

Project 223 Clarifications to Guidance – March 22 through April 30, 2016

Question: Can day treatment be an allowable cost?

Clarification: **States should consider which of the nine services required by the grant would include day treatment. It would be an allowable cost only if it fell under one of the nine services required by the grant, and if it were not provided in an institutional setting.**

Question: Is there any guidance available regarding how to ensure that duplicate primary care services are not received and billed for? For example, if a patient comes to the CCBHC for outpatient substance use disorder therapy and already has their own primary care provider whom the individual sees regularly, what is the guidance regarding how to make sure that the individual does not receive the additional/redundant primary care services at the CCBHC? As well, how do we fiscally account for that - if the individual's independent primary care provider has already billed for the primary care services, and now the individual is in the CCBHC, how do we account for the primary care service costs that are included in the CCBHC PPS? Would it be possible to use the special rate option for primary care services?

Clarification: **Please see Criterion 4.g.1. Only outpatient clinic primary care screening and monitoring are CCBHC services.**

Question: Is the certification guide the tool we should use? Will it be accompanied with a grading scale? What if a site scores great in certain areas but needs improvement in others, can we still certify them or will they need to rank satisfactory on all domains/levels? Will the state rate/rank the sites subjectively or will you provide a grading metrics for each question?

Clarification: **We offered the certification guide that is posted on the SAMHSA web site as a tool that you can use. We do not require that you use it and it will not cost you points if you do not. The CCBHC Criteria Checklist is attached to the demonstration program application guidance that you will use to apply to participate in the demonstration program. That checklist will allow you to rate all of the CCBHCs in the state on a four point scale to allow for the possibility that all CCBHCs may not be fully in compliance.**

Question: If a CCBHC contracts with a state-sanctioned crisis service, can that crisis service provider also become a DCO? (Question in regards to whether a particular entity can become a DCO.)

Clarification: **Please refer to Criterion 4.c.1: “Unless there is an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services that dictates otherwise, the CCBHC will directly provide robust and timely crisis behavioral health services. Whether provided directly or by the CCBHC or by a state-sanctioned alternative acting as a DCO, available services must include the following:**

- **24 hour mobile crisis teams,**
- **Emergency crisis intervention services, and**
- **Crisis stabilization.”**

Question: Our agencies who are eligible for CCBHC certification serve a number of counties or catchment areas. Knowing that the CCBHC is required to provide services to any person seeking behavioral health services, does that apply to clients living outside the catchment area?

Clarification: **See Criteria 2.e.1 and 2.e.2. 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.**

Question: May we have more than one CCBHC in a service area? We do not want to split the service area to create smaller areas served by each CCBHC. We want to have two CCBHCs in the same service area, both providing the full array of services, but each serving fewer individuals. The intention is to increase access and availability. The two CCBHCs in one service area would be operated by the same provider. It would give people choices.

Clarification: **Yes, as long as the needs assessment documents the need.**

Question: Payment Regulations: Does the state need to promulgate regulations or sign contracts by 10/1/16? Can the state submit draft regulations or contracts to SAMHSA as evidence of readiness to implement the demonstration, and then finalize them after SAMHSA awards the demonstration?

Clarification: **Contracts do not have to be signed by 10/31/16, the date of your demonstration application. They do however need to be ready for signature upon notification that the state was selected to participate in the demonstration program and fully executed before the program launch date.**

Question: Are DCOs able to contract with multiple CCBHCs?

Clarification: **There is nothing in the Criteria to prohibit a DCO from contracting with more than one CCBHC.**

Question: Is it a requirement that a CCBHC provide evening and weekend hours at all of the offices of the CCBHC or can this be limited to our larger locations?

Clarification: **Please refer to Criterion 2.a.2., “The CCBHC provides outpatient clinical services during times that ensure accessibility and meet the needs of the consumer population to be served, including some nights and weekend hours.” Needs assessments should evaluate accessibility and availability for all individuals - including those served as well as those who are under-served and unserved. States have discretion about CCBHC locations and operating hours based on the needs of all individuals.**

Question: Staffing Plan - If a CCBHC is required by a state’s law to be accredited by a state-approved accrediting body (e.g. TJC, CARF or ACHC), could the staffing plan simply state that the CCBHC must be in compliance with the accrediting body’s staffing standards. Since SAMHSA is encouraging accreditation and our state mandates it, it seems overly-bureaucratic to add another layer of requirements.

