PRESBYTERIAN MEDICAL SERVICES

BEHAVIORAL HEALTH PAYMENT MODELS AND INTEGRATION

BEST PRACTICES

OCTOBER 2015

DOUG SMITH, EXECUTIVE VICE-PRESIDENT

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HISTORY AND SUMMARY

PMS today:

- 50 FQHC/Community Health Centers (30 have BH co-located)
- 70,000 users
- 350,000 Outpatient Medical, Dental and Behavioral Health Visits per year
- Joint Commission Accredited NCQA PCMH Level 3 Recognized

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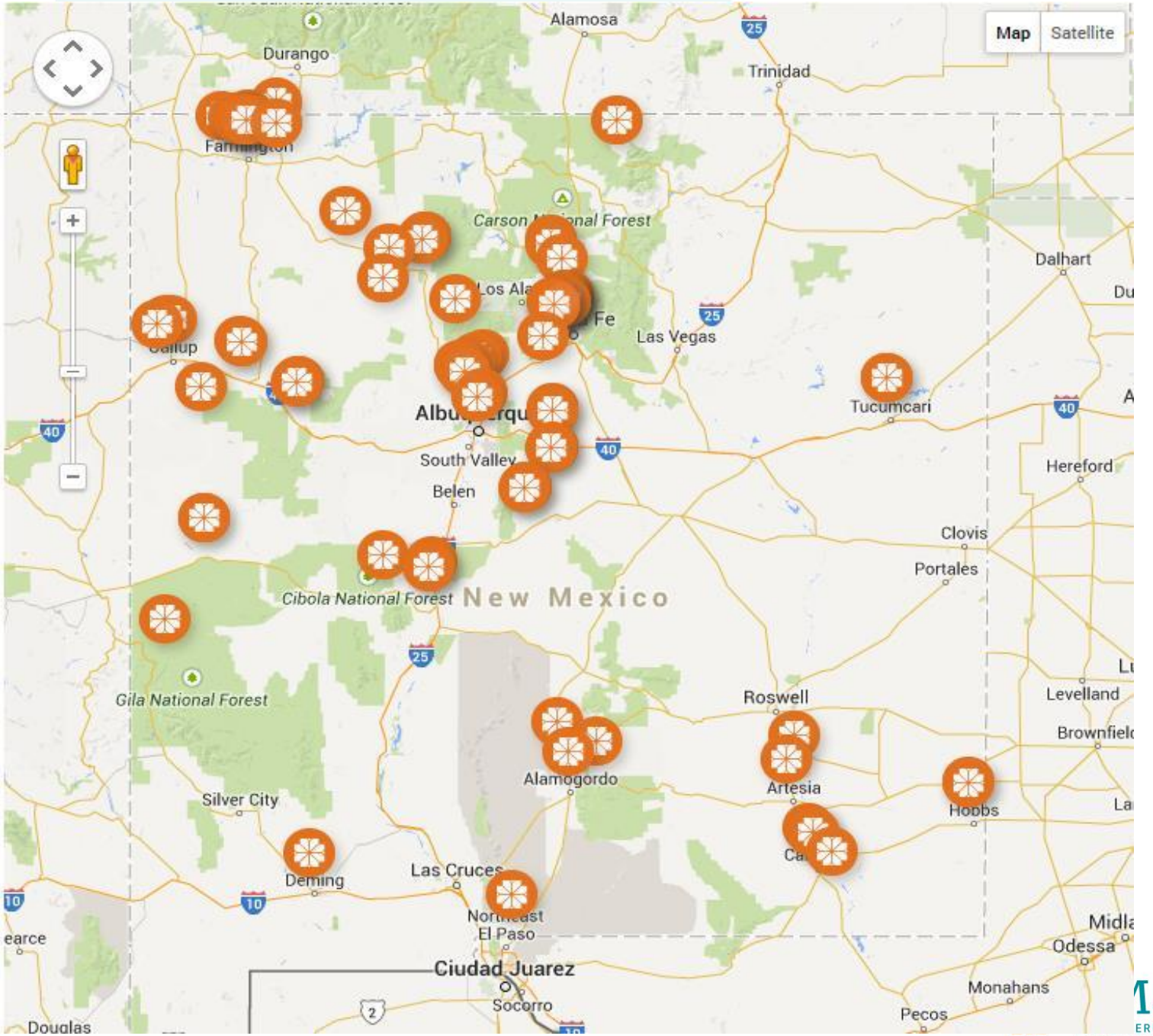

