Behavioral Health Initiatives

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning

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Agenda

- Opioid Treatment Program Weekly Reimbursement Bundle
- Certified Community Behavioral Health Clinics
- Mobile Crisis Units

Acronyms

- Family and Social Services Administration (FSSA)
- Centers for Medicare & Medicaid Services (CMS)
- Office of Medicaid Policy and Planning (OMPP)
- Indiana Health Coverage Programs (IHCP)
- Opioid Treatment Program (OTP)
- Certified Community Behavioral Health Clinics (CCBHCs)
- Healthcare Common Procedure Coding System (HCPCS)
- Division of Mental Health and Addiction (DMHA)
- Managed Care Entity (MCE)
- Fee-for-service (FFS)
- Healthy Indiana Plan (HIP)

Opioid Treatment Program Weekly Reimbursement Bundle

OTP Weekly Reimbursement Bundle

- BT202357 announced transition from per diem reimbursement code to weekly bundle G-codes.
- Effective July 1, 2023, HCPCS code H0020 was end-dated.

Covered Services

The following services are included in the weekly per diem rate for OTPs:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications
- Dispensing and administering MAT medications, if applicable
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Prior Authorization is not required for OTP services, but certain documentation must be maintained.

G-Codes

- With this change, Indiana Medicaid reimburses G-codes G2067-G2080 with the exception of G2075.
- G-Codes cover the following MAT treatments:
  - Methadone
  - Buprenorphine
  - Naltrexone

Additional Codes

The following codes can be billed in addition to G-codes if rendered on the same day:

- 81025- Pregnancy Testing
- 85025- CBC (Complete Blood Count) Testing, as needed
- 86580- Tuberculosis Testing
- 86592-86593- Syphilis Testing
- 86704, 86705, 86706, 86707, 86708, 86709, 86803, 86804- Hep A, B, and C Testing
- 90862- Pharmacologic Management
- 99000-99001- Specimen Handling
- 99212-99215- One Office Visit Every 90 Days

Claim Guidance

Per CMS guidance, professional providers should use the CMS-1500 form with the following information:

- Place of Service Code 58 (Non-residential Opioid Treatment Facility)
- HCPCS codes associated with the OTP service
- Codes describing add-on services or ordering medication
- NPI of person prescribing or ordering medication
- Organizational NPI as the billing provider

Certified Community Behavioral Health Clinics

What is a CCBHC?

Certified Community Behavioral Health Clinics (CCBHCs) provide a comprehensive range of mental health and addiction services for anyone seeking services, regardless of their diagnosis, insurance, place of residence, or age.

National Council for Mental Wellbeing

The CCBHC model is a proven outpatient model that:

- **Ensures access** to integrated services including 24/7 crisis response and medication-assisted treatment
- **Meets strict criteria** regarding access, quality reporting, staffing, and coordination with social services, justice, and education systems
- **Receives funding** to support the real costs of expanding services to fully meet the need for care in communities through a Prospective Payment System (PPS) rate

Why CCBHC?

The national data shows that **CCBHCs are changing the mental health and substance use care landscape**, through their use of evidence-based clinical care and effective financing. In 2022, the data showed that …

27
new staff positions filled per clinic, on average since becoming a CCBHC

33%
of all CCBHCs can see a client with any condition in the same day

71%
of all CCBHCs can see a client with any condition within one week

90
more people per clinic served, prior to becoming a CCBHC

National Council (2022). CCBHC Impact report. https://www.thenationalcouncil.org/resources/2022-ccbhc-impact-report/

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Key Benefits of CCBHC for Indiana:

1. **Ensure complete transparency** into the effectiveness of the behavioral health system.

2. **Strengthen the whole ecosystem** by linking behavioral health care with other community pillars such as education, justice, and housing systems.

3. **Build tailored treatment pathways for individuals**, rather than fit complex individuals into a one-size fits all approach.