Clarification: **See Criteria 1.a and 1.b.2. The staffing plan is influenced by many factors including the needs assessment, services to veterans, and other state-determined criteria. States are responsible to certify that clinics meet the criteria specific to CCBHCs.**

Question: The CCBHC is required to treat anyone who requests and is in need of service. How should the CCBHC handle care coordination in a situation in which someone comes in for a primary substance abuse service but refuses to sign consent to the release of information?

Clarification: **Please see Criteria 3.a.2 which requires “Necessary consent for release of information is obtained from CCBHC consumers for all care coordination relationships. If CCBHCs are unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program requirement 3, such attempts must be documented and revisited periodically.”**

Question: Is the national evaluation taking place over the two demonstration years or is it for a longer period?

Clarification: **Yes, it is for the two year demonstration program.**

Question: Is supported employment allowable under psychiatric rehabilitation

Clarification: **Yes, supported employment is allowable as an Evidence-Based Practice. See Criterion 4.i.1.**

Question: Is Medication Assisted Treatment a required service?

Clarification: **No, MAT is not a required service unless the State defines it as an outpatient service under Criterion 4.f.2. This addresses “...evidence-based medication evaluation and management (including but not limited to medications for psychiatric conditions, medication assisted treatment for alcohol and opioid substance use disorders (e.g., buprenorphine, methadone, naltrexone (injectable and oral), acamprosate, disulfiram, naloxone), prescription long-acting injectable medications for both mental and substance use disorders, and smoking cessation medications); community wrap-around services for youth and children; and specialty clinical interventions to treat mental and substance use disorders experienced by youth (including youth in therapeutic foster care).” This list is not intended to be all-inclusive and the states are free to determine whether these or other evidence-based treatments may be appropriate as a condition of certification.**

Question: If a State has multiple schools and multiple school districts within one CCBHC catchment area, must the CCBHC complete formal agreements with all schools or school districts?

Clarification: **We suggest that you prioritize some, referring to your needs assessment to determine relative priority. After completing formal agreements with the most critical districts or schools, during the demonstration period the CCBHC should work on increasing the number of agreements. The State may be able to help CCBHCs by asking the State Department of Education to inform school districts about the importance of these working relationships and agreements. See Criteria 3.C in the Criteria which addresses Care Coordination Agreements and contingency plans when these cannot be established within the time frame of the demonstration period.**

Question: Mobile Crisis 24/7 is one of the required 4 core CCBHC services that a CCBHC must provide directly. If the CCBHC does not currently have an established catchment area, and based on the requirement that a CCBHC cannot turn away anyone due to location or ability to pay, how will that affect the provision of services in a large geographical area? Would the CCBHC need to identify a catchment area? If they do, what is the distance then identified that would be outside that catchment area?

To expand on the question above, if a CCBHC provides many community based services (outside the 4 walls) and does not have an identified catchment area, again, would a catchment area need to be identified? If not, how would a CCBHC comply with seeing any consumer regardless of residence and ability to pay given such a large geographical location?

Clarification: **The Criteria require the state to conduct a community needs assessment for each CCBHC. The service area (we are using that term instead of catchment area) must be defined by the state in order to determine the “community” to be served by the CCBHC. The CCBHC’s staffing plan, EBPs, cultural and linguistic capabilities, and service hours should be established based on the population residing within that service area.**

**This will also help when CCBHCs develop “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.” See Criteria 2.e.2 on page 22 for details.**

Question: Guidance on the SAMHSA website indicates that CCBHCs are required to provide four levels of detoxification services and specifies how they are to be provided - level 1 directly; that it is preferred for CCBHCs to provide level 2 directly; that levels 3.2 and 3.7 should be provided directly, by a DCO or via a referral. Criterion 4.c.1 indicates only that the CCBHC ensure that detoxification services are available within the CCBHC structure, which can be defined by the state. If a state does not license one of the four levels of detoxification services, so that one of the levels is not available in the state, will that service be required to be provided by a CCBHC?

