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March 29, 2016

To: ABH Members
From: Vic DiGravio, President/CEO
Lydia Conley, Vice President for Mental Health
Re: **Update on MA Certified Community Behavioral Health Clinic Initiative**

Please note that the information in this memo is based on the best information available at the time of drafting. Where CCBHC documentation from the Commonwealth, the Substance Abuse and Mental Health Services Administration (SAMHSA) or the Centers for Medicare and Medicaid Services (CMS) contradict information in this memo, that information should be followed.

The Commonwealth, through a partnership among the Department of Public Health (DPH), the Department of Mental Health (DMH), and MassHealth, has released a Request for Applications (RFA) for Certified Community Behavioral Health Clinics (CCBHC). The state has indicated that it will "certify two or more applicants as CCBHCs." Successful applicants will have the opportunity to participate in a two-year national demonstration project beginning in 2017, if the Commonwealth is selected to participate.

I. Background

The Protecting Access to Medicare Act (PAMA) included Section 223, a provision known as the Excellence Act, which establishes a two-year demonstration project to create "Certified Community Behavioral Health Clinics" (CCBHCs). The intent of the law is to create behavioral health clinics that have a federal definition with defined quality standards and reimbursement that reflects the cost of care. Twenty-four states, including Massachusetts, received planning grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop a Demonstration application and prepare for implementation. As of this time, up to eight of the twenty-four states with planning grants will be selected for the Demonstration.

II. Planning Grant Requirements and Timeframe

By October 2016, Massachusetts and the other twenty-three state planning grantees must complete the following tasks as part of their application for the Demonstration program:

- certify at least two CCBHCs; and,
- develop a cost-related Prospective Payment System (PPS) for each CCBHC, i.e., each clinic will receive its own rate based on allowable costs and needs specific to the clinic.

The SAMHSA Planning Grant Request for Applications (RFA) requires that states certify at least two community behavioral health clinics that represent diverse geographic areas, including rural

and underserved areas. Further guidance indicates that at least one clinic must be in a "rural and/or underserved area."[1] States have great flexibility in defining these terms.[2]

In public forums, state agency staff members have indicated that certification of two clinics is the floor, and that the Commonwealth anticipates certifying more than two clinics for purposes of the Demonstration project.

The SAMHSA Planning Grant RFA allows states to select between daily and monthly PPS rates. The state has selected the daily PPS rate option offered under the SAMHSA Planning Grant RFA. Under the two allowable PPS options, *the PPS rate constitutes the entirety of payment for CCBHC services delivered to CCBHC clients*. There is no billing of MassHealth beyond the PPS claim.

III. Demonstration Timeline

States must apply to become part of the eight-state demonstration project by October 31, 2016, and SAMHSA will notify the successful state applicants in January 2017. SAMHSA recently announced that planning grant states selected to participate in the Demonstration will be authorized to launch their programs upon notification in January 2017 and **not later than July 1, 2017**. Selected states will specify a launching date upon which all CCBHCs in the state will begin providing CCBHC services under its selected PPS. The state's Demonstration program will end two years after the launch date.

Resources:

- National Council's Integrated CCBHC Certification Criteria Feasibility and Readiness Tool.
- *CCBHCs 101: Opportunities and Strategic Decisions Ahead*, Presentation, National Council Conference 2016, March 2016.

IV. Massachusetts Certification Process and Timeline

Although this is not a procurement, a Request for Applications (RFA) for certification has been posted on COMMBUYS, the Commonwealth's official procurement record system.

The Commonwealth released its RFA on March 24, 2016. At the time of publication, the certification timeline was described as follows:

- Potential applicants were requested to submit a letter of intent by no later than **March 30, 2016 at 5 pm**.
- An applicants' conference webinar will be held for interested organizations on **March 31, 2016 at 3:00 pm**.

[1]See also, P.L. 113-93, Section 223, d. 1., directing SAMHSA to select demonstration participants that "represent a diverse selection of geographic areas, including rural and underserved areas."

[2]SAMHSA's *Guidance to Planning Grant States* indicates that State applications will be required to "[c]ite documentation including medically underserved area (MUA) designations that at least one CCBHC is located in a rural and/or underserved area."

- Questions regarding the CCBHC RFA may be submitted to by no later than **12 noon on April 12, 2016**.
- Responses to the RFA by are due no later than **12 noon on April 25, 2016**.

At the time of publication, six CCBHC documents were posted:

1. RFA Brief Summary
2. RFA Information and Instructions
3. RFA Agency Application
4. RFA Clinic Site Application
5. RFA FAQs
6. RFA Letter of Intent

The Commonwealth has indicated that it will begin review of the applications for certification within a week of the closing of its Request for Applications. Clinics will be certified through an application review and site visit process.

After the RFA closes, the Commonwealth anticipates reviewing applications for approximately one week to ensure that they meet the minimum requirements. Applicants will be rated as "ready to implement," "mostly ready to implement," "ready to implement with remediation" or "unready to implement", [3] based on their application responses. Teams of reviewers will then conduct readiness assessment site visits of applicant organizations, beginning with those rated "ready to implement" on the basis of RFA responses, as part of the certification process beginning in May 2016.

