State Learning Collaborative

Session 2: Achieving Integration of Substance Use Disorder (SUD) Services within the CCBHC Model

March 28, 2024

CCBHC S-TAC

CCBHC State Technical Assistance Center

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Jane King

Senior Consultant
Practice Improvement & Consulting

Ann Mukherjee

Manager, Policy
Policy Department

Annie Benjamin

Coordinator
Practice Improvement & Consulting

Melanie Whitter

Deputy Executive Director & Director, Research and Program Applications

Doug Fuller

Associate Director of Research & Program Applications

Becky Vaughn

Senior Research Associate

Welcome back!

Agenda

- Review of last session
- Caring for people with co-occurring disorders
- An example from NJ
- Q&A
- Discussion: How can states encourage integrated care?

Last Time

- Orientation on the LC and Introductions
- Overview of the role of SUD care in the CCBHC criteria
- Collaboration is key
- Early planning for claim systems updates is crucial
- Defining SUD services provides opportunities for practice transformation
- Integration of SU and MH is needed at the state level AND clinic level

LET'S GET
STARTED

Focus of CCBHC Criteria

The Protecting Access To Medicare Act of 2014 (PAMA) makes clear that, regardless of condition, CCBHCs must provide services to anyone seeking help for a mental health or substance use condition, regardless of their place of residence, ability to pay, or age. This includes any individual with a mental or substance use disorder who seeks care, including:

- Those with serious mental illness (SMI)
- Substance use disorder (SUD) including opioid use disorder (OUD)
- Children and adolescents with serious emotional disturbance (SED)
- Individuals with co-occurring mental and substance use disorders (COD)
- Individuals experiencing a mental health or substance use-related crisis

General Concepts for Integrating Care

- Collaboration between MH and SU and Medicaid agencies/departments/divisions at the state level is essential
- Collaboration with Licensing Boards and Licensing divisions builds toward integration of MH and SU services
- Assess need for how CCBHCs will need to vary from existing rule and statute when duplicative or in conflict with CCBHC and plan for allowing those variances
- Remove barriers to integrated care provision within policies, billing requirements, licensing and others
- Consider impacts to data collection
- Consider impacts to cost reporting and PPS rate-setting

Clinical Considerations for Integrated Care

Clinical Consideration	State Actions
Community Needs Assessment • Establishes need for integrated MH/SU care • Estimates number of individuals with co-occurring needs • Regular updates provide opportunities to re-assess need	• Suggest determining need for co-occurring services statewide within the optional state Needs Assessment (NA) • Define clinic NA requirements that assess community need for co-occurring services • Clearly define update timelines and requirements • Provide flexibilities for clinics to be responsive to community need
Continuous Quality Improvement • Provides real-time response to integrated care • Structure for rapid change to continue to meet community need	• Consider adding items to required CQI elements • Provide TA about Plan-Do-Study-Act model

Clinical Considerations for Integrated Care

Clinical Consideration	State Actions
Philosophical Mind Shift • Integrated care is totally different from aligned care • Former MH- or SU-only clinics must shift how their organization works • MH and SU professionals expand knowledge base to consider whole person	• Provide TA to clinic leadership about the need for speaking to the mind shift first before operationalizing CCBHC • Cross-train providers (MH train SU and SU train MH)
Recovery-Oriented Care • Both MH and SU care is recovery-oriented now • Harm Reduction and Motivational Techniques	• Provide TA about what it means to be recovery-oriented • Use recovery-oriented language
Confidentiality • HIPAA • 42 CFR Part 2	• Crosswalk the requirements in each • Consider how CCBHCs will have to remain compliant to both