CCBHC Criteria

By meeting the following criteria, CCBHCs across the country are transforming systems by providing comprehensive, coordinated, trauma-informed, and recovery-oriented care for mental health and substance use conditions.

Availability & Accessibility of Services

Care Coordination

Organizational Authority & Governance

Scope of Services

Staffing

Quality & Other Reporting

Organizational Authority, Governance & Accreditation

Types of CCBHCs:

- **A Non-Profit**
- **Part of local government behavioral health authority**
- **Under the authority of Indian Health Service or Indian Tribal organization**

Other Considerations:

- States are encouraged to require national accreditation
- Governing board members “reasonably represent” those served

Comprehensive Care is Key

CCBHCs provide a comprehensive array of services needed to create access, stabilize people in crisis, and provide the necessary treatment for those with the most serious, complex mental illnesses and substance use disorders.

24/7/365 Mobile Crisis Team Services

Help people stabilize in the most clinically appropriate, least restrictive, least traumatizing, and most cost-effective settings.

Immediate Screening & Risk Assessment

To ameliorate the chronic comorbidities that drive poor health outcomes and high costs for those with behavioral health disorders.

Easy Access to Care

With criteria to assure a reduced wait time so those who need services can receive them when they need them, regardless of ability to pay or location of residence.

Expanded Care Coordination

With a focus on whole health and comprehensive access to a full range of medical, behavioral and supportive services.

Tailored Care for Active Duty Military and Veterans

To ensure they receive the unique health support essential to their treatment.

Commitment to Peers and Family

Recognizing that their involvement is essential for recovery and should be fully integrated into care.

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WHO can access CCBHC services?

- Anyone who requests care for mental health or substance use
- Accessible regardless of one's ability to pay, place of residence, or age
  - Includes developmentally appropriate care for children and youth

Nine Core Services

- Crisis Services
- Screening, Diagnosis, & Risk Assessment
- Psychiatric Rehabilitation Services
- Outpatient Primary Care Screening & Monitoring
- Targeted Case Management
- Peer, Family Support, & Counselor Services
- Community-Based Mental Health Care for Veterans
- Person- & Family- Centered Treatment Planning
- Outpatient Mental Health & Substance Use Services

Community Needs Assessment

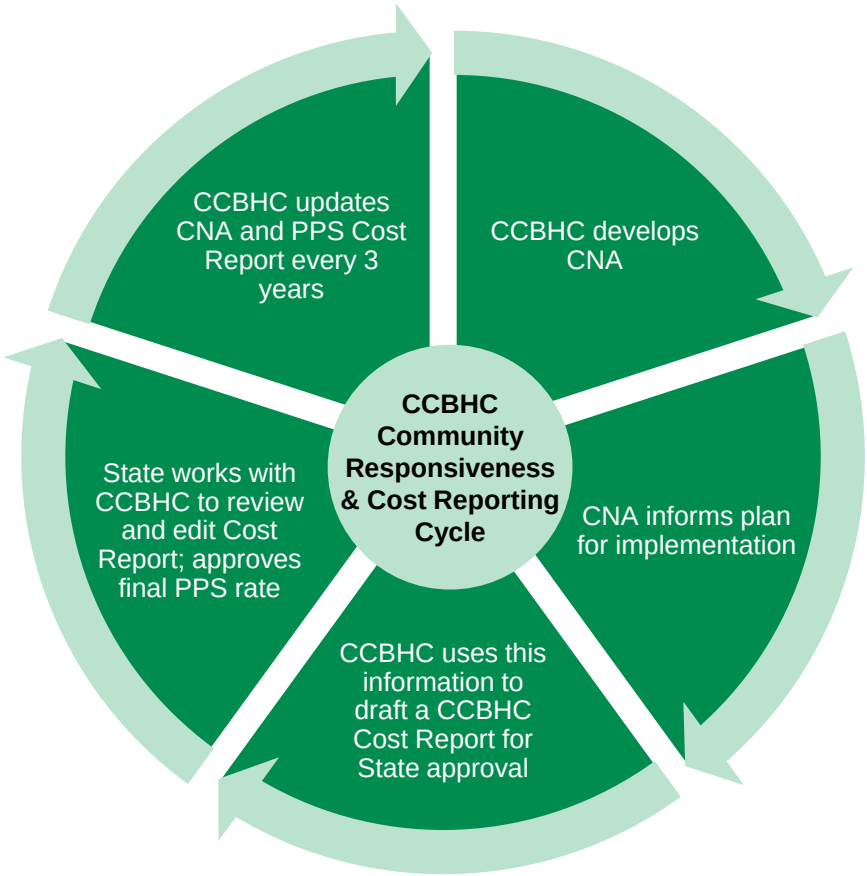
A systematic approach to identifying community needs and determining program capacity to address the needs of the population being served.