PMS Statewide Service Locations

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BEHAVIORAL HEALTH

PMS today:

- 150,000 Outpatient BH visits Annually
- Behavioral Health Core Service Agency (LC 1, 5,7, 11, 13)
- 16 bed Adolescent Residential Treatment Center (RTC)
- Veterans and Families Support Services (VFSS)
- Dually licensed
  - D & T , CMHC
    - Medication Management
    - Individual, Group, Family Therapy
    - Comprehensive Community Support Services
    - Crisis Intervention
    - Psycho-social Rehabilitation

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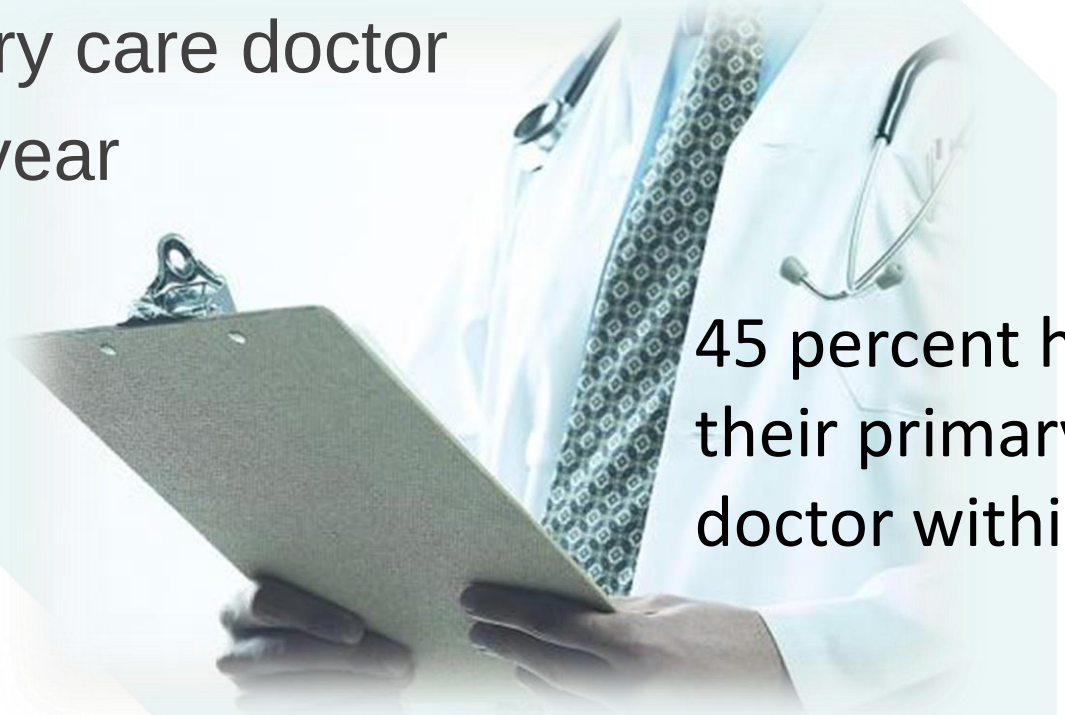
WHY INTEGRATE

77 percent of individuals who die by suicide had visited their primary care doctor within the year



45 percent had visited their primary care doctor within the month

18 percent of elderly patients visited their primary care doctor on same day as their suicide

(SAMSHA 2015)

