpretation, or conclusion based on these data is solely that of the authors and not International Business Machines Corporation

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COVID-19 has led to vast unemployment, paired with pockets of income and racial disparities

~16% peak unemployment projected by the Congressional Budget Office, sustained at ~8-10% through end of 2021[1]

Black Americans were 3x and Hispanic/Latinx

Americans were 2x more likely to report loss of health insurance during the pandemic compared with white respondents[2] [3]

$12.5B
in tribal government revenue at stake due to shutdown of tribal gaming enterprises, risking financial viability of healthcare infrastructure

On top of the financial toll, Navajo nation has higher per capita rate of COVID-19 infection than any US state[4]

39% of jobs held by Black workers are vulnerable as a result of the COVID-19 crisis

compared with 34% of jobs held white workers[5]

40% of the revenues of black-owned businesses are located in the five most vulnerable sectors (e.g., leisure, hospitality, retail)

compared with 25% of the revenues[6] **of all US businesses**

1 Congressional Budget Office, https://www.cbo.gov/publication/56351.
2 McKinsey COVID-19 Consumer Survey as of 6/8/2020. Respondents were asked whether they have lost health insurance since the beginning of the Coronavirus / COVID-19 pandemic began (e.g., due to job loss), but exact reasons for job loss were not reported
3 Commonwealth Fund. How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care
4 The Harvard Project on American Indian Economic Development, https://ash.harvard.edu/files/ash/files/hpaied_covid_letter_to_treasury_04-10-20_vsignedvfinv02.pdf
5 McKinsey Global Institute analysis; 'Vulnerable' jobs are subject to furloughs, layoffs, or being rendered unproductive (for example, workers kept on payroll but not working) during periods of high physical distancing.
6 Analysis of 2012 Survey of Business Owners.

Source: McKinsey & Company, Jobs at Risk (States), McKinsey's article: "COVID-19: Investing in Black lives and livelihoods," Bureau of Labor Statistics

Medicaid enrollment could reach unprecedented levels, which may persist through 2021

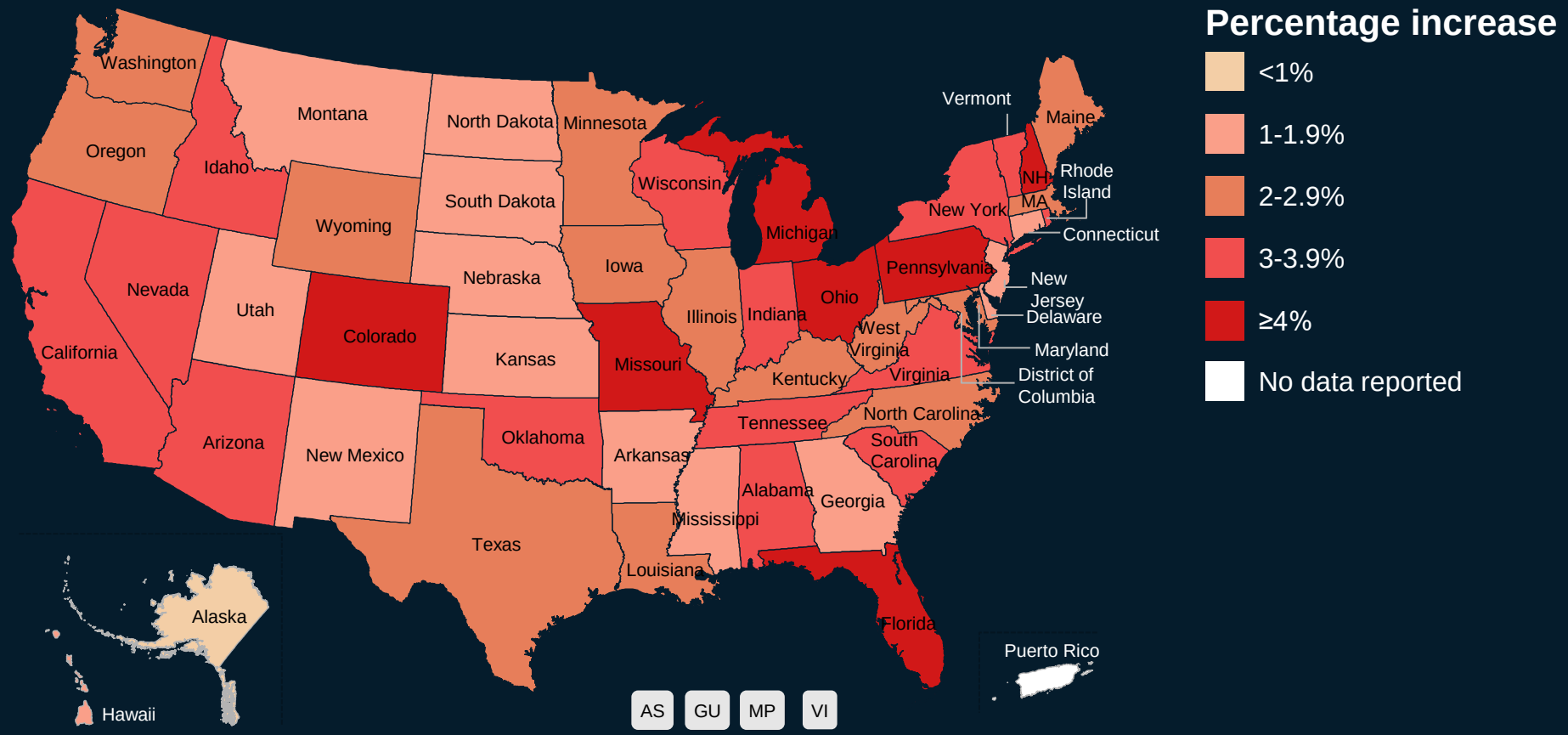
Factors contributing to Medicaid enrollment increase during COVID-19	Potential impact on enrollment through 2021
1 **Loss of coverage** Driven by unemployment-related loss of employer-sponsored coverage or financial strain	**2021 enrollment could remain higher than pre-COVID estimates**, as some COVID-19-driven loss of coverage could persist through 2021
2 **Regulatory flexibilities** Including autorenewal for all existing Medicaid enrollees, and "presumptive eligibility" which covers all COVID-19 related costs regardless of insurance coverage	**Reduced churn from autorenewal** could persist through 2020, and into 2021, with some states potentially phasing in reintroduction of renewal requirements in lieu of a drastic cut to enrollment

Medicaid costs will increase by significant amounts in different states

Under a baseline scenario[1], there could be an increase of 3.1% in Medicaid spending across the United States

California and New York have projected **Medicaid spend increases** of $4.8B and $2.3B respectively

