

NWX-SAMHSA CMHS

**Moderator: David DeVoursney
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10:45 am CT**

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode. At the end of today's presentation, we will conduct a question-and-answer session. During that time, all lines will be live and interactive.

It is advised when not speaking, to utilize the mute function on your phone. If you do not have a mute function, you may press Star 6 two mute and unmute.

Today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the meeting over (David DeVoursney). Sir, you may begin.

(David DeVoursney): Great. First, I just want to thank you all for being here. I know it's been quite a while to get here to this point.

And now you have access to \$4 million, or up to \$4 million over the next two years and you're probably wondering how do we get started? What are the next steps? What do I have to do?

And our job is to help you through that and hopefully we'll be helpful in getting you on the road to success with your CCBHC. But the overriding message, I think, for today's Webinar is that we're very excited about this program and we're very excited to have all of you with us.

And I also understand that we moved the time of this Webinar back by half an hour because of a (SPARS) Webinar which was scheduled actually after we originally planned this Webinar.

So I apologize for changes in your schedule, but also for subjecting you to back to back Webinars in one afternoon. We're going to talk little bit about (SPARS) on our Webinar but not nearly as much as you just heard.

And we think we have some good news for you in terms of the (total burden) of what we're expecting you to collect and (SPARS). So, with that, we'll get started with today's Webinar.

So, if you have questions, please type your questions in the question box and we will try and address them. Otherwise, you know, you can just wait for the verbal question and answer at the end of the presentation, and that will be great too.

If we run out of time to do questions, you have our email addresses there in this presentation and we'll send this presentation out to you. So, you know how to find us and that's our job, so looking forward to trying to get your questions answered as we move forward.

So, today, my colleague, Tenly Biggs and I, are going to provide you with an introduction and overview. Our expert (grants management) specialist, (Louis

Velasco), is here and he's going to talk you through the grants management portion of today's presentation.

You'll have me, again, to talk a little bit about technical systems and (the resources) we have available for evaluation. Some details to the Medicaid demo for certified community neighborhood health clinics, and then the certification process.

And then finally, Tenly is going to wrap up with a couple of slides on the disparity impact statement process and some key dates for you to pay attention to. And then we will end with questions. So...

Woman: Sorry, technical difficulties. There we go.

(David DeVoursney): So, I do want to kind of introduce you to the federal team and most of us are here in the room. A couple couldn't make it but you'll be getting to know them in due course.

So, I didn't really just kind of want to go around the room and for folks that are here, if you just want to say your name and introduce yourself that would be great.

I'm (David DeVoursney). I'm the branch chief of the Community Support Programs Branch, a branch that houses the TCBHC expansion program.

(Mary Blake): Hi everybody. My name is (Mary Blake) and I am really looking forward to working with those of you I'll be working with.

(Tenly Biggs): Yes, ditto. This is Tenly Biggs. Also excited to work with you.

(Roxanne Castaneda): (Roxanne Castaneda), also grants project officer were CCBHC.

(Lewis Velasco): And I'm (Lewis Velasco). Under grants specialist for the CCBHC program.

(David DeVoursney): And a couple of people could be here today. Joy Mobley is actually usually the ringleader of this whole operation and unfortunately she had to be out of the office today. So you're stuck with me as we run through a lot of these lights.

And then (Rachel Steidl) is the most recent addition to our team and she's also going to join, I think, for portions of today's Webinar. But she had another commitment but, I'm looking forward to working with her on these grants as well.

I do want to say just a couple of introductory remarks before we get into the meat of the Webinar. You know, this is a really important program. I think everybody on the phone, you've all worked in the behavioral health system.

You know that our system is a fragmented system, a system that provides people with an incomplete set of reports. Some communities to portions of their systems really well and other portions not well.

Other communities, you know, have really just bare-bones support. And, you know, really across our (states and communities). There's just a patchwork and I think, you know, a lot of really good hard-working people are trying to make the best of the systems they have.

And that includes (resources) at the state level, trying to build systems. That includes providers. That includes peers, caseworkers, you name it. There's a whole number of people who are doing their best.

But they're all worked within the same framework and that framework is the framework that are financing drives us into peculiar corners of service delivery, where services are offered for multiple different providers and often not in a coordinated fashion, our behavioral health is siloed from physical health.

And the result is really poor care experience and poor outcomes and poor quality for the people we serve. (CCBHCs), I think, unlike almost any other intervention in government, has the potential to change that.

And really our goal is very simple - to take organizations, to give them the mandate and standards to provide a comprehensive set of services to serve people with mental and substance use disorders.

And then, with that, to provide sufficient financing that is actually an achievable goal. And so, this is much larger than the usual grant we would give to a clinic.

A clinical grant tends to be around \$400,000 per year and this is a \$2 million per year grant. So this is a really a bold undertaking on your part and it's a big leap to take on that type of capacity and to try and make that kind of (systemic change).

But I just want to thank you for taking that leap with us. And I know that you all kind of sharing the vision that it's really about providing these comprehensive services and helping people with mental and substance abuse disorders really reach their full potential and lead the life they want to leave to pursue their recovery.

So, I just wanted to thank you for that and those are my introductory remarks and will move into the meat of the presentation. I'll turn it over to Tenly.

(Tenly Biggs): Yes. So what is your government project officer's role? We are the federal representative responsible for overall grant monitoring and grantee compliance to the requirements of the grant award.

We approve all program changes which includes budget, project scope and project director and key personnel. We review and discuss your annual reports. We also review and discuss your (GPRA) or (NOMs) data which you'll learn more about in this presentation, and, of course, supporting you in achieving your program goals.

So, these are some typical topics that we see quite often in the beginning of a start up of the grant, so things such as changing key staff. You know, sometimes at the time of the application you have one person that you thought would be our project director but then there's turnover or you end up hiring somebody else.

And so before you even do anything else, you have to let us know immediately, us meeting your GPO, and (Lewis). And so email us. We have an asterisk there because you also have to submit a key (personnel) request change through ERA (commons) which is how you first, you know, submitted the application.

So, I would suggest that prior to even submitting that through ERA, contact us so that we can give you the information about what is required in the key personnel request.

And, of course, the major one is project director position. So if you have a different project director, that's considered key staff. That's the person you want to give us all the information.

You know, if there's a change in scope of the project, if you're not sure what that means, contact your GPO. So whenever you outline in your application, that's what we're going to hold you accountable to.

So you have any questions, I know some folks have reached out to some of us. So if you have questions about that, you're not really sure, you want to think it through, you know, contact your GPO.

If it's related to the budget, contact (Lewis). You know, (Lewis) and the team, we coordinate really well together so we can, you know, (set the time) and talk through some of the things that you might be going through.

Again, budget questions, contact both of us but (Lewis) will be your main point of contact. (SPARS) – excuse me – as (David) mentioned earlier, we were just Webinar about (SPARS).

And so anything related to (SPARS), though, you should be contacting us or the (SPARS) help desk which is also listed at the very bottom of the slide. Anything related to (SPARS), you know, grantee management and, you know, the point of contact for that.