The RFA Information and Instructions indicate that "[o]nly those applicants who achieve CCBHC criteria scoring ratings between 1 (ready to implement) and 2 (mostly ready to implement) by **August 1, 2016** (emphasis supplied) will potentially have the opportunity to participate in the national demonstration project." Clinics certified later in the process will not be eligible for participation in the Demonstration.

A. Applicant Eligibility

Page three of the RFA Information and Instructions details eligibility requirements. Providers seeking certification must be organized in one of the following ways under federal rules: not-for-profit, part of a local government behavioral health authority; or be operated under the Indian Health service, tribe or tribal organization.[4]

"Further, those seeking certification must be a health care organization with:

- At least one existing dually-DHCQ and BSAS licensed behavioral health clinic in Massachusetts;
- In good standing with BSAS and DHCQ; and
- Established before April 1, 2014."[5]

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[3] The SAMHSA *Guidance to Planning Grant States to Apply to Participate in the Section 223 CCBHC Demonstration Program* asks states to rate their CCBHCs as whole on this scale for each criterion on SAMHSA's "State's Compliance with CCBHC Criteria Checklist" (an attachment to the guidance). http://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-application-guidance.pdf.

[4] P.L. 113-93, Section 223, a. 2. F.

[5] "No payment shall be made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act [April 1, 2014]." P.L. 113-93, Section 223, d. 5. C. ii. II.

Massachusetts will "certify at least one CCBHC from a rural area" and it includes an Appendix to its *CCBHC Information and Instructions* document that defines those communities that meeting the state-established definition of rural.

> **Important:** Although the RFA requests organizational-level information via the CCBHC Agency Application**, certification is site-specific. The Clinic Site Application must be "completed for *each* site listed in Part 1 that your agency wishes to certify and meets the requirements (BSAS licensed, DHCQ licensed and established before April 1, 2014)."**

Internal Designated Collaborating Organizations

A clinic may establish a Designated Collaborating Organization (DCO) relationship with its other sites for those services that are allowed to be delivered through this type of arrangement, i.e., primary care screening and monitoring; targeted case management; psychiatric rehabilitation services; peer support, counseling and family support services; and intensive community-based care for members of the armed services and veterans.[6] Using this structure, a provider organization will need to be able to determine its CCBHC clients and attribute costs and services delivered to the certified clinic site and any DCO site, *including its internal DCOs*, for cost reporting, quality reporting and claims submission purposes. **Please see page 8 for more information on DCOs**.

V. CCBHC Requirements[7]

Section 223 of PAMA outlines a series of requirements for CCBHCs around:

- Staffing;
- Availability and Accessibility of Services;
- Care Coordination;
- Scope of Services;
- Quality and Other Reporting; and,
- Organizational Authority/Governance.

The development of the criteria in these areas has been delegated to SAMHSA and the Centers for Medicare and Medicaid Services (CMS).

A. Staffing

The statute includes requirements for multidisciplinary staff, and ongoing staff training to meet the needs of the cultural and linguistic populations the clinic serves; however, it largely leaves staffing requirements to SAMHSA and the individual states. SAMHSA outlines staffing requirements in Section 1 of *Appendix II: Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified*

[6] SAMHSA *Frequently Asked Questions, Question 17s and 18.* http://www.samhsa.gov/sites/default/files/grants/pdf/faq/sm-16-001-faq_1.pdf.

[7] P.L. 113-93, Section 223, a. 2. A-E. ***Please note the SAMHSA Planning Grant RFA and other SAMHSA and CMS documentation elaborates on these requirements in considerable detail***.

Community Behavioral Health Clinics.[8]

In its January 29, 2016 presentation to eligible provider organizations, the Commonwealth presented the following Clinic "Must Dos" for certification relative to staffing:[9]

- Update a Commonwealth-conducted needs assessment to reflect the clinic's population served and include cultural, linguistic and treatment needs;
- Staff is appropriate for consumer population in terms of size and composition;
- The CEO maintains a management team appropriate for the size and needs of clinic based on needs assessment and staffing plan;
- Minimum requirements: Must have a CEO and a *psychiatrist serving as medical director* (who does not need to be full time, depending on size.) Exceptions are made for medical director if the area served is a HRSA designated behavioral health professional shortage area.);
- Staff must include, through employment or formal arrangements, credentialed substance abuse specialists;
- Training Plan [for all employed and contract staff and DCO staff that addresses areas such as cultural competence, person- and family-centered, recovery-oriented, evidence-based and trauma-informed care; and primary care/behavioral health integration and that includes, at orientation and annually thereafter, risk assessment, suicide prevention and suicide response, the roles of families and peers; and other trainings as may be required]; and,
- Staff must have linguistic competence for population served.

1. Staff Credentials

CCBHC providers, including CCBHC-client-serving DCO providers, must have and maintain all necessary state-required licenses, certifications, or other credentialing, with providers working toward licensure, and appropriate supervision in accordance with applicable state law.[10]

Providers must be legally authorized in accordance with federal, state and local laws, and act only within the scope of their respective state licenses, certifications, or registrations and in accordance with all applicable laws and regulations, including any applicable state Medicaid billing regulations or policies.