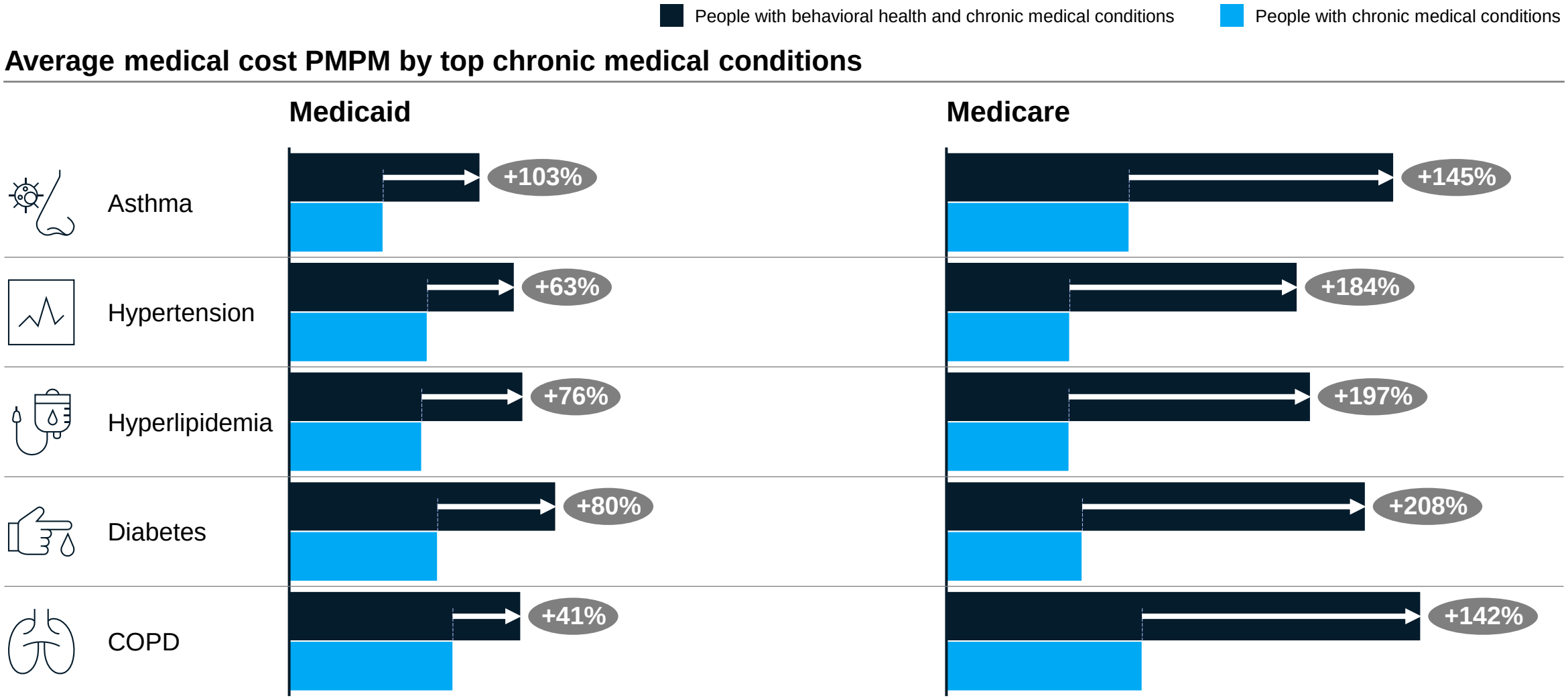
Medicaid spend increase



1. Deep recession in first half of 2020 followed by modest rebound. Travel and business restrictions in effect through late second quarter

Source: Moody's: Stress-Testing States: COVID-19 https://www.economy.com/getlocal?q=37F6F320-EF2A-4806-9AAB-EADE66FA0317&app=download

For members with BH conditions, the cost of chronic medical conditions is more than twice that of the rest of the population



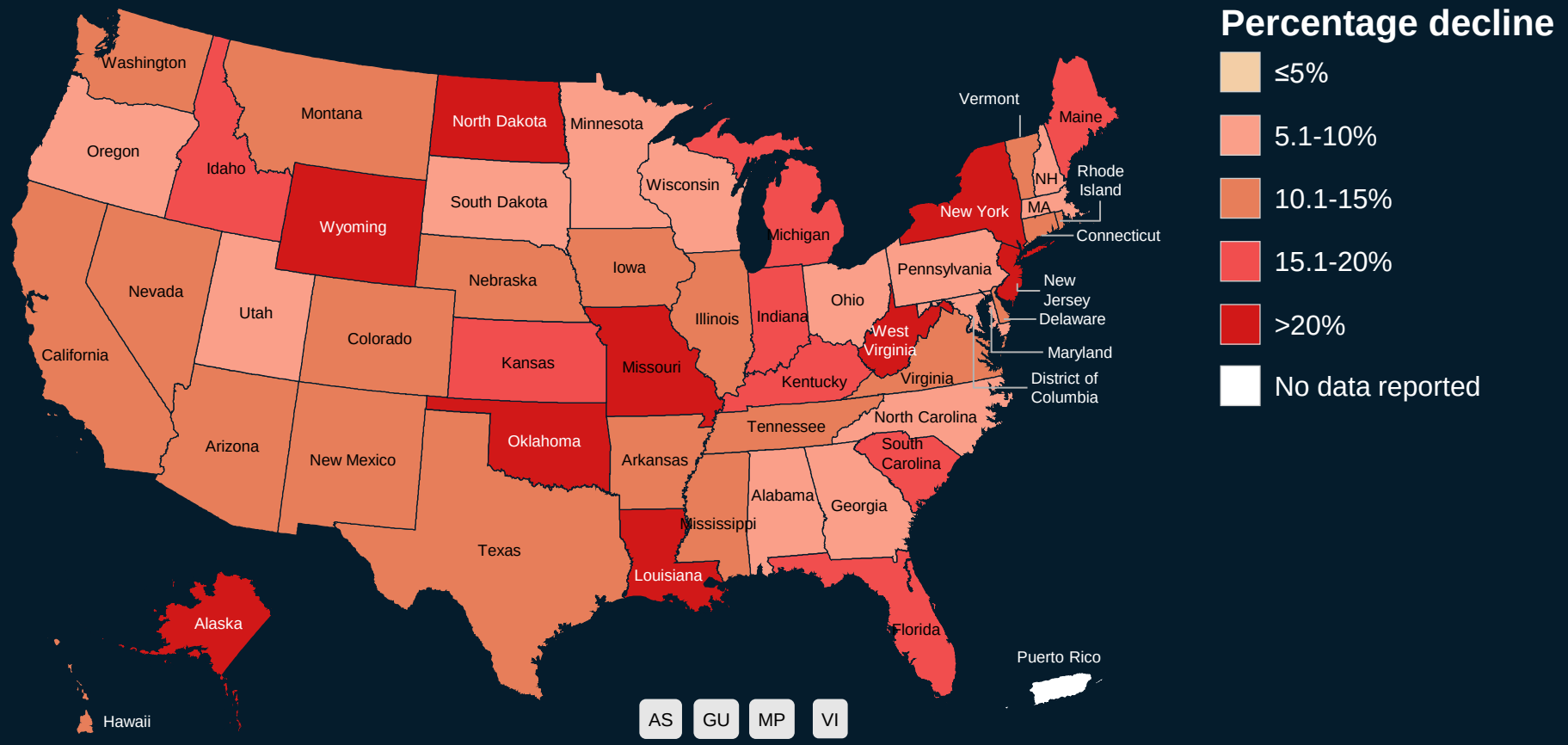
Source: 2018 data from Medicare FFS Limited Data Set, de-identified Medicaid data, IBM's Truven MarketScan Commercial Database (any analysis, interpretation, or conclusion based on these data is solely that of the authors and not International Business Machines Corporation)

Yet, financial pressures will persist as several states are projecting significant tax revenue declines

Among the largest states- including New York, California, and Illinois - **state revenues have fallen by 13%** on average[1]

California and New York have projected **budget shortfalls** at $61B and $54.3B respectively, for FY 2020[2]

Revised state fiscal year 2021 tax revenue declines



1. National Conference of State Legislatures; https://www.ncsl.org/research/fiscal-policy/coronavirus-covid-19-state-budget-updates-and-revenue-projections637208306.aspx
2. LA Times : "Governors across U.S. face tough choices as coronavirus takes its toll on state budgets" https://www.latimes.com/world-nation/story/2020-05-16/coronavirus-states-reopen-business-economy-deficit-jobs

Source: National Conference of State Legislatures; https://www.ncsl.org/research/fiscal-policy/coronavirus-covid-19-state-budget-updates-and-revenue-projections637208306.aspx, : Moody: Stress-Testing States: COVID-19 https://www.economy.com/getlocal?q=37F6F320-EF2A-4806-9AAB-EADE66FA0317&app=download

In the short term, the expanded federal match may alleviate some state budgetary pressures as Medicaid costs rise

