Certification	
Questions	**Clarification**
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?** **b. contractually required the DCO to add the CCBHC as an insured on the DCO's medical malpractice insurance policy?**	Yes, both a. and b. are permissible.
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?	The CCBHC and DCO are not required 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.
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?	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.
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?** **b. filing claims with Medicaid and other payors on behalf of the CCBHC?**	**a. A state may choose to permit CCBHCs to delegate responsibility for the listed activities to DCOs.** **b. The CCBHC may not delegate this responsibility to the DCO. The CCBHC bills the state Medicaid office and reimburses the DCO for services rendered**
Some payors, including some Medicaid programs, require claims to include the NPI of a supervising clinician, who must be on site when the service is rendered. How will this be handled with respect to services rendered by DCOs?	States are responsible for setting policy on NPI reporting for services rendered by DCOs.
Can you please clarify who the populations of focus are for a CCBHC and are there 3 or 4 populations? It is clear that SED and SMI are two populations of focus, however, what is intended by additional language found in other places specific to SUD and then in another place we see "others" listed. (The PowerPoint lists three populations of focus but the RFA indicates 4): **a. How is "chronic SUD" as listed in the PowerPoint from the Introduction to CCBHC in June 2015 defined and how is "long term and serious substance use disorders" from the RFA, Part 1,page 4 defined?** **b. Is "others with mental illness and substance use disorders" from the RFA, Part 1, page 4 a 4th population of focus and how is it defined?**	**a. Terminology describing duration and severity 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 treat 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 services provided through a DCO.** **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.**

In looking at the CCBHC services criteria, does 4.h. 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"?	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 CCBHC 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.1The 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.

During the "Guidance to States to Apply for the Section 223 CCBHC Demonstration Program" webinar on February 3rd, a representative from Iowa inquired about integrating Health Homes into the CCBHC PPS Demonstration Project. Missouri is considering whether to integrate the cost of its CMHC Healthcare Homes into the proposed Prospective Payments to CCBHCs. If a state did integrate health home costs into the Prospective Payments to CCBHCs, we assume that the CCBHC would no longer receive a PMPM payment of health home services, that the costs associated with providing health home services would be included in calculating the PPS rate, that the CCBHC would continue to provide health home services (which may or not count as a visit),and that, under the CC PPS-1Option, when an eligible individual received a CCBHC service provided by an eligible provider, constituting an eligible visit, the CCBHC would receive a PPS payment based on its daily visit rate which incorporated the cost of providing health home services. Is that correct? We see advantages and disadvantages to integrating health home costs into the PPS rate. Of course, health home services are an example, par excellence, of the CCBHC service "Outpatient clinic primary care screening and monitoring of key health indicators and health risk". Incorporating the cost of health home services into the PPS rate has the advantage of capturing the enhanced Medicaid match for two years. But we want to be sure that converting this monthly model to the daily visit model embodied in the CC PPS-1Option would not negatively impact the CCBHC reimbursement, especially in light of the fact that many of the most important functions of the health home staff are not likely to be considered to involve a "visit", and that this is a "Medicaid only" service in terms of reimbursement.	CCBHCs are required to provide the nine demonstration services as indicated by Section 223 of the Protecting Access to Medicare Act, (b)(2)(C).The statute does not require states to dismantle existing delivery systems, such as Health Home Services. As participants in this demonstration, states have flexibility in planning their demonstrations and their applications should include details about key components of their CCBHC proposal such as non-duplication of payment and the incorporation of the expected costs of the nine demonstration services into the PPS rate.
Crisis Services and the requirement for level one withdrawal: PA has state sanctioned crisis services. We believe we can use those sanctioned services, as long as they provide the required level one withdrawal, and still meet the criteria. Is this accurate? Of course the crisis services would need to meet other crisis services requirements.	Yes, you are correct.
Clinics here have raised questions about 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? PA currently accepts masters level clinicians.	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 state, is informed by the state's initial needs assessment, and includes 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."
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?	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
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?	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.

