MDI Medical Directors Education:

NATIONAL COUNCIL for Mental Wellbeing

HEALTHY MINDS STRONG COMMUNITIES

CCBHC Medical Directors and Quality Measurement – Key Insights and Practical Examples, CQI Plan, and Link to Payment

January 23, 2025

Disclaimer

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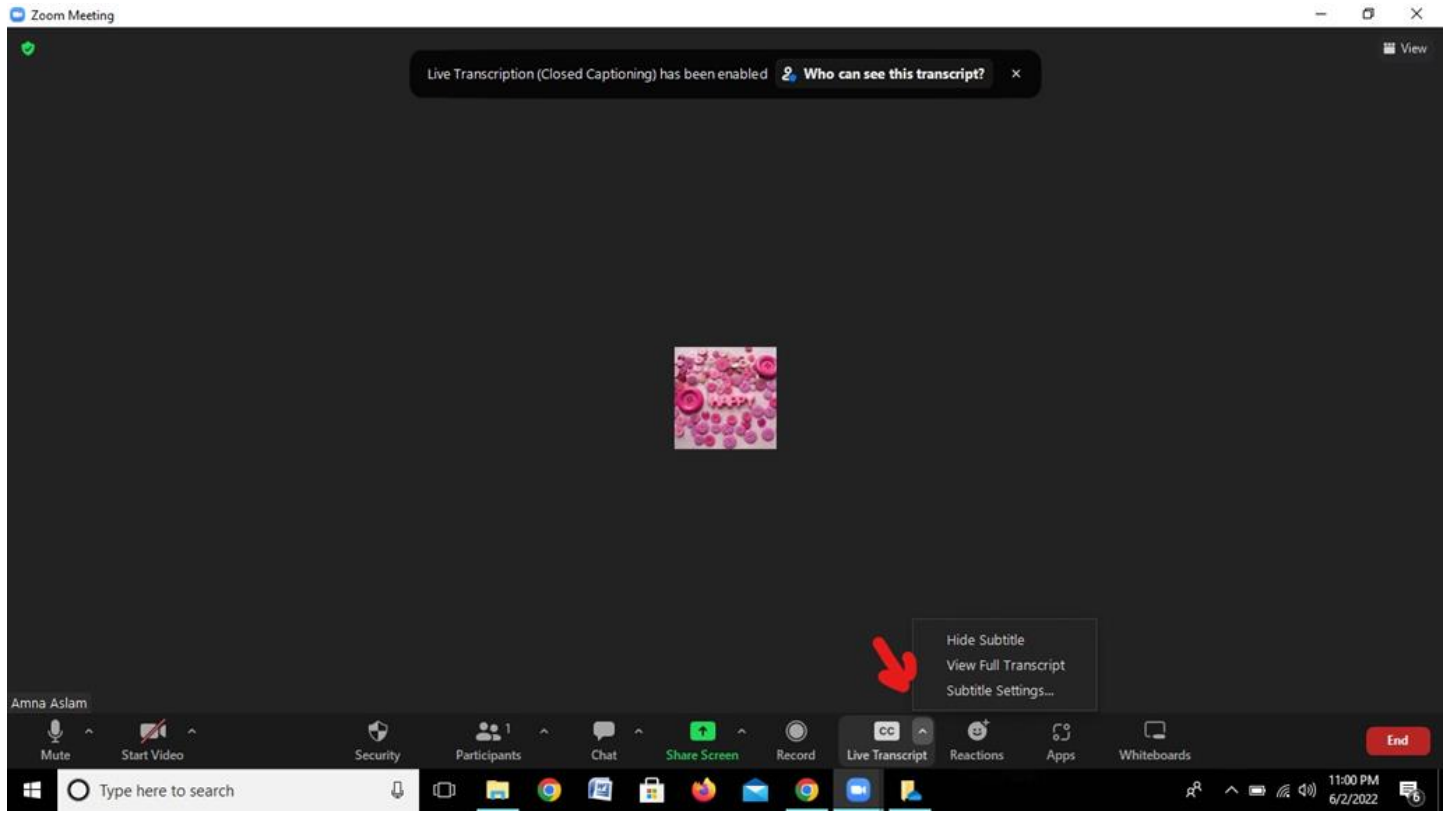