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INTEGRATED DELIVERY MODEL

- PMS vision of integration is based on:
- A fully integrated electronic health record – “Golden Thread”
- Shared Dashboard – Gaps in care / Medication reconciliation / Care Plans
- Warm handoffs in co-located Medical & BH programs
- Universal screening for depression and substance abuse
- Screening for Medical Condition
- Interdisciplinary Team Meetings
- CMHC delivery model co located within PCMH
- Telephonic psychiatric consultation for primary care providers
- Telehealth services maximized to improve access to services

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EVIDENCED BASED PRACTICES

- Assertive Community Treatment (ACT)
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavioral Therapy (DBT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Multi Systemic Therapy (MST)
- Matrix Model for Intensive Outpatient (IOP)
- Community Reinforcement Approach (and CRAFT)
- Peer Support for Serious Mental Illness
- Supported Housing for Chronically Homeless Adults
- SBIRT (Brief Intervention)
- Seeking Safety
- Relapse Prevention Therapy
- Trauma-Focused/Informed Thereapy
- Suboxone

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- NEW MEXICO MODELS (PILOTS) THAT WILL DRIVE INTEGRATION and REFORM PAYMENT

- Certified Community Behavioral Health Clinics (CCBHC)

- ACA Section 2703 Health Homes (HH)

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CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS (CCBHC)

- Excellence in Mental Health Act
- Creates federal definition/criteria for Certified Community Behavioral Health Clinics (CCBHCs)
- Improves Medicaid reimbursement for CCBHC services (PPS)
- Makes CCBHC services mandatory in Medicaid
- Creates a loan fund to support the modernization and construction of community-based mental health and addiction treatment facilities.

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CCBHC KEY DATES

SAMHSA

- May 20, 2015
  - CCBHC criteria and Prospective Payment System (PPS) regulations published
  - Planning grant RFA published
- August 5, 2015 Planning Grant Application deadline
- October 2015 Planning Grants awarded
- November 2016 Demonstration Grant deadline
- January 2017
  - Demonstration states selected from among those that received planning grant
- ALSO KNOWN AS FQ**B**HC

- **New Mexico has submitted a planning Grant with PMS as the Pilot Location during the planning phase – <u>Planning grant FUNDED 10/1/15</u>**

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CCBHC GOVERNING STRUCTURE

- CCBHCs will be:

- Nonprofits
- Governing board members reasonably represent those served in terms of “geographic areas, race, ethnicity, sex, gender identity, disability, age, and sexual orientation”
- Either by at least 51% being consumers with mental illness or adults recovering from SUD *or* a substantial number representing these groups plus other specific methods for consumer and family input
- States are encouraged to require accreditation by an appropriate nationally-recognized organizations (CARF, COA, AAAHC,TJC)

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CCBHC MINIMUM STANDARDS

- The Act establishes standards in six areas that an organization must meet to achieve CCBHC designation
    1. Staffing
    2. Accessibility
    3. Care coordination
    4. Service scope
    5. Quality/reporting
    6. Organizational authority

    7. Paid using a Prospective Payment System (PPS)

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CCBHC CARE COORDINATION

- Required linkage with FQHCs/rural health clinics, unless the CCBHC provides comprehensive healthcare services
- Inpatient psychiatry and detoxification transitions
- Post-detoxification step-down services
- Residential programs
- PCMH / Specialty Providers
- Other social services providers, including
- Schools
- Child welfare agencies
- Juvenile and criminal justice agencies and facilities
- Indian Health Service youth regional treatment centers
- Child placing agencies for therapeutic foster care service
- Department of Veterans Affairs facilities
- Inpatient acute care hospitals and hospital outpatient clinics

CCBHC SERVICE SCOPE

- Direct provision of outpatient mental health and substance use disorder services
- Screening, assessment and diagnosis, including risk assessment
- Person and Family-centered treatment planning
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk
- Crisis mental health services
- 24-hour mobile crisis teams
- emergency crisis intervention services, and
- crisis stabilization
- Targeted case management
- Psychiatric rehabilitation services
- Peer support and counselor services and family supports
- Intensive, community-based mental health care for members of the armed forces and veterans, particularly those in rural areas