B. Availability and Accessibility of Services

Crisis management services must be available and accessible 24 hours a day. CCBHC services must be made available to all individuals enrolled Medicaid, i.e., managed care

[8] SAMHSA *Planning Grant RFA – Appendix II: Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics*.

[9] *Becoming a CCBHC: Introduction, Services and Organizational Structure*, Slide 6, January 29, 2016. The slide summarizes some of the SAMHSA criteria at a very high level.

[10] P.L. 113-93, Section 223, a. 2. A; SAMHSA *Planning Grant RFA – Appendix II: Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics*, 1.b.1.

and fee-for-service enrollees, in the geographic service area.[11] In addition, CCBHCs cannot reject clients for CCBHC services or limit these services *on* ***the basis of a patient's ability to pay or a place of residence***. CCBHCs are required to develop the use of a *sliding scale* fee schedule for payment in these instances, including the provision of free care.[12]

Important:	CCBHCs must offer all nine-required services to its clients even if they are uninsured, commercially insured, or under-insured. Further, if the CCBHC is not contracted with a commercial insurer for all nine services, the CCBHC will need to offer the nine required services to the insured individuals. The PPS rate will not cover the cost of services delivered to non-Medicaid beneficiaries. Unlike with Federally Qualified Health Centers, there is no supplemental payment to cover the cost of care to uninsured, insured or under-insured individuals.

In its January 29, 2016 presentation to eligible provider organizations, the Commonwealth presented the following Clinic "Must Dos" for certification relative to availability and accessibility of services:

- Available hours including some nights and weekends.
- Outreach and engagement services available to assist consumers to access benefits.
- Outpatient services for established consumers who need an appointment will have one scheduled within 10 business days.
- Crises management services available.
- No one denied services because of an inability to pay and will have a sliding fee scale available.
- The CCBHC has an agreement establishing care coordination expectations with FQHCs to provide health care services to the extent the services are not provided by the CCBHC.
- The CCBHC has an agreement establishing care coordination with program that provides inpatient psychiatric treatment.
- The CCBHC has an agreement establishing care coordination expectations with inpatient acute-care hospitals.[13]

C. Care Coordination

CCBHCS are required to coordinate care across setting and providers, and are required to have "partnerships or formal contracts" with:

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[11] CMS *Section 223 Demonstration Programs to Improve Community Mental Health Services Qs & As – Set II,* Number 15.

[12] P.L. 113-93, Section 223, a. 2. B.

[13] *Becoming a CCBHC: Introduction, Services and Organizational Structure*, Slide 7, January 29, 2016. The slide summarizes many of the SAMHSA criteria at a very high level.

- Federally-qualified health centers or rural health clinics to provide FQHC services;
- Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs;
- Other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities, child placing agencies for therapeutic foster care service, and other social and human services.
- Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other VA facilities; and
- Inpatient acute care hospitals and hospital outpatient clinics.

Resource:

- *Emerging Compliance Hotspots for CCBHCs: Care Coordination and Arrangement with Designated Collaborating Organizations*, Webinar Recording and Slides, National Council/Feldesman Tucker Leifer Fidell LLP Presentation, February 29, 2016.

D. Required Scope of Services

CCBHCs are designed to provide a comprehensive range of mental health and substance use disorder services, and they will be required to offer nine services plus care coordination activities.

The following four required services must be offered **directly** by the CCBHC:[14]

1. Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization ***(See page 11 for important Massachusetts-specific exception to this requirement)***;
2. Screening, assessment and diagnosis including risk management;
3. Patient-centered treatment planning; and,
4. Outpatient mental health and substance use services.

The following five required services may be offered directly by the CCBHC and/or through a formal contract with a Designated Collaborating Organization (DCO):

5. Primary care screening and monitoring;
6. Targeted case-management;
7. Psychiatric rehabilitation services;
8. Peer support, counseling services, and family support services; and
9. Intensive community-based mental health care for members of the armed services and veterans.

[14]SAMHSA *Planning Grant RFA – Appendix II: Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics*.

1. Designated Collaborating Organization (DCO) Arrangements

Under the SAMHSA RFA, 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 (as allowed – see above) under the same requirements as the CCBHC.[15] "Even if, however, a DCO supplies some aspect of required services, the CCBHC is still regarded as providing the service and is clinically responsible for the services provided." Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters are treated as CCBHC encounters for purposes of the PPS.[16]

Important:

- CCBHC maintains clinical and financial responsibility for care furnished by DCO(s).
- Payment for DCO services included within scope of CCBHC PPS rate.
- CCBHC **must** serve as the Medicaid billing provider for DCO services.

This means that the CCBHC must have formal arrangements with its DCO(s) for the purchase of CCBHC services and the reporting of encounter, cost and other required data.[17]

Massachusetts has proposed to SAMHSA that an exception to the DCO service payment requirements be made for crisis services, [18] ***at least when the CCBHC does not operate the local Emergency Services Program (ESP).*** **Please see page 11 for more information.**

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[15] The SAMHSA *Planning Grant RFA* states that CCBHC-DCO agreements must be formal agreements. "As used in the context of scope of services and the relationships between the CCBHC and DCOs, a formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized. This formal relationship does not extend to referrals for services outside either the CCBHC or DCO, which are not encompassed within the reimbursement provided by the PPS."