If you have day-to-day project questions, again, please contact your GPO. And then anything related to the project goals.

Award information, some of you may know that we award up to 52 grantees so far, up to \$2 million per year for two years, and you started on September 30. Now, I'm turning it back to (David).

(David DeVoursney): Thanks, so, the purpose of this grant program, as I said a little bit earlier is to increase access to and improve the quality of community health services to the expansion of certified community behavioral health clinics, CCBHC.

The CCBHC extension grant program must provide access to services for people with serious mental illness, substance use disorders including opioid disorders and then children and adolescents with serious emotional disturbances and individuals, of course, was co-occurring disorders and co-occurring mental health and substance use disorders.

And to the extent that this program will improve the behavioral health of individuals across the nation by providing comprehensive community-based mental health and substance use disorder services, treatments for co-occurring disorders and advance the integration of behavioral health with physical health care.

Now, we also expect you to utilize evidence-based practices on a more consistent basis as a result of this grant and promote improved access to high-quality care using money in this grant program.

This is one of the (expansive) services grant program, so (unintelligible) service grant programs result in the delivery of services as soon as possible after award, so at the latest, we expect you to start implementing services under this grant by the fourth month after the grant has been awarded.

You know, we mentioned key personnel earlier and I think (Lewis) is going to go into a little more detail about this later, but the key personnel for this grant are the project director, which is a minimum (mobile) effort of .5 full-time equivalent sessions, and then the evaluator.

So these are the two positions you need approval for under the grant. So, what are the required activities under the grant? You must use (expansive) services grant funds, which is a shock, primarily to provide services.

That's what they're there for. And in providing these all in services, you have to meet the CCBHC certification criteria. And you'll see a link here on the Web site – sorry, up on the Webinar, to those criteria.

There also on our SAMHSA Web site and there's a – on the CCBHC program page and a checklist of these criteria was included in the funding opportunity announcement that you all responded to.

These criteria are really the roadmaps implementing a CCBHC, so I always say, if you want to read one document to understand what we want to accomplish under a CCBHC, start with these criteria.

So, I just want to underscore how important these criteria are for you and what we're doing. So, what to the criteria include? They include a lot of different areas, but they require the delivery of nine different service areas in keeping with their criteria I just mentioned.

There's a crisis mental health service including 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization. Screening assessment, diagnosis, including risk assessment.

Patient centered treatment planning or similar processes including risk assessments and crisis planning. And comprehensive outpatient mental health substance abuse services.

So these four you see on the screen are services that must be provided directly by the CCBHC itself. Other services can be provided by a direct collaborating organization.

But for these four core services they have to be provided by the CCBHC organization itself. I just want to make that distinction. The one tweak to that is those crisis mental health services, if those services are provided already by some kind of state sanctioned network that exists in your area where your CCBHC is, then that is acceptable.

Those crisis services can be provided by that other existing network. But if you don't have that type of network in the area that you are, the state sanctioned, then you are responsible for providing those crisis services under this grant.

So what else? We have - we expect that people provide targeted case primary care screening monitoring and key health indicators, clinical monitoring for adverse effects of medications, including monitoring of metabolic syndrome.

Targeted case management, psychiatric rehabilitation services, social support opportunities to establish models such as (unintelligible) that provide therapeutic individual and group interactions, assistance with employment, housing and other community recovery support.

Development of comprehensive community recovery support including peer support, consular services and family support. Intensive community-based

mental health services for members of the armed forces and veterans, and assertive community treatment.

And assertive community treatment is a little bit unique because this is something that was not specifically mentioned as a part of the CCBHC Medicaid demonstration that is not explicitly mentioned inside the certification criteria, but it is a requirement of this CCBHC expansion (grant).

We also expected to provide - to establish (unintelligible) judicial officials and court systems to provide assisted outpatient treatment when ordered if that's applicable in your state.

We also expect you to establish an advisory work that's comprised of individuals with mental and substance abuse disorders with family members to provide input and guidance through CCBHC on implementation services and policies.

You also must develop and implement plans for sustainability to ensure delivery of services once federal funding is in. I'm going to turn things over to (Lewis) now to talk a little bit about the financial management aspects of your grant.

(Lewis Velasco): Thank you, (Dave). So these are a few of the topics we'll cover on the financial management portion of this presentation. So, you applied for the grant. You're probably already a little familiar with the area common systems.

But I'll try to give a brief overview of the different tasks and (have some) screenshots of the area commons in different tasks before (tasks) that we'll be doing throughout this grant.

So this is a (whole) screen. If you go to the ERA.NIH.gov Web address, we now require all post-award requests in response to special conditions your awards were issued with or submission of FFR and programmatic progress reports and ERA problems.

So, you have no choice but to become familiar with the system. So, to log on, click on that orange box on the right-hand side, commons log in. And enter your user name and password.

Now, this will be the screen, the welcome screen, you'll see once you log on. Now, we'll go over a few different paths, but right now we're going to review, since you guys are probably at this point, responding to special conditions.

You can access that a few different ways. Since this is not an NIH grant, if a non-research grants, so you go to that right most tab down in research and either click manage post-award (assignments) or managed (unintelligible).

So, with responding to special conditions, there are three different ways you can access the service tracking tab where you respond to special conditions your award may have.

That first link has an overview on, like, the (lead) page and Section 4, I think it is, on a step-by-step guide for responding to special conditions. But some of samples of special conditions your award they have guidance – programmatic.

We might be asking you for additional details or asking you to revise your budget for any allowable costs or, you know, over budget and certain things. If you're an indirect cost rate agreement, you need a copy of that.

You need a copy for that on the award. If an individual's name came out, key staff individual, came out on the system, on (SAM), dot gov, then we would have placed that special condition on it.

Federal disparity impact, other, kind of encompasses anything else. So those are some of the examples. So, beginning with - depending on your role within your organization, you would see different screens within (RA) commons.

The authorized organizational rep for signing official in your organization, abbreviated the SO role, this person would not see the list of all grants reorganization upon accessing this section.

You would have to enter the grant number and search. And in this case, they access that through the static tab that was on the previous slide and search their grant number.

At the bottom, the grant came out, they would (unintelligible) tracking that way. The PD or BI roles, the role the organization assigned you, you have the list of (all) grants.

So in this case, this grant for this individual has two different grants showing and they would access whichever grant they're looking for, the special conditions through the (V terms) tracking column on the right hand side.

In terms of having a role assigned, you would go to that individual of your organization, the SO role, and that person would control the different assignments and grants that day, I guess, would allow you to see within your organization.

So that the individual on your side that you should be working with to have the proper roles assigned to yourself. So, again, these are two other ways that you can access special conditions or terms.

You can access this through the amendment tab that was on that first original line when we logged in, on the non-research tab, or the other managed continuation tab.

So, then, in this case, it all leads to the same place. This is the new terms tracking - the page you would go - you would see once you click on new terms tracking.

Each special condition or term would have its own row and you would respond to it individually. So then, in this case, there – the – sorry, the grant eclipse on the initiate – or, sorry, the response to the special conditions.

