Behavioral Health Landscape Scan

September 2019

Themes

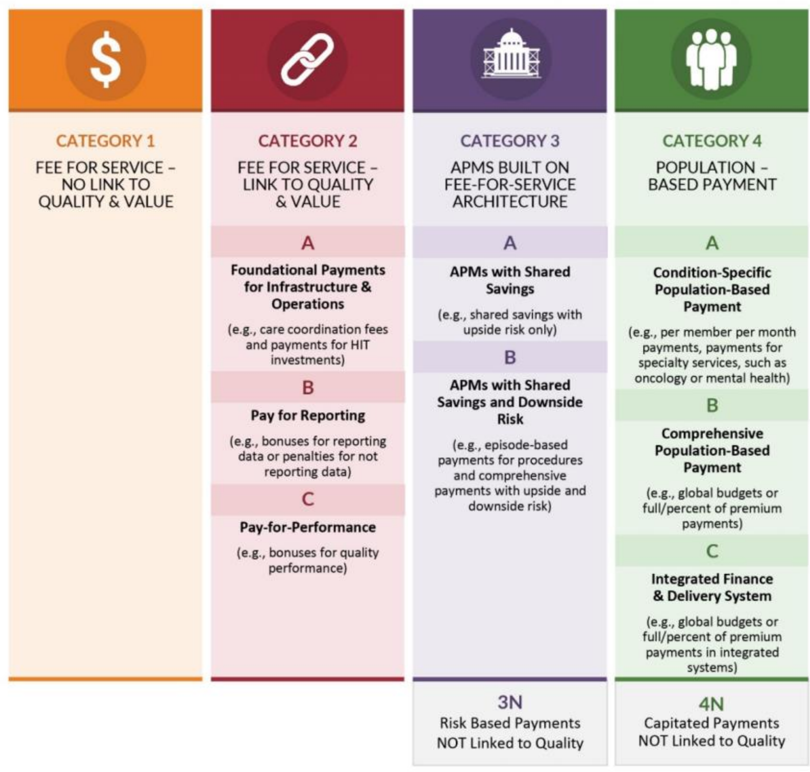
- ✓ Value
- ✓ Quality
- ✓ Integration
- ✓ Access

Value-Based Purchasing and Care

- Fee-for-service health care rewards volume, does not reward value
- Value-based purchasing programs adopt purchasing approaches that reward health care providers for quality care
- Payment and care models designed to address Triple Aim:
  1. Improving the patient experience of care (including quality and satisfaction)
  2. Improving the health of populations
  3. Reducing per capita cost of health care
- Approaches that factor in care quality are called Alternative Payment Models (APMs)
- In 2017, 34% of all health care payments were tied to APMs.
  - Differs by market (28% commercial, 50% Medicare Advantage, 38% Medicare FFS, 25% Medicaid)

Value-Based Purchasing and Care

- Wide variety of approaches:
  - Shared savings
  - Shared risk
  - Bundled payments
  - Population-based payments
- Accountable Care Organizations, Centers of Excellence, Health Homes (the Behavioral Health Community Partners program is essentially a Health Home) are delivery systems that can be supported through a variety of payment approaches



Payment and System Transformation

- Evidence of cost and health savings is still mixed for Accountable Care Organizations (ACOs) – significant variability.
- CMS continues to promote movement toward ACOs in Medicare and is substantially accelerating path to downside risk.
- In Medicaid, 12 states (including MA) have active ACO programs and at least 10 more are pursuing them.
- General policy focus on “value-based purchasing and value-based care” and integrated care models.
- Not many mature models specific to BH.

Massachusetts

Medicaid

Delivery System Reform Incentive Payment Program: Check-In

- In 2018, MassHealth began implementing an ambitious Delivery System Reform Incentive Payment (DSRIP) Program approved by CMS. Goals of program:
  - ensure financial sustainability of MassHealth (~40% state budget);
  - improve population health and care coordination through payment reform and value-based payment models;
  - improve integration of physical and behavioral health care; and
  - scale innovative approaches for populations receiving long-term services and supports

Delivery System Reform Incentive Payment Program: Check-In

- Program elements included $1.8B in time-limited investments that diminish over 5 years. Investment areas include:
  - **Accountable Care Organizations (ACOs)** ($1.1B investment) – 17 provider-led organizations that coordinate care, have an enhanced role for primary care, and are rewarded for value (improving total cost of care and outcomes), not volume
  - **Community Partners (CPs)** ($547M investment) - provider-led, community-based entities focused on the member that partner w/ ACOs and collaborates w/ MCOs, providers, and social services/community resources to support improved care delivery & member experience. Two types: 18 Behavioral Health (BH) and 9 Long-Term Services and Supports (LTSS) CPs
  - **Statewide Investments** ($188M investment) – Healthcare workforce development and training, targeted technical assistance for providers; improved accommodations for people with disabilities; other priorities