Goal: Identify current conditions and desired services or outcomes in the community, based on data and input from key community stakeholders.

- CCBHCs must conduct or collaborate with other community stakeholders to conduct a community needs assessment.
- Specific CCBHC criteria are tied to the community needs assessment and reflect the treatment and recovery needs of those who reside in the service area across the lifespan.

Putting the Community in CCBHC

- CCBHCs are developed to address the community needs through the following process:
  - State defines CCBHC Criteria
  - CCBHC develops Community Needs Assessment (CNA)
  - CCBHC uses CNA to develop plan for implementation
  - CCBHC submits CNA and proposed implementation to the State for review
  - CCBHC builds PPS rate based on implementation plan in the Cost Report template
- CNA and CCBHC Cost Reports are updated and approved by the State every 3 years



Community Needs Assessment Elements

1. A description of the physical boundaries and size of the **service area.**
2. Information regarding **mental health and substance use conditions and related needs in the service area**
3. **Economic factors and social determinants of health** affecting the population's access to health services
4. **Cultures and languages of the populations** residing in the service area.
5. **Plans to update the community needs assessment** every 3 years.
6. Input regarding:
    - cultural, linguistic, physical health, behavioral health **treatment needs**;
    - **evidence-based practices** and behavioral health **crisis services**;
    - **access and availability of CCBHC services**
    - **potential barriers to care**

Who fills out the Community Needs Assessment?

Input areas and channels for the Community Needs Assessment input can include:

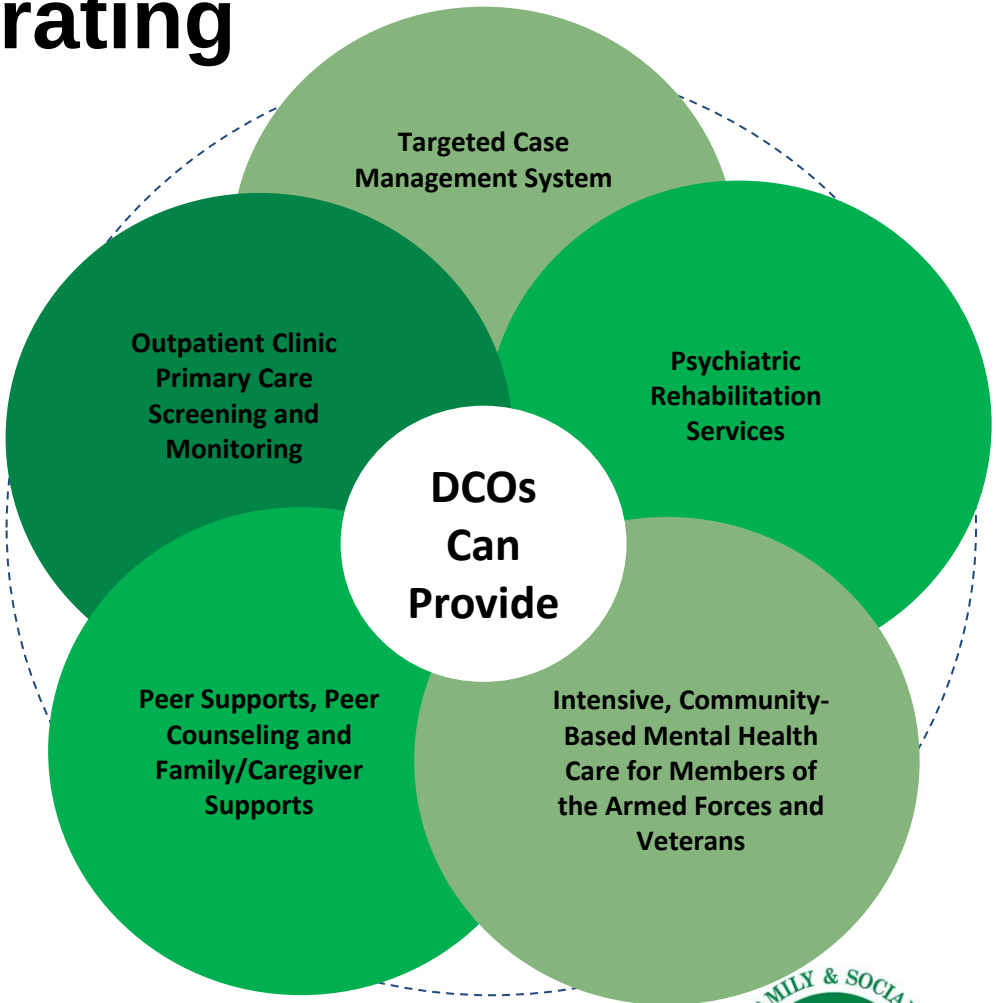
- Individuals receiving clinic services
- Inpatient psychiatric facilities, inpatient acute care hospitals, hospital outpatient clinics
- Individuals with lived experience of mental health and substance use SUD conditions
- Representatives from local K-12 schools
- Health centers and local health departments
- Crisis response partners
- Department of Veterans Affairs facilities

Partnership Types in CCBHC

DCO	Care Coordination
Formal Relationship	Referral Agreement
CCBHC is clinically responsible.	Organizations maintain autonomous operations.
DCO services are accounted for in PPS rate.	No change to payment structure.
Paid through PPS rate. DCO arrangement may include compensation from CCBHC.	No consideration is exchanged between CCBHC and other entity.
Furnish CCBHC services in accordance with schedule of fees, discounts, and corresponding written policies.	Consumers and/or payors are billed for the services provided, independent of the CCBHC.
Optional	Mandatory

Designated Collaborating Organization (DCO)

- Entity not under the direct supervision of the CCBHC, but engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC
- DCO services and pay structure is accounted for in development of the CCBHC PPS rate
- DCOs can be a nonprofit, for-profit, or government entity



5 Required Clinic-Collected Measures

Reporting Requirements of a CCBHC
Time to Services (I-SERV)
Depression Remission at Six Months (DEP-REM-6)
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)
Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD)
Screening for Social Drivers of Health (SDOH)

13 Required State-Collected Measures

Reporting Requirements of the State	
Patient Experience of Care Survey	Follow-Up After Emergency Department for Alcohol or Other Dependence (FUA-CH and FUA-AD)
Youth/Family Experience of Care Survey	Plan All-Cause Readmission Rate (PCR-AD)
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	Follow-up care for children prescribed ADHD medication (ADD-CH)
Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)	Antidepressant Medication Management (AMM-BH)
Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)
Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH & FUM-AD)	Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)	

Billing Rate Changes

Prospective Payment System (PPS) Rates

- A single, bundled payment rate for each qualifying patient visit for all covered services and supplies, regardless of intensity or quantity of service, provided during the visit
- PPS-1 & PPS-3, daily
- PPS-2 & PPS-4, monthly
- Each CCBHC has a unique payment rate based on its care delivery / population served
- No financial incentive to provide lots of units of service when fewer services would be as effective

- CCBHC Covered Services
- Anticipated "Budgeted" Costs
- Direct Costs & Allocated Overhead

$$\frac{\text{Total "Allowable" CCBHC Costs}}{\text{Total CCBHC Visits}} = \text{CCBHC PPS Rate}$$

- Services VS Billable Visits
- Daily VS Monthly Visits
- Anticipated Visits

WHAT does this change?