Any response has a limit of ten attachments and they have to be in PDF format. The submission status and date will update when you submit it. If you want to see your - all the attachments together as one consolidated view, you can click the view submission for a preview of what you would submit before you ultimately submit it.

There will be cases when we still do need additional information or something is missing. In that case, we would send a RAM back to you for a request for additional materials.

In this case, if you were responding to a RAM of ours, you would go back to the view term tracking area. Instead of initiating the response to the special condition, you would be revising the documentation you already submitted.

You would either remove the documents that you need to or at more, whatever you need to do to respond to it and – yes, that would be - and I guess that bottom picture there at the bottom of the screen shot, it's the GPO, GMF ultimately accepts the response status of the column of the submission status would - I'm sorry, the due date status and submission status.

It would show as submitted and results, so that's how you would know when we accepted. You will receive notifications for milestones when things are accepted within your (commons).

For a post-award, an amended request, which we'll go more in detail of some of the different post-awards amendment requests later, but these are the screens you will see.

Again, like I referenced before, the signing official screen, on the right-hand side, you won't see the individual grants assigned to your organization. You have to search those specific grants.

The PVPIs here on the left-hand side has each one listed that they are allowed to access through their organizations. And that you would click on initiate a post-award amendment requests on that green tab that's circled in orange.

Then that drop-down menu shows the different types of post-award (amendment) requests available to submit. At that point, when you initiate a post-award amendment requests, it will interface with the Assist system which, if you worked on the original grant application - and probably, a few worked on any applications, I think Grants.gov also worked with the Assist system.

You're probably familiar with the system already, but each post-award amendment request has different requirements, different documents that are required to be submitted with it.

The two that are always required with any post-award amendment request is the SS424 cover page and the (HHS) checklist. Again, depending on which post-award amendment request you initiate, you might have more or less (tabs) than this.

If you need to add an additional formats isn't, I guess, like any of the tabs available, you can always add an optional form which you do on the left-hand column of the screen.

So once you prepare the post-award amendment request, review it, upload all the information and documents that you need to, you would click on update submission status on the left-hand side of the screen and click ready for submission.

And the system will do a (home) check to verify whether all required information is filled in. If not, it would not allow you to, I guess, go through that ready for submission steps with the ERA commons.

Any post-award amendment request needs to ultimately be signed off by your authorized organizational representative or any individual in your organization that has that SO role.

They would log into the NRA commons the same way you did, access (bids) and ultimately review and finally submit the post award amendment request.

When submitting, you will receive a notification that it is submitted and we'll do our part to review, get back to you with any information we may need, additional information, and process it as quickly as possible.

So, I kind of went into this already with the previous slides, so I'll just kind of skipped through this, but this would be similar to responding to special conditions. This is just if we request additional materials, whether it's through - for a post-award amendment request or for special condition.

So, now will going to post award actions. That is any activities that take place after the award was made and some of these post-award actions require approval from your GPO and GMS before there's ultimately allowed to be put into place.

Also (unintelligible) requests are submitted via ERA commons. And the SAMHSA Web site below has much more detailed information on the post award changes.

And we'll review these four different ones, particularly the first three. The fourth one won't apply to you guys as much until you're finished with this first year in the award.

So, your key staff and level of effort changes (or done one) (unintelligible) but this program requires a project director of at least a 50% level of effort and an evaluator.

The evaluator does not have a requirement for a level of effort, a minimum level of effort. To change these individuals or to reduce their level of effort by more than 25% in time, would require prior approval from SAMHSA.

So, in this case, the project director, that 80% level of effort, the project evaluator, that 20% level of effort, the - if any of these individuals are changing or a new individual be hired in their place or fill in their place, obviously that needs prior approval.

That 25% threshold is just an example of how you would calculate whether they're reducing their time. If it reduces by more than that 25% threshold, then it would require our prior approval, as well.

I guess – no – yes, so that's it. So, as I said before, each post-award amendment request requires a different set of forms. I'll just highly quickly some - I guess now that we're working exclusively with the ERA commons, it's very important for what a project director changes being made to include that (four set) of information, the ERA commons ID for that individual devil take the project director wrote.

That's just so that we link the correct profile that you are using as the project director with the grant because there have been cases where I've linked the project director, an individual with an ERA commons that is an incorrect one or maybe an old profile that was used before and not the current one that that project director is using.

So, it's very important to include, on any key staff change, or any project director change, the ERA commons ID. But these are just the four requirements - documents required to – for a key staff change.

Budget revisions would be any (actual results and) reallocation of funds at within and between approved budget categories. The - what we consider significant budget change or ordering (prior rule) from SAMHSA would be a

change that is, in this case, that it's a large award amount would be \$250,000 at least.

The 25% is way over that, for most of the award, I guess - I guess there might be a few awards - no, I don't think there are. So it would be whichever is less, but I think for the majority of the CCBHC programs, the \$250,000 threshold would be the requirement for when you need a prior approval for a budget change.

Cases where prior approval is always required would be if you, at the organization, are on restricted status. I don't think any of the CCBHC grants are, if I recall.

If you are reallocating funds to a budget category that is currently at zero dollars but you want to add money into that category, that would automatically trigger a prior approval need from SAMHSA.

Any equipment - any piece of equipment greater than \$25,000, and cost sharing or matching doesn't really apply to CCBHC so that isn't applicable.

So just an example of how you would go about calculating whether a proposed budget change would require prior approval, the first column would be, in this example, the approved year one budget as was issued with the original notice of award.

And then that second column would be the proposed budget this organization wants to change to. You would take the difference between each category, add them up in that column on the right hand side and get the change.

Now, I know there are pluses and minuses here, but I'm just - in this example, in this budget revision example, we're just sort of adding numbers straight. So all those numbers on the third column, (code) \$260,000, so that required prior approval.

If, for some reason, that number was below \$250,000, but let's just say that equipment line that was originally at zero is now \$30,000, that, by itself, would require prior approval. So there are two examples of needing prior approval in a budget change.

So just, again, these are the required tabs for a budget and prior tabs (reforms) for a budget revision within ERA commons. I think the only one I'll say here is number four.

If there's an updated indirect cost rate agreement, include it with the submission. That's not always going to be the case. They're only usually updated every year or two.

(Unintelligible) just a little more I guess on the gray area, whether it's not as defined as a budget change, but if you do need, say, definitely like work with your project officer, if you think that a change that you are making to your program could potentially be considered a change in scope, those are some common factors - maybe, I guess, general or broad common factors on things that may indicate a change in scope if necessary.

Yes, you can go to the next slide. And similar to the budget revision, we sort of have required, and I think that is it. There would be cases, I guess, when making these post-award amendment requests that, I guess, some have another narrative attachment tabs.

I don't know if, in every case, you're going to have to upload, you're going to have anything that ends up going to that, but the system will still require you to upload something on that tab.

So, just to meet the requirement of the system to have something in that tab, you maybe have to maybe upload a second time, one of these documents you have or upload something to trigger that are too, I guess, to avoid error that the system may bring up before you ultimately submit a request.