[16] SAMHSA *Planning Grant RFA – Appendix II: Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics,* Program Requirement 4, Scope of Services; *Appendix III: Section 223 Demonstration Programs to Improve Community Mental Health Services Prospective Payment System (PPS) Guidance*, Section 2.1: Certified Clinic PPS (CC PPS-1). See also *CMS Section 223 Demonstration Programs to Improve Community Mental Health Services Qs & As – Set II*, Number 6, the "CCBHC must bill Medicaid for [Demonstration] services" delivered by DCO.

[17] *CMS Section 223 Demonstration Programs to Improve Community Mental Health Services Qs & As – Set II,* Number 5, the "CCBHC will typically pay the DCO a contracted rate for a defined service."

[18] *Massachusetts CCBHC RFA Information and Instructions*, Footnote 1: "Further clarification is being sought from SAMHSA on how crisis services can be delivered to meet this requirement, given the current practice in Massachusetts and state discretion in other areas of this planning grant. MA intent will be to build on the existing ESP infrastructure. Additional information to assist applicants in meeting this requirement will be presented on the applicants' conference call, in Frequently Asked Question Factsheets, and during the Certification Process."

Finally, in a Frequently Asked Questions document, SAMHSA clarified that one part of an organization could serve as a CCBHC and another part can be a DCO to that CCBHC.[19]

Apart from DCO arrangements, 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 referred services is not through the PPS but is made through standard MassHealth billing.

The National Council for Behavioral Health has partnered with Feldesman Tucker Leifer Fidell LLP to develop a DCO contracting toolkit which we understand will be available later this Spring.

Resources:

- *Becoming Best Friends: CCBHCs and Designated Collaborating Organizations*, Presentation Slides, National Council/Feldesman Tucker Leifer Fidell LLP Presentation at National Council Conference 2016, March 2016.

- *Emerging Compliance Hotspots for CCBHCs: Care Coordination and Arrangement with Designated Collaborating Organizations*, Webinar Recording and Slides, National Council/Feldesman Tucker Leifer Fidell LLP Presentation, February 29, 2016.

2. Services in Massachusetts

Important: In its planning grant proposal, the Commonwealth crosswalked CCBHC-required services with services currently offered under MassHealth. There are population and service gaps between current services and services that CCBHCs are required to offer. (The cross walk is on the following page for reference). The Commonwealth is working to define the scope of nine required-CCBHC services in Massachusetts, but it has not yet been finalized.

Because CCBHCs are responsible for the delivery of all required services, the answers to how the Commonwealth intends to address these gaps and the extent to which clinics can partner with other entities are critical to the evolving certification process.

[19] *SAMHSA Section 223 Frequently Asked Questions*, Question 18. "Can one clinic in a larger non-profit organization be a CCBHC and another part of the non-profit organization be a DCO for the CCBHC? Answer: Yes, as long as the clinic meets the CCBHC criteria and the relationship between the clinic and the other component of the non-profit meets the DCO requirements in the criteria. For example, if a large non-profit organization has only one clinic that is a CCBHC but the non-profit also operates a state-sanctioned, certified or licensed crisis behavioral health crisis system, the crisis system may be a DCO for the CCBHC as long as the requirements of that relationship are satisfied."

MA Planning Grant Proposal Service Crosswalk (Service Design Still in Development)	
CCBHC Required Service	**Current MassHealth Coverage**
24-hour mobile crisis teams, emergency crisis intervention, and crisis stabilization	Emergency Service Programs created in 1966.
Behavioral health screening	Required at well child visits and paid. Can be provided to adults in an office visit, without a separate fee.
BH and risk assessment and diagnosis	Service code for outpatient MH and outpatient SUD.
Patient-centered treatment planning, including risk assessment and crisis planning	Intensive Care Coordination (ICC) for children with SED includes family directed, child guided treatment and crisis planning.
Outpatient MH and SUD services	Covered service.
Screening and monitoring of key health indicators and health risk	Covered for community health centers and primary care providers.
Targeted case management	Covered for children with SED (ICC) and for DMH eligible adults.
Psychiatric rehabilitation services	Covered for people with MH, often using State Match under Rehab. Option claiming processes. Being considered for SUDs.
Peer support, peer counselor services and family supports	Family Partners available to members under 21 with BH needs as the State Plan service "Family Support and Training." Other services, including Emergency Services Programs, Community Based Flexible Support Programs, and, for members under 21, Mobile Crisis Intervention and Therapeutic Mentoring, can use peer staff.

The crosswalk reveals substantial service gaps relative to populations. For example:

- Patient-centered treatment planning is currently available only for children via Intensive Care Coordination (ICC) as part of CBHI;
- Targeted case management is currently available only to children with SED via ICC and certain adults through DMH case management;

- Family supports are available only through Family Support and Training under CBHI and peer supports are largely embedded in other services such as ESP, CBFS, Mobile Crisis Intervention and Therapeutic Mentoring; and,
- Psychiatric rehabilitation is currently offered only through DMH-contracted Community-Based Flexible Supports.