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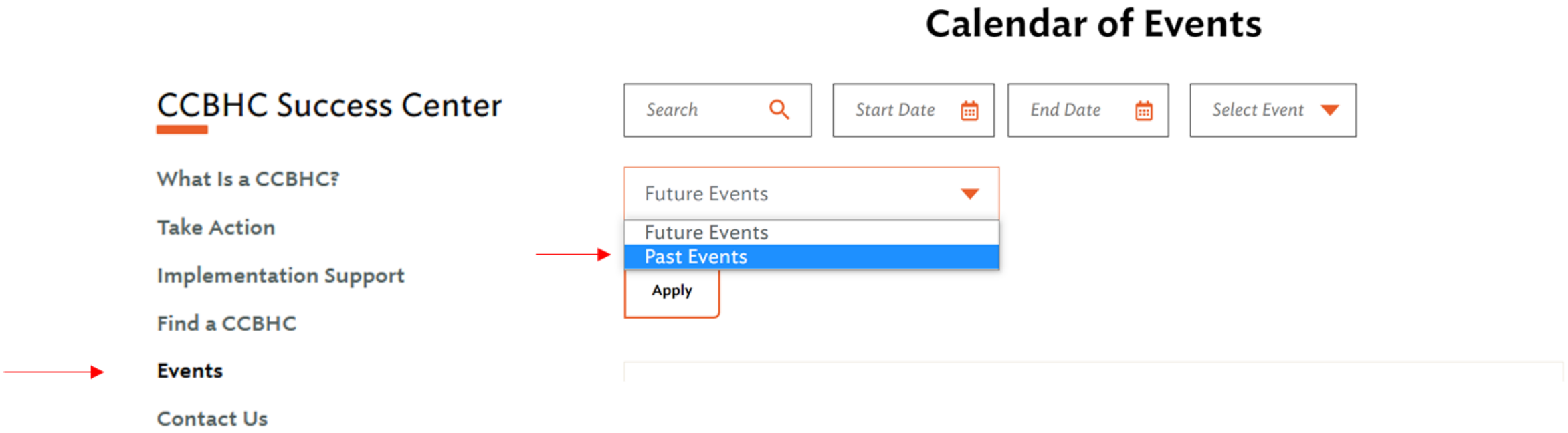
Today's Session: Slides and Recording

Slides and the session recording link will be available on the CCBHC Success Center website under "Past Events" within 2 business days.



Speakers

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Agenda

- Medical Director & Quality Measurement
  - Medical director involvement in clinical quality
  - CQI Plan
  - Key Insights and Examples
- CCBHC Performance and Payment
- Q&A

Medical Director & Quality Measurement

Medical Director Involvement in Clinical Quality

“The Medical Director is involved in the aspects of the CQI plan that apply to the quality of the medical components of care, including coordination and integration with primary care”

- Medical Director develops protocols for screening common physical health conditions.
- Medical Director establishes protocols conform to screening recommendations of USPSTF

Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria Updated March 2023 (samhsa.gov)

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Continuous Quality Improvement (CQI) Plan

- Addresses how the CCBHC will review known significant events including, at a minimum:
  - (1) deaths by suicide or suicide attempts of people receiving services;
  - (2) fatal and non-fatal overdoses;
  - (3) all-cause mortality among people receiving CCBHC services;
  - (4) 30-day hospital readmissions for psychiatric or substance use reasons;
  - (5) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan

Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria Updated March 2023 (samhsa.gov)

Assessing Organizational Approach to Quality

Leadership/Governance

Oversight Responsibility for Quality

Resources

Tools to support Quality (Incident Reporting, Dashboards)

Executive Supports

Board and Executive Team (Knowledge and Training)

Informatics/Data

Clinical Workflows and Data Reporting – inputs, outputs

Quality Expertise

Formal or Informal Training

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Assessing Medical Director Knowledge about Quality

- Quality Science – extensive knowledge base and structure on tools/measurement approach

- Tools to get started
  - Institute of Healthcare Improvement (IHI) Open School
  - Specialized Quality Training Programs (i.e. Johns Hopkins, Intermountain, etc.)
  - Quality project mentorship (Certifications in Lean, Six Sigma)

Example: Developing a CQI Plan

- Goals
- Governing Body
- Leadership
- Review Committees
  - Closed Records Review
  - Medical Peer Review
  - Pharmacy Peer Review
  - Nursing Peer Review
  - Licensed Professional Review
  - Institutional Review Board (IRB)
- System Quality, Safety and Experience Committee
  - Pharmacy and Therapeutics
  - Infection Prevention
  - System Accreditation
  - PI Councils
  - Internal Learning Collaboratives
  - Care Pathways