And then, just one additional thing that I just thought of now is the SF424s and the checklist forms are already embedded in the system. When you initiate a post-award amendment request or any – yes, a post-award amendment request or even with your continuation application, those - some of the information and fields on those forms will be automatically populated.

Some, you could change. Some you can't. But that - those are one thing where the forms aren't required to be brought from outside of the system into the system.

Those are already embedded in the ERA common system. So I'll just go over, quickly, the carryover request and will probably, at some point, have another Webinar or presentation on carryovers when it comes time next year for you guys to start configuring carryover requests.

But there are two types of carryover requests, an automatic intent and a formal option, which is, at the moment, the threshold is 10% for this. It may be increased to 25%, but that - nothing with that is official yet.

So, at the moment, I'm going by what the current guidance is within SAMHSA so we'll just go 10% for (briefly touched on) carryover requests.

You can - you could either do one or the other. You can't submit both - you can't request both automatic content and the formal request, so if you're considering between the two types of carryover, what you want to do, if you don't need the full amount, (all the way to the balance), and you want access to the funds quicker, the intent option might be the better option for you.

But if you are really set on spending the majority of your allocated funds and it's over the 10% threshold, then the formal request, which will take longer to review and approve, is the option.

How you would calculate this, so if your award amount for year two, in this example, is \$2 million, you just multiply it by the 10%. The threshold, in this case, is \$200,000.

If what you want to carry over is greater than that, you would need to submit a formal request through area commons. If you want to carry over less than that, it would be automatic.

And on the next slide, I'll show you how to do that. The carryover request, to move forward on a formal request – well, I guess for any carryover request, but a FFR must be on file.

So, at the end of year one, you will have to submit an FFR and I guess you cannot access carryover funds or we cannot move forward on a carryover request until a current FFR report is on file.

If you have restricted funds, which, for example, let's say if we restricted funds because you don't have an indirect cost sharing agreement on file, and

in the notice of award, let's say, we restricted the funds that were budgeted for indirect costs.

And then let's say you pass year one and those funds were never used. If you still have not addressed that indirect cost agreement issue, those funds still remain restricted and cannot be utilized in the carryover requests until we resolve that restricted issue.

(If a grantee) is unrestricted status, it looks like (unintelligible). I don't think any CCBHC organizations are, cannot use the intent to carryover. They would need to request a formal variety of a carryover to utilize carryover in any case.

So, the intent option, how you would indicate to us when you want to exercise this is when submitting the FFR, there's a line 12, a remarks section where you can type into that section of the FFR that you plan to utilize the automatic intent option.

And in that, you would explain - or not explain, but you would sort of - this detail, the amount you want to carryover and we would certify it on our end when we review and approve the FFR and at that point, you would automatically have access to that carryover option.

The formal request is greater than 10%, this requires prior approval from your GPO or GMS. And these are the documents that are required within the NRA commons to submit a carryover request.

So, I don't know - just to speed it up a little, I'll pass this so you can (unintelligible). So I'll just go to the continuation applications briefly, but I know you're still kind of starting up and getting things going.

But we do have pretty early deadlines for continuation applications. So while you're still probably not even starting to, you know, you're still hiring and getting special conditions for year one results, the continuation application deadline will (unintelligible).

It's usually mid, late January, turned February. There's not a date established yet for that, but, yes – no, so that would be – so the continuation application like the post-award amendment request and response to special conditions are required to be submitted through the NRA commons.

You would access that through the managed continuations tab. You guys only have two years in this program so you will only see one out support year. That bottom screenshot, you kind of see the out years for this grant.

There are three in this case. And you will only be able to access it when the open date has arrived. I'm not sure when the open date would be for grantees accessing their continuation applications, but would probably be a good, like, month or two before the due date.

There will be a lot more information sent out about applying to continuation. So, and similar to before, this is the screenshot of the Assist system went to interface with it and all the different tabs required for continuation application.

Just one detail that I guess that applies to the financial side of the continuation application, you have the option to either submit a budget, detailed regular budget like you did for your grant applications or an attestation.

You could do both but if your budget is not changing by more than 25%, and the way you calculate that is similar to I explained in the revised budget slide, the attestation letter to take the place of the detailed budget if that's the case.

And I know a lot of grantees exercise that option when possible because it does make the process of submitting a continuation application a little quicker and simpler.

So – And the last topic, I think I'll be covering on the finance side of things, as the financial report requirements. The FFR is an annual report required to be submitted to SAMHSA.

And the financial past transaction report this a quarterly report required to the payment management system you use to draw down funds. This is a screenshot of the FFR, the standard form 425 to do on an annual basis, 90 days after the end of your budget period.

So, in your case, it will be due - the first one will be due on December 31, 2019. These are just - I won't go into this super detail now, but Line 10F and Line 10H are liquidated unobligated obligations.

An obligation our orders placed for properties and services contracted from awards made in similar transactions during a given period that require payment by you as the grantee.

Unliquidated - the way we define it is, if it's for an obligation made but, say, the bill hasn't been paid for the expenditure has not been reported. And towards the end of budget periods, this kind of gets tricky whether something is unliquidated or unobligated.

When the time comes to -for you guys to make your (first set of requirements) will be late-2019, I guess. If you need more information or have questions you can contact me.

The federal past transaction report is due quarterly to payment management. This is something that we are not involved with, but it's due 30 days after each calendar quarter.

So your first one for this grant will be due on January 30. It asks for similar information as the FFR and we just ask that you pay attention to this because your account could be restricted within CMS if you do not submit the transaction reports on time.

And then just some expected upcoming dates and deadlines. I know this is more programmatic. There may be more, but continuation applications, we expected deadlines to be either late January or early February.

The continuation notice of awards will probably be released sometime in the summer. And the FFR and first programmatic partnership report will be December 31, 2019.

So, I'll try to just go into a little bit, when I'm reviewing a budget or when a grants specialist is reviewing a budget there are some things, I guess, we look at and some common questions we have that we end up having to go back to grantees for.

That HSRA link is good resource for especially looking up allowable and unallowable costs so you can form administrative requirements for HHS awards.

Title 45, Part 75, if you have any doubts on something or you need a reference on a proposed cost you want to include in your budget, that's definitely – that's sub-part E, cost principles section, and is a good resource.

So, some common funding restrictions, (Ofem), so words have a – they said food is unallowable but they do allow light snacks and refreshments for events during - you know, for grants that have to be no greater than \$3 per person.

And the intent of limitations for all types of grants is \$30 per person. CCBHC, specifically, those three (unintelligible) are restrictions that were in the FOA.

When you're submitting your continuation application, if you're going to submit a detailed budget with that, I would recommend you outline those costs within the budget to show or identify that you are meeting all of these three restrictions.

For personnel, just on salary, make sure to include the annual salaries for each individual level of effort. If they being paid-out on an hourly or rate, hourly rate basis, just the number of hours in their rate.

For travel cost, the sort of what we verify or what we go to to make sure the costs are reasonable and allowable as we get paid. City (unintelligible) this is for flights and GSA hotel and per diem rates for the different states and cities around the country.

So I guess when you're preparing a budget I would recommend those two things and for mileage reimbursement rates we follow the IRS rate which is 54-1/2 right now and I'm sure 2019 there'll be an updated figure.