We are seeking additional clarification regarding potential CCBHC that operate from multiple sites. Does each clinic site have to offer all of the required services? What is the proximity requirement for sites? If we have a large program, under one management structure that offers SUD services in one location, mental health service in another, crisis services from another, is that permissible?	We anticipate the CCBHCs will be multiple site organizations in some communities. The purpose of the CCBHC is to improve quality and access and these are key determinants for consideration when states are selected for the demonstration program. All nine services must be available to everyone in the community served by the CCBHC. Please refer to the SAMHSA 223 website, Certification Resources and Guides.
Can you please provide some clarity regarding how states are able to comply with the Corporate Practice of Medicine rules as it relates to criteria 4.a.1. that states that "the CCBHC is ultimately clinically responsible for all care provided. The decision as to the scope of services to be provided directly by the CCBHC, as determined by the state and clinics as part of certification, reflects the CCBHC's responsibility and accountability for the clinical care of the consumers." There is some confusion regarding how are CCBHCs that do not provide primary care services, but rather contract with the DCO for the primary care services are able to be ultimately clinically responsible for all care provided, giving the limits set by the corporate practice of medicine rules.	CCBHCs are responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk as well as care coordination with primary care providers. They are not responsible for the provision of primary care.
Is there any additional guidance available about the recommended radius or region for the needs assessment?	The state prepared needs assessment will have a significant impact on many criteria, including staffing plans, EBP's, and cultural requirements. The needs assessment defines geographic service areas. CCBHCs or community behavioral health provider service areas conform to the needs assessment.
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 providers types that are not currently covered under the state plan? Example would be Community Health Workers. (Question in regards to which state providers can render demonstration services.)	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.
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?	See Criteria 2.e.1and 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 § 223 (a)(2)(B)), may any consumer be refused services because of place of residence.
Data Collection & Evaluation	
Questions	**Clarification**
For a new assessment on a client at a CCBHC, is it allowable to both schedule clients and allow Walk-in availability for clients?	Yes, as long as services comply with the certification criteria. See Criteria 2.b.regarding timely access to services and initial and comprehensive evaluation.
Prospective Payment System	
Questions	**Clarification**
We have received questions about the use of estimated charges in PPS-2. The guidance to states in the January 12 CMS TA call indicated (on slide 6) that charges incorporated into the final version of the cost report may include anticipated visits and charges for CCBHC services not provided prior to DYI. It appears from line 2 of the cost PPS-2 cost report that estimated charges must be included as there will be no way of including actual charges for services not formerly offered. Yet, without a clear indication in the cost report that estimated charges may/must be included, organizations may be hesitant to sign off on a cost report that includes estimated charges. Could you confirm whether estimated charges may be included in the cost report?	We confirm that estimated charges may be included in the cost report to the extent a clinic and/or state believes that actual charges are not representative of the charges that will occur during a demonstration year.

We are concerned that CCBHCs will experience major challenges with implementing a cost-to-charge ratio in DY1as a means of associating costs with special populations. In comparable instances where CMS has used a cost-to-charge ratio as a means of fine-tuning the PPS rate, such a ratio can be used only where there is the following paper trail: {1) a charge master that is in place for the cost report year, and (2) claims data containing detailed HCPCS/CPT coding for that year. For Medicare FQHC, Medicare began requiring the detailed coding in 2011, and the base years for the PPS rates were subsequent to 2011. We anticipate this type of detailed coding being extraordinarily difficult for behavioral health organizations to report in DY1. In addition to there being wide variation in whether behavioral health entities currently maintain schedules of charges, there is also presumably wide variation in the extent to which state Medicaid agencies currently require those providers to use detailed HCPCS/CPT coding. For that reason, a cost-to-charge ratio for the CCBHC base years doesn't yet exist- there simply isn't enough information- but perhaps it could exist for later years after the CCBHCs have been given time to develop their charge masters and ramp up their coding capabilities. We suggest that CMS implement an alternative initial approach: CMS could hold off on the idea of unique rates for patient populations for the first couple of years, or it could apply adjusters to the overall per UME rate based on national data about the cost of serving those categories of patients until individual provider data is available.	We agree that during the cost report year a charge master encompassing all of the demonstration services may not be in place. Additionally, a clinic may not have complete data on service usage during the cost report year. To address the issue of incomplete data, CMS: (1) permits clinics to estimate charges, costs and visits in a manner consistent with state policy, and (2) allows states to elect to rebase PPS in DY2 to reflect actual data from DYI. Additionally, the states may elect to use a different allocation methodology by developing their own cost report and using the CMS cost report crosswalk tool, or they may use the PPS-1rate (statewide) to accommodate clinics who cannot develop the necessary data for PPS-2.
CMS's instructions as to how it wants rows 4 and 5 completed appear to contradict the template. The cost report template, through how the fields are populated, suggests that CMS has in mind total costs (for all populations), as reflected on the trial balance; however, the instructions suggest that CMS has in mind the total cost associated with certain populations. Which types of costs are to be entered on rows 4 and 5?	Lines 4 and 5 of the CCPPS-2 tab are automatically populated from the trial balance and indirect cost allocation tab and they are used to calculate total allowable costs. This total is divided by the total charges from line 3 to calculate the cost to charge ratio. The ratio is then multiplied by each population's charges to come up with the applicable costs. The directions for these two rows indicate that total direct and indirect costs are automatically populated on the form. The directions for the columns indicate that costs by certain populations will be entered. These costs are automatically generated by the cost to charge ratio. A user only needs to enter charges on the form
Either method of entering costs will be problematic for the cost-to-charge calculations. If CMS intends for CCBHCs to enter the costs associated with specific populations in rows 4 and 5, that appears to be a circular calculation: it is impossible to specifically identify the service costs associated with a specific population; it's for that reason that CMS is suggesting an allocation mechanism. If CMS intends for CCBHCs to enter total costs associated with the whole population, then CMS is setting up a cost-to-charge ratio that is apples-to-oranges (overall costs for all populations compared to charges associated with a subpopulation). Importantly, a cost-to-charge ratio cannot be obtained by dividing total allowable costs by total charges on claims, because the total costs would include the costs of serving all patients, even the uninsured, whereas the charge/claims data would include only data from patients covered by that pay or. Can CMS provide any clarity on this point?	As stated in the PPS TA webinar, clinics will need to have a charge master in order to implement the cost to charge ratio as demonstrated in the CMS cost report. The charges would be equal for all beneficiaries regardless of payer which enables a calculation of total allowable costs by total charges. During the webinar we covered how to fill out the PPS-2 rate tab; attached are the slides.