DSRIP: BH CPs

- BH CPs perform comprehensive care coordination and care management for individuals with complex BH needs.
- Payment Model:
  - Fee-for-service and APM aspects
  - Per member per month (pmpm) fee – payment the same whether the person requires more or less intense service – provider decides based on person's needs
  - Payment contingent upon delivery of qualifying activity
  - Quality-related payment withhold – metrics relate to avoidable utilization, coordination of/connection to care, certain clinical measures (similar to CCBHC)
- Includes ongoing infrastructure funding (also pmpm basis) to support IT/IS, data analytics, training, etc.

DSRIP: Statewide Investments

- DSRIP Statewide Investments has 11 investment areas, **more than half of which focus on community-based behavioral health organizations/professionals**, which could potentially be replicated in the future. Categories include:
  - Student Loan Repayment – Primary Care and Community BH (licensed staff)
  - Behavioral Health Workforce Development (masters-prepared)
  - Community Partner Recruitment Incentive Program
  - Primary Care/Behavioral Health Special Projects Program
  - Community-Based Recruitment & Retention: Family Medicine and NP
  - Community-Based Recruitment & Retention: CMHC BH Recruitment
  - Community Health Worker Training Capacity Expansion Grants
  - Peer Specialist Training Capacity Expansion Grants
  - Community Health Workers Supervisor Training Program
  - Recovery Coach Supervisor Training Program
  - Competency-Based Training for ACOs and CPs

Retention (Student Loan Repayment – Primary Care and Community BH (licensed staff); Behavioral Health Workforce Development (masters-prepared))

Recruitment (Community Partner Recruitment Incentive Program; Primary Care/Behavioral Health Special Projects Program; Community-Based Recruitment & Retention: Family Medicine and NP; Community-Based Recruitment & Retention: CMHC BH Recruitment)

Pipeline (Community Health Worker Training Capacity Expansion Grants; Peer Specialist Training Capacity Expansion Grants; Community Health Workers Supervisor Training Program; Recovery Coach Supervisor Training Program)

Ambulatory BH Treatment System

ABH Member Data

- In 2017, 100% of responding ABH member organizations reported losses on outpatient services with an average loss of $582,057.
  - 52% reported wait times of more than 1 month for children for routine assessments with a psychiatrist/nurse prescriber.
  - 16% were not accepting new referrals for children.
  - 60% reported wait times of more than 1 month for adults for routine assessments with a psychiatrist/nurse prescriber.
  - 12% were not accepting new referrals for adults.
- In 2018, the average reported loss for ABH members rose to $665,759.
  - 46% of responding ABH members reported one or more vacancies for a psychiatrist prescriber and 50% reported one or more vacancies for a nurse prescriber.
  - 74% of respondents said they currently maintain a wait list for outpatient services.
- Reported reasons for these wait lists include:
  - Waiting for an independently licensed clinician for an adult (84%), waiting for an independently licensed clinical for a child (75%), and waiting for a prescriber for an adult (54%) and a prescriber for a child (46%).

System Transformation: Ambulatory BH Treatment System

- EOHHS held a public listening session series throughout the summer to help inform the "creation" of a Behavioral Health Ambulatory Treatment System.
- Issues/Challenges
  - Individuals/families cannot easily access ambulatory behavioral health treatment (barriers include insurance, stigma, navigation, lack of understanding of options and providers).
  - "Despite $1.9 billion in investments from 2016-2022 and significant policy reforms, significant challenges in accessing ambulatory behavioral health treatment remain."

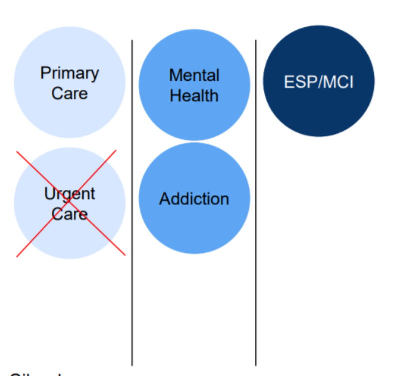
Ambulatory BH Treatment System

- Future State
  - Patients **enter through any door** and **transition to appropriate levels of care**.
  - Primary care practices have the capacity and competence to provide integrated treatment for mental health, substance use and co-occurring disorders.
  - **Specialty behavioral health care** provides **integrated treatment** for mental health, substance use and co-occurring disorders addiction treatment with **urgent and walk-in access.**
  - **24/7 behavioral health crisis response system** that supports stabilization and successful transitions to an appropriate level of treatment.