Equipment, we consider anything and this is from that CFR document that was referenced in your earlier slide but if any piece of the equipment with a useful life of more than one year and then a per-unit or unit price of more than

\$5000, anything that's less than \$5000 is considered supplies and should be included in supplies category.

I know contractual cost is probably the area that on your side it's the hardest to get the most detailed budgets for but we do ask that you try to provide as broken-down and detailed a budget even if its estimates as possible (of) so that we have the documentation on our end that we need to keep budgets.

Indirect costs, if you are requesting indirect costs, that is the de minimus rate which is that second bullet plus it's whatever is your organization's indirect costs we need a copy of that agreement and then I won't go too much into detail but just pay attention to when you're calculating the indirect costs in your budget that you follow the direct cost-based language which the next slide has examples on it.

I don't know if we'd do it too closely but you guys can you know, just reference it when needed so think that it provides slides and I'm finally handing it off to an expert.

(David DeVoursney): Excellent, appreciate it. Now this is going to point you guys to a few resources you have as far as technical assistance and other informational resources. First in your FOAs specifies that you can spend up to \$25,000 per year to purchase technical assistance. That's, you know, technical assistance that's reasonably related to the goals of the grant.

If you have questions, you can ask your project officer but you have a pretty wide latitude as long as it is related to the goals of the grant. SAMHSA is in the process of standing-up mental health technology transfer centers which are a network of centers across the country, 12 in total, one for each HHS region

and one focused-on tribal issues and one focused-on Hispanic and Latino issues.

They should be operational as of November and really getting going over the course of the next year so they will be a source of information for you. I think that we're over the (focusing) on integration which should be pretty relevant to these grants so they can support you and, you know, just by having resources up on their sites and they'll be running programs and things like that.

We are in the process of setting-up the list-serve for grantees so hopefully that'll be a good way for you to communicate with your peers and also with the project team here and I think often we find in our projects that the people who know the most about how to make these programs work are the people who are running the programs.

And different programs have different strengths and so I think it's a great opportunity for you all to learn from each other and we hope to facilitate that. There's also a number of resources that are up on the SAMHSA Website and you can see right here the link to our page which is focused-on the certified community behavioral health clinic program.

It's called Section 223 because that's the section of the Protecting Access to Medicare Act that originally authorized the Medicaid demonstration program so that's where you can find a lot of information about the CCBHC program, the full certification criteria as well as the documents and clarifications as included on the page, the technical specifications for the quality measures are included in this page.

There are a series of Webinars on quality measurement with the PowerPoints and recordings available there linked at the page. There are resources related to care coordination for CCBHCs, CCBHCs and cultural competence in governance and oversight as well as the first-year report to Congress on the CCBHC Medicaid demonstration.

I just want to say something really briefly here about quality measurement. As you may have noticed in the FOA there is a requirement to select 21 quality measures as a part of the program. We are looking at this issue right now. Some of those measures require state infrastructure that most of the clinics participating in this grant program will not have access to.

So we are kind of reviewing to see what it will be suitable for you to report on in terms of the quality measures. The other thing is that we have to go through of course at the federal level (unintelligible) will review in order when (in meantime) we do data collection and that review takes a period of months and that's something we've not yet done for these quality measures.

We're still looking at them so it will be sometime before we specify exactly what we need from you in terms of quality measurement but I did just want to give you, you know, kind of a heads-up that eventually we will be asking you to submit some quality measures but we may ask you the full scale for the 21 quality measures that were laid-out in the CCBHC sort of (unintelligible) criteria.

One final point on this slide, we are planning to do a number of Webinars hopefully over the next year or so to help you acclimate to the CCBHC model and to share relevant information about the certification criteria and other aspects of the program and more (to scale) about this Webinar is really important so I want to talk to you a little bit about certification.

And I know this is probably the elephant in the room. A lot of you have e-mailed us your questions about certification. We've also heard from a number of the states that already are participating in the CCBHC demonstration program with questions about what our certification process is going to be for these CCBHC expansion grants.

As you know from the FOA in order to participate you had to be a certified CCBHC or meet all the CCBHC criteria and able to become certified within four months following the award so of course you're probably familiar with the certification criteria and I've already mentioned them earlier in the Webinar but they are available as a part of the FOA on the CCBHC Website.

I wish I could say that we're about to give you detailed guidance on what the certification process is going to look like. We are still working through those details for guidance on what our certainly process under the CCBHC expansion grant is going to look like is forthcoming.

I know that's a disappointment to some of you but it is something that we're working hard on and trying to do in a reasonable way that will be helpful and also ensure that people are paying close attention to and doing their best to implement this CCBHC model.

So with that, moving on to data collection and performance management, so all SAMHSA recipients - grant recipients - are required to collect and report data so that SAMHSA can meet its obligations under the Government Performance and Results Act - sorry - Government Performance and Results Modernization Act of 2010.

So grantees are going to be using the national outcome measures that CMHS uses. Those are reported through a system called the SAMHSA Performance Accountability Reporting System or SPARS and you just probably have heard a lot about this if you attended the Webinar that came right before this one.

So we recognize that there are going to be, you know, by what you submitted in your applications as many as 200,000 people walking to your clinics in the first year of the grant alone and so we didn't think it would be reasonable for us to expect that you would collect (NOMs) data for all 200,000 of those individuals.

So what we're working-on is trying to get you to administer the (NOMs) with 10% sample a random 10 sample of the participants of the people coming to your clinics. We're working on it, you know, exactly the kind of guidelines that you need to implement that and working with (bars) to figure-out the best way to communicate that to you.

So more and more information will be forthcoming around this but I did want to tell you that we're not expecting you to collect (pars) data or (NOMs) data on every single person who comes through your door but it will be 10% sample.

So we are asking that you submit and as the Department has been asked to submit an annual report due December 31st of 2019 that will include reporting of quality measures if we get you guys in soon enough that were identified in the funding opportunity announcement as well as narrative reports on progress barriers and other information and just a couple of quick notes.

No more than 15% of your total grant award for each budget period may be used for data collection and performance measurement over performance and

no more than 20% of the total award each budget period may be used for infrastructure at all.

All right, a couple of notes on Medicaid and the CCBHC expansion grant so there are kind of two groups of grantees that we're probably going to refer to moving forward participating in the CCBHC expansion grant program.

Fifteen of you are official CCBHCs participating in the Medicaid demonstration and then the remaining 37 are not currently participating in the CCBHC Medicaid demonstration.

Those in the Medicaid demonstration receive prospective payment system payments and their states receive an enhance match for the services that they provide through those that are funded by the prospective payment system so that's for 15 of you.

For 37 of you you're not participating in the Medicaid program and as a result you are not entitled to either a prospective payment system or to and your state is not entitled to any kind of enhanced match associated with CCBHC for the services you're providing. I just want to make that clear.

This slide here is really referring to the sites that are not participating in the Medicaid demonstration and so these are just I wanted to make this clear so the SAMHSA grant funding is made available to CCBHC expansion grants under the Consolidated Appropriation Act of 2018 for approved expenditures as specified in the FOA, the funding opportunity announcement.