Charge data for many types of patients is simply not available. It is impossible to derive an accurate cost-to-charges ratio based on "total service costs (all populations)" because no provider will ever have total claims/charge data for all of the services it provides. Instead, typically providers have charge data only for a subset of their services: those services provided to individuals covered by a specific pay or, reflected on claims to that pay or containing CPT/HCPCS codes. To derive an accurate global cost-to-charge ratio of the type envisioned here, the provider would have to be able to amass charge data associated with all patients- including Medicare, Medicaid, uninsured, private pay. That task would probably exceed the ability of any health care provider, and it would certainly exceed the ability of CCBHCs which will be newly developing their schedules of charges. This is shown on paragraph 2 of tab 14 in the instructions, where CMS defines a cost-to-charge ratio as "total costs, including anticipated costs for all users ... divided by all charges for all users regardless of payor." That second component of the comparison is impossible to produce as a practical matter. CMS itself noted this in the background research supporting the FQHC Medicare PPS rate. A more feasible cost-to-charge ratio would be to compare "Medicaid costs (per UME or per encounter) to Medicaid charges." Practically speaking, for that reason, a cost-to-charge ratio can be applied only after a cost-based rate specific to one payor has been derived. Can CMS provide any clarity on this point?	Your question appears to assume that clinics participating in this demonstration have limited to no experience in billing for services. We are concerned that a clinic lacking experience in this basic business activity would not have the ability to meet the criteria for certification which include, among other activities, annual cost reporting. If a state finds that the proposed method is unworkable for their providers, they have the option to develop alternative methodologies or to utilize the PPS-1 rate.
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?	Thank you for helping us to clarify this; we understand how it might have been read that way. Here's further clarification: We do not anticipate modifying the guidance to permit PPS payments to CCBHCs for CCBHC services provided by organizations other than DCOs. No policy memorandum, referred to above, was attached
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? Follow-up comment about question: My recollection is they wanted to know if the person went to receive a required service from an entity the CCBHC had no existing relationship, would the clinic need to pay for the service and if	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 it has not delivered directly or through a formal arrangement with a DCO.
For those states with pre-existing behavioral health home models what are the options for including or excluding the payment for those services in the PPS rate? so would it be with the PPS rate?	The statute does not require states to dismantle existing delivery systems, such as Health Home Services. As participants in this demonstration, states have flexibility in planning their demonstrations and their applications should include details about key components of their CCBHC proposal such as non-duplication of payment and the incorporation of the expected costs of the nine demonstration services into the PPS rate.