The CCBHC billing structure changes the **incentive and ability for behavioral health (BH) providers to provide truly evidence-based, integrated, and whole person care.**

Service Reimbursement Model (current)	Fixed Reimbursement Model (CCBHC)
BH providers bill and receive reimbursements per service (Fee-For-Service)	All costs associated with providing whole-person integrated care are factored into a fixed, clinic-specific daily or monthly rate
BH providers can't cover costs for providing evidence-based, integrated, and whole person care	CCBHCs encompass costs of: • Care coordination • Administration • Staff • All care for patients regardless of the # of visits or insurance status
Negatively incentivized to fit the provision of care to billable services	

Options for States via Medicaid

Medicaid Waiver (e.g., 1115)
Enables states to experiment with delivery system reforms
Requires budget neutrality
Must be renewed every 5 years
State must be sure to specify inclusion of selected CCBHC services (some may not otherwise be included in the plan)
With CMS approval, offers opportunity to continue or establish PPS

State Plan Amendment
Enables states to permanently amend Medicaid plans to include CCBHC as a provider type, with scope of services, criteria and requirements, etc.
Does not require budget neutrality
With CMS approval, can continue PPS
Cannot waive “state-wideness,” may have to certify additional CCBHCs (future CCBHCs may be phased in)

WHY now?

Section 223: Protecting Access to Medicare Act

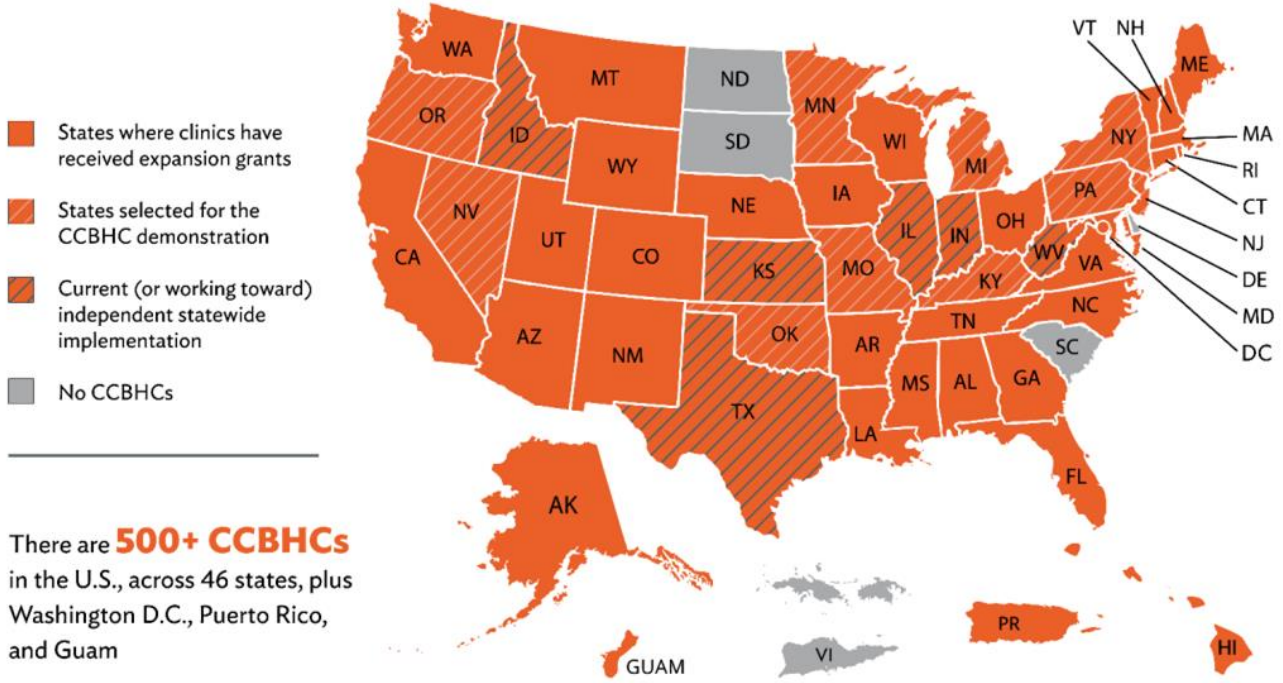
- Created the two-year demonstration program pilot for states to certify CCBHCs
- Originally implemented in eight states