In addition to the grant funds, to the extent that CCBHC grant services are covered under a state's Medicaid program, the CCBHC provider - sorry,

expansion area provider - can receive payment rates authorized under the Medicaid state plan authority or through managed care.

So basically CCBHC E grants that are not participating in the Medicaid demonstration, you can still bill Medicaid the way you have before and we'd expect that you continue to do that but you don't get any new billing sources as a result of participating in these expansion grants.

And then finally for duly-eligible beneficiaries, for expansion grants that are not participating in the demonstration, the provider will receive cost-sharing amounts for duly-eligible beneficiaries consistent with the current Medicaid methodologies specified in your state plan so basically you'd be operating the same way that you have been according to your state plan the CCBHC expansion grant does not change that.

So for Medicaid and clinics, these are some point bullets on Medicaid and clinics that are both participating in the CCBHC Medicaid demonstration and the CCBHC expansion grant program here at SAMHSA.

So if any CCBHC location recognized under the two-year Section 223 Protecting Access to Medicare Act demonstration and selected as a CCBHC under this opportunity will receive grant funding and either the prospective payment System 1 daily payment or a prospective System 2 monthly rate for CCBHC demonstration services.

You'll be getting kind of two CCBHC strands of funding. For any demonstration service delivered by a CCBHC, states are required to pay up to the TCS rate for services delivered to duly-eligible beneficiaries. This is really important.

No costs that are included in the calculation of the Medicaid demonstration PPS should be included in the SAMHSA grant budget as grant funded expenditures. That would be double-tipping and that's definitely not allowed so if you're paying through your PPS, you should not be paying through also by your grant fund.

So finally states should continue to report expenditures if the states are participating in the demonstration for CCBHCs under the demonstration on CMS 64 Lines 2C, 18A5, 18D1E, 18D2E and 64.21 Line 3B.

For CCBHC expenditures - that's expansion grant expenditures - states will continue to report Medicaid expenditures according to current state practice for non-223 for the non-demonstration expenditures.

Woman 1: Okay, SPARS, that was a lot that we just covered so I'm going to switch gears on your guys and talk about SPARS. As I'm sure that was mentioned earlier today during the training, you need to complete the annual goals and budget training node that is on November 30th and you're expected to enter the annual goals and budget information. Know that it's in January 30th, 2019.

I also recommend you know, again we'll get in touch with you as your GCOs kind of go over, you know, the goals and budget and IPPs and so if you have question, you know, feel free to talk to us first before you go into this and start entering those numbers.

Your project officer will have at least 30 days or a little bit more to review these annual goals and budgets before we approve them so in terms of the other indicators listed here, the infrastructure promotion and prevention indicators - we call them IPPs - those are also due January 31st so we have 01

which is the number of individuals contacted through program outreach efforts.

A4, the number and percentage of workgroup advisory council or members who are consumers or family members, F1 which is screening the number of individuals screened for mental health or related interventions, and PC2 which is the number of organizations coordinating or sharing resources with other organizations as a result of the grant.

All four IPP indicators, there's more information about each of those within SPARS. There's whole manual on IPPs. You can actually download it and then take a look and look up these orders, there's quite a lot of IPPs and so you want to make sure you're looking at the correct one.

And to be quite frank even with the acronyms, some of them can be kind of tricky so just make sure you're looking at the right one because if you're looking at 01 which is outreach we will also have them called OC with is organizational change so just picture you're not missing, you know, the IPP acronyms and if you have questions about those, be sure to reach-out to us.

Again when you're entering annual goals and budget, there is a section on IPP so you also have to project each year for two years the number of outreach efforts you're going to make, you know, all of those indicated listed under the IPPs, you're going to have to make those projections for each year and what ends-up happening is that every quarter you're going to report based on those IPPs what happened in the past quarter.

So for example in Year 1 you're going to make an assumption you know, in your application you said you were going to serve 100 people, this is just telling making-up a number so let's say 100 is the correct number that you're

going to serve. During the course of the quarter, each quarter, you're going to go back and tell me, you know, this past quarter we actually screened 25 people so that's how we're going to be able to match it whether or not you're meeting the goals of your grant.

So SPARS (unintelligible) right there, of course if you have questions you can call and you can e-mail them and there's more information on that Website. The study impact statement, I don't know if folks forgot about this or not but this was in your notice of award, it is due November 30th.

All of our discretionary grants are required to submit (unintelligible) and texting this, these three criteria or components that actually also sit in your notice of award, I'm not going to read through, I'm just only give folks time to answer to ask any questions they may have.

But if you have specific questions about the DIS, please e-mail your GPO and we can you know, again show you some resources that you can look at in terms of how to address these three components.

Some key dates that we mentioned before, this particular (disgrace) impact statement is due November 30th to both (Lewis) and your GPO. Please remember that this is a condition of your award. You have to complete this. Again like we mentioned before, for SPARS training by November 30th, entering your actual goals and budget by January 30th, you should start beginning your services as of February 1st.

As your GPO we ask that you keep us in touch in terms of whether or not service delivery did begin or not, you know, and again what (Dave) had mentioned earlier in terms of the CCBHC criteria, you'll get more guidance about that but we're going to basically ask for submission of proof of

compliance and then the annual report will be due sometime next year,
December of next year.

Okay, I know some folks have put-in some questions in the chat box. I think
some we tried to answer, others we may leave for future e-mail
correspondence but I guess we can open-up the line now if folks want to ask
their questions directly.

Coordinator: All right, and at this time all participant lines will be live and interactive. It is
advised when not speaking to utilize the mute function on your phone. If you
do not have a mute function on your phone, you may press star 6 to mute and
unmute.

((Crosstalk))

(BR): (BR) in New Jersey, (unintelligible).

((Crosstalk))

(David Davorney): We're getting some noise in the background. Folks can keep your phones
muted if you're not asking questions, appreciate it. Is there a question from
New Jersey?

((Crosstalk))

(David Davorney): Oh boy, let me turn you because I got the Webinar thing going-on.

((Crosstalk))

(David Davorney): If you keep phones muted, we'd really appreciate it if you're not asking questions.

Woman 1: (Brandon) is there any way we can just track them one by one? I think people just ended-up all unmuting their lines for some reason.

Coordinator: Yes, sure, one moment.

(David Davorney): So do we have any questions? Or we just answered everything already?

Coordinator: Would you like me to just go ahead and do the star 1 prompt so that I can ...

Woman 1: Yes.

(David Davorney): Yes, maybe actually, thanks.

Woman 1: Thank you.

Coordinator: Sure, not a problem. All right and at this time if you would like to ask a question, please press star 1, please unmute your phone and record your first and last name clearly when prompted. Your name is required to introduce your question. To withdraw your question, you may press star 2.

Once again at this time if you would like to ask a question over the phone line, please press star 1. All right, one moment, please, for our first question. Our first question is from (Anna). Your line is open.

(Anna): Hello?

Woman 1: Hello, hello (Anna)?

(Anna): Well, this is (Janice). You may have misunderstood my name.

