

The Role of Critical Access Behavioral Health Agencies in a Reformed Behavioral Health System

Peggy S. Terhune

This commentary discusses the role that Critical Access Behavioral Health Agencies (CABHAs) currently play in meeting the behavioral health needs of people in North Carolina, the opportunities and challenges that CABHAs will confront under the state's section 1915(b)/(c) Medicaid waiver, and the future of CABHAs under the Affordable Care Act.

In 2009, the North Carolina Department of Health and Human Services created a new category of provider agency for mental health and substance abuse services, the Critical Access Behavioral Health Agency (CABHA). The department's chief goal in taking this step was to ensure that critical services are delivered by a clinically competent organization that offers appropriate medical oversight and has the ability to deliver a robust array of services [1]. The CABHA model is an outgrowth of the Piedmont Behavioral Health (PBH) Comprehensive Community Provider (CCP) model. However, the CABHA model added required but unfunded positions, including a medical director, chief clinical officer, and quality management and training director. This modification added more than \$500,000 in unfunded costs to the CABHAs, with no revenue source to offset the expense. Another difference between the CABHA and the CCP was that the CABHA rules specified an array of basic services as well as two enhanced services around a continuum of care.

PBH, which is a managed care organization (MCO), created the CCP model as part of North Carolina's section 1915(b)/(c) Medicaid waiver pilot project, which began in 2005. The organization chose 3 clinically competent and accountable providers, made them responsible for providing core clinical services for at least 2 of the 3 primary disability categories (mental illness, substance abuse, and intellectual or development disabilities), and required them to provide at least 5 distinct services [2]. The specific decision to create 3 CCPs was based on a capacity study and geo mapping, which examined the likelihood and location of individuals in the PBH 5 county catchment area that would require behavioral health services. PBH determined, based on this analysis, that 3 comprehensive provider organizations could meet the

population need and remain fiscally solvent without receiving any additional funds from PBH other than the expected fee-for-service. With their fiscal stability assured, those organizations could focus on providing clinically appropriate services at the lowest possible cost. In addition, having a low number of CCPs ensured that communication between CCPs was frequent, which helped build trusting relationships.

Monarch offered to become the first CCP and worked collaboratively with PBH to create and refine the concept. Two more CCPs were added, and the 3 organizations worked together collaboratively, often functioning almost as different arms of the same agency. Consumers were readily referred from one CCP to another. The CCPs and PBH met frequently to work through issues that emerged, streamlining processes to facilitate positive outcomes. For example, when it became clear that a person needed a higher or lower level of service, common practice prior to the CCPs was to refer and discharge, even though it might take several weeks for the new service to begin. The three CCPs met with the MCO and agreed that the referring agency would continue to provide services until the acquiring agency could initiate services. In this way, individuals were not "dropped" within the system, but continuous care was ensured. Consumer satisfaction increased, consumer health improved, costs were managed effectively, and communication between CCPs regarding individual consumers was frequent and remarkably effective. In addition, PBH was able to establish specific quality outcomes and to benchmark the CCPs against state and national indicators as well as against each other. The ability to consistently gather appropriate data allowed PBH to demonstrate that quality of care improved.

The state's CABHA concept derived from this effective model, but thus far, CABHAs have not been as successful as PBH's CCPs. Concerned about how to maintain quality in networks that are not closed, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance

Electronically published June 7, 2012.

Address correspondence to Dr. Peggy S. Terhune, 738 North Lake Dr, Asheboro, NC 27205 (peggy.terhune@monarchnc.org).

N C Med J. 2012;73(3):195-198. ©2012 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2012/73308

Abuse Services (DMHDDSAS) has imposed rigorous requirements on CABHAs, such as the previously mentioned additional positions that were not allowed to generate revenue. The process for becoming a CABHA is complex, and rules for CABHAs have changed over time. The initial plan to have a limited number of providers (75-100) was not realized; at one point this number grew to more than 225 [3]. Seeing fragmentation, DMHDDSAS undertook CABHA reviews, choosing 75 of the organizations at random to audit. Some CABHAs (including the original CCPs in PBH) received perfect scores, but many providers were given a plan of correction or were immediately decertified as CABHAs.

PBH requested a waiver from CABHA requirements, as the MCO believed the new requirements to be unnecessary, but the request was not approved. As a result, they lost high-quality provider organizations that had been providing services, which necessitated PBH to direct services to less capable entities [4]. Although PBH has multiple CABHAs in their catchment area, they continue to allow only the three CCPs to function as comprehensive providers. PBH realized that if they were to use all approved CABHAs as CCPs, then the economies of scale and tightness of collaboration and cooperation experienced by the 3 original CCPs would cease to exist. PBH did see value in the addition of a psychiatrist to the team, however, and enhanced the psychiatric rate. Use of the services of the psychiatrists who are medical directors has made it possible to improve the quality of services while furthering the concept of coordination with health care. This has produced better outcomes for consumers at lower cost and has resulted in a focus on coordination with the consumer's Medicaid "health home."