Clarification: **CCBHCs are required to provide the first four of five withdrawal management services for adults, and those services must be available and readily accessible as part of CCBHCs' crisis services. These four services are levels 1, 2, 3.2, and 3.7. (please see our clarification at <http://www.samhsa.gov/section-223/care-coordination/substance-use-disorder-treatment-providers> that includes a link to the American Society of Addiction Medicine where these four ambulatory and medical detoxification services are defined:**

- 1-WM: Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery. **The CCBHC must directly provide 1-WM.**
- 2-WM: Moderate withdrawal with all-day withdrawal management support and supervision; at night, has supportive family or living situation, likely to complete withdrawal management. **The CCBHC is encouraged to directly provide 2-WM. While the CCBHC must have the 2-WM level of ambulatory withdrawal management available and accessible to eligible consumers, it is not a requirement that this service be provided directly, although it is encouraged.**
- 3.2-WM: Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery. **May be provided directly either by the CCBHC or through a DCO relationship or by referral.**
- 3.7-WM: Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, or nursing monitoring. **May be provided directly either by the CCBHC or through a DCO relationship or by referral.**

See also Attachment 1. CCBHC Criteria Checklist of the "Guidance to Planning Grant States to Apply to Participate in the Section 223 CCBHC Demonstration Program. On pages 34 and 35 of the Checklist, Criteria 4.C. Crisis Behavioral Health Services, the state must rate the clinic on the following criteria: "The following services are explicitly included among CCBHC services that are provided directly or through an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services: (1) 24 hour mobile crisis teams, (2) emergency crisis intervention services, (3) crisis stabilization services, (4) suicide crisis response, and (5) services for substance abuse crisis and intoxication, including ambulatory and medical detoxification services." If the CCBHC is unable to provide one of four levels of detoxification services directly, through a DCO, or by referral, even if the state does not license these services, you must rate the clinic accordingly and provide justification at the end of the program requirement checklist. States may use the narrative justification to explain deficiencies in services and how they will be addressed. The demonstration program intends to move services and treatment to a higher level of accessibility, availability, and quality.

Question: Do CCBHCs need contracts with FQHCs or just agreements?

Clarification: **3.c.1 is specific to FQHCs and allows an agreement initially. 3.c.1 goes on to say that “CCBHCs are expected to work toward formal contracts with entities with which they coordinate care if they are not established at the beginning of the demonstration project.”**

**The purpose of the initial agreement – and the contract that follows - is spelled out in Criteria 3.c.1-c.5, to address the underlying reasons and some instances in which agreements or contracts are required, the types of entities with which CCBHCs should have agreements or contracts, and some content requirement for agreements and contracts.**

Question: We are looking for guidance on the screening assessment and treatment planning requirements for consumers who are already receiving services from the CCBHC at the time of certification. Can the state establish criteria for acceptable screenings, etc. that were done within a certain time period prior to CCBHC certification? Can the state establish a phase-in period for CCBHCs to renew and update all assessments and treatment planning based on CCBHC criteria?

Clarification: **See Criteria 2.b.2. “The comprehensive person-centered and family-centered diagnostic and treatment planning evaluation is updated by the treatment team, in agreement with and endorsed by the consumer and in consultation with the primary care provider (if any), when changes in the consumer’s status, responses to treatment, or goal achievement have occurred. The assessment must be updated no less frequently than every 90 days unless the state has established a standard that meets the expectations of quality care and that renders this time frame unworkable, or state, federal, or applicable accreditation standards are more stringent.” We interpret these Criteria to mean that all existing CCBHC consumers will have a comprehensive review and update of their treatment plans within 90 days of the first day of CCBHC service implementation.**

Question: Many questions have also arisen about the 51% consumer/family board representation requirement. Please clarify. What is SAMHSA's expectation for CCBHCs meeting the 51% requirement or providing a plan and timeline to meet this requirement? Can a CCBHC demonstrate "meaningful consumer participation" in organizational governance in other ways to meet the requirement without 51% consumer participation and without having a plan and timeline for 51% participation?