Example: Mortality Review

- Mortality (Suicide, Overdoses, All Cause): Closed Records Review Committee
  - Chaired by VP Quality
  - Incident Reporting Process (RL Datix Software) for all Death events reported to Staff
    - Quarterly/Biannual Matching with Medical Examiners Data
  - Monthly Review Meeting
  - Membership includes Clinical Providers and Department Leaders

Example: Incident Review

- **Sentinel Events:**
  - Root Cause Analysis (lengthier review with investigative process and recommendations)
  - Timeline analysis, detailed review of departmental involvement in case and opportunities for improvement
- **High-Risk Events:**
  - Precursor Safety Events or Events with High-Risk Exposure (Rights Violation, Elopement, Legal/Risk Implications, Staff/Patient Safety)
  - Clinical leadership across departments to review incident, assess for individual and systems improvements using Just Culture approach
- **Routine Review:**
  - Reviewed and closed by Local Unit Leaders, learnings disseminated at local level
- **Incidents are trended and analyzed, and reported** (System Quality, Safety and Experience Committee)

Example: Depression Remission Project

Goal: The purpose of this project is to increase the six-month remission rates of Major Depressive Disorder (MDD) for adult patients with an MDD Dx by 5 percentage points for fiscal year (Calculated Baseline # -> Improvement by 5%).

Charter Team

- **Clinical**
  - **Medical**
    Nursing
  - **SW/Clinicians**
  - **Pharmacists**
- **Operations**
- **Quality**
  - **Data Analytics**
  - **PI (Lead)**
- **Informatics**

Early Discoveries / Tests of Change

- **Process Improvements**
  - PHQ-2 then triggering PHQ-9 → **Modify to PHQ-9 only**
  - Infrequent collections of PHQ-9s → **At least monthly for moderate & severe MDD**
  - PHQ-9s collection on all patients → **Only collect for patients with MDD (except on initial intake)**
- **Treatment**
  - **Accurate Chart Capture of Diagnosis**
  - Chart audits not showing consistently implemented MDD treatment → **Develop recommended algorithm/care pathway for MDD**

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Depression Remission Measure: Observations & Suggestions

- Measure currently already part of CCBHC performance
- Measure is remission in 6 months (PHQ-9 < 5)
  - Benchmarks not yet available
  - Likely will be low percentage improvement

- As medical director, can emphasize measure as an opportunity to promote evidence-based treatment (measure is stringent)
  - Understand measure definitions
  - Informatics to help support role

CCBHC Performance and Payment

PPS Rate Setting Formula

$$\frac{\text{Total allowable costs of providing services per year, for all clients}}{\text{Total number of daily (PPS-1 or -3) or monthly (PPS-2 or -4) visits per year, for all clients}} = \textbf{Daily (PPS-1 or -3) or monthly (PPS-2 or -4) per-visit rate, paid only for Medicaid encounters}$$

- **Allowable costs** include direct costs (e.g. salaries, supplies), allocated indirect costs (e.g. rent, insurance); and anticipated direct/indirect costs.
- **One visit** = one day or month in which a "qualifying encounter" took place, regardless of number of services provided during that day or month.

PPS Structure and Options

- **Daily Rate**
  - **PPS-1**: One payment per client for any day in which the client receives at least one service
  - **PPS-3:** One payment per client for any day in which the client receives at least one service, which includes a Special Crisis Service rate component
- **Monthly Rate**
  - **PPS-2:** One payment per client for any month in which the client receives at least 1 service
  - **PPS-4:** One payment per client for any month in which the client receives at least 1 service, which includes a Special Crisis Service rate component
  - Rate may be stratified by population complexity, with higher rates for higher-complexity clients and lower rates for the general population
- Quality Bonus Payments are optional in PPS-1/3 and required in PPS-2/4.
- CCBHCs must file annual cost reports and states must rebase PPS rates at least every three years

Special Crisis Service Rates

- Under PPS-3 and PPS-4, the **Special Crisis Service (SCS)** rates allow states to set at least one of three separate monthly rates for CCBHCs providing crisis services.
- The three categories of Crisis Services for which SCS rates can be set are:
  - Mobile Crisis Services as outlined under section 9813 of the American Rescue Plan Act (ARPA)
  - CCBHC Mobile Crisis Services that do not meet the criteria above but meet criteria described in section 4.C of the updated SAMHSA CCBHC Criteria.
  - On-site CCBHC crisis stabilization services.