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.1states that, "Nothing in these criteria prevent a CCBHC from providing other primary care services." However, Appendix Ill - 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	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
Managed Care - If CCBHC rates included B3 services currently provided under our BHO capitation, would the State retain its waiver authority to provide these services under a capitation as well?	The state would still maintain the (b} (3} authority to provide these services outside of the CCBHC and that would not be part of the PPS rate. In the instance that the state provides (b)(3} services through a CCBHC, the service would need to be provided in the context of one of the nine demonstration services and be paid through the PPS rate.
Will services provided by DCOs also contribute to quality bonus payments?	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 payment within their contract with the DCO.
Our state currently pays its Medicaid Managed Care Organizations a set per-member-per-month (PMPM} capitation payment for services. We expect to incorporate the CCBHC PPS payment into the capitated rate. Since we expect to employ this approach, could we contract with the Medicaid MCOs to complete and audit the cost reports with the CCBHCs?	The criteria for a state to certify a clinic to participate in the demonstration require at 5.a.5. "CCBHCs annually submit a cost report within six months after the end of each demonstration year to the state. The state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each demonstration year to CMS." As such, a Medicaid MCO would be able to review a CCBHC's cost report for completeness and submit the report and any additional clarifying information to CMS on behalf of the state so long as the state's contract with the MCO specifies these activities. The cost of the MCO completing these activities on behalf of the state should not be considered CCBHC service costs when developing the capitation rates paid to the MCOs.

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)?	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 §223 (a) (2) (C)) as a program requirement and TCM (PAMA §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.
How can we ensure non-CCBHCs aren't delivering duplicate care the CCBHCs are getting paid for under the PPS methodology? Would all non-CCBHC claims have to be denied for CCBHC members? Example: CCBHS member goes to CCBHC site A for care and is served under the CCBHC model and the site received the CCBHC PPS rate. Then the CCBHC member goes to a non-CCBHC site (not a DCO) and gets services covered under the PPS, but the non-CCBHC bills for the service through their normal reimbursement process. Not sure how to handle these types of scenarios.	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 §223 (a) (2) (C)) as a program requirement and TCM (PAMA §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.
General Questions	
Questions	**Clarification**
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}{1); 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?	We will take your recommendation under advisement. Thank you.
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?	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.
There may be complications in billing services rendered by DCOs to managed care plans {Medicaid and otherwise) if the CCBHC is in the plan's network, but the DCO is not. How will this be handled?	States will work with their providers and MCOs to address this issue.
Can a for-profit serve as a DCO? I believe the answer is yes. A CCBHC has to be not-for-profit, but not the DCO.	Please see the SAMHSA website at http://www.samhsa.gov/section-223/certification-resource-guides/ccbhc-eligibility.
What is the current standing of aligning CCBHC goals with that of Behavioral Health Homes?	CCBHCs are required to provide the nine demonstration services as indicated by Section 223 of the Protecting Access to Medicare Act, {b} (2} (C). The statute does not require states to dismantle existing delivery systems, such as the coordination of care provided via Health Home Services. As participants in this demonstration, states have flexibility in planning their demonstrations and their applications should include details about key components of their CCBHC proposal such as non-duplication of payment and the incorporation of the expected costs of the nine demonstration services into the PPS rate
Can clarity be provided with regards to specific services which can be provided in compliance with the “non-four walls” requirement of the CCBHC?	The state has the flexibility to determine which services can be provided outside the four walls and enumerated.

Can court-ordered SUD and SUD without counseling (State Plan currently requires counseling for SUD) be included as allowable costs?	These 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.
When a site becomes a CCBHC, will it be a state or federal certification?	State

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

Clarifications to State Questions	
Questions	**Clarification**
Can day treatment be an allowable cost?	**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.**
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?	**Please see Criterion 4.g.1. Only outpatient clinic primary care screening and monitoring are CCBHC services.**
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?	**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.**
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.)	**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."**
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?	**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.**
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.	**Yes, as long as the needs assessment documents the need.**

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?	**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.**
Are DCOs able to contract with multiple CCBHCs?	**There is nothing in the Criteria to prohibit a DCO from contracting with more than one CCBHC.**
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?	**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.**
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.	**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.**
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?	**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."**
Is the national evaluation taking place over the two demonstration years or is it for a longer period?	**Yes, it is for the two year demonstration program.**
Is supported employment allowable under psychiatric rehabilitation	**Yes, supported employment is allowable as an Evidence-Based Practice. See Criterion 4.i.1.**
Is Medication Assisted Treatment a required service?	**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.**
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?	**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.**

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 identity 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?	**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.**
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?	**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.**

Do CCBHCs need contracts with FQHCs or just agreements?	**.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.**
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?	**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.**
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?	**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).**
Can you provide clarification between a contractor/subcontractor and a DCO, what (if any) distinction lies between them	**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…"**

How should a state choose their control groups?	**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.**
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.	**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.**
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?	**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."**
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."	**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.**