System Transformation Phase II: Ambulatory BH Treatment System

Together, we have an opportunity to envision an ambulatory behavioral health system

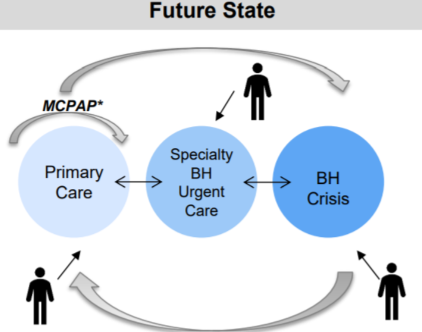
Current State



- Siloed care
- More complex to navigate and access than physical health care
- Not integrated for primary care or mental health and addiction
- Limited urgent care for behavioral health
- No continuum

*Massachusetts Child Psychiatry Access Program (MCPAP)

Future State



- Patients enter through any door and transition to appropriate levels of care
- Primary care practices have the capacity and competence to provide integrated treatment for mental health, substance use and co-occurring disorders
- Specialty behavioral health care provides integrated treatment for mental health, substance use and co-occurring disorders addiction treatment with urgent and walk-in access
- 24/7 behavioral health crisis response system that supports stabilization and successful transitions to an appropriate level of treatment

Next Steps:

- RFI -late Summer/early Fall
- Roadmap Concept/New Listening Sessions – Fall 2019
- Roadmap for comment – Winter 2019/2020

Full presentation: https://www.mass.gov/files/documents/2019/06/13/bh-presentation_0.pdf

Are Certified Community Behavioral Health Clinics (CCBHCs) part of the solution?

What is a CCBHC? The Federal Construct

- Legislation in 2014 established a federal definition and criteria for Certified Community Behavioral Health Clinics (CCBHCs)
  - 20 states (including MA) were selected for planning grant and 8 (MA was not selected) were funded for 2-year Demonstration.
- CCBHCs receive a Medicaid reimbursement rate based on their anticipated costs of expanding services.
- States selected one of two Prospective Payment System rate models for their CCBHCs – PPS-1 (cost-based, daily rate similar to FQHCs) and PPS-2 (population-variable, monthly rate with mandatory quality component tied to payment).
- CCBHCs must report on 21 administrative and clinical quality measures.
- Congress continues to signal interest in program extension/expansion through grants and time-limited extensions but no permanent commitment.

Certified Community Behavioral Health Clinics

- Certified Community Behavioral Health Clinics (CCBHCs) are a **new Medicaid provider type** designed to provide a comprehensive range of MH & SUD services.
- CCBHCs must **provide or contract with partner organizations** to provide 9 services with an emphasis on 24-hour crisis care, evidence-based practices, care coordination, and integration with physical health care.

Nine required CCBHC services are:

1. **Crisis mental health services** including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization*;
2. **Screening, assessment and diagnosis** including risk assessment***;**
3. **Patient-Centered treatment planning** or similar processes, including risk assessment and crisis planning*;
4. **Outpatient mental health and substance use services*;**
5. **Outpatient clinic primary care screening and monitoring of key health indicators and health risk****;
6. **Targeted case management****;
7. **Psychiatric rehabilitation services**;**
8. **Peer support and counselor services and family supports****;
9. Intensive, community-based **mental health care for members of the armed forces and veterans**.

* = CCBHC must deliver directly (exemption for pre-existing state crisis systems).
** = may be delivered by collaborating organization.

CCBHC Early Indicators: Access

- There are 66 CCBHCs in the 8 demonstration states: Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon and Pennsylvania (total of 113 in 21 states if grant-funded clinics included).
- Early results show major workforce expansions at CCBHC locations across all states, with **100% of CCBHCs nationwide reporting they have hired new staff, with a total of 1,160 new staff hired**. These newly hired staff **include 72 psychiatrists and 212 staff with an addiction specialty or focus**.
- **87% of CCBHCs reported that they have seen an increase in the number of patients served**. For the majority of CCBHCs, this represents up to **a 25% increase in their patient caseload**.
- **68% have reduced wait times** between call/referral and service (**46% offer same-day access**)

Ambulatory BH Treatment System: Open Questions

- CCBHC, CCBHC-like, something else?
- Universal vs. targeted investment or both?
- Partnerships among providers like CP?
- Payment methodology and investment scope?
- Procured, certified, RFA, other?
- Scope and geography?
- CBHI?
- Access for populations historically underserved?
- Connections to primary care?
- Role of crisis/ESP?
- Role of Community Partners?
- Role of commercial and public insurance?
- Who will staff all of the enhancement?