(David Davorney): Oh, (Janice).

Woman 1: Okay, sorry.

((Crosstalk))

(Janice): All right, this is (Janice) from Deschutes County and my question is specific to the metrics. You referenced 21 metrics and said that you were going to be looking at how those might be reported and which ones would still be required and we of course in our State of Oregon have been already reporting on nine of the metrics. Is that nine included in the 21 total or do you understand those as we do?

(David Davorney): Yes, no, so there are 21 total metrics that we're representing in the F weight, nine of those are clinic-level metrics and (both of them) are state-level metrics that require state data so it's good that you are collecting nine. I'm trusting you're collecting the nine clinic-level metrics. Are you an existing CCBHC?

(Janice): For an existing CCBHC we are collecting the nine clinic-level metrics and I have one follow-up question and that has to do with the requirement to do a 90-day update on the assessment. It's been a subject of lots of conversation in our state and we're wondering whether or not there's been conversation at the national level about taking another look at that particular requirement.

(David Davorney): If you could actually e-mail that question offline, I'm just trying to make sure I understood it so if you can send that e-mail to (Mary Blake) here, that

she's your project officer and then we will follow-up and if it's kind of tied to the - this is related to the Medicaid demonstration - or to the CCBHC ...

((Crosstalk))

(Janice): It was a requirement, it was a requirement of the Medicaid demonstration that an assessment and service plan be updated every 90 days and it has been a subject of conversation so I'm happy to e-mail that question to (Mary).

(David Davorney): Yes, we'll get together with the Medicaid team and make sure we get you an answer to that, thanks.

(Janice): Thank you.

Coordinator: Our next question is from (Jessica Benton), your line is open.

(Jessica Benton): Hi, can you guys hear me? Hello?

Woman 1: Yes, we can hear you.

(Jessica Benton): Okay, great. My question is about the (NOMs). I'm thrilled that we're doing a sample, that's exciting. Will we be held to an 80% follow-up requirement?

Woman 1: You're talking about reassessment rates?

(Jessica Benton): Yes, ma'am.

Woman 1: Okay, so I think that particular percentage is I don't know if that's the current percentage right now but we do have, you know, an expectation across all of it.

((Crosstalk))

(David Davorney): Yes, so different SAMHSA grants I think SCSEP may have as far as (unintelligible) may have play a different process. We'll have to check on that and get back to you.

(Jessica Benton): Okay.

(David Davorney): You can send us an e-mail, that'd be great.

Woman 1: Certainly, yes.

(Jessica Benton): Okay, great. I have one more question if my line is still open.

Woman 1: Sure.

(Jessica Benton): Do you know if we'll have the ability to batch upload into the SPARS system?

(David Davorney): No.

Woman 1: It's never worked for other grants.

(David Davorney): Unfortunately.

(Jessica Benton): Okay, thank you so much.

Woman 1: Thank you.

Woman 1: You're welcome.

Coordinator: Our next question is from (Marenchis), your line is open.

(Marenchis): Hi, I was wondering if you had a specific template that you were wanting us to use for the needs assessment?

(David Davorney): Was the needs assessment included in the certification criteria?

(Marenchis): The - yes, the compliance.

(David Davorney): Nothing that's not already included in the certification criteria.

Woman 1: So I don't think there's a specific template from SAMHSA per se but if there is like a needs assessment that you guys are using already, they use people to demonstrate that you're meeting the criteria we've put in the checklist in Appendix M (unintelligible).

(Marenchis): Okay.

(David DeVoursney): There's a specific needs assessment that goes into the staffing plan I think and so we can also check just to make sure but I don't believe we have a specific format but we'll get back to you on that.

(Marenchis): Okay, thanks.

Coordinator: Our next question is from (Catherine Golar). Your line is open.

(Catherine Golar): Good afternoon. My question is specifically about primary care and I understand that there's a lot of flexibility as to how it's established and I also saw that there's an expectation that we monitor metabolic syndrome. Is there

other guidance available about how we should set things up or is it very open-ended?

(David DeVoursney): Were those requirements from primary care screening and monitoring, you know, kind of the details included in the certification criteria is this the most that, you know, we're probably going to be offering as far as, you know, what's required of you in terms of, you know, the best practices or ways to do that.

You know, we may be able to direct you to some online resources, you know, there's definitely other programs (unintelligible) other kind of things but probably not we don't have the kind of extensive guidance about that I don't think. Anybody else?

(Catherine Golar): So my follow-up is is it very flexible then so we can actually design a way (that there's) certain institution?

(David DeVoursney): Yes, I think so, you know, the idea is that, you know, we want to make sure that, you know, folks are tracking, you know, the physical health needs of people and doing screening and monitoring of our time to make sure that their needs are addressed.

(Catherine Golar): Thank you.

Coordinator: Our next question is from (Chris Axford), your line is open.

((Crosstalk))

(David DeVoursney): Actually before we go a question, I have one quick question from the online so this is a question from New Jersey, we're a New Jersey certified a

new CCBHC billing the PPS rate for the pilot. Does this mean that we can continue to bill the PPS rate for the expansion? No.

The expansion is complete separate, you know, your PPS rate continues to be available for the duration of your Medicaid demonstration and then what you know, arrangement your state comes to is what you do with Medicaid after that.

This expansion is completely separate and in no way entitles you to any additional Medicaid billing, really what you get out of this demonstration is the expansion grant funding to be up to \$2 million per year for two years.

And then we have another from online, will GPRA be customized for this project? If so, when will we get it? We have submitted some program-specific measures. They're not too onerous I hope but they're still undergoing their own clearance and so we'll be releasing this as soon as we are able.

Woman 1: Sorry, we can go back to (Chris Axford).

(David DeVoursney): Thanks.

(Chris Axford): My question was really similar to the first person but I just want to confirm, with the 21 clinical quality measures and we are an existing CCBHC, of course we're reporting on the nine clinic measures, you are not holding us to reporting on the other 12 measures ourselves? Is that correct because we would not necessarily have access to some of that information?

(David DeVoursney): Right, no, and that's exactly the kind of we don't want to ask you to do something that you won't be capable of doing so we're looking at the issue right now and trying to decide exactly how we're going to approach that. The

guidance is going to be forthcoming but we recognize exactly that problem that you just stated and so you know, the guidance that we provide is set to generate a response to that.

(Chris Axford): Okay, very good, thank you.

Coordinator: Our next question is from (Melanie Atkins). Your line is open.

(Melanie Atkins): Yes, the first question is for the answers you're getting back to individuals on, will those be going-out to everyone or just the specific questioner?

(David DeVoursney): If you're also interested in one of the questions, we're just responding to people in e-mails but if there's something that you'd like also, you know, please e-mail us so we're able to respond to you. We weren't going to ...

((Crosstalk))

(Melanie Atkins): Okay.

(David DeVoursney): ... at some point we may do a frequently-asked questions but for now I think if you have something you're interested in, please e-mail your project officer.

(Melanie Atkins): Okay, our question was how are you defining baseline for the 10% (rain and) sample?

