

## Demonstration State Application Guidance Clarifications and Corrections

The entire guidance has been reviewed and approved by the Office of Management and Budget under the Paperwork Reduction Act and released to Planning Grants for CCBHC grantees shortly after the planning grants were awarded. During the intervening months, corrections and clarifications have been necessary to align the application guidance with what we have learned over that period. The following clarifications and corrections provide the narrative core of a webinar provided to grantees in early February 2016. Changes to the text are preceded by “Correction”.

### Part 1. Attachments

#### Attachment 1. State’s Compliance with CCBHC Certification Checklist

- The checklist underscores the discretion that states have in establishing standards for staffing, accessibility, quality services, care coordination, quality measures and governance.
- The checklist should be used to rate ALL CCBHCS in the state and to describe the CCBHCs readiness, as a whole to implement each criteria:
  1. Ready to implement
  2. Mostly ready to implement
  3. Ready to implement with remediation
  4. Unready to implement
- Use the checklist to verify that all the CCBHCs in the state are certified by Oct. 31 and if not, what will be done to ensure that the criteria is met. This one checklist will verify that every CCBHC in the state complies with each and every criteria. These are the same CCBHCs that are listed in attachment 2, and that will launch in 2017 should the state be part of the Demonstration. CCBHCs may not be added to this list after it is submitted. While states are expected to certify all clinics by October 31, 2016 the form permits options if some or all of the clinics have not met one or more of the criteria. To be clear, the reviewers will want to see checklists that have a low number, meaning that most clinics are “ready to implement” but it is unrealistic to think that every clinic will meet every criteria at all times. Do not be vague when writing explanations in the boxes, and do not ignore any of the criteria. . The checklist will be reviewed for completeness by the reviewers. Be clear in explanations so the reviewers understand what is planned.
- **CORRECTION:** Page 22 of the application guidance should read CCBHCs have ~~completed~~ **a state prepared** needs assessment. Put a rating in the box that tells the reviewer what has been done. So, for example if s the state have prepared an assessment of the needs of the target population for all selected CCBHCs, put a rating of 1 on the first space. If needs

assessments have been prepared for some of CCBHCs, put in a 2 or 3 and if there are no needs assessment prepared, put in a 4.

Other criteria rely on the completion of the needs assessment. For example 1.a.3 “CCBHC management staffing is adequate for the needs of CCBHCs as determined by the needs assessment and staffing plan.” Without a completed needs assessment, the state will be unable to determine if the management staffing is adequate. The needs assessment will likely be a joint project by the state and the CCBHCs in order to outreach to stakeholders and current consumers and access assessments and reports that have already been collected locally. CCBHCs may work with the state on assessing the needs and may submit a needs assessment or data to the state. However, the responsibility falls on the state to prepare an assessment for the CCBHCs.

- **CORRECTION:** On page 27 of the application guidance, it should read: “\_\_\_\_\_ CCBHC services are aligned with state ~~or county/municipal~~ court standards for the provision of court-ordered services.”
- **CORRECTION:** On page 29, Criteria 2.c. should read: “\_\_\_\_\_ CCBHCs are required to ~~work with~~ educate consumers at intake and **work with them** after a psychiatric emergency or crisis to create, maintain and follow a crisis plan.
- SAMHSA issued guidance on Criteria 4.C pages 34-35, Crisis Behavioral Health Services related to withdrawal management from substances and updated that guidance to include referrals for the two higher levels of withdrawal management required as part of crisis response. Guidance can be found at <http://www.samhsa.gov/section-223/care-coordination/substance-use-disorder-treatment-providers>
- **CORRECTION:** Scope of Services - 4.F on pg 37 the words “evidence based” were missing in the text and should read “CCBHCs **use evidence based** approaches when addressing the needs of children ....”
- 6 B Governance on page 42 addresses the approach or approaches certified by the state that CCBHCs use to ensure meaningful participation, related to 6.b.1, 2 and 3 in the criteria. Rate how ready CCBHCs are to implement this area. Identify which method was used regarding board governance to certify the CCBHCs. If more than one option was used in the state please identify the CCBHC to which the option applies. Attach a list to the application or write this information in the box.