Bipartisan Safer Communities Act

- Demonstration expanded to include ten new states every two years starting in 2024
  - IN applying in March 2024
- Biggest federal investment in MH care since 1963 Community Mental Health Care Act

Nationwide CCBHC Momentum!

Status of Participation in the CCBHC Model



Today, there are more than 500 CCBHCs and CCBHC grantees in 49 states and territories, including new grantees awarded in September 2022. This report contains data collected from CCBHCs and grantees that were active as of August 2022, covering 249 of 450 sites.

National Council (2022). CCBHC Impact report. https://www.thenationalcouncil.org/resources/2022-ccbhc-impact-report/

HOW are we working towards CCBHCs?

Stakeholder Input

Goal: *Gather stakeholder input on initial Indiana CCBHC program design and expectations for CCBHC providers*

- Request for Information (RFI) posted in **July 2023**; responses received **August 2023**
- Currently considering stakeholder input in developing solicitation to select pilot sites

Select Pilot CCBHC Sites

Goal: *Competitively select provider sites to serve as pilot CCBHCs in the federal Demonstration Program*

- Post Request for Services (RFS) in **October 2023**, with requirements for pilot sites
- Applications due **November 2023**
- Issue RFS Award selecting Demonstration Program pilot sites by **January 2024**

Obtain Federal Funding Match

Goal: *Apply for the federal pilot CCBHC program, which offers enhanced federal match to implement CCBHC in selected pilot sites*

- Federal application due around **March 2024**
- Designate pilot sites in **June 2024**
- Demonstration begins in **July 2024**

State Plan Amendment (SPA)

Goal: *Implement CCBHC statewide through a SPA as directed by SEA1*

- If selected for Demonstration, may apply for SPA by **December 2027**
- If not selected for Demonstration, may apply for SPA by **December 2025**

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CCBHC Timeline for Indiana

Flexibility may be available with both Medicaid Demonstration and SPA

National Council (2023). CCBHC Timeline for Indiana. https://www.in.gov/fssa/dmha/files/CCBHC-timeline-Indiana.pdf

Major Upcoming Milestones

**Request for Service (RFS): Competitive procurement method that does not require evaluation of price. Our RFS will identify prospective CCBHCs for the demonstration.*

RFI

- **RFI posted 7/7**
- RFI responses due 8/15
- Integrate RFI responses into RFS

RFS*

- **Issue RFS 10/2** (due 11/15)
- Issue RFS Award selecting Demonstration Program sites Jan 2024

SAMHSA Demonstration

- Finalize PPS rates Feb 2024
- **Application due Mar 2024**
- Designate sites June 2024
- Demonstration begins July 2024

SPA

- If selected for Demonstration, may submit SPA by **12/31/2027**
- If not selected, may submit by **12/31/2025**

Direct questions may be answered through email at CCBHCQuestions@fssa.in.gov

Scan or click here for up-to-date information on Indiana's Pathway to CCBHC.

CCBHC FAQs 

1. Why is the CCBHC model important to Hoosiers?

Simply put - Increased access to care. Establishing the CCBHC model at the state level will ensure complete transparency into the effectiveness of the behavioral health system, link behavioral health care services with other community pillars such as education, justice and housing system, and provide the opportunity to build in tailored treatment pathways for individuals, rather than fit complex individuals into a one-size fits all approach.