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CCBHC PPS OPTION 1

Certified Clinic PPS (CC PPS-1) is an FQHC-like PPS that provides reimbursement of cost on a daily basis

- Cost-based, per clinic rate that applies uniformly **to all CCBHC services rendered by a certified clinic**, including those delivered by qualified satellite facilities
- Pays CCBHCs a daily rate that is a fixed amount for all CCBHC services provided on any given day to a Medicaid beneficiary
- Cost and visit data from the demonstration planning phase will be updated by the Medicare Economic Index (MEI) or by rebasing of the PPS rate
- Based on total annual allowable CCBHC costs divided by the total annual number of CCBHC daily
- State may elect to offer Quality Bonus Payment (QBP)

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CCBHC PPS OPTION 2

- Certified Clinic PPS Alternative (CC PPS-2) is a cost-based, per clinic **monthly rate** that applies uniformly to all CCBHC services rendered by a certified clinic, including all qualifying sites of the certified clinic
- Required elements:
  - A monthly rate to reimburse the CCBHC for services
  - Separate monthly PPS rates to reimburse CCBHCs for higher costs associated with providing all services needed to meet the needs of clinic users with certain conditions
  - Requires the state to select quality measure(s) as permitted and make bonus payments to incentivize improvements in quality of care
- States will develop a standard monthly rate and also will develop monthly PPS rates that vary according to users' clinical conditions
  - State has flexibility in determining how PPS rates could vary
  - An outlier payment is part of the CC PPS-2 and reimburses clinics for costs above a state-defined threshold (either on a monthly or annual basis)
  - Ensures that clinics are able to meet the cost of serving their users

ACA SECTION 2703 HEALTH HOMES

- The Affordable Care Act of 2010, Section 2703, added section 1945 to the Social Security Acti creating an created an **optional Medicaid State Plan benefit** for states to establish Health Homes.

- Opportunity for states to receive additional Federal support for enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for Medicaid beneficiaries who have chronic conditions with complex needs.

- Requires States to include a “Target Population”

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HEALTH HOMES

- The health home model is built on and meant as an expansion of the medical home or patient-centered medical home
- What's the difference between a health home and a medical home?

1) Focus on people with specific chronic physical and/or behavioral health conditions