Six Measures Required for Quality Bonus Payments (QBP)

1. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD-AD) - *new measure since 2024*
2. Depression Remission at Six Months (DEP-REM-6) - *was optional prior to 2024*
3. Time to Services (I-SERV) - *new measure since 2024*
4. Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)
5. Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)
6. Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)

Required Measures Optional for QBP

7. Follow-Up After Emergency Department Visit for Substance Use (FUA-CH and FUA-AD) - *new measure since 2024*

8. Plan All-Cause Readmissions Rate (PCR-AD)

9. Follow-Up Care for Children Prescribed Attention- Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)

10. Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC) - *new measure since 2024*

11. Screening for Depression and Follow-Up Plan (CDFCH and CDF-AD)

Non-Required Measures Optional for QBP

12. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA) (SRA-C)

13. Adult Major Depressive Disorder: Suicide Risk Assessment (SRA) (SRA-A)

14. Controlling High Blood Pressure (CBP-AD)

15. Weight Assessment and Counseling for Nutrition and Physical Activity for children/Adolescents (WCC-CH)

Ground Rules

- PPS- 1 (daily general PPS) and PPS-3 (daily crisis PPS option) **MAY** include a QBP
- PPS- 2 (monthly general PPS) and PPS-4 (monthly crisis PPS option) **MUST** include a QBP
- No QPB is allowed soley for reporting CCBHC quality measures
- The CCBHC **MUST** meet the threshold for **ALL SIX** required QBP measures to receive any QBP
- QBPs shall be made for achieving quality related targets within a specified timeframe and also year-over-year improvements in quality outcomes
- Consequences for not meeting the QBP thresholds
  - No QBP
  - PPS payments remain unchanged
  - The QBP is not treated as a revenue offset against cost the PPS rate

States Design the QBP Methodology

- The threshold that triggers payment on each individual measure
  - (e.g., the percentage of improvement in a quality metric within a particular period)
- The methodology for making the payment
  - on a per claim basis or as a lump sum payment; and
  - how often payment is made)
- The amount of payment.

Other State Flexibilities

- Setting their QBP thresholds to have different targets for each individual measure based on national, statewide or provider specific data.
- In addition to single numeric thresholds, states can also set thresholds based on a provider specific amount of improvement in a performance year.
- Making weighted QBPs to CCBHCs who achieve on quality measures, where the amount providers receive varies by quality measure.
- States may also tier QBPs made to providers where different payments can be made based on the level of achievement at or above the threshold for each measure.

State of QBP Systems

Exhibit V.7. State QBP Systems		
State (number of CCBHCs)	**Amount State Initially Estimated for QBPs per DY**	**Plans for Use of Required Measures and Optional Measures for QBPs**
Minnesota (6)	5% of total payments, or about $2.5 million	6 CMS-required measures, plus 2 optional measures (CDF-A and PCR-AD)
Missouri (15)	1% of total payments, or about $4.2 million	6 CMS-required measures
New York (13)	About $2 million	6 CMS-required measures, plus 1 optional measure (PCR-AD) and 2 state-specific measures
New Jersey (7)	About $350,000	6 CMS-required measures
Oklahoma (3)	1% of total payments, or about $1 million	6 CMS-required measures
Source: Mathematica and RAND's review of state materials and state response to interview questions.		

https://aspe.hhs.gov/sites/default/files/documents/6b9cdcb7cb75ec2c59a029b40d6b2e63/ccbhc-report-congress-2023.pdf

Award of QBPs

Exhibit V.8. Award of QBPs

State (number of CCBHCs)	Number of CCBHCs that Received Payments and Total Aggregate Payments to CCBHCs in:			
	DY1	DY2	DY3	DY4
Minnesota (6)	2 of 6; Total payments: $740,049	None; Thresholds not met	None; Thresholds not met	None; Thresholds not met
Missouri (15)	15 of 15; Total payments: $17,210,855	15 of 15; Total payments: $19,138,499	15 of 15; Total payments: $22,123,047	15 of 15; Total payments: $14,852,349
New York (13)	None; State reported that thresholds not met	None; State reported that thresholds not met	None; State reported that thresholds not met	None; State reported that thresholds not met
New Jersey (7)	6 of 7; Total payments: $27,000	6 of 7; Total payments: $132,000	6 of 7; Total payments: $339,500	6 of 7; Total payments: $250,321
Oklahoma (3)	None; State reported that thresholds not met	None; State reported that thresholds not met	n.a.	n.a.