A checkbox to 6.b.4 does not adequately verify the state process to ensure certification as an alternative to 6.b1, 2 or 3. 6.b.4 – “As an alternative to the board membership requirement,

any organization selected for this demonstration project may establish and implement other means of enhancing its governing body's ability to ensure that the CCBHC is responsive to the needs of its consumers, families, and communities. Efforts to ensure responsiveness will focus on the full range of consumers, services provided, geographic areas covered, types of disorders, and levels of care provided. The state will determine if this alternative approach is acceptable and, if it is not, will require that additional or different mechanisms be established to assure that the board is responsive to the needs of CCBHC consumers and families. Each organization will make available the results of their efforts in terms of outcomes and resulting changes.”

States may use 6.b.4 to certify that a clinic ensures responsiveness to the full range of consumers, services provided, geographic areas covered, types of disorders, and levels of care provided either as proposed by the clinic or as imposed by the state. For each clinic certified under 6.b.4, the state must describe the alternative in the comment box and justify the decision to certify the clinic under this criteria rather than 6.b.1,2,or 3. Add additional pages as necessary to CCBHC Criteria Checklist.

#### **Attachment 6. SAMHSA's Budget Justification**

- **CORRECTION:** Attachment 6 is no longer necessary. States may disregard this attachment in their submission. States have been provided guidance on the process and required documents to request a no-cost extension of the planning grant to complete the goals of the grant.

### **Part 2. Program Narrative**

The Narrative is organized by the requirements of the grant and in the same fashion as the quarterly reports, the statute, the RFA, and the planning groups into four sections: engaging stakeholders; certifying clinics, establishing a PPS and data collection and quality measures. The last section will focus on projections.

- **CORRECTION:** Under Section B. you may attach pages, in addition to the 30 page maximum for “a description and justification of the evidence based practices that the state has required.”
- Section C. Development of enhanced data collection and reporting capacity. The Certification Criteria requires reporting based on several sources, including:
  - Claims or encounter data
  - EHR or patient registries
  - Administrative reports (e.g., cost reports)
  - Surveys (e.g., MHSIP)

Some of these data sources will be utilized to create quality measures, some may be used as inputs in the development of the prospective payment system (PPS), while other data sources may be generated as part of the certification process. While we are still in the design phase of the evaluation, we can tell you that the evaluator may also need access to some of these data sources. For example, while states will need to use claims data to report the required quality measures, the evaluator may also need claims and encounter data to evaluate the costs of providing services to CCBHC consumers in both the CCBHC setting and other settings. Therefore, the evaluation contractor will need to have access to claims and encounter data for CCBHC clients and potentially, for comparison group clients.

- Section D. (15 points) Participation in the national evaluation of the Demonstration Program.

The Demonstration Application Webinar in February 21016 presented changes to section D of the application guidance and the rationale for those changes. Federal staff provided the following guidance. Because the demonstration application guidance was developed early , some of the underlying assumptions regarding the work of the evaluation design team have since evolved. At this point, the evaluation team does not anticipate talking to every state. Whether the evaluation design team talks to a planning grant state or not, will not have any bearing in evaluating applications. Instead, please describe the state's participation in the TA Data Collection group calls, particularly as it pertains to the selection of a comparison group. Several strategies for the identification and selection of comparison groups were discussed. While we understand that a final selection cannot be made until after the demonstration starts, it is important to try to anticipate the needs of the evaluator in this area. Accordingly, please describe how the group discussions have impacted or influenced plans, describe potential comparison groups that might be feasible in the state, the types of data that could be made available for this group, and how the data might be used to assess access, quality and scope of services available to Medicaid enrollees served by the CCBHCs. If the state has any time sensitive investments that would need to be made to enable the collection of data for any potential group, please let the TA group know.