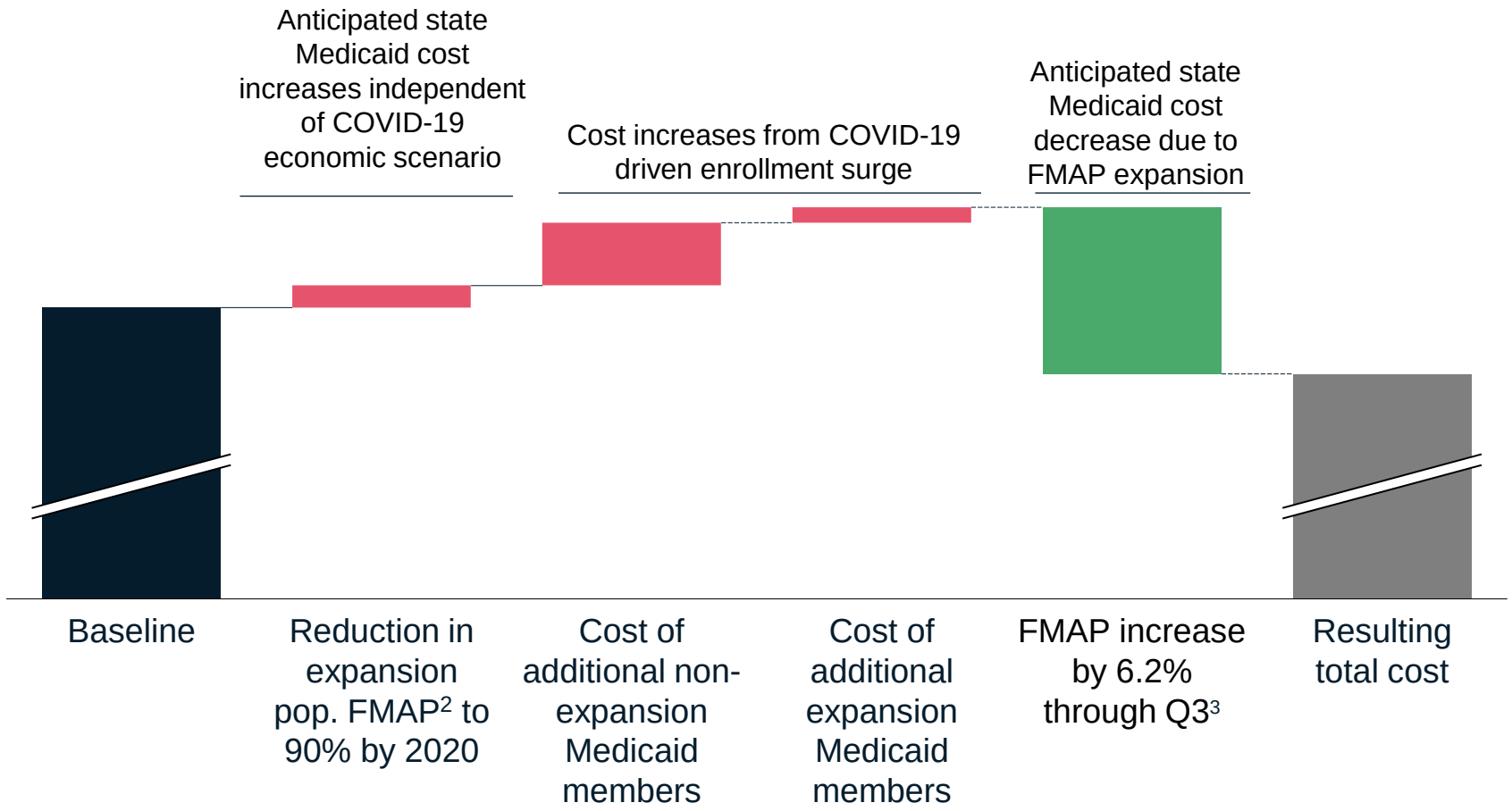
Though a slower-than-expected economic recovery would pose budgetary issues once expanded FMAP ends

Across expansion states, Medicaid cost as a percentage of total state revenues may increase, driven by:

- Increased enrollment of traditional and expansion members
- Anticipated changes to FMAP[2]
- Reduced state tax revenue

2020 projected state Medicaid costs[1] for expansion states in an economic downturn

California under B2 - Virus recurrence; slow long-term growth insufficient to deliver full recovery



1. Accounts for state portion of the cost (i.e., total cost less federal match). Assumes calendar year 2020 | 2. FMAP: Federal Medical Assistance Percentage, DSH: Disproportionate Share Hospital. | As of 6/10/20 DSH payment reductions have been deferred for 2020 and are thus not included | 3. Scheduled 6.2% increase in FMAP for non-expansion enrollees due to COVID-19

Source: Holahan J, The 2007–09 recession and health insurance coverage, Health Affairs, 2011;30(1):145–52; Jacobs PD et al, Adults are more likely to become eligible for Medicaid during future recessions if their state expanded Medicaid, Health Affairs, 2017;36(1):32–9; Moody's Analytics stress testing states, 2018; National Association of State Budget Officers, Fiscal survey of the states; McKinsey Healthcare Recession Model; McKinsey Medicaid Reform Model

Contents

COVID-19 has increased the importance of virtual health care

Demand for telemedicine from consumers

Provision of telemedicine from providers

Reimbursement of telemedicine by private and public payers

Before COVID-19

11% of consumers reported having ever used telemedicine in 2019

4% of providers reported using telemedicine for follow-up care before the pandemic began

Lower reimbursement from payers and narrow deployment of telemedicine

During COVID-19

46% of consumers are now using telehealth to replace cancelled healthcare visits

50-175x more telehealth visits relative to before the pandemic

57% of providers view telehealth more favorably

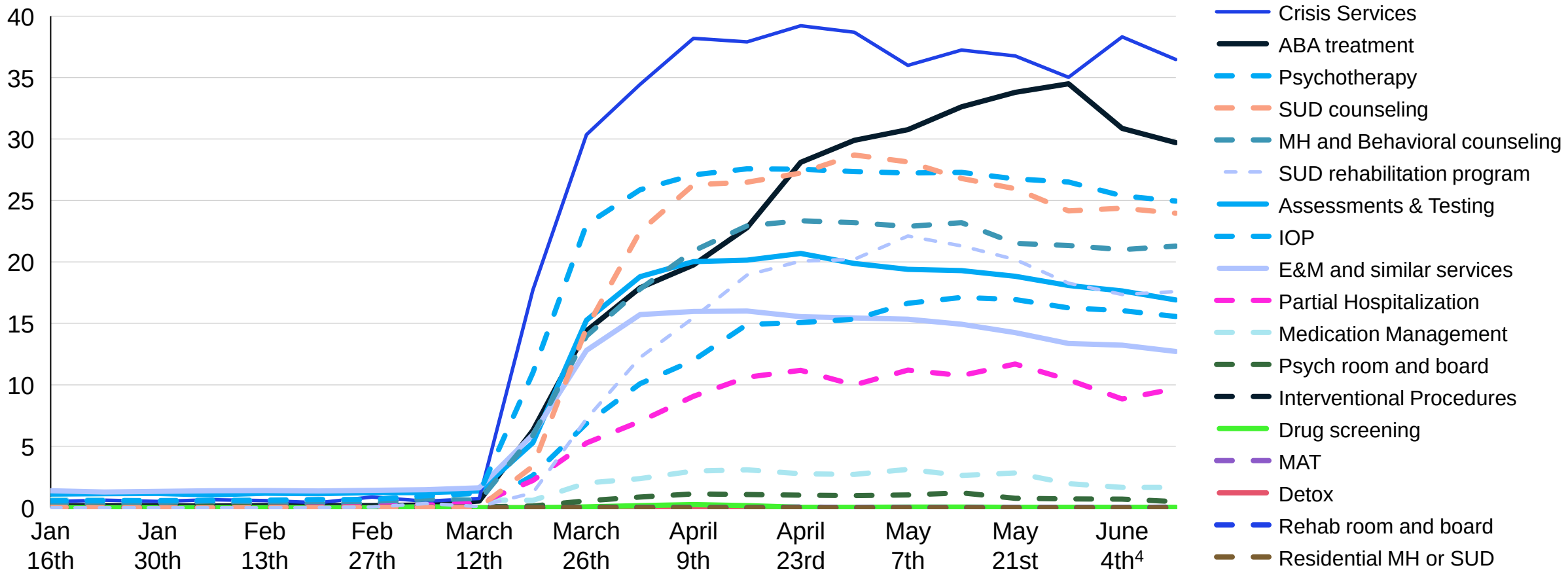
60% of employers are starting, expanding, or continuing to offer telehealth benefits

80 new services approved by CMS's new regulatory flexibility

Source: 2020 McKinsey Employer Health Benefits Survey, 2020 McKinsey COVID-19 Consumer Survey, 2020 McKinsey COVID-19 Physician Survey