State-Contracted Services

Data Points

- DMH Adult Community Clinical Services (ACCS) has a total staff vacancy rate of 19.92% with clinical leadership vacancies of 10.97%, clinical only of 30.01%, and direct care of 19.21% (April 2019).
  - There is variability by contract and geography.
  - Providers report vacancies are due in large part to non-competitive salaries embedded in the rate.
- Gallagher Surveys data show that overall pay rates in MA acute care hospitals are significantly higher than in ABH member organizations with the exception of the Clinical Nurse Specialist position.
  - **The overall pay gap for comparable jobs was 22.8%,** although the difference does vary by job.

Chapter 257 of the Acts of 2008

- Chapter 257 established a transparent, uniform process for the establishment of human and social services rates "which are reasonable and adequate to meet the costs which are incurred by efficiently and economically operated social service program providers."
- Baker-Polito Administration has worked to implement the law in accordance with statutory calendars (rates reviewed biennially).
- Use of provider Uniform Financial Reports as source of salary and other cost benchmarks has been a significant hindrance to development of Chapter 257-set rates that allow providers to meet **competitive wage and fringe benefit needs, reduce staff turnover/remedy vacancies**, address training needs, attend to maintenance, keep up with insurance costs, meet and plan for infrastructure and IS needs, etc.

Chapter 257: Next Steps

- ABH, the Association of Developmental Disabilities Providers (ADDP), the Providers' Council and the Children's League of Massachusetts have been working with EOHHS to devise strategies to help human service organizations confront the workforce crisis.
- The trades and EOHHS together agreed on the following principles:
  i. Any solution to the workforce crisis involving new funding for provider rates must be established **within the parameters of Chapter 257**;
  ii. The Commonwealth will **use salary benchmarks other than the UFR** to develop rates;
  iii. When establishing provider reimbursement rates, **priority should be given to identifying critical salary positions that have high vacancy rates** (e.g. Direct Care and Clinical positions); and
  iv. The Commonwealth and provider community should **explore standardizing various factors** (such as taxes and fringe) across all Chapter 257 rates.
- As a result of this work, rates set for FY20 implementation include increases in funding which are targeted for investments in direct care and clinical staff.
- Work is ongoing to refine approach for FY21 rates.

Rate Setting

- FY20 Review Complete:
  - BSAS Residential Rehabilitative Services
  - DMH and DCF Family Stabilization (certain services)
  - PACT
  - Respite
- For FY20 Pending:
  - Clubhouse
  - SUD ATS/CSS
- FY21 TBD:
  - DMH Adult Community Clinical Services
  - Caring Together
  - BSAS Ambulatory and Co-occurring Enhanced
  - DMH Flex Services

Legislature & Budget

Legislature: Mental Health Bills

- Senate has indicated that there will be a mental health bill this legislative session.
- House passed a children's health and wellness bill that does the following:
  - Requires MassHealth to cover individuals under the age of 26 who were previously in DCF c/c.
  - Requires health insurance carriers to maintain accurate provider directories.
  - Directs EOHHS in consultation with the Office of the Child Advocate, DMH, DCF, DEEC, and DESE to develop a pilot program of 3 regional childhood behavioral health centers of excellence.
  - Creates a task force on pediatric behavioral health screening to examine efficacy of the CANS and other screening tools.

FY2020 Budget

- Overall, a good budget for BH. The budget includes:
  - ABH's priority legislation limiting insurance **clawbacks** to a twelve-month period.
  - Additional **$1 million for DMH housing assistance** (help ~80 individuals).
  - BSAS is funded at $162,749,348, an increase of $7M over projected FY19 spending levels.
  - $10M in new funding for medication assisted treatment in County Correctional facilities.
  - **$400K for address backlogs in licensure application processing** for BH professionals.
  - **$10M Behavioral Health Outreach, Access, and Support Trust Fund**. Dedicates $500K for a public awareness campaign and **$2M for loan forgiveness for mental health professionals**.
  - $5M for harm reduction efforts, including pilot "to advance the creation of new supportive places for treatment and related observation". Specific funding initiatives: $1.5M to increase availability of sterile injection equipment/syringe disposal; $150K for a pilot to provide access to fentanyl testing strips; and, $300K to increase the availability to naloxone kits prior to ED discharge.

Take Aways

- Access, Quality, Value, and Integration are important considerations for policymakers and elected officials.
- Significant need for focused advocacy in MA in coming months:
  - BH Ambulatory Treatment System
  - Chapter 257 Rates/Services
  - Workforce
  - BH Legislation

Thank you!!

Questions?