The Commonwealth appears poised to address these issues through a combination of service expansion, e.g., peers; service definition, i.e., determining that existing services meet the definition for a CCBHC-mandated service; and revenue offsets in rate development, e.g., CBHI services.

3. Crisis Services – Massachusetts

The SAMHSA Planning Grant RFA provides *"[u]nless 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 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."*

The Commonwealth's CCBHC RFA also includes "suicide crisis response" and "services for substance abuse crisis and intoxication, including ambulatory and medical detoxification services" in its definition of crisis services.[20] This is consistent with the SAMHSA Planning Grant RFA.

The Commonwealth has taken the position that the Emergency Services Programs (ESPs) are an existing state-sanctioned system such that **a CCBHC need not directly provide crisis services**.[21] However, "CCBHCs that do not operate ESPs will be responsible to offer crisis outpatient care for their clients and assist their clients to utilize ESPs, when necessary."

Important: ***At the time this memo was finalized***, the Commonwealth, based on CMS feedback, had taken the preliminary position in conversations that CCBHCs that do not provide ESP crisis services will not need to pay ESPs directly for those services. Rather, a CCBHC without an ESP likely will be required to have a DCO arrangement with an ESP that pays the ESP provider for care coordination and data exchange.

[20] *Massachusetts CCBHC RFA Information and Instructions*, Appendix A: Definition of Terms. The SAMHSA *Planning Grant RFA* indicates in Appendix II, 4. C. that these are required crisis services.

[21] Massachusetts CCBHC Provider Information Session January 29, 2016, Questions and Answers, Question and Answer 35. "Massachusetts State sanctioned emergency service programs will continue to be responsible for delivering crisis intervention and related services in their designated catchment areas."

ABH's understanding is that the ESP-DCO costs associated with care coordination will be reflected in the non-ESP CCBHC's PPS. The ESP *services* will be reflected as a cost offset in the cost report of the non-ESP's CCBHC and will not affect its PPS. However, a CCBHC that **operates** an ESP *may* be required to report ESP costs on its cost report and this will be factored into its PPS.[22]

VI. Population-Specific Service Consideration

Important: ABH understands that Children's Behavioral Health Initiative (CBHI) services may **not** be part of the CCBHC Initiative and will be excluded from the payment model. The RFA documentation is silent on this issue. This is an area where state policy elaboration is urgently required.

VII. Payment and Cost Reporting

A. Payment

The Commonwealth has selected PPS Option 1 (PPS-1) available under the planning grant. This option is an FQHC-like PPS that provides reimbursement of cost on a daily basis (as does the method for FQHC services reimbursement). Under PPS-1, states have the option to provide quality bonus payments to CCBHCs that meet defined quality metrics.

Each rate is clinic-specific, i.e., developed using the clinic's unique, *allowable* costs in delivering CCBHC services. The rate is based on total annual allowable CCBHC costs divided by the total annual number of CCBHC daily visits (all clients, not just Medicaid members) to establish a uniform daily payment.[23] Because CCBHCs may be delivering services they may not currently offer, employing new provider types, and incurring costs to prepare to become certified, **estimated costs related to services or items not incurred during the planning phase but projected to be incurred during the demonstration are allowed.**

The cost of CCBHC services associated with Designated Collaborating Organizations (DCOs) is included in cost reporting and the rate. 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**.

[22] Massachusetts CCBHC Provider Information Session January 29, 2016, Questions and Answers, Question and Answer 49 "SAMHSA awarded no funds to MA under the CCBHC planning grant for distribution to providers. Further, the CCBHC National Demonstration project identifies no funds for this purpose. If I'm the ESP, what does the CCBHC do with me [payment]?" Answer: "ESPs are a state sanctioned system for the provision of behavioral health crisis services. A CCBHC may accept PPS payment, but may not be paid twice for the same service given to a client. Revenues received for ESP service may be offset against the cost of ESP services on the CCBHC cost report."

[23] CMS *Certified Community Behavioral Health Clinic Cost Report*, Daily Visits tab.

Payment is triggered by the delivery of a CCBHC service on a given day, i.e., if a client receives a CCBHC service, the CCBHC receives its daily rate; if the client does not receive a service, there is no payment. The same rate is paid for each qualifying unit of CCBHC service, regardless of the intensity of services provided. **For a multi-site CCBHC, only one visit per day can be counted for the entire CCBHC**. For a CCBHC and its DCO(s), only one visit per day can be counted for the entire CCBHC.[24]

Important:

- Under this program, care coordination is an activity and not a service, and as such, does not trigger payment.
- CMS stated in its *Question & Answers Set II* document that "a state may potentially include in the determination of the PPS calculation cost associated with the time spent by CCBHC staff on care coordination; however, in order to definitively answer this question CMS would need more detailed information about the methodology for allocating cost…"

SAMHSA Description of CCBHC PPS-1 Option***

The state must implement CC PPS-1 as a daily rate. The following formula is used for calculating the Demonstration Year 1 rate for the PPS-1:

$$\frac{\text{Total annual allowable CCBHC costs}^{*}\ \text{^}}{\text{Total number of CCBHC daily visits per year}^{**}}$$

*Note: For Demonstration Year 1, the total annual allowable CCBHC costs collected during the demonstration planning phase must be trended forward by the Medicare Economic Index (MEI) to reflect changes due to inflation. The Demonstration Year 1 rate will be updated again for Demonstration Year 2 by the MEI or by rebasing of the PPS rate.