Many behavioral health services have made major shifts to telehealth-based delivery

% of total behavioral health claims[1] in 2020 that are delivered through telephonic setting[2], by type of service[3]



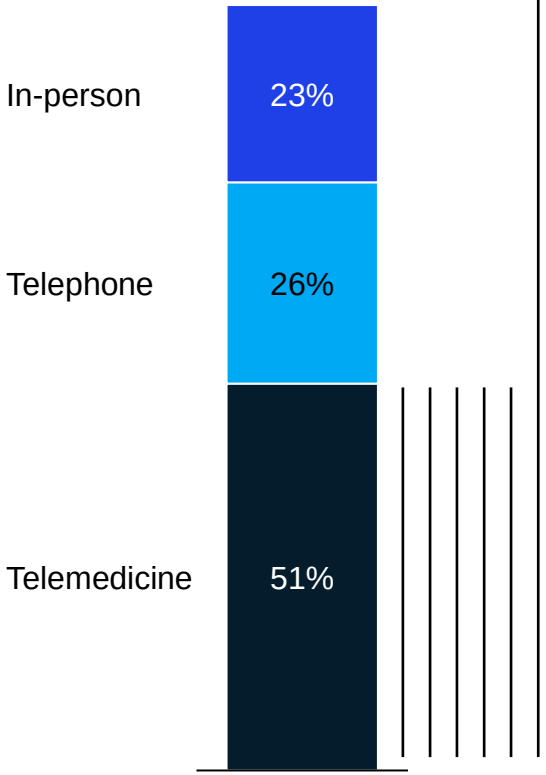
1. Claims with both a primary diagnosis of a behavioral health condition, and a procedure code or revenue code indicating behavioral health treatment; additionally, a subset of BH services shown for simplicity – not included are: ACT, Ancillary services, case management and care coordination, documentation, psychosocial services and supports, medication administration, and other/unspecified services with a BH diagnosis
2. Telehealth delivery identified by procedure code modifier 'GT'
3. Does not include pharmacy claims, only medical claims; note that some pharmaceuticals are billed through medical claims (e.g., methadone, specialty pharmacy)
4. Claims completeness is ~90% as of 60 days prior to date analysis was run, therefor data may not reflect full post-adjudication picture after early June

SOURCE: Compile Healthgraph Claims, all payor types, CY2019 and 2020

Satisfaction with tele-behavioral health is high; seeing healthcare providers they know is an important driver of consumer satisfaction

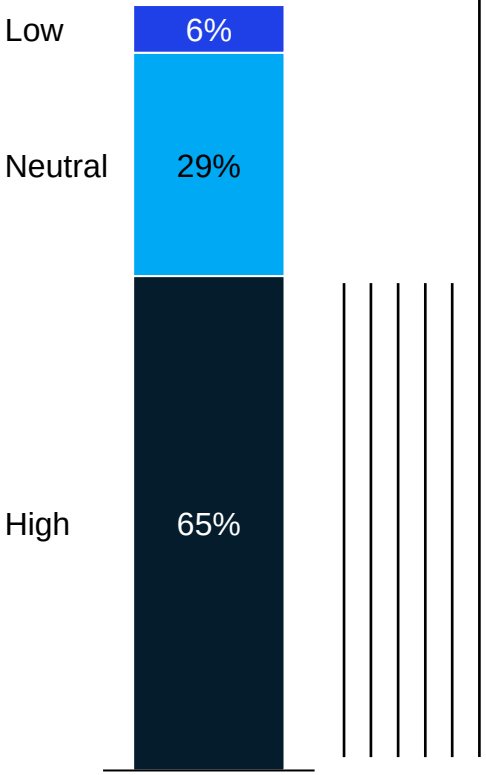
Modality of most recent appointment with a psychologist or psychiatrist

N = 95



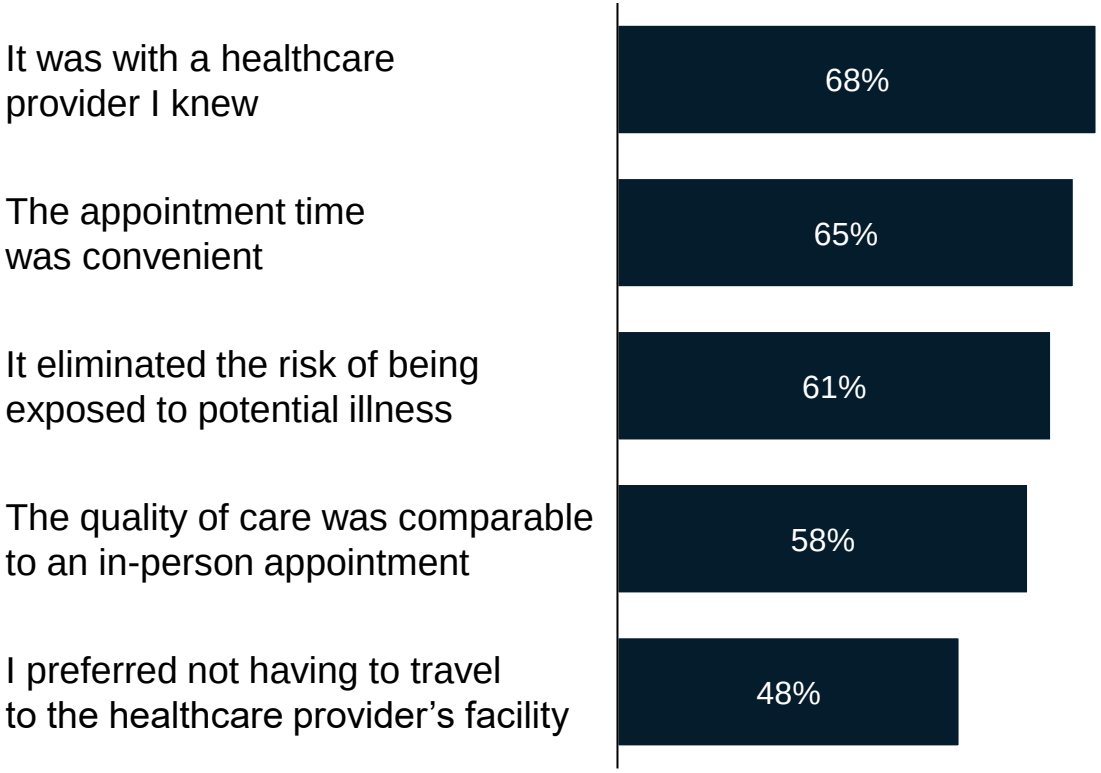
Satisfaction with tele-behavioral health visit

N = 48



Top reasons for high satisfaction

N = 31



Source: July 2020 McKinsey COVID-19 Consumer Survey

Tele-behavioral health leverages innovative digital tools that have received $4.3 billion in funding though June 2020

Type of innovation	Description	Private equity/venture capital funding through June 2020[1], $M	Examples
Digital platforms to provide care	Platforms that connect patients with behavioral health providers	1,352	DOCTOR on DEMAND, talkspace
Digital therapeutics	Clinically validated digitalized therapy options that can be prescribed to treat behavioral health conditions	924	AKILI, PEAR THERAPEUTICS
Patient self-help/ management	Support tools that enable people to manage their behavioral health conditions (e.g., guided/recorded exercises, suggested activities, daily reminders)	846	HEADSPACE, meQuilibrium
Data and analytics	Solutions that generate and deliver analytic insights, such as personalized behavioral health treatment plans or predictive analytics to inform early interventions	620	Quartet, lyra
Innovations in care delivery	Care delivery models that offer wraparound supportive services or integrated primary and behavioral health care	441	Medsphere, Netsmart
Electronic health record/workflow tools	Platforms that enable comprehensive patient management (e.g., case documentation, clinical information system, behavioral health electronic health records)	119	iorahealth, neurotrack

1. Reported funding by PEs/VCs, excluding debt financing, IPOs, acquisition deals; since start of 2015 and through Jun 30, 2020