Clinical Considerations for Integrated Care

Clinical Consideration	State Actions
Integrated Assessment • Initial and Comprehensive Evaluation data elements • Initial and Comprehensive Evaluation timelines • Screening tools	• Ensure collaborative relationship with SU and MH policy areas with Medicaid and Licensing • Allow unlicensed staff to collect evaluation and screening data elements to preserve licensed professional time • Review billing codes to allow for either licensed SUD, licensed MH professionals or dually-licensed professionals to file assessment claims • Consider creating more billing opportunities for screening • Consider opportunities for CCBHCs to bill for both Initial and Comprehensive evaluations (remove limits and/or prior authorizations) • Define and train on an integrated architecture for assessment such as the ASAM 6 Dimensions or the Comprehensive Health Integration (CHI) framework • Crosswalk existing MH and SUD assessment requirements with CCBHC requirements to ensure all current elements are included, duplications are removed, and the integrated evaluation process is streamlined • Modify existing assessment billing codes that define CCBHC required elements and allow for integrated data collection, even when using "shadow billing" • Consider date of triage being point of first contact for measuring time to Evaluation and time to service outcome measures

Clinical Considerations for Integrated Care

Clinical Consideration	State Actions
Integrated Treatment Planning and Documentation • Integrated treatment plan elements • Documentation requirements	• Ensure collaborative relationship with SU and MH policy areas with Medicaid and Licensing to build • Review billing codes to allow for either licensed SUD, licensed MH professionals or dually-licensed professionals to supervise treatment according to plan and consider impacts if "shadow billing" • Define and train on an integrated architecture for treatment planning and documentation of progress such as the ASAM 6 Dimensions • Crosswalk existing MH and SUD treatment planning and documentation requirements with CCBHC requirements to ensure all current elements are included • Modify existing or create new billing codes that define integrated treatment planning • Consider EHR programming updates CCBHCs will need to do for integrated care

Clinical Considerations for Integrated Care

Clinical Consideration	State Actions
Integrated Care Coordination • Assessment of holistic needs (housing, employment, education, primary care…) • Care coordination interventions included in integrated treatment plan	• Do NOT define care coordination with a Medicaid billing code in order to allow person-centered and provider type flexibility • Define care coordination communication requirements for multiple care coordinators including managed care • Consider having ways the clinics document care coordination to collect data as well as review compliance with integrated care coordination
Integrated Crisis Services • Addressing suicide and overdose prevention • Ambulatory withdrawal management • "Medication First" MAT induction • Coordination with residential WM and crisis stabilization	• Review crisis billing codes to allow for licensed SUD and MH professionals to file crisis claims • Review current state sanctioned crisis system requirements and determine a process for aligning them with SAMHSA crisis and CCBHC requirements • Define ambulatory WM allowing for multiple provider types (prescriber, counselor, care coordinator, crisis worker…) • Remove restrictions to accessing medications particularly for OUD

Clinical Considerations for Integrated Care

Clinical Consideration	State Actions
Multi-disciplinary teams	• Open up opportunities for unlicensed staff to gather information, perform screenings, and develop plans to build in cost efficiencies • Allow creativity in provider types for care coordination such as medically trained staff or Cultural Brokers or peers • Provide TA and training around Team Based Care and Clinical Care Pathways
Evidence Based Practices	• Evaluate current EBPs for applicability with SUD and MH • Consider “allowable” EBPs vs. “required” to allow clinics to be responsive to their community needs assessments • Consider how an allowable or required EBP can supplement the list of required services (Example: MAT in KS) • Provide TA and training for new EBPs and define early to allow CCBHCs to put cost of training and implementation of EBPs in their cost reports

Evidence Based Practices

- Based upon the findings of the community needs assessment, certifying states must establish a minimum set of evidence-based practices required of the CCBHCs.
- Among those evidence-based practices states might consider are the following:

  Motivational Interviewing; Cognitive Behavioral Therapy (CBT); Dialectical Behavior Therapy (DBT); Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP); Seeking Safety; Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (FACT); Long-acting injectable medications to treat both mental and substance use disorders; Multi-Systemic Therapy; Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Cognitive Behavioral Therapy for psychosis (CBTp); High-Fidelity Wraparound; Parent Management Training; Effective but underutilized medications such as clozapine and FDA-approved medications for substance use disorders including smoking cessation.