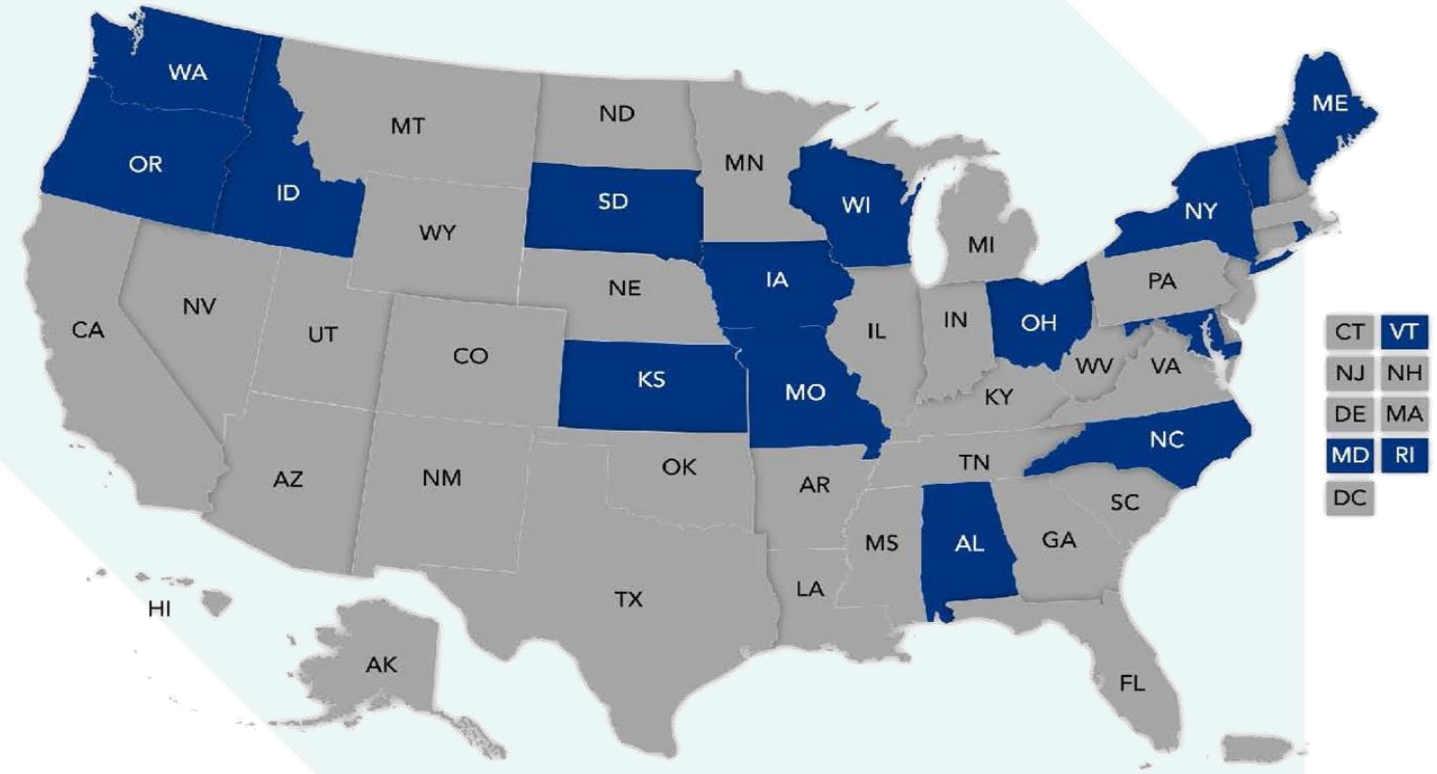
Health homes are specifically for Medicaid beneficiaries with chronic illnesses as defined in section 2703 of the ACA

2) Variety of providers who may deliver health home services

In contrast to the physician-led primary care focus of the medical home, health homes offer person-centered, team-based care coordination with a strong focus on behavioral health care and social supports and services

3) Elevated importance placed on integration and on linking enrollees to non-clinical community social and long term services and supports

Approved Medicaid Health Home State Plan Amendments *(effective November 2014)*



As of November 2014, 16 states have a total of 20 approved Medicaid health home models.

	States with Approved Health Home SPAs (number of approved health home models)	Alabama, Idaho, Iowa (2), Kansas, Maine, Maryland, Missouri (2), New York, North Carolina, Ohio, Oregon, Rhode Island (3), South Dakota, Vermont, Washington, Wisconsin

NEW MEXICO HEALTH HOME PILOT?

New Mexico has identified Chronic Mental Health Disorder – SMI / SED

Coordinates both behavioral & physical health, with family support, and community services such as housing, job placement, transportation and peer support.

NEW MEXICO HEALTH HOME

- 2 Pilot Locations – PMS (FQHC) and Mental Health Resources (CMHC)
- Have 2 or more chronic conditions
- Have one chronic condition and are at risk for a second
- **Have one serious and persistent mental health condition**

HEALTH HOME SERVICES

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient & family support
- Referral to community & social support services

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NM BH HEALTH HOME

STAFFING REQUIREMENTS

- Health Home Director
- Health Promotion Coordinator
- Care Coordinators
- Community Liaison
- Clinical Director
- Peer Support Specialists – Certified by the State
- Medical Consultant
- Psychiatric Consultant
- IT Staff