States should carefully consider whether they will require IRB clearance to collect data for this project and for their own quality assurance purposes. In this section, states should outline whether they anticipate that IRB approval will be required. If states determine that IRB approval will be needed, they should describe their plans to secure this approval and a timeline for doing so. During the Orientation Webinar in July, Federal staff provided greater clarity on the criteria as follows:

- A description of the capacity and willingness to assist HHS to assess the cost, quality, and scope of services provided by CCBHCs and the impact of the demonstration programs on the federal and state costs for a full range of mental health and substance abuse services

(including inpatient, emergency, and ambulatory services paid for through sources other than the demonstration program funding).

**Clarification:** Describe the state's participation in the Data Collection Planning Group calls, particularly as it pertains to the selection of a comparison group. Several strategies for the identification and selection of comparison groups were discussed. While we understand that a final selection cannot be made until after the demonstration starts, it is important to try to anticipate the needs of the evaluator in this area.

- ~~A summary of discussions with the federal evaluation planning team regarding the selection of an appropriate comparison group for an assessment of access, quality, and scope of services available to Medicaid enrollees served by CCBHCs.~~

**CORRECTION:** Describe how the group discussions have impacted or influenced plans, potential comparison groups that might be feasible in the state, the types of data that could be made available for this group, and how the data might be used to assess access, quality and scope of services available to Medicaid enrollees served by the CCBHCs.

- The status of requests or planned requests for an Institutional Review Board's approval to collect and report on process and outcome data (as applicable and necessary).

**Clarification:** Outline whether the state anticipates that IRB approval will be required. If states determine that IRB approval will be needed, they should describe their plans to secure this approval and a timeline for doing so.

- Section E. has the most points assigned because the statute at subsection 223 (d)(4)(A) under which the program is authorized is explicit that preference must be given to selecting demonstration programs where participating CCBHCs will achieve at least one of the of these goals. Therefore, select one or more of the following goals and develop baseline and projecting data to show how the state's participation will advance goals.
  - Provide the most complete scope of services as described in the Criteria to individuals eligible for medical assistance under the state Medicaid program; And/or
  - Improve availability of, access to, and participation in, services described in Criteria to individuals eligible for medical assistance under the state Medicaid program; And/or
  - Improve availability of, access to, and participation in assisted outpatient mental health treatment in the state; And/or
  - Demonstrate the potential to expand available mental health services in a demonstration area and increase the quality of such services without increasing net federal spending

### **Part 3. PPS Methodology**

- Section 1 contains basic information about PPS for demonstration services.
- In section 2 the state will explain its FFS PPS rate methodology including, but not limited to, how it will update the rate from DY1 to DY2, and about the elements of its rate such as the quality bonus payment , outlier payment and how special populations were identified. Please find text boxes for each section and attach additional pages to complete the response if necessary.
  - In section 2 the state first will indicate whether it plans to use PPS-1 or PPS-2. This section is structured to allow the state to explain how it plans to implement the various rate elements such as the quality bonus payment, outlier payment etc. The state's responses will be placed in text boxes and additional pages may be attached if the text boxes are not large enough. The state's response is limited to 30 supplemental pages added by the state when the text boxes are not large enough. The 30 page count does not include the cost report and cost report instructions or application form.
  - In Section 2.1.b the state must describe how it will implement the quality bonus payment including the measures to be used and how the payment will be made. The questions on QBPs are the same no matter if the state is using PPS 1 and PPS 2. The 6 required quality measures are noted in Table 3 of the PPS guidance.
  - Section 2.2 refers to PPS-2 only. These questions are to identify the different populations and rates that there will be, as well as explaining how the outlier payment is made.
- In section 3 we ask for information about whether any of the clinics participates in the Medicaid program as a FQHC, clinic services provider or tribal facility. In the application we request the state to attest that it will require each certified clinic in its CCBHC cost report to indicate if it is dually certified as one of these types of entities.
- Section 4 is devoted to cost reporting and documentation requirements. Here the state is requested to indicate whether it will use its own cost report or the CMS CCBHC cost report. Please see the end of this slideshow for CMS's cost report review timeline.
- Section 5 covers managed care and mirrors the elements presented in the PPS guidance.