Clinical Considerations for Integrated Care

Clinical Consideration	State Actions
Provider Licensure	• Collaborate with licensing boards (Psychology, Social Work, LPC/C, SUD counseling) to consider integrated instead of dual licensure • Consider collaborating with colleges/universities to ensure MH coursework in SU education and SU coursework in MH education as well as building workforce pipelines
Program Licensure	• Collaborate early and often with licensing divisions • Crosswalk the licensing requirements for SU and MH clinics to minimize conflict and duplication and increase alignment • Consider standard variances to current licensing standards that act as barriers to integrated care
Funding Sources • Medicaid • State Funds	• Analyze the payer mix at all prospective CCBHCs to make plans for coverage of costs of non-Medicaid beneficiaries • In states without Medicaid Expansion, consider TA provision about braiding funding and how to properly document in a cost report

Example from New Jersey

Robert Eilers, MD, MPH, DMHAS

Medical Director

New Jersey Department of Human Services

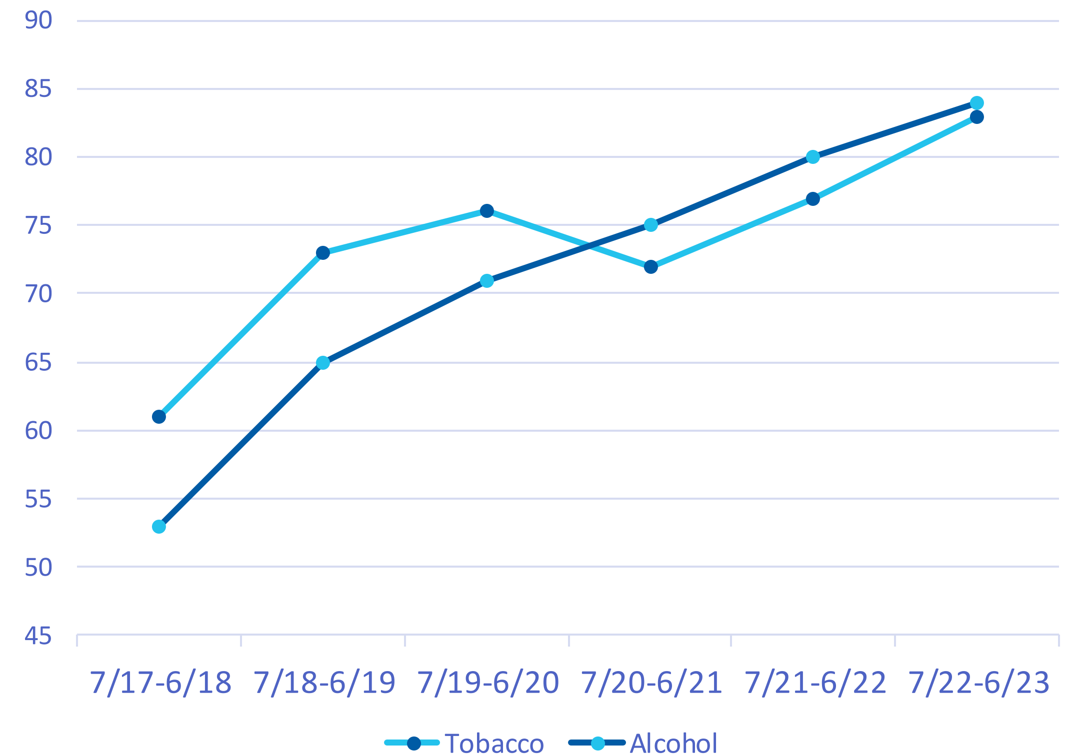
Division of Mental Health and Addiction Services