Source: Mathematica and the RAND Corporation's analysis of state official reports.

Notes: Five of the original demonstration states responded to questions from the evaluation team about QBPs. Oregon does not award QBPs and data were unavailable for Nevada. Michigan selected the PPS-1 with QBP but has not yet begin awarding payments.

n.a. = not available.

https://aspe.hhs.gov/sites/default/files/documents/6b9cdcb7cb75ec2c59a029b40d6b2e63/ccbhc-report-congress-2023.pdf

Award of QBPs Continued

Exhibit ES.2. Award of QBPs				
State (number of CCBHCs)	Number of CCBHCs that Received Payments and Total Aggregate Payments to CCBHCs			
	DY1	DY2	DY3	DY4
Minnesota (6)	2 of 6 Total payments: $740,049	None; thresholds not met	None; thresholds not met	None; thresholds not met
Missouri (15)	15 of 15 Total payments: $17,210,855	15 of 15 Total payments: $19,138,499	15 of 15 Total payments: $22,123,047	15 of 15 Total payments: $14,852,349
New York (13)	None; state reported that thresholds not met	None; state reported that thresholds not met	None; state reported that thresholds not met	None; state reported that thresholds not met
New Jersey (7)	6 of 7 Total payments: $27,000	6 of 7 Total payments: $132,000	6 of 7 Total payments: $339,500	7 of 7 Total payments: $250,321
Oklahoma (3)	None; state reported that thresholds not met	None; state reported that thresholds not met	n.a.	n.a.

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CCBHC PPS and QBP Resources

- Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2023 https://aspe.hhs.gov/sites/default/files/documents/6b9cdcb7cb75ec2c59a029b40d6b2e63/ccbhc-report-congress-2023.pdf

- Section 223 Certified Community Behavioral Health Clinic (CCBHC) Demonstration Prospective Payment System (PPS) Guidance Updated February 2024 https://www.medicaid.gov/medicaid/financial-management/downloads/section-223-ccbh-pps-prop-updates-022024.pdf

Questions?

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CCBHC Forum at NatCon25

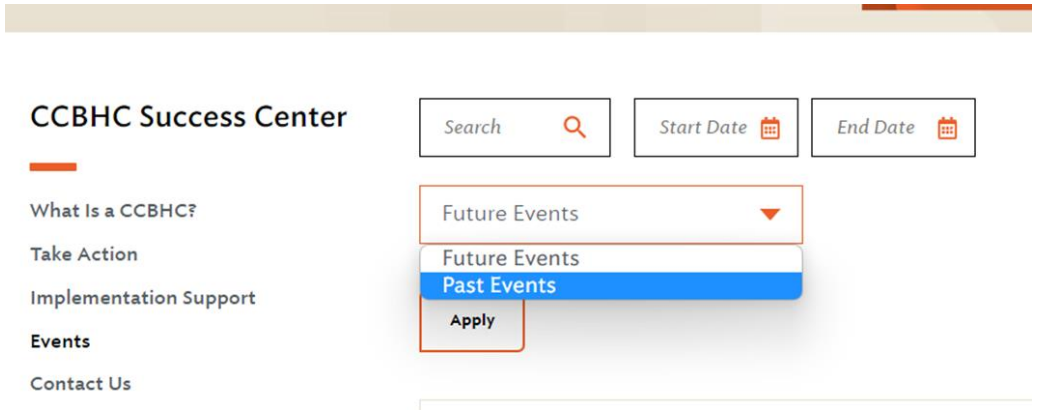
- **What:** National Council is hosting a **full-day pre-conference CCBHC Forum**
- **When:** Sunday, May 4, 2025
- **Who:** Designed for everyone- state health officials, policymakers, CCBHCs, advocacy groups, researchers and other stakeholders.
- Forum activities include:
  - Joint programming with National Council's Crisis Response Services Summit, exploring how the CCBHC model enhances effective crisis systems
  - Deep-dives into current CCBHC topics such as evaluating statewide impact, DCOs, SUD care, children's services, and more

- Registration is available now! CCBHC E-Grantees will receive a half day registration.

Thank You!

Thank you for attending today's webinar.

Slides and the session recording link will be available on the CCBHC Success Center website under "Events" > "Past Events" within 2 business days.



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