SAMHSA Clarification to CCBHC Questions

Question: Would a CCBHC still meet SAMHSA's requirement of being "clinically responsible" for provision of services rendered by DCOs if the CCBHC contractually required the DCO to indemnify the CCBHC against malpractice liability for CCBHC services furnished by the DCO?

> **Clarification:** Yes, this would be permissible

Question: Would a CCBHC still meet SAMHSA's requirement of being "clinically responsible" for provision of services rendered by DCOs if the CCBHC contractually required the DCO to add the CCBHC as an insured on the DCO's medical malpractice insurance policy?

> **Clarification:** Yes, This would be permissible

Question: Would the CCBHC still meet SAMHSA's requirement of being "clinically responsible" for the provision of services rendered by the DCOs if the DCO's clinicians maintained charts in the DCO's own separate health record, and then shared information appropriately with the CCBHC? Or, are the CCBHC and DCO required to maintain charts in the same health record?

> **Clarification:** The CCBHC and DCO are not required to maintain charts in the same health record. CCBHCs are responsible for the treatment planning. CCBHC records must reflect services are being rendered in compliance with the treatment plan. The CCBHC record must reflect a complete and accurate depiction of services for which the CCBHC is responsible for overseeing including services provided by a DCO

Question: Must a CCBHC have registered a patient, screened him/her for eligibility for the sliding fee discount schedule, and conducted the required CCBHC clinical screening, before the individual can access a service rendered in a DCO?

> **Clarification:** Yes. This is one of four core services that must be provided directly by the CCBHC. The CCBHC will provide this service, develop the treatment plan and refer the individual to needed services within the CBHC and to any DCOs as warranted.

Question: Can you please clarify who the populations of focus are for a CCBHC and are there 3-4 populations?

> **a)** How is "chronic SUD" defined and how is "long term and serious substance use disorders" from the RFA, Part 1, Page 4 defined?
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> **Clarification to a:** Terminology describing duration of substance disorders should be understood according to current criteria most widely used in the diagnosis and treatment of such disorders (i.e. – DSM v; ICD 10). Terms such as "chronic" and "long term and severe" SUD should be understood in that context as communicating the intent that CCBHCs shall manage and utilize the full scope of

clinical resources needed to successfully threat those who are most severely impacted by substance use disorders. CCBHCs may provide a full array of SUD treatment either through direct provision of services or through services provided through a DCO.

b) Is "others with mental illness and substance use disorders" from the RFA, Part 1, Page 4 a fourth population of focus and how is it defined?

Clarification to b: No. "Others with mental illness and substance use disorders" communicates the intent that CCBHCs will serve all those with mental illness and/or substance use disorders who seek treatment, rather than limit treatment exclusively to individuals with SMI/SED/chronic SUD. Additional populations of focus may be identified according to state priorities, especially as derived from the Needs Assessment.

Question: In looking at the CCBHC services criteria, does 4.h.1. imply states need to create a target population for case management, if it does not already exist, for "Persons deemed at high risk for suicide, particularly during times of transitions such as from an ED or psychiatric hospitalization?"

Clarification: Yes. Regardless of other diagnosis, those deemed at high risk of suicide are specified to receive targeted case management (TCM). The duration of TCM for these individuals may be time limited, for example until no longer deemed at high risk. The CCHBC can establish appropriate utilization criteria to dictate length of service for TCM, but should ensure continuity of service during transitions in care. An important function of the Needs Assessment is identifying and clearly specifying other populations for TCM and the appropriate scope of their services. These may vary locally among different CCBHCs.

CCBHC criteria – 4.h.1 The CCBHC is responsible for high quality targeted case management services that will assist individuals in sustaining recovery, and gaining access to needed medical, social, legal, educational, and other services and supports. Targeted case management should include supports for persons deemed at high risk of suicide, particularly during times of transitions such as from an ED or psychiatric hospitalization. Based upon the needs of the population served, states should specify the scope of other targeted case management services that will be required, and the specific populations for which they are intended.

Question: If a CCBHC client chooses to receive a service outside of the CCBHC's direct or indirect services, will that client still be considered a CCBHC client and will the clinic be obligated to pay the outside provider for that service under the PPS rate?

Clarification: PPS rates are paid to CCBHCs for services that they or DCOs provide. The CCBHC is not obligated to pay the PPS rate for services that is has not delivered directly or through a formal arrangement with a DCO.

Question: Clinics have raised questions bout the licensure requirement. Are all clinicians required to have or be in pursuit of their license? With the BH provider shortage, can a clinic be licensed and individuals who are supervised by a licensed clinician count?

> **Clarification:** Please refer to the complete Criteria 1.b.2., Licensure and Credentialing of Providers, page 13 of the Criteria. It reads in part, "The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the states, is informed by the state's initial needs assessment, and included clinical and peer staff…The CCBHC must have staff, either employed or available through formal arrangements, who are credentialed substance abuse specialists… CCBHCs are not precluded by anything in this criterion from utilizing providers working towards licensure, provided they are working under the requisite supervision."