Integrating Services in CCBHCs

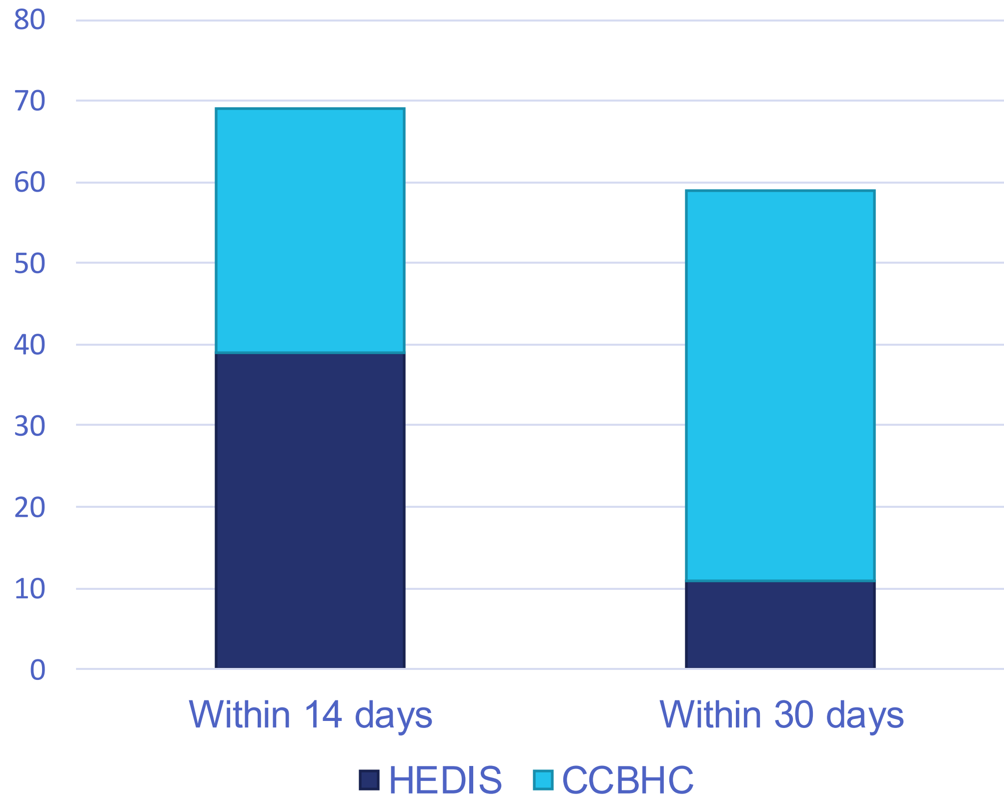
- Addressed barriers to providing integrated services in 7 providers certified to participate in the CCBHC Medicaid Demonstration.
  - mental health and addiction services
  - behavioral health and primary care (screening, referral and coordinating care)
- Developed performance measures to assess delivery of integrated SUD services, including MOUD
- Provided T/A and support to providers to improve client outcomes

Change in Percentage Screened with Follow-Up Year 1 – Year 6

- 83% adults screened for tobacco use in DY6
- 84% adults screened for unhealthy alcohol use in DY6*