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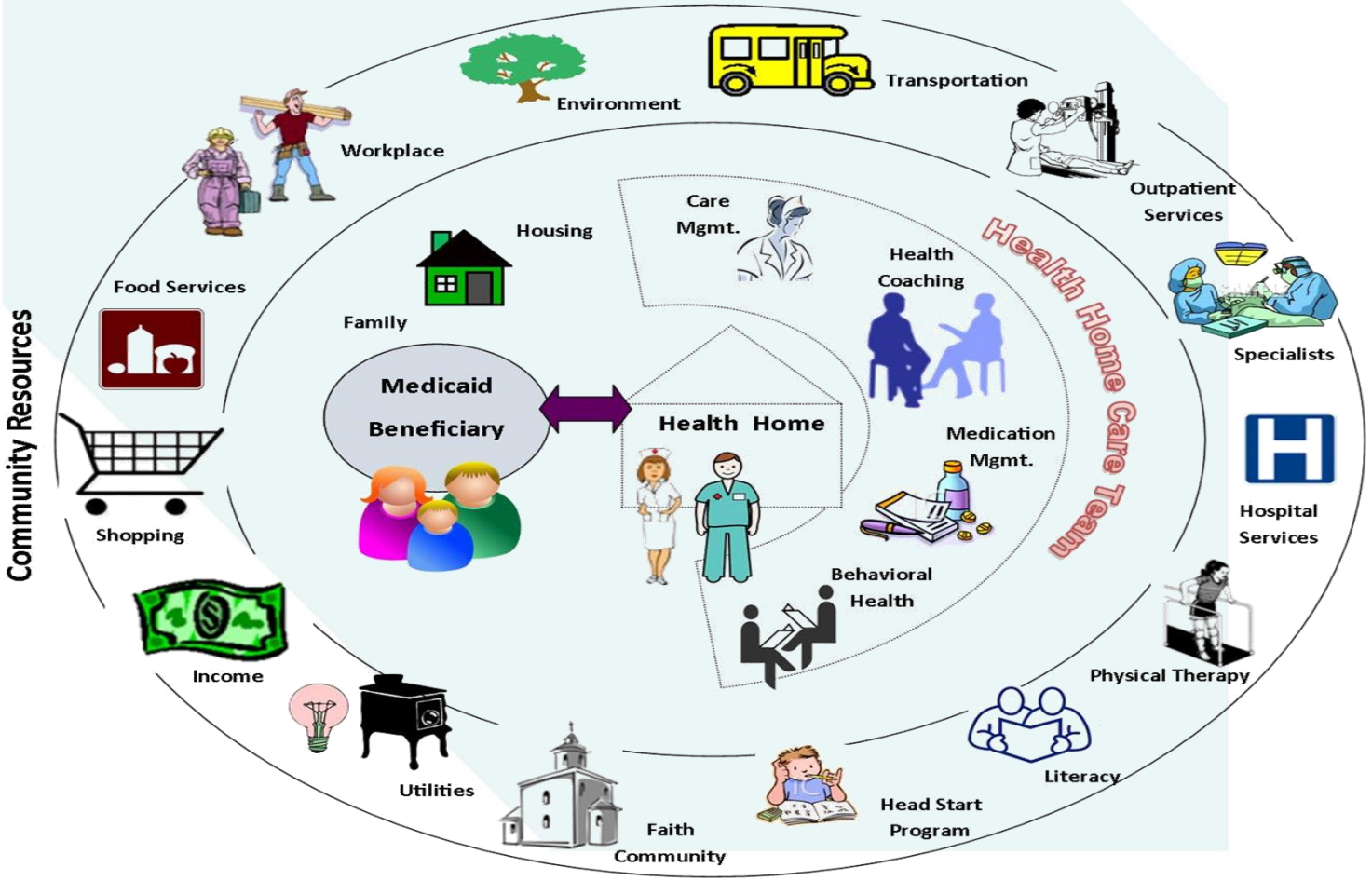
NEW MEXICO HEALTH HOMES: *INTEGRATED CARE MODEL*