Question: The following excerpts from Appendix II – Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Community Behavioral health Clinics contain many sections indicating CCBHCs are required to provide primary care services. However, Section 223(a)(2)(D)(V) of PAMA states that, "outpatient clinic primary care screening and monitoring of key health indicators and health risk" is the minimum required CCBHC primary care service. Further, Criteria 4.g.1 states that, "Nothing in these criteria prevent a CCBHC from providing other primary care services." However, Appendix III – Section 223 Demonstration Programs to Improve Community Mental Health Services Prospective Payment System (PPS) Guidance, Section 4.2.c states, "states must identify and remove all non-CCBHC allowable costs in order to determine PPS. The statute implementing this demonstration prohibits payment for the following non-CCBHC services: inpatient care, residential treatment, room and board, or any other non-ambulatory expenses, as determined by the Secretary." The section goes on to say, "Examples of additional types of costs incurred for non-CCBHC services include costs to support the provision of dental and optometry services." Although it is clear that CCBHCs are required to provide primary health care services, either directly or through agreements with DCOs, it is not clear which of the primary care services a state can consider to be "CCBHC services." This distinction between "CCBHC services" and non-CCBHC services" is important for purposes of identifying costs that can or cannot be included in the cost report as an allowable cost to calculate a PPS rate.

> **Clarification:** As specified in the section 223(a)(2)(D)(v) of the PAMA and detailed in section 4.G. of the Criteria, CCBHCs are required to provide outpatient clinic primary care screening and monitoring. In interpreting this requirement to develop the PPS rate, SAMHSA recommends that states adopt the Medicaid definition of screening services at 42 CFR 440.130 (b): "the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases." This definition will assist states in determining which services constitute primary care screening and monitoring for purposes of coverage and payment under this demonstration.

Question: If the needs Assessment for one CCBHC indicates a need for an additional service that is not indicated in the needs Assessment for a different CCBHC, must the state require all CCBHCs to be able to provide the additional service? Or, can the state's certification requirements differ by CCBHC?

Clarification: The needs assessment is to be used to determine staffing, linguistic and cultural competence, and the evidence based practices needs of the community that the CCBHC serves. There is no requirement to develop additional services based on the needs assessment. The community needs assessment applies to CCBHC service that community. The stat must also develop a minimum set of evidence based practices that are required across the state and should be using the statewide stakeholder engagement process to develop the minimum set of practices. The state may also consider the local needs assessment for the statewide process, but it is not required. Please see http://www.samhsa.gov/section-223/certification-resource-guides/conduct-needs-assessment.

Question: Can court-ordered SUD and SUD without counseling (State Plan currently requires counseling for SUD) be included as allowable costs?

Clarification: Theses services would be allowable costs to the extent that they fall under one of the nine services required by the grant, excluding services provided in an institutional setting.

Question: Will services provided by DCOs also contribute to quality bonus payments?

Clarification: Services that are used in the development of the PPS rate, provided by a CCBHC or DCO, will count toward meeting quality bonus measures. The DCO contracts with the CCBHC to provide demonstration services and as such does not submit a claim or receive payment from the State Medicaid Agency. However, a CCBHC may include a description of quality bonus measures and criteria for quality bonus payments with their contract with the DCO.

Question: When developing services to be included in the CCBHC that are not already covered by the state plan, is it also allowable to look at alternative provider types that are not currently covered under the state plan? Example would be Community Health Workers.

Clarification: The state may contract with providers not covered by the Medicaid State Plan in order to meet the requirements of the Criteria. The State should refer to the Criteria, section 1.b.2 on page 13, to ensure that providers meet the necessary requirements.

Question: For CCBHCs in areas that border other states, does the CCBHC have to provide services for out of state clients? Just emergency services for out of state patients?

Clarification: See Criteria 2.e.1 and 2.e.2 on page 22. CCBHCs have protocols addressing the needs of consumers who do not live close to a CCBHC or within the CCBHC catchment area as established by the state. CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence. The required protocols should address management of the individual's on-going treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing CCBHCs to refer and track consumers seeking non-crisis services to the CCBHC or other clinic serving the consumer's county of residence. For distant consumers within the CCBHC's catchment area, CCBHCs should consider use of

telehealth/telemedicine to the extent practicable. In no circumstances (and in accordance with PAMA Section 223 (a)(2)(b)), may any consumer be refused services because of place of residence.

Question: Once a person is enrolled or identified as a CCBHC member, will they be locked into the CCBHC site in which they are enrolled or can they go to a non-CCBHC site for services? How do we ensure the CCBHC PPS rate is paid for CCBHC members only (we discussed having CCBHC identifiers to denote individuals for whom a CCBHC PPS claim can be made)?

Clarification: Medicaid beneficiaries are allowed free choice of providers as indicated in 1902(a)(23). As such, they are able to receive health services at their choice of CCBHC or non-CCBHC. To ensure the CCBHC PPS rate is paid only for the nine demonstration services when provided by a CCBHC, the Medicaid billing form will be adjusted to indicate a CCBHC encounter, likely through the addition of a new Place of Service Code. Although there is the concern of duplication of services, CCBHCs are required as a participant in the demonstration to provide are Care Coordination (PAMA Section 223 (a)(2)(c)) as a program requirement and TCM (PAMA Section 223 (a)(2)(D)(vi)) as one of the nine services. If done correctly, the use of TCM and care coordination should minimize duplicate care to beneficiaries.