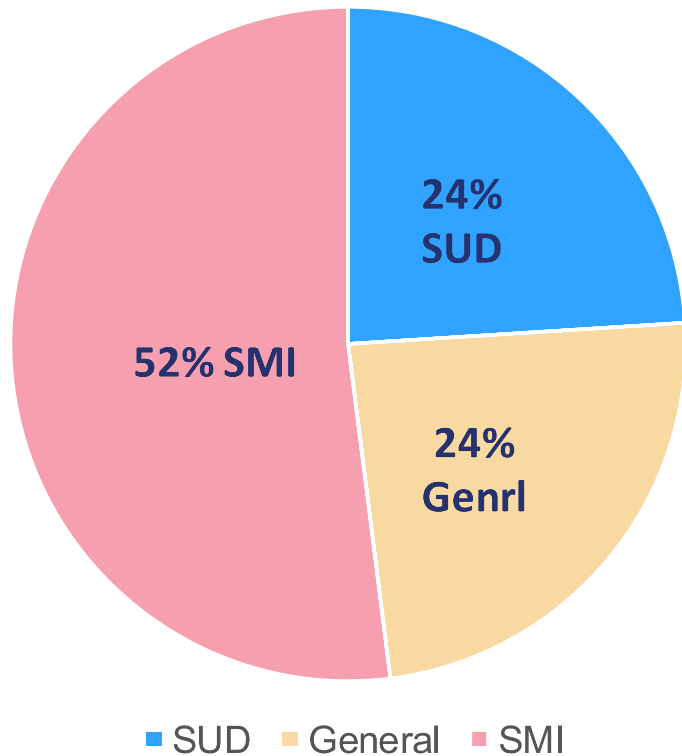


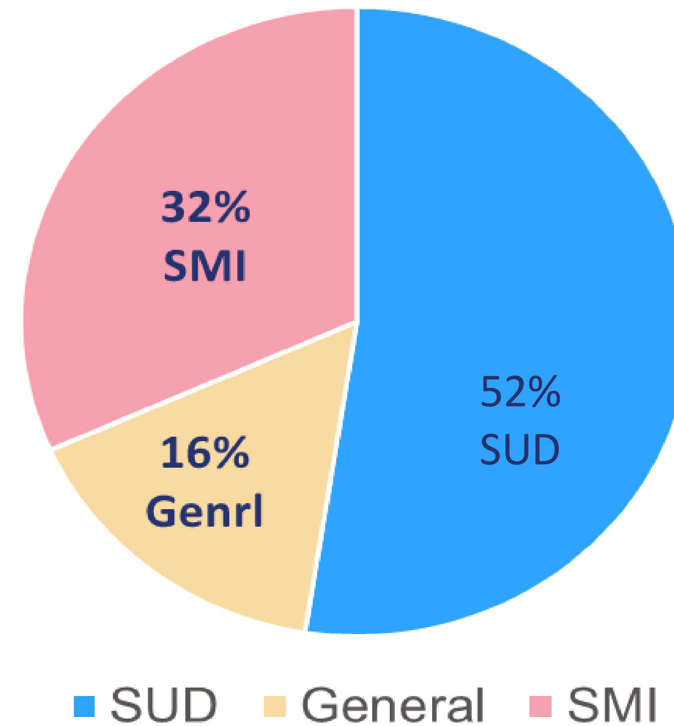
Substance Use Disorder Treatment



- 69% unhealthy alcohol users 18-64 initiated treatment within 14 days
- 59% of consumers 18-64 initiated treatment and had >2 additional AOD services within 30 days
- CCBHCs far outperformed HEDIS Medicaid averages DY1 to DY5
- In DY5, CCBHCs outperformed HEDIS averages by 30 and 48 percentage points for initiation and engagement of AOD treatment

Distribution of Substance Use Disorder Identified by Primary Diagnosis and MOUD Treatment (DY5)





NEW JERSEY HUMAN SERVICES | DMHAS Division of Mental Health and Addiction Services

Clinical considerations for integrated care

- What is the current status of integration at your state level?
- What barriers are you discovering now?
- Which considerations resonated with you to remove or reduce those barriers?
- What are the key takeaways you have from this session?

What examples can you offer for handling Data Collection and meeting Quality Standards?

Send your willingness to share to

Ann Mukherjee AnnM@thenationalcouncil.org

Annie Benjamin AnnieB@thenationalcouncil.org

How did we do?

Please answer a few questions to let us know how we did and what we can do to support you in future sessions.

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Thank you!

Next Session: Thursday, March 28, 2024

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Jane King, PsyD, LP (she, her, hers)
Senior Consultant
Practice Improvement & Consulting
National Council for Mental Wellbeing
(202) 964-5800
Janek@TheNationalCouncil.org

Becky Vaughn, MSEd (she, her, hers)
Senior Research Analyst
National Association of State Alcohol
and Drug Abuse Directors (NASADAD)
(202) 292-4872
BVaughn@NASADAD.org

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