Source: Crunchbase; Company websites

There are 4 major mechanisms for telehealth waivers to become permanent

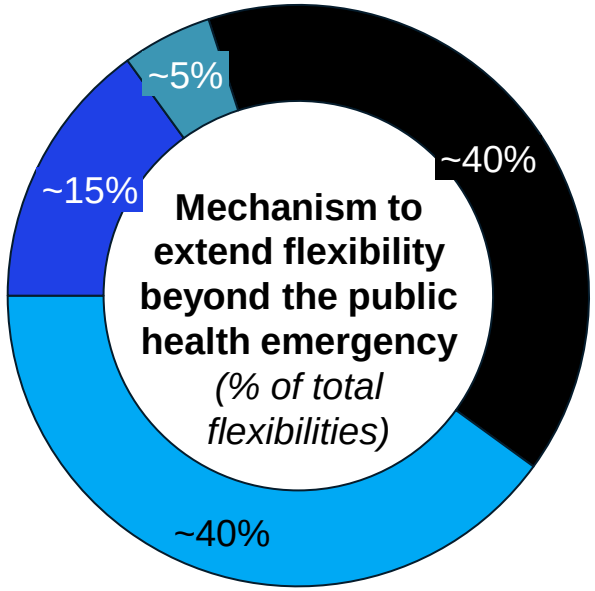
NON-EXHAUSTIVE

Guidance (clarifications of existing rules that are not subject to notice and comment periods)**:**

- Telehealth inclusion in MA risk adjustment calculations

Legislation (passed by both houses of Congress and then signed by the president)**:**

- Discretion for non-HIPAA compliant technology
- Utilization of health savings accounts to cover telehealth without first reaching the deductible



CMS waiver authority (broad authority for CMS to waive certain statutory and regulatory requirements for Medicare & Medicaid)**:**

- Audio-only telehealth flexibilities (Medicare)
- Federal Qualifying Health Center and Rural Health Clinic telehealth Medicare reimbursement rates
- Limitations on clinicians able to practice telehealth

Rulemaking (agency implementations of laws created with notice & comment periods)**:**

- Stipulating telehealth services able to be covered under Medicare
- Providing virtual check-ins to first time patients (Medicare)
- Allowances for remote patient monitoring (Medicare)

1. https://www.whitehouse.gov/briefings-statements/record-press-call-presidents-action-protect-seniors-diabetes
2. https://www.healthleadersmedia.com/innovation/senate-hearing-demonstrates-support-permanent-changes-some-telehealth-policies

Source: McKinsey Center for US Health System Reform team analysis

NOT TO BE CONSTRUED AS LEGAL ADVICE

Based on initial analysis, over **80% of the changes made to telehealth would not require congressional action** to keep in place after the pandemic (assuming willingness to use CMS' waiver authority)

CMS Administrator Seema Verma indicated that the agency is in the process of **reviewing these waivers ahead of the end of the public health emergency** and expect **some provisions to become permanent**[1]

The Senate Health, Education, Labor, and Pensions committee chairman Senator Lamar Alexander (R-TN) has specifically called for **originating site waivers** and **expansion of services available for Medicare reimbursement to remain after the emergency period**[2]

Contents

The behavioral healthcare system continues to face cross-cutting, interlinked challenges

Limited focus on **prevention and early intervention** programs for BH conditions

Low **levels of BH literacy** and lingering stigma relating to BH conditions

Low **integration** of physical health, behavioral health, and health-related basic needs

Lack of scale for **evidence-based interventions** for BH conditions

Lower **reimbursement** and under-funding of BH services

Shortage of **BH professionals** and physical health professionals with BH competency

Certified Community Behavioral Health Clinics (CCBHCs) can be effective models to address many of these challenges

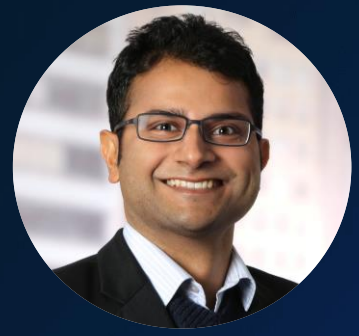
Challenge	CCBHC impact
Limited focus on prevention and early intervention programs for BH conditions	• Improved access to upstream, evidence-based care
Low integration of physical health, behavioral health, and health-related basic needs	• Coordinated care and integration of behavioral health and primary care • Financial incentives for reporting and care coordination
Lack of scale for evidence-based interventions for BH conditions	• Improved access to evidence-based BH care (e.g., MAT) • Bundled payments-enabled flexibility to create new services (e.g., street outreach, peer-run crisis respite)
Lower reimbursement and under-funding of BH services	• Comparable data across CCBHCs on quality and financial metrics • Increased financial transparency and payment tied to value
Shortage of BH professionals and physical health professionals with BH competency	• Enhanced FMAP and bundled payments to give providers more predictable budgets, enabling them to hire more BH professionals

Source: National Council for Behavioral Health

Thank you

Kana Enomoto

Senior Expert
Washington, D.C.



Nikhil Seshan

Engagement Manager
New York

Questions and Discussion

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The CCBHC Perspective from State Officials

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

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

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

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Perspective from Texas

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

TEXAS
Health and Human Services

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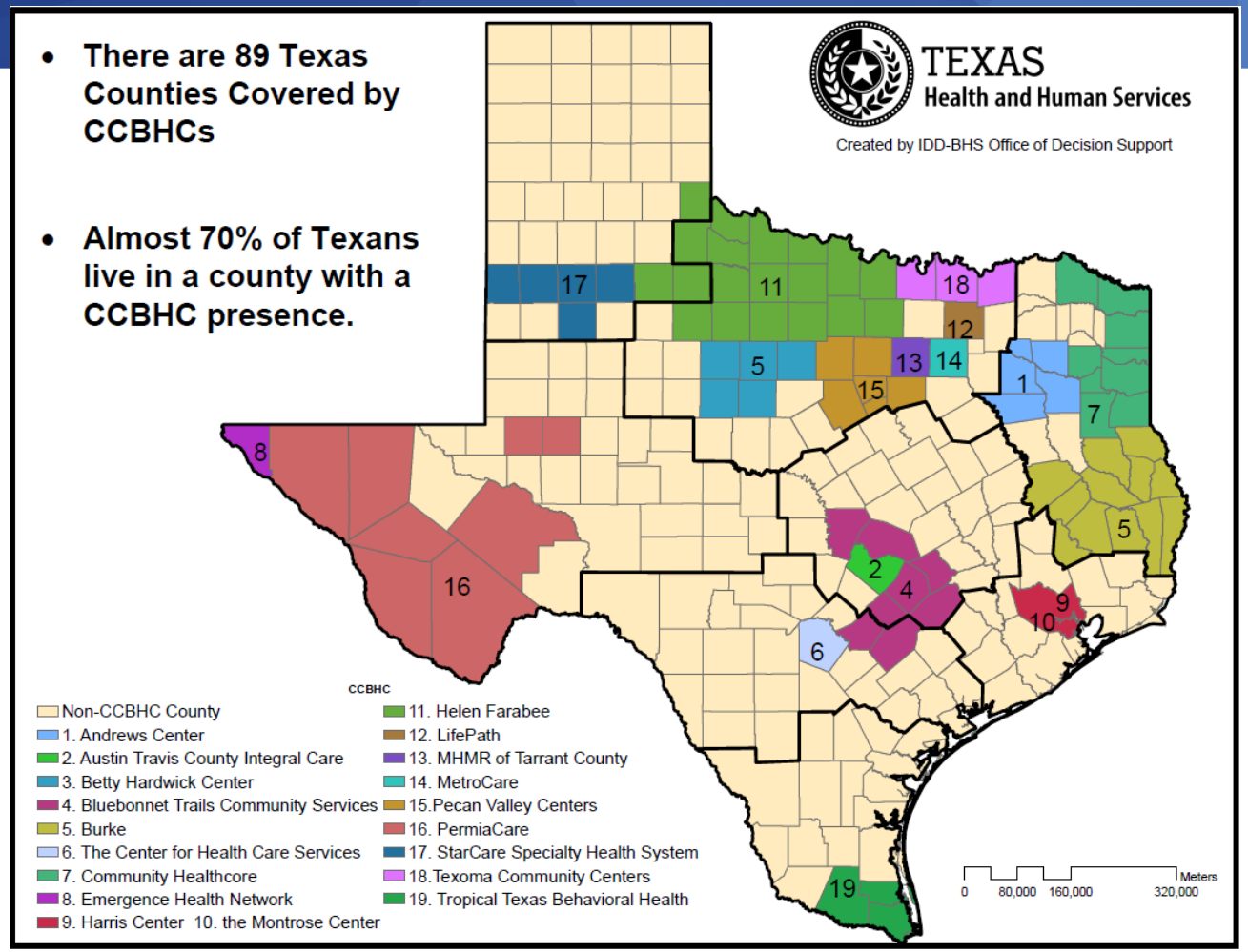
Building a Presence