Clarification: **See all of Criteria 6.B: Governance. 6.b.1 refers to “...a substantial portion of the governing board members meeting this criteria and other specifically described methods for consumers, people in recovery and family members to provide meaningful input to the board about the CCBHC’s policies, processes, and services.” 6.b.2 says “The CCBHC will describe how it meets this requirement or develop a transition plan with timelines appropriate with timelines appropriate to its governing board size and target population to meet this requirement.” Criteria 6.b.3 and 6.b.4 address challenges with meeting the requirement and alternatives to the requirement. 6. b.6 states, “States will determine what processes will be used to verify that these governance criteria are being met.” Note that states will describe their guidance to CCBHCs “regarding the CCBHCs organization governance that ensures meaningful input by consumers, persons in recovery, and family members” in their applications to participate in the Demonstration Program (Guidance to Planning Grant States to Apply to Participate in the Section 223 CCBHC Demonstration Program).**

Question: Can you provide clarification between a contractor/subcontractor and a DCO, what (if any) distinction lies between them

Clarification: **DCOs are not under the direct supervision of the CCBHC while contract staff are.**

**Please see the Criteria which includes this definition of a “Designated Collaborating Organization (DCO): A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. The CCBHC maintains clinical responsibility for the services provided for CCBHC consumers by the DCO. To the extent that services are required that cannot be provided either by the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for care coordination including services to which it refers consumers. Payment for those referred services is not through the PPS but is made through traditional mechanisms within Medicaid.”**

**See Criterion 1.b.2 which reads in part, “The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state, is informed by the state’s initial needs assessment, and includes clinical and peer staff. In accordance with the staffing plan, the CCBHC maintains a core staff comprised of employed and, as needed, contracted staff, as appropriate to the needs of CCBHC consumers as stated in consumers’ individual treatment plans and as required by program requirements 3 and 4 of these criteria...”**

Question: How should a state choose their control groups?

Clarification: **The state is not responsible for choosing their control groups. The national evaluator will select a control group after the start of the demonstration and after the certified clinics have been established. The national evaluator may select a comparison group that includes comparison clinics, or the national evaluator may select a comparison group that is comprised of comparable individuals to those using the CCBHCs. In either case, after a comparison group is defined, the State will be responsible for providing claims or encounter data for the comparison group of individuals (either selected by being clients of a comparison clinic, or being in an identified group). A state can recommend comparison groups to the national evaluator if the state would like to do so.**

Question: If a CCBHC has multiple sites, do all outpatient services for all age groups need to be provided in each site? Is it possible for all services to be provided at each site with the different sites serving different age groups? We have some programs interested in becoming a CCBHC but they have different sites for children and adults.

Clarification: **CCBHCs can use multiple sites or offices that focus on a specific population. The full array of services should be equally accessible to all people, regardless of age, who live in the service area.**

Question: We understand that the four core services must be provided by the CCBHC. Must the other five required services be provided by the CCBHC or by a DCO, or could some of these five required services be provided by another provider under contract to the CCBHC?

Clarification: **The four core services must be provided by the CCBHC. Please see Criteria 4.c.1, 4.d.1, 4.e.1, and 4.f.1 for the four core services to be provided directly by the CCBHC. The other five required services are listed in Program Requirement 4 of the Criteria and must be provided either by the CCBHC or by a DCO. Please see 4.a.2 of the Criteria, “The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, consistent with the consumer’s freedom to choose providers within the CCBHC and its DCOs.”**

Question: Our state is working hard to expand the use of trained peer specialists, who often work part time. They are valuable resources that we would like to maintain on governing and advisory boards. Please confirm that these individuals would not be subject to the “health care industry” limitation which states that “No more than one half (50%) of the governing board members may derive more than 10% of their annual income from the healthcare industry.”

Clarification: **The requirement that “No more than one half (50%) of the governing board members may derive more than 10% of their annual income from the healthcare industry” applies to all members of CCBHC governance.**