^Non-allowable (e.g., uncompensated care, non-CCBHC services, excluded services such as inpatient and residential treatment, etc.) and non-reimbursable (lobbying, organizational, etc.) costs must be excluded. Additional guidance is in the SAMHSA Planning Grant RFA – Appendix III, Section 223 Demonstration Programs to Improve Community Mental Health Services Prospective Payment System (PPS) Guidance and CMS CCBHC Cost Report and Instructions.

**Visits are for all clients, not just Medicaid enrollees.

***Source: SAMHSA *Planning Grant RFA – Appendix III: Section 223 Demonstration Programs to Improve Community Mental Health Services Prospective Payment System (PPS) Guidance*, Section 2.1.

[24] CMS *Certified Community* Behavioral Health Clinic *Cost Report*, Daily Visits tab and CCBHC Cost Report Instructions for Daily Visit tab.

The SAMHSA *RFA Planning Grant* includes the calculation example below to illustrate the PPS-1 rate mechanics. The hypothetical clinic's total allowable annual costs of $10,000 are divided by 100 total annual daily visits. This calculation results in a $100/visit payment rate, regardless of the participant type, CCBHC services provided, or overall costs associated with the visit.

Participant	Number of Daily Visits in a Year	Trended Annuals Costs[a], $	PPS-1 Payment Per Daily Visit[b], $	PPS-1 Payment[c], $
A	25	2,250	100	2,500
B	15	450	100	1,500
C	10	600	100	1,000
D	5	750	100	500
E	35	2,350	100	3,500
F	8	3,000	100	800
G	2	600	100	200
Total	**100**	**10,000**		**10,000**

[a] Annual costs may be determined for each participant.

[b] PPS-1 Payment Per Daily Visit = Annual Costs ($10,000) / Number of Daily Visits in a Year (100) = $100

[c] PPS-1 Payment = Participant Number of Daily Visits in a Year * CC PPS-1 Payment Per Daily Visit ($100)

In addition, Quality Bonus Payments (QBPs) are allowable, but not required, for specific measures under this PPS model. The Commonwealth has not made a decision on whether QBPs will be available.[25]

Relative to payment for services delivered to Medicaid managed care enrollees, the States have two options:

- fully incorporate the PPS payment into the managed care capitation rate, or
- use a reconciliation process to make a wraparound supplemental payment to ensure that the total payment is equivalent to CCBHC PPS.

The Commonwealth has not indicated which approach it will take.

B. Cost Reporting

CCBHCs will be required to report ***actual*** costs - including costs for services which the CCBHC will continue to receive revenue from another source - incurred in FY2015 for providing required CCBHC services. Providers will be able to report and justify cost changes ***anticipated*** to be incurred during Demonstration Year 1.

[25] Massachusetts CCBHC Provider Information Session January 29, 2016, Questions and Answers, Question and Answer 19.

Costs are broken out on the cost report by job title and indirect cost category, not by the nine required services. Massachusetts is proposing to modify the CMS CCBHC Cost Report to change the job titles to align with those in the state's Uniform Financial Statements and Independent Auditor's Report (UFR), while leaving the substance largely the same. This modified report must be approved by CMS. ABH ***strongly*** encourages organizations that are considering certification to review the CMS CCBHC Cost Report and Cost Report Instructions.

Under the Commonwealth's developing approach, certain CCBHC-mandated services such as ESP, CBHI, and Psychiatric Rehabilitation (through Community-Based Flexible Supports), will likely require reporting as revenue offsets.

Important:

- The Commonwealth's cost treatment of ESP crisis services, CBHI services, and psychiatric rehabilitation services is under development.
- The Commonwealth's policy on anticipated costs is under development.
- The Commonwealth's policy on visit enumeration remains under development.

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- *Getting Paid as a CCBHC: Cost Reporting Principles*, Presentation, National Council Conference 2016.
- *Emerging Compliance Hotspots for CCBHCs: Billing Medicaid*, Webinar Recording and Slides, National Council/Feldesman Tucker Leifer Fidell LLP Presentation, February 10, 2016.
- *Compliance Hotspots for CCBHCs: Establishing a Base Year Rate,* Webinar Recording and Slides, National Council/Feldesman Tucker Leifer Fidell LLP Presentation, January 26, 2016.
- *Follow the Money: Investing in the Success of Your CCBHC with Cost Reporting*, Webinar Recording and Slides, National Council/McBee Associates Presentation, July 30, 2015.