TEXAS
Health and Human Services

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



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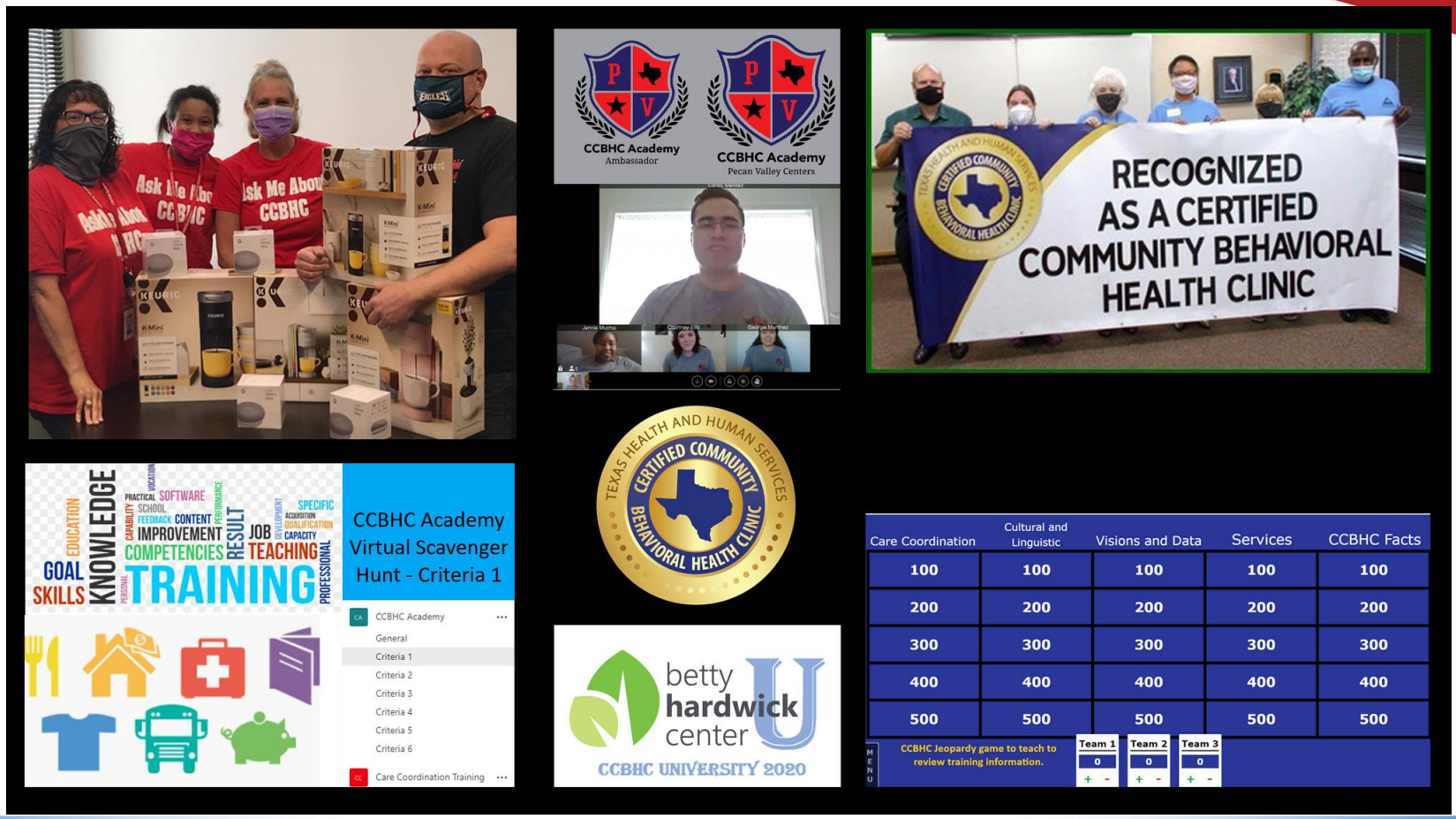
Building a Brand

TEXAS
Health and Human Services



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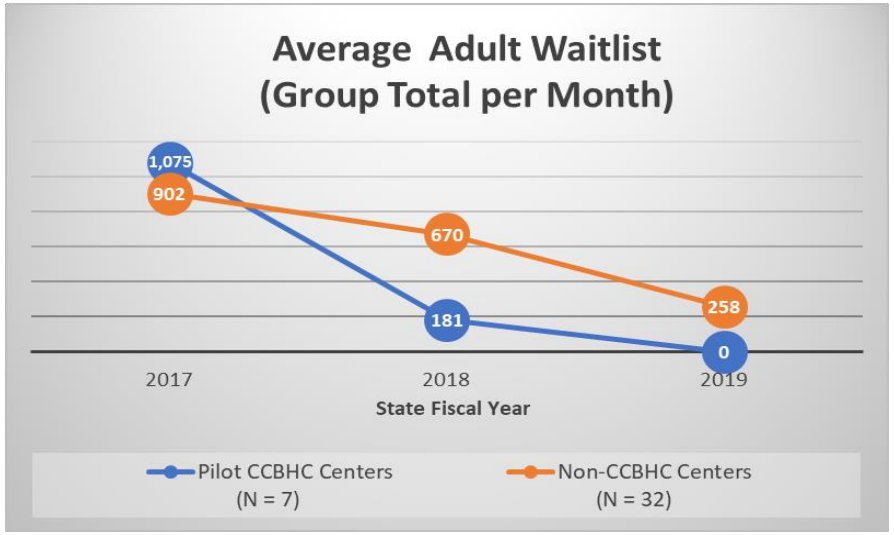
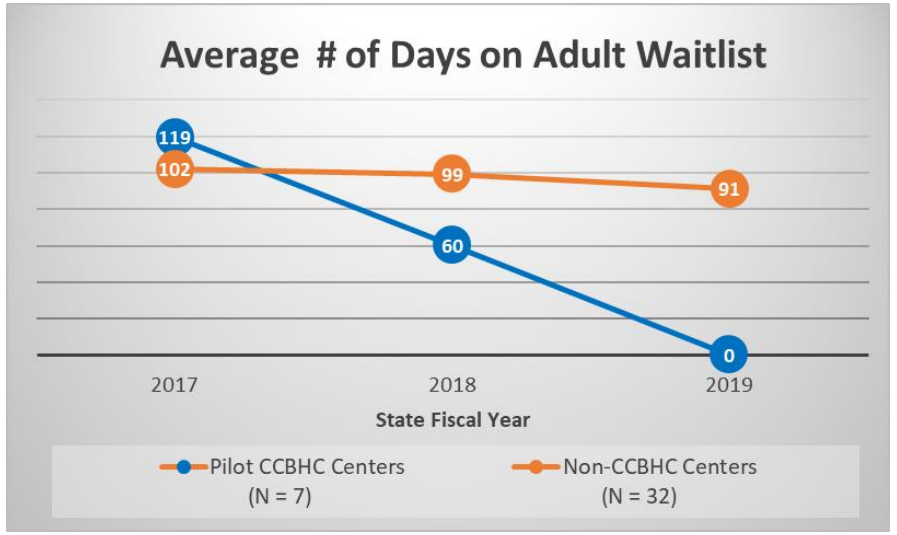
Early Outcomes