Because the state did not limit the number of CABHAs, and because most local management entities (LMEs)—which manage providers and public funds for local consumers—have not worked to develop trust and collaboration between providers, the CABHA system has not yet met the state's goal of "[moving] the public system over time to a more coherent service delivery model that reduces clinical fragmentation at the local level and begins to prepare the provider community for the changes that will be required in a waiver environment" [1]. LMEs have not been given the authority to replicate the PBH CCP model. Today, the delivery of care continues to be effective in the geographic area served by PBH, but it is still disjointed and fragmented in new locations, including the counties new to PBH.

Opportunities and Challenges of the 1915(b)/(c) Medicaid Waiver Statewide Implementation

As PBH's CCP pilot project demonstrated, one of the benefits of having a limited number of comprehensive providers is improved coordination of services and supports, ensuring that evidence-based, cost-effective, medically necessary services are provided within the Medicaid waiver plan model. With coordination and communication, care can be provided at the right clinical and fiscal level to meet

consumer needs. As LMEs merge with one another to form managed care organizations (MCOs), all LME/MCOs will have the opportunity to achieve this, yet it may be that few will succeed in doing so.

A significant factor in PBH's success with CCPs is its ability to have a closed network. PBH determines who will provide which services within its geographic area. By having this level of control, PBH can ensure that the right number of clinically competent providers are offering a specific service, so that the provider's volume of business will be sufficient to maintain its fiscal stability. Many providers appreciate this type of fiscal awareness in an MCO but nevertheless resent the oversight that dictates each provider's business model. In a Webinar presentation on February 12, 2012, Annette Downey, Executive Director of Community Living Services in Ferndale, Michigan, stated that in Michigan, under managed care the consumer (rather than the network) drives the viability of the provider. Organizations there succeed not because a network has selected them to provide certain services, but because they provide a higher quality of service, which leads more consumers to choose to receive care from them. It is unlikely that a consumer-driven system would be effective in North Carolina at this time, however, because the state and the LMEs do not always have effective tools to eliminate poor providers.

The state's decision to create CABHAs was an excellent attempt to re-create and improve upon the CCP model, but the CABHA initiative has been somewhat unsuccessful in achieving its goals. Some organizations that have been approved as CABHAs have attempted to replicate the continuum of care and coordination that has proved effective. Others, however, became CABHAs only in an effort to continue to provide the profitable services in their business array. Political pressures exerted by organizations focused on survival and profit led to the state's decision to approve many more CABHAs than would be needed if the CCP model were being re-created in each LME/MCO area. There are simply too many CABHAs; with a large number of provider organizations, it will not be possible for the LME/MCO to replicate PBH's success.

As the state moves to provide managed care through 11 LME/MCOs, the use of CABHAs as originally intended is in question. House Bill 916, which calls for statewide expansion of the 1915(b)/(c) Medicaid waiver, says that in implementing the expansion, the state should "maintain fidelity" to the PBH demonstration model [5]. Given that CABHAs were not part of the PBH pilot model, which used CCPs to provide a continuum of services within a closed network, it would seem that each LME/MCO should be required to choose a small group of comprehensive providers to serve those functions. New LME/MCOs, however, have been instructed that although they can close their networks, all existing providers must be enrolled in the network, whether competent or not, and the LME/MCO is not to eliminate any providers for the first year. This negates the ability of

the LME/MCO to ensure that the network only has clinically competent, ethical providers. However, if the closed model is appropriately used, there will not be any need for state-certified CABHAs.

Existing LMEs are moving from a system in which they have been only partly responsible for quality of care and provider performance to an insurance-based model in which they will have complete responsibility. Although the state has been working and continues to work with the LMEs as they become MCOs, providing technical assistance in areas such as technology, claims processing, network relations, quality management, and so on, LMEs are being asked to morph into a completely different type of organization. Expertise in a new industry is difficult to develop in the short time allotted to each potential MCO. As the LME/MCOs struggle with the operational basics of becoming an insurance company, they have thus had to put aside the issue of how best to provide clinical coordination in a fiscally viable manner through comprehensive providers.

A significant challenge to successful use of either the CABHA model or the CCP model by the new LME/MCOs is the provider/LME relationship. Each LME has its own culture, and each LME relates to providers differently. In the geographic regions to be served by some of the LME/MCOs, the relationship between providers and LMEs is hostile at best; the LME perceives itself to be in total control, and rather than working with providers in a system driven by shared values, it expects to manage quality through extensive monitoring to ensure that the providers in the network perform well. In some instances, the LME has a benign relationship with its providers, but the LME and the providers operate as silos. A constructive, collaborative relationship between the LME/MCO and the provider community is essential if either the CABHA model or the CCP model is to be successful. If the culture of the network is one of distrust between the LME and the providers, that distrust may extend to relationships between providers. In this type of culture, the potential benefits of a CABHA or CCP model will not be realized. Collaboration, cooperation, and a focus on meeting the needs of the consumer must be values that the providers and the LME share, and partners must trust one another. In some networks, that culture of trust plainly does not exist.