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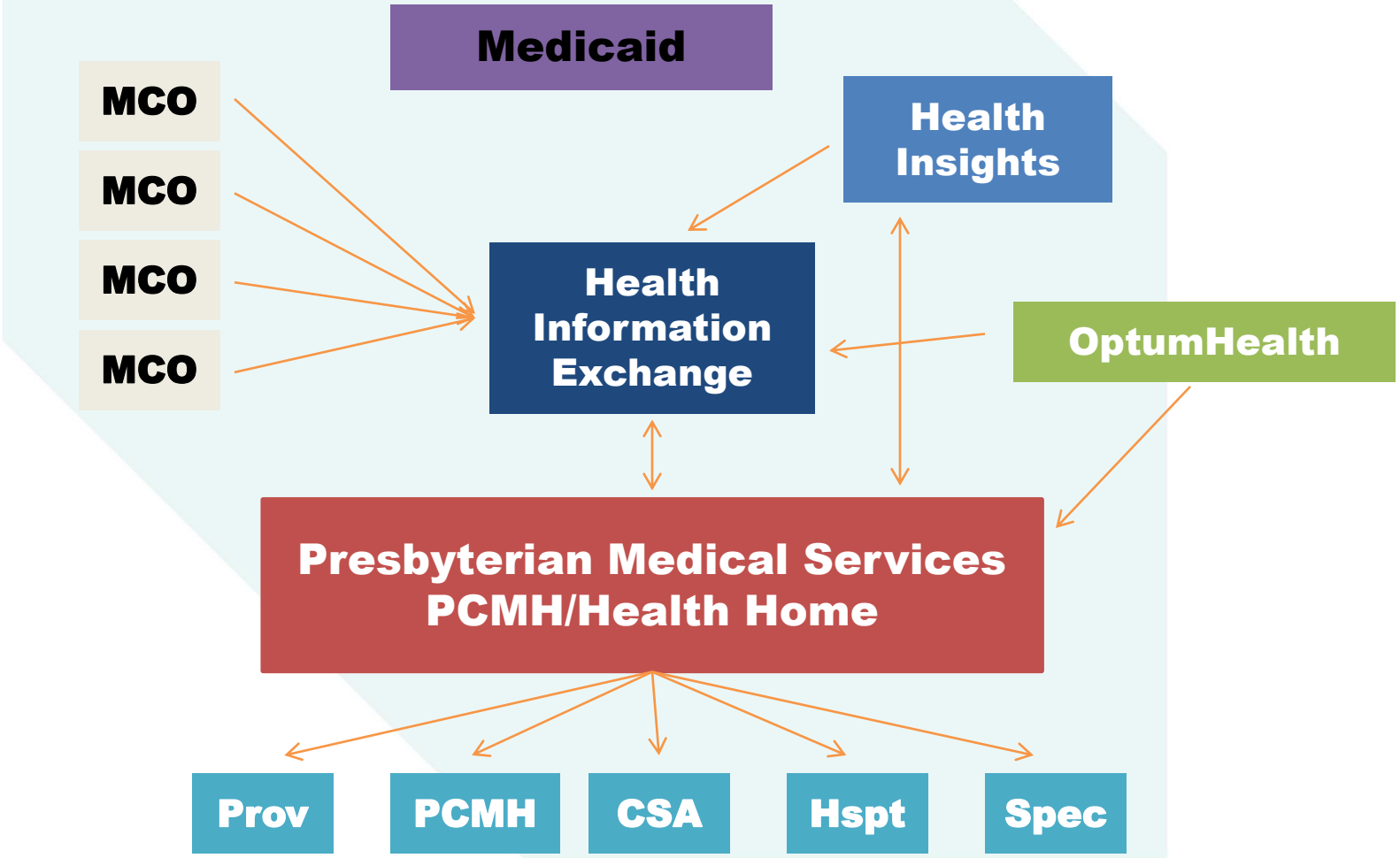
PARTNERS IN EXCHANGING INFORMATION



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FINANCING

- ☐ MCO identify eligibility by County, and clinical criteria
- ☐ Pilot location will receive “Ramp Up” funding – anticipated at 3 months operating costs
- ☐ Health Home will receive PMPM for required services. Anticipated to be $350.00 PMPM
- ☐ Health Home will continue to bill for services rendered and receive FFS reimbursement (PPS for FQHC)

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QUESTIONS?

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