VIII. Quality Reporting and Health Information Technology (HIT)

The SAMHSA Planning Grant RFA requires a clinic to have "the capacity to collect, report, and track encounter, outcome, and quality data, including but not limited to data capturing: (1) consumer characteristics; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9)

consumer outcomes" for all CCBHC consumers (in some instances, data collection for Medicaid enrollees only is allowable).[26]

The reporting criteria include 32 quality measures that CCBHCs and/or the State must collect. Seventeen of these are reported at the clinic level, although most will require data submission from the clinics. The clinic-specific measures are intended to address quality, access, and care experience. Examples include:

- Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients;
- Number of Suicide Deaths by Patients Engaged in Behavioral Health (CCBHC) Treatment;
- Patient experience of care survey;
- Documentation of Current Medications in the Medical Records;
- Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up;
- Controlling High Blood Pressure; and
- Screening for Clinical Depression and Follow-Up Plan.[27]

SAMHSA anticipates that that data sources for the clinic-specific measures will primarily be the clinic's EHR, patient records, electronic scheduler, consumer/family surveys, encounter data, and tools such as the PHQ-9.

In order to ensure the capacity to report and to improve care coordination, CCBHCs will be required to have a "health information technology (IT) system that includes, but is not limited to, electronic health records. The health IT system has the capability to capture structured information in consumer records (including demographic information, diagnoses, and medication lists), provide clinical decision support, and electronically transmit prescriptions to the pharmacy. To the extent possible, the CCBHC will use the health IT system to report on data and quality measures."[28] The HIT system will be required to meet the "Patient List Creation" criterion established by the Office of the National Coordinator (ONC).[29]

CCBHCs will be required to demonstrate capacity to share clinical and quality data with DCOs, collect data from DCOs for reporting purposes and comply with privacy and confidentiality laws. SAMHSA also requires the tracking of admissions/discharges to/from "inpatient psychiatric treatment, with ambulatory and medical detoxification, post-detoxification step-down services, and residential programs" and transfer records. Finally, the CCBHC must develop a 2-year plan to improve "care coordination between the CCBHC and all DCOs using a health IT system."[30]

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[26] SAMHSA *Planning Grant RFA*, *Appendix II: Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics*, 5.a.1.

[27] SAMHSA *Planning Grant RFA*, *Appendix II: Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics*, *Appendix A*.

[28] SAMHSA *Planning Grant RFA – Appendix II: Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavio*ral Health Clinics, Criteria 3.B: Care Coordination and Other Health Information Systems.

[29] See 45 CFR §170.314(a)(14) for more.

[30] SAMHSA *Planning Grant RFA – Appendix II: Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavio*ral Health Clinics, Criteria 3.B: Care Coordination and Other Health Information Systems.

IX. Governance and Accreditation

A. Governance

SAMHSA's final certification criteria require that CCBHCs be required to have board membership "representative of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, and sexual orientation, and in terms of types of disorders."[31] In addition, Boards must include "meaningful participation" by consumers and family members through one of three ways:[32]

- **Option 1:** Fifty-one percent of the board is comprised of families, consumers, or people in recovery from behavioral health conditions. The CCBHC must describe how it meets this requirement or provide a transition plan with a timeline that indicates how it will do so.
- **Option 2:** A substantial portion of the governing board members meet the criteria, and there are other specifically described methods for consumers, people in recovery, and family members to provide meaningful input to the board about CCBHC policies, processes, and services. The CCBHC must describe how it meets this requirement or provide a transition plan with a timeline that indicates how it will do so.
- **Option 3:** Other means are established to enhance the governing body's ability to ensure that the CCBHC is responsive to the needs of its consumers, families, and communities, focusing on the full range of consumers, services provided, geographic areas covered, types of disorders, and levels of care provided. Under this option, the state must determine if the approach is acceptable, and, if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes.

The Massachusetts certification criteria allow applicants to describe their plans to complete any of the three options.

Finally, no more than 50 percent of the governing board members may derive more than 10 percent of their annual income from the health care industry.[33]

B. Accreditation

The SAMHSA Planning Grant RFA encourages states to require CCBHC accreditation by one of national accrediting bodies, e.g., the Joint Commission, the Council on Accreditation [COA], etc. Massachusetts has chosen not to do so. However, it is ABH's understanding that SAMHSA is considering mandating CCBHC-specific accreditation by the Joint Commission as a condition of certification in the future.

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[31] SAMHSA *Planning Grant RFA – Appendix II: Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics*, Criteria 6.B: Governance.

[32] SAMHSA *Planning Grant RFA – Appendix II: Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics*, Criteria 6.B: Governance. See also: http://www.samhsa.gov/section-223/governance-oversight/addressing-board-requirements#participation.

[33] SAMHSA Planning Grant RFA – Appendix II: Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics, Criteria 6.B: Governance.