Given that LME/MCOs are required to adhere to the PBH model, they should choose a limited number of comprehensive providers for their network (based on capacity studies and geo-mapping) and use those entities to provide comprehensive services. The LME/MCO should then facilitate the depth of collaboration and coordination necessary to create an almost seamless system for referring patients from one comprehensive provider to another. An important concern is that LME/MCOs may not be able to quickly implement an insurance model and may have difficulty negotiating the intricacies associated with determining outcomes and cost-effectiveness in meeting medical necessity. PBH had 5 years

to acquire and refine the necessary skills. As LMEs become MCOs, they are likely to become bogged down in the minutiae of operations—technology, legal contracts, meeting the requirements of the Centers for Medicare and Medicaid Services, and the like. LME/MCOs are unlikely to be able to truly focus on quality of care and outcomes in the first few years of their existence.

What Will Happen in 2014 Under the Affordable Care Act (ACA)

When the ACA goes into effect in January 2014, LME/MCOs will continue to manage the Medicaid funds and available state and county money that are designated for mental health, developmental disability, and substance abuse services. Because the ACA includes a state option to provide health homes for enrollees, the need for coordinated, effective services will become even more critical.

As various health practices prepare for the ACA, they are already integrating health homes with mental health services. For example, some oncologists in Charlotte have hired a licensed clinical therapist to provide counseling to oncology patients [6]. It may be that then the oncology practice will refer to specialty behavioral health providers only those patients whose mental health problems are severe. Comprehensive community providers who do not collaborate with health homes by providing for some of the short-term needs of consumers will be relegated to serving only those with more significant needs, which will cause a cultural shift for providers that some may not be able to make.

It is anticipated an outcome model (rather than a fee-for-service model) may drive the system. If so, each provider will be required to demonstrate that they are able to provide care that will make the person who receives it healthier. This will only be possible if an organization has a strong continuum of care, can seamlessly move a person through the services they require, focuses on effective outcomes, and ensures that the least costly service possible is used.

With a CCP model, the MCO will be better able to limit the number of contracts it manages and to provide a platform for coordination of care and accountability. If multiple CABHAs are providing disjointed services, the ability of the MCO to ensure accurate data, appropriate outcomes, and seamless delivery of coordinated services and continuity of care will deteriorate. Money will be spent ineffectively, and outcomes will be less desirable.

Provider organizations should focus on ensuring effective, fiscally viable outcomes. LME/MCOs and provider organizations should work to develop the positive relationships, close collaboration, and coordination that are found in the PBH network. LME/MCOs should limit the number of comprehensive providers in order to obtain the maximum benefit for consumers. The CABHA rules should sunset, and MCOs should be allowed to manage their networks through their own chosen comprehensive providers. NCMJ

Peggy S. Terhune, PhD executive director/CEO, Monarch, Albemarle, North Carolina.

Acknowledgment

Potential conflicts of interest. P.S.T. is employed by Monarch, which is a large provider within the PBH network and has worked with PBH since before the inception of the section 1915(b)/(c) pilot project. Monarch is a both CCP and a CABHA. Monarch also provides services and supports to people who receive funding from all 11 potential MCOs.

References

1. Critical Access Behavioral Health Agencies: More information. Web site of North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. <http://www.ncdhhs.gov/mhddsas/providers/CABHA/indexmore.htm>. Accessed April 17, 2012.
2. Shipman P. The PBH Model for Managed Care Operations: A White Paper. 2012 (unpublished).
3. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services. CAHBA Certification List. http://www.ncdhhs.gov/mhddsas/providers/CABHA/cabha_certificationlist_03-02-12.pdf. Accessed April 26, 2012.
4. CABHA conflicts within an MCO. Web site of Benchmarks: An Alliance of Agencies Helping Children, Adults, and Families. <http://www.benchmarksnco.org/wp-content/uploads/2012/03/CABHA-Conflicts-Under-MCOs.pdf>, accessed April 17, 2012.
5. 2011-264 NC Sess Laws. <http://www.ncleg.net/Sessions/2011/Bills/House/PDF/H916v5.pdf>. Accessed April 17, 2012.
6. Support Services Web page of Carolinas Medical Center Blumenthal Cancer Center. <http://www.blumenthalcancercenter.org/body.cfm?id=35>. Accessed April 17, 2012.

Feeling lost, lonely, desperate?



**When it seems like there's
no hope, there is help.**

If you or someone you know is thinking about suicide,
call the National Suicide Prevention Lifeline:

1-800-273-TALK (8255)
With help comes hope.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Printed 2006 • Reprinted 2009 • CMHS-SVP06-0162

**NATIONAL
SUICIDE
PREVENTION
LIFELINE**
1-800-273-TALK
1-800-273-8255
www.suicidpreventionlifeline.org