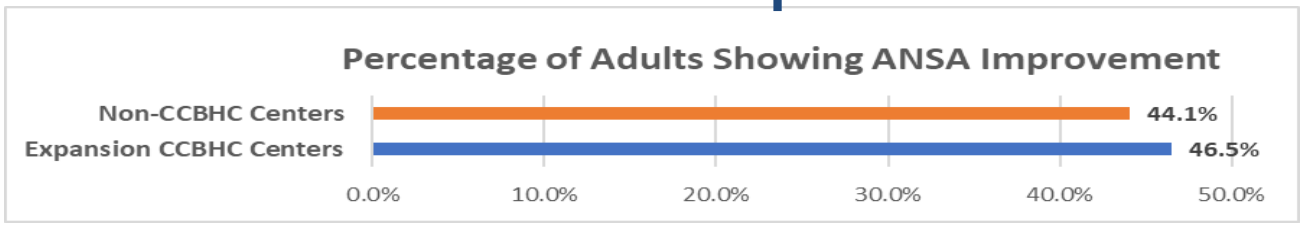
TEXAS Health and Human Services

Eliminated Adult Waitlists in Seven Pilot Sites





Adult Functional Improvement



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Guiding Principle

TEXAS Health and Human Services

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

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Texas CCBHC Contacts

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CCBHC Perspective from New York

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

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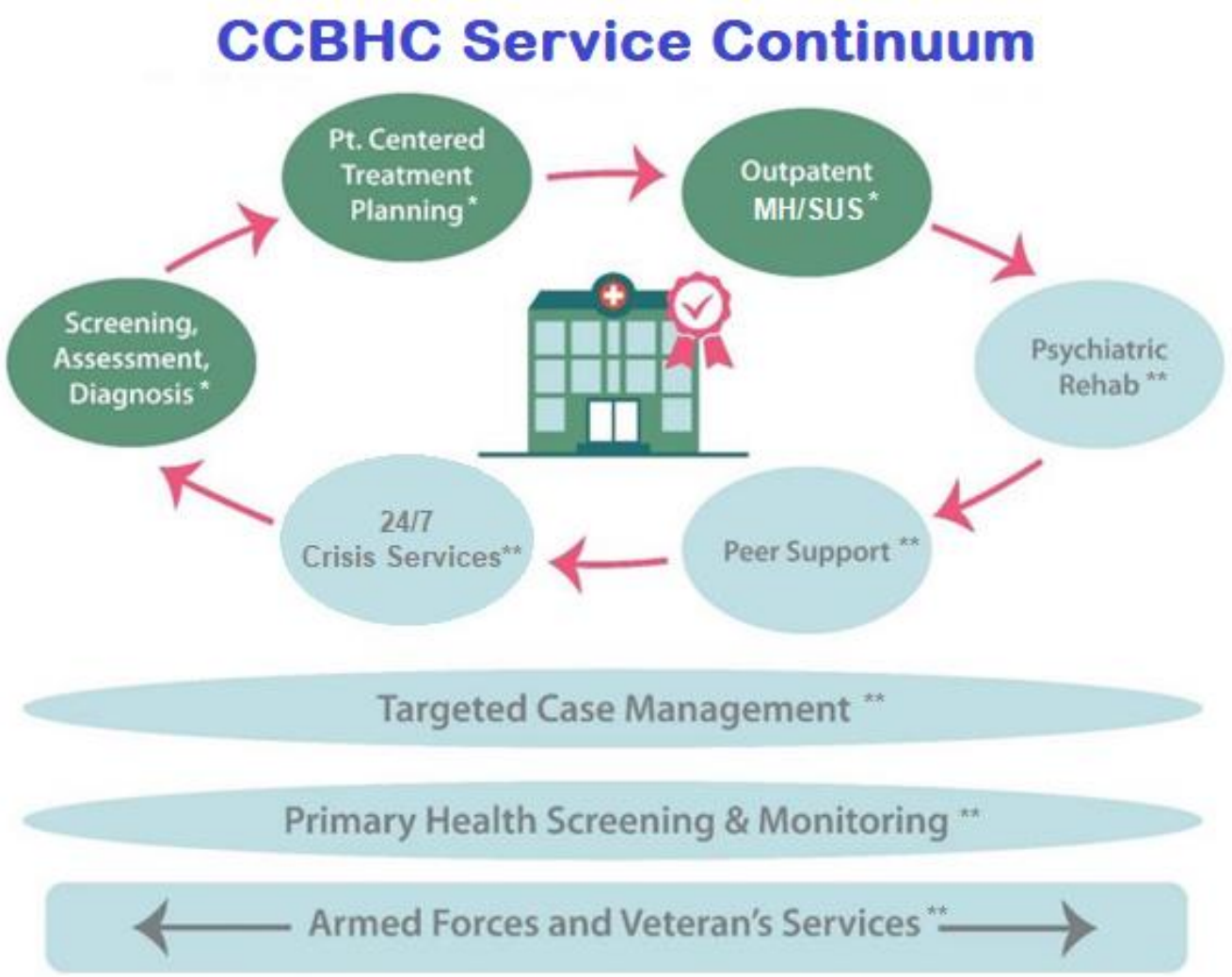
In NYS there are:

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



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

CCBHC Insights & Year 1 Outcomes: Access

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

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

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

CCBHC Insights & Year 1 Outcomes: Access

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

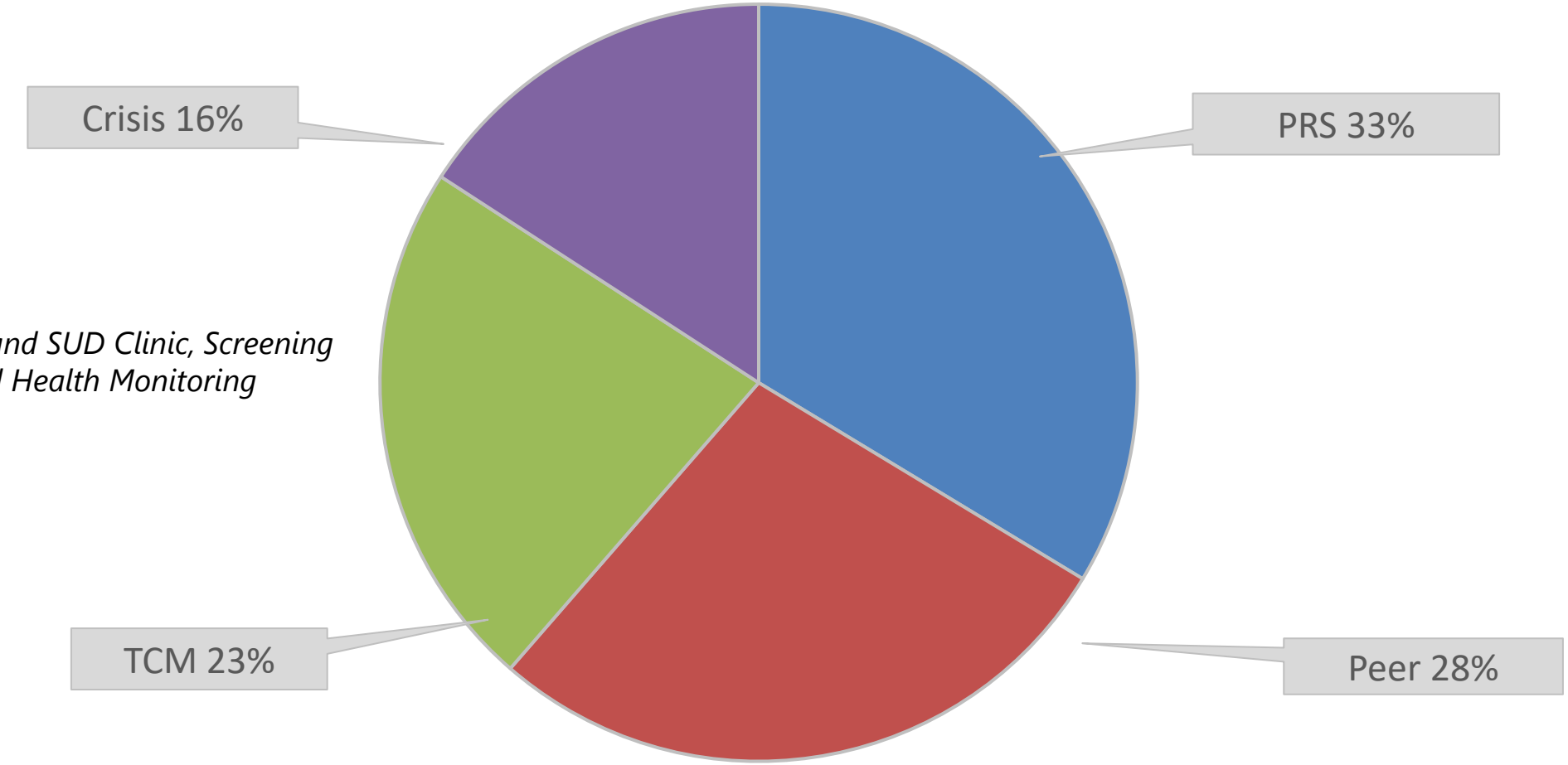
CCBHC Integrated Care

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

CCBHC Insights: Engagement

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

Distribution of Non-Clinic CCBHC Services



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

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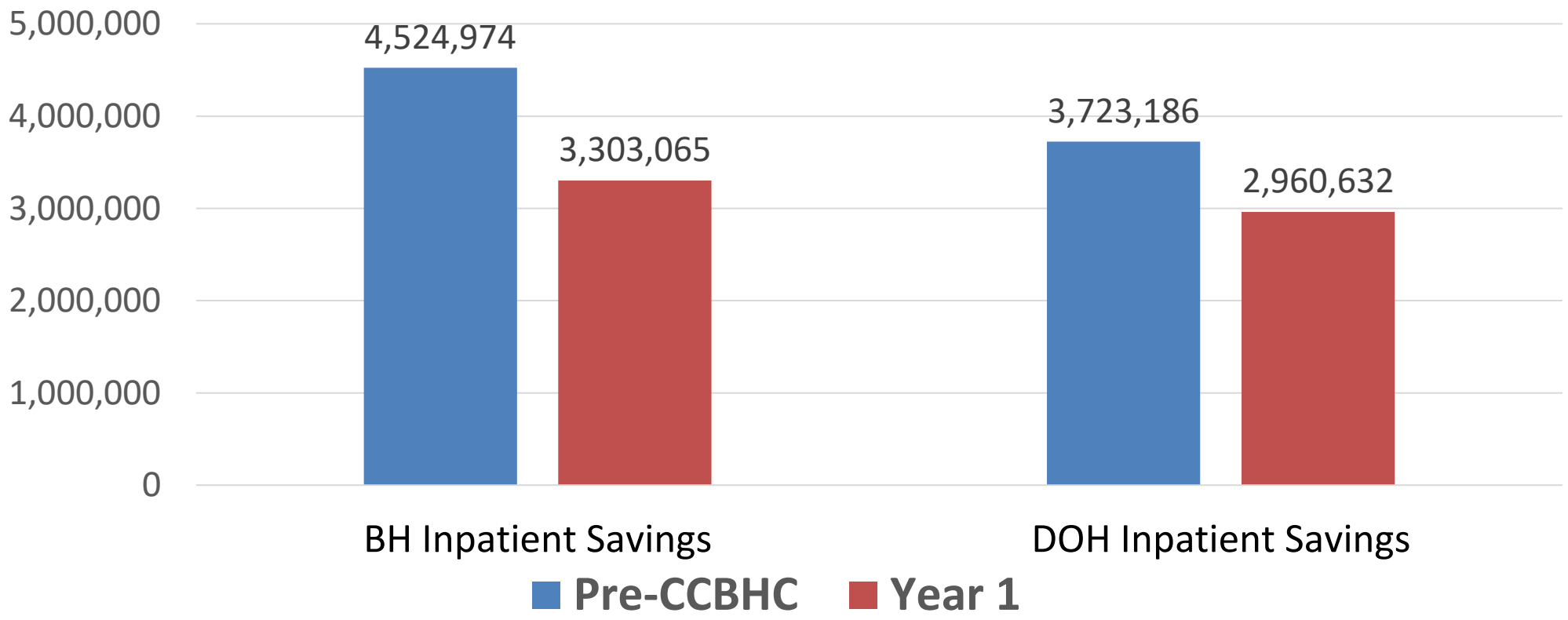
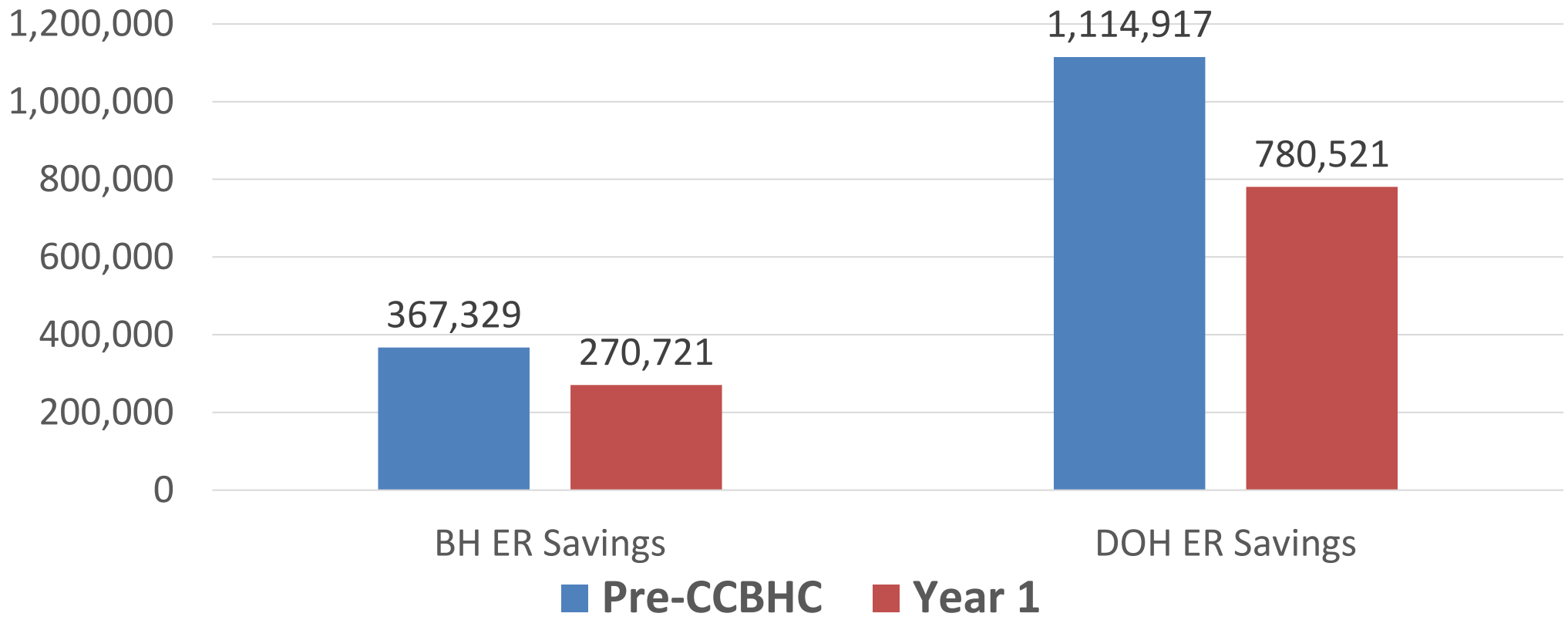
CCBHC Monthly IP Savings in First Year (in dollars)



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

CCBHC Monthly ER Savings in First Year (in dollars)



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

OMH/OASAS CCBHC Oversight

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

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

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

Finance: CCBHC Medicaid Rates

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

Challenges:

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

NYS CCBHC Sustainability Plan If Model is Discontinued

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

Takeaways of CCBHC Model

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

Perspective from Nevada

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

Nevada Department of Health and Human Services
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Transforming Nevada's Behavioral Health System

Why did your state pursue the CCBHC model?

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

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Transforming Nevada's Behavioral Health System

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

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

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

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Transforming Nevada's Behavioral Health System

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

✓ *State Plan Amendment*

Any barriers or facilitators in pursuing it?

✓ *Leadership and a culture of excellence*

✓ *All services were already in the state plan*

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

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

✓ *Multidisciplinary team approach*

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Transforming Nevada's Behavioral Health System

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

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

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Transforming Nevada's Behavioral Health System

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

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

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Planning and Implementation

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Questions and Discussion

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CCBHC Success Center (link)

Thank You!

Contact us: CCBHC@TheNationalCouncil.org

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