X. Mandates

The following are required of CCBHCs based on the federal law creating CCBHCs, the Planning Grant RFA, or supplemental guidance from federal and state agencies:

- SAMHSA-Required Assessments
  - Military experience - Screening
  - Tobacco use - screening and cessation intervention
  - Alcohol/substance use - screening, brief counseling, referral for full assessment and treatment if screening identifies unsafe use
  - Major depressive disorder and suicide risk assessment - Screening and follow up plan
  - Learning disabilities - assessment

- SAMHSA-Required Interventions
  - Motivational Interviewing
  - Shared Decision Making - An approach to care through which providers and consumers of health care come together as collaborators in determining the course of care
  - Psychiatric Advanced Directives - Advance wishes related to treatment and crisis management or consumers' decisions not to discuss those preferences

- Massachusetts-Required Assessments/Interventions
  - Community Needs Assessment[34]
  - All CCBHC provider staff must be trained in Motivational interviewing
  - Child and Adolescent Needs and Strengths (CANS) for children Ages 0 to 20
  - Assessments/Interventions for Other Populations – Evidence-Based Practices informed by Community Needs Assessment

The CCBHC Initiative is complicated in terms of both planning and certification process. We look forward to having additional questions answered by the Commonwealth during the applicants' conference webinar. As always, if you have any questions, please feel free to contact either of us.

[34] The state prepares the initial needs assessment, including cultural, linguistic and treatment needs, and staffing plan. After certification, the CCBHC updates the needs assessment and staffing plan, including both consumer and family/caregiver input. Ongoing needs assessments are required. SAMHSA *Planning Grant RFA – Appendix II: Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics*, Criteria 1.A: Staffing.

Appendix

I. Organizational Readiness

The National Council for Behavioral Health has developed an Integrated CCBHC Certification Criteria Feasibility and Readiness Tool (I-CCFRT) that organizations can use to help determine whether or not it is feasible to move forward to become a CCBHC or whether it may be more appropriate to become a DCO for a CCBHC. The readiness portion of the tool tracks very closely to the SAMHSA Planning Grant RFA requirements that all CCBHCs are required to meet. Interested providers should pay close attention to this tool.

Note: The tool is general to federal requirements and does not include Massachusetts-specific criteria that are currently under development.

II. Federal Requirements and Guidance

- P.L. 113-93, Section 223 (Excellence Act): https://www.congress.gov/113/plaws/publ93/PLAW-113publ93.pdf
- SAMHSA Section 223 (CCBHC) Resource Landing Page: http://www.samhsa.gov/section-223
- SAMHSA Planning Grant RFA: http://www.samhsa.gov/sites/default/files/grants/pdf/sm-16-001.pdf
- SAMHSA Planning Grant FAQs #1: http://www.samhsa.gov/sites/default/files/grants/pdf/faq/sm-16-001-faq_1.pdf
- SAMHSA Guidance to Planning Grant States to Apply to Participate in the Section 223 CCBHC Demonstration Program (includes SAMHSA's "State's Compliance with CCBHC Criteria Checklist") http://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-application-guidance.pdf
- CMS Section 223 (CCBHC) Landing Page: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/223-demonstration-for-ccbhc.html
- CMS Questions and Answers Set #1: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/section-223-set-i-qsandas.pdf
- CMS Questions and Answers Set #2: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/section-223-set-2.pdf

- CMS CCBHC Cost Report: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/ccbhc-cost-report.xlsx

- CMS CCBHC Cost Report Instructions: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/ccbhc-cost-report-instruction.pdf

III. National Council for Behavioral Health Resources

- National Council CCBHC Portal (fact sheets, webinars, federal information links, etc.): http://www.thenationalcouncil.org/topics/certified-community-behavioral-health-clinics-3/

National Council Conference Presentations

- *CCBHCs 101: Opportunities and Strategic Decisions Ahead*, Presentation, National Council Conference 2016, March 2016.

- *CCBHC Masters Class: Back Office Management,* Presentation, National Council Conference 2016, March 2016.

- *Getting Paid as a CCBHC: Cost Reporting Principles*, Presentation, National Council Conference 2016, March 2016.

- *Becoming Best Friends: CCBHCs and Designated Collaborating Organizations*, Presentation Slides, National Council Conference 2016, March 2016.

- *Creating the Strategy, Structure & Process for CCBHC Quality Reporting*, Presentation, National Council Conference 2016, March 2016.

- *The Role of CCBHCs in Monitoring and Managing Chronic Illnesses*, Presentation, National Council Conference 2016, March 2016.

National Council Webinars

- *Compliance Hotspots for CCBHCs (Part 1): Establishing a Base Year Rate,* Webinar Recording and Slides, National Council/Feldesman Tucker Leifer Fidell LLP Presentation, January 26, 2016.

National Council Webinars *Continued*

- *Emerging Compliance Hotspots for CCBHCs (Part 2): Billing Medicaid* Webinar Recording and Slides, National Council/Feldesman Tucker Leifer Fidell LLP Presentation, February 10, 2016.

- *Emerging Compliance Hotspots for CCBHCs (Part 3): Care Coordination and Arrangement with Designated Collaborating Organizations*, Webinar Recording and Slides, National Council/Feldesman Tucker Leifer Fidell LLP Presentation, February 29, 2016.

- *Follow the Money: Investing in the Success of Your CCBHC with Cost Reporting*, Webinar Recording and Slides, National Council/McBee Associates Presentation, July 30, 2015.