2. Who is eligible to receive care at a CCBHC?

CCBHCs are required to serve anyone who requests care for mental health or addiction, regardless of their ability to pay, place of residence, or age - including developmentally appropriate care for children and youth.

CCBHC FAQs 

3. How will expansion to the CCBHC model be funded?

CCBHCs will be funded and supported by a prospective payment system or PPS, which provides a sustainable and flexible funding model to support the CCBHC. For more information, view the SAMHSA Prospective Payment System Reference Guide.

4. How does the CCBHC model address financing barriers when seeking access to behavioral healthcare?

The CCBHC model pays clinics a Medicaid rate inclusive of their anticipated costs of expanding service lines and serving new consumers. Under the PPS model, each CCBHC receives a fixed, clinic-specific rate for each qualifying visit, regardless of the intensity or quantity of service provided.

5. What are the hours of a Certified Community Behavioral Health Clinic?

CCBHCs are required to provide services during times that facilitate accessibility and meet the needs of the population served, including outside of standard business hours, such as some evening and weekend hours. In addition, CCBHC crisis response services must be available 24 hours per day, 7 days a week

CCBHC FAQs

6. How does the CCBHC model fit into Indiana's developing crisis system?

Crisis services are a core service requirement for CCBHCs. CCBHCs can provide crisis services directly or through a formal partnership. The developing crisis continuum in the state will interoperate and support the CCBHC crisis services. Currently, Indiana will be the FIRST STATE to include alignment across the crisis continuum with the 988 Suicide and Crisis Lifeline, creating one unified, 24-hour system of care from a call or text to treatment and recovery. This approach can also create an interconnected system to support the existing not-for profit and faith-based groups that are working to address these issues on a community level.

7. What effect does the CCBHC model have on the current behavioral health workforce shortage?

CCBHCs' Medicaid rates cover costs associated with hiring new staff such as licensed counselors or peer support specialists, paying employees a competitive wage in the local market, and training staff in required competencies such as care coordination and evidence-based practices.

Mobile Crisis Units

Mobile Crisis Units- BT202364

- BT202364 announced the IHCP would be adding mobile intervention services rendered by mobile crisis teams.
- Being implemented as part of *House Enrolled Act* 1222 (2022) as part of the 988 Suicide and Crisis Lifeline initiative.
- Effective July 1, 2023

Mobile Crisis Unit Coverage

- Coverage applies to all managed care programs.
  - Includes HIP, Hoosier Healthwise, and Hoosier Care Connect
- FFS and Emergency Services Only programs (Package E and Package B) are also covered.

Services may not be covered under certain limited-benefit programs.

Crisis Intervention Services

The following are reimbursable crisis intervention services for DMHA-designated mobile crisis units:

- S9484- Mobile crisis response **without** transportation, up to 3 hours
- S9484 UB- Mobile crisis response **with** transportation, up to 3 hours
- S9485- Mobile crisis response **without** transportation, 3 hours or more
- S9485 UB- Mobile Crisis response **with** transportation, 3 hours or more
- H0034 U9- Medication training and support, per 15 minutes
- H2011 UA- Crisis intervention service, per 15 minutes

Important Notes

- FFS providers have a 180-day filing period.
- Noncontracted MCE providers have a 180-day filing period for claim submission.
- Contracted MCE providers only have a 90-day filing period for claim submission.
- Only mobile crisis units designated by DMHA and follow *IC 12-21-8-3* and *IC 12-21-8-10* can receive reimbursement.

Resources Available

Resources

- **What resources are available to providers?**
  - Regional Field Consultants
  - Provider Reference Materials
  - Provider Education

Additional Resources

- **OMPPProviderRelations@fssa.IN.gov**
  - For individual provider concerns requiring assistance from the state
    - Claim denials
    - Procedure explanations
    - Eligibility issues
- **IHCPListens@fssa.IN.gov**
  - Feedback on IHCP presentations
  - Ideas for future presentations or workshops
  - Questions to be answered in future publications

Questions?