

Section 223 Demonstration Program for Certified Community Behavioral Health Clinics (CCBHCs)

Clarifications to Guidance – Jan. 1, 2016, to Feb. 29, 2016

SAMHSA, CMS, and ASPE have provided the following responses to questions from states and clinics regarding the Section 223 Demonstration Program and CCBHC certification process. For more information on the program and to access helpful resources and guides, please visit SAMHSA's [Section 223 website](#).

Question: Our interpretation of SAMHSA's guidance is that where CCBHC requires services are furnished via DCO, the CCBHC will be required (1) to procure DCO services contractually, at fair market value; and (2) to serve as the billing provider for the service rendered by the DCO. These requirements are more restrictive than the HRSA requirements governing community health centers, which contemplate that CHC required services may be provided on a referral basis. We believe the requirements will lead to numerous undesirable policy consequences as described in the attached memorandum. In addition, we do not believe that PAMA § 223 requires SAMHSA to impose such restrictive requirements in this regard. Would SAMHSA consider modifying its guidance so as to permit CCBHCs to provide required services not only through the DCO mechanism, but also through formal referral relationships, where the referral provider (not the CCBHC) is clinically responsible for the care and serves as billing provider?

Clarification: **We do not anticipate modifying the guidance to permit PPS payments to organizations other than DCOs through their CCBHCs. No policy memorandum, referred to above, was attached.**

Question: Would a CCBHC still meet SAMHSA's requirement of being "clinically responsible" for provision of services rendered by DCOs if the CCBHC

a. contractually required the DCO to indemnify the CCBHC against malpractice liability for CCBHC services furnished by the DCO?

Clarification: **Yes. This would be permissible.**

b. 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 that 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 CCBHC and to any DCOs as warranted.**

Question: Would a CCBHC meet SAMHSA’s definition of being “financially responsible” for the provision of DCO services if the CCBHC contractually delegated to the DCO the following functions:

- a. verifying patient’s insurance status, collecting cost-sharing, and applying the sliding fee discount?

Clarification: **A state may choose to permit CCBHCs to delegate responsibility for the listed activities to DCOs.**

- b. filing claims with Medicaid and other payers on behalf of the CCBHC?

Clarification: **The CCBHC may not delegate this responsibility to the DCO. The CCBHC bills the state Medicaid office and reimburses the DCO for services rendered.**

Question: Federal law contains a safe harbor for purposes of the Anti-Kickback Statute (AKS) to permit federally-qualified health centers (FQHCs) to receive remuneration in the form of items, services, or donations that relate directly to services included in the health center’s scope of project, where the remuneration is not conditioned on the amount of Federal health care program business generated between the parties. See 42 U.S.C. § 1320a-7b(b)(3)(I); 42 C.F.R. § 1001.952(w). Congress’ main goal in enacting this safe harbor (and HHS’ main goal in promulgating regulations that clarify it) was to strengthen FQHCs’ capacity to care for underserved populations by allowing the health centers to enter arrangements with other types of health care providers, under which the other provider confers some type of benefit on the CHC that advances access to care in the community. The lack of a parallel “safe harbor” may impede effective care coordination for CCBHCs. Given that care coordination and person-centered care are the linchpins of the CCBHC program, as described by SAMHSA, would SAMHSA/CMS consider advocating for a parallel AKS safe harbor for CCBHCs?

Clarification: **We will take your recommendation under advisement. Thank you.**

Question: Can a group of community mental health centers come together to form a CCBHC or would one need to be the lead and others be the DCOs?

Clarification: **This question relates to the prohibition against satellite facilities established after 4/1/2014. A group of existing community centers may come together to form a new CCBHC. Any subsequent proposal from the entity to create an additional CCBHC would be regarded as a satellite facility.**

Question: What constitutes a satellite facility?

Clarification: **We are continuing to look at this question. The statute does not define the meaning of satellite in the statute. To respond to your question, we are reviewing the use of the term by behavioral health agencies, Medicaid, and FQHCs.**

Question: The following excerpts from Appendix II – Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics contain many sections that indicate 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 that, “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 Designated Collaborating Organizations (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 which can or cannot be included in the cost report as an allowable cost to calculate a PPS rate. Can states determine whether the following services can be considered “CCBHC” services for purposes of calculating the PPS?

- Tobacco screening for pregnant women
- Family Planning and counseling services
- Birth control pills
- Dental screening performed by a nurse practitioner
- Radiology services
- Drug testing and other laboratory services
- Pharmacy claims

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.**

***Protecting Access to Medicare Act**

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 be able to provide the additional service? Or can the state’s certification requirements differ by CCBHCs?

Clarification: **The needs assessment is to be used to determine staffing, linguistic and cultural competence, and the evidence based practice 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 serving that community. The state 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: Criteria 3.c.4 requires CCBHCs to have an agreement establishing care coordination expectations with the nearest Department of Veterans Affairs’ medical center, independent clinic, drop-in center, or other facility of the Department. Because of Nevada’s vast geographic

area with low population density, the nearest VA facility for many parts of Nevada is located in a border state. How will this impact the state's demonstration grant application, and what should the state require from CCBHC's related to requirements to provide services to veterans?

Clarification: **Please refer to 4.K.1 describing the requirements of the CCBHC to deliver services to veterans. There is nothing in the criteria to prevent the CCBHC from referring consumers who are veterans to the closest VA facility if it is located in a different state.**