(David DeVoursney): So we're still working-out the details and guidance about the 10% SPARS sample and we'll be getting that out to you as soon as we're able, you know, I think the things that we'll be stressing in that is that we want it to be a random

sample and that the idea is that we want to capture the people coming into the clinic and representative samples so ...

Woman 1: And that's will include a definition for the baseline.

(David DeVoursney): ... exactly, yes.

Woman 1: Great.

(Melanie Atkins): I just got an e-mail from one of my grantees and I just want to reaffirm what (David) said about the PPS rate that if you're already a demonstration grant, you will not be using the PPS rate on your expansion grant so if you're in the Medicaid demonstration grant, you can go ahead and do as you've been doing but the expansion grant is completely separate and you will not be billing at that rate for the SAMHSA expansion grant.

(David DeVoursney): Yes, and so just to be really clear about this, the Medicaid demonstration for most clinics is running a or between April, June or July of 2017 to April or July of 2019 depending on which state and which clinic in which state and that's the period for which you would be eligible for the PPS and you'd be charging that PPS for Medicaid-eligible beneficiaries who are participating in the CCBHC.

This SAMHSA expansion grant is for an additional block grant funding of the amount that you were approved for as a part of your grant award over the two years. You can use that money for the purposes of this grant opportunity as you specified in your application. It is separate from the Medicaid funds that are under your PPS or for other clinics that aren't a part of the demonstration, their existing Medicaid funds however they're arranged.

This opportunity the CCBHC expansion grant it really only concerns the extra up to \$2 million for two years of SAMHSA grant funding. It doesn't entirely if anything it helps in Medicaid except for what you already have whether or not you're an expansion grant, that's not to say demonstration or if you're one that has (participated) in a demonstration.

No, you do not meet so we had a question from online, the question is do we need to need for an oral participant until those additional government measures are available? No, you know, the expectation is that we're going to try and get people to start service delivery as soon as possible but no later than four months after award so please don't wait to an oral participant for the guidance on (unintelligible).

So sorry, another question, once the other 12 measures are established, will we be asked to report data retroactively? Again, you know, we're working on guidance on the quality measures. This would seem to me to be pretty unreasonable of us to ask you to go back in time to report data that is not necessarily available at the clinic levels.

So I'd ask that you probably not do this but the guidance says any yet available so at this point I'm not going to give you a set-in-stone answer to that.

Woman 1: Any more questions on the phone?

Coordinator: Yes, we have a question from (Melissa Ritter). Your line is open.

(Melissa Ritter): Hi, I had a question about the cross-site evaluator. Is there one first of all and if there is, is there going to be an additional measures of indicators that we'll

need to report along with the SPARS data or will they just utilize what we're entering into SPARS?

(David DeVoursney): There is not a cross-site evaluation for this program so what we've talked about today is as of now is the only thing that we're actively collecting as far as the quality measures.

(Melissa Ritter): Great, thank you.

(David DeVoursney): Annual reporting.

Coordinator: I'm showing no further questions on the phone line

Woman 1: Oh wow. No further questions.

(David DeVoursney): No further questions, yet we still have eight minutes we can ...

Woman 1: Pick our brains or e-mail us.

(David DeVoursney): ... yes, so we do have a great project team here. Folks are here of everyone of expertise and we're looking forward to supporting you and your grant. We are very excited about this project. We really think it will (unintelligible) really appreciate you hanging with us through two Webinars this afternoon.

Woman 1: There's one more.

(David DeVoursney): No, at least we got one more question online.

Woman 1: At this time.

(David DeVoursney): Okay, the question is what information is the grantee required to enter into SPARS besides what is mentioned in the SPARS slide sheet, what are the consumer's information, mechanical indicators, bloodwork required to be entered into SPARS?

So again there will be kind of project-specific measures that are currently under review and we will provide information about those when they're available. They're trying to make it workable for you given the volume of the folks that you see here in the agencies so right now I don't think we're anticipating anything that requires bloodwork.

So but again we'll be providing more specific guidance as soon as we're able to after we get clearance for the data collection.

((Crosstalk))

Coordinator: And we do have more questions that on the phone line. Our next question is from (Donald Thompson). Your line is open.

(David DeVoursney): Go ahead, (Donald).

(Donald Thompson): Hello, thanks. Question about enrollment. If we were to proceed with enrollment, I'm just trying to picture that right now, we will be having people sign the general consent form to participate in the project but at this point in time we would not know now would we be able to collect information in regard to other assessment instruments.

Which raises the question in my mind do we run into trouble then later down the line because we have enrolled participants with missing data?

(David DeVoursney): So I think you know, we'll try and get you more guidance on the SPARS data collection as we're able, you know, related to the setting the 10% sample and collection of the data. I think you know, with grants like this size, start-up is always an issue and we just don't want to hold-up start-up based on data.

We will work with you on SPARS and the related issues of data entry and any missing data and, you know, we are very focused-on getting data from our grants so we would like to work with you on that moving forward but I think the overall message is we wouldn't want to hold you up on implementation to wait for data entry.

I think implementation should come as soon as possible no later than four months and we'll work with you around these entries. Does that make sense?

(Donald Thompson): Yes. Thanks.

Coordinator: All right, our next question is from (Grace White), your line is open.

(Grace White): Hi. We have been certified by the State of Texas as a CCBHC. Are we going to need to be recertified by SAMHSA since our state is not part of the Medicaid demonstration project?

(David DeVoursney): I kind of knew this question was going to come-up, you know, and I appreciate Texas, you know, moving forward with doing what they can outside of the Medicaid demonstration. I think that's great.

We're and this is one of the questions we're thinking about so you know, unfortunately I wish I could give you an answer right now but as I said earlier,

probably the least-satisfying part of this call is that we're not able to give you full information on what we're doing around certification and that's ...

((Crosstalk))

(Grace White): Okay.

(David DeVoursney): ... we're aware of that situation and appreciate what you're already doing.

(Grace White): Okay, thank you.

Coordinator: Our next question is from (Jessica Benton), your line is open.

(Jessica Benton): Hi again, guys. I have a follow-up question from two different things that have come-up so with the 21 quality criteria, I'm hearing the message about, you know, additional guidance coming later down the line and I just wanted to clarify, is the reporting timeline for whatever criteria are decided only annual?

(David DeVoursney): So, you know, once the quality measures are established, I think they'd be more or less a continuous but you'd be reporting them to us in your annual report.

(Jessica Benton): Got it, and then to clarify something that I think his name was (Donald) was asking, if we are able to start enrollment before the CCBHC-specific (NOMs) is approved, should we use the existing CMHS (NOMs) or would we just not do a (NOMs) until we have the CCBHC-specific ones?

(David DeVoursney): I don't want to give you the wrong answer here so I'm going to say this tentatively, I think you would still want to connect with CMHS (NOMs) and, you know, then we would, you know, as the program-specific questions get

approved, so I will say that the program-specific questions are a very small part of the overall data collection. Most of it is the CMHS (NOMs).

(Jessica Benton): Okay, thank you.

Coordinator: Our next question is from (Chris Axford). Your line is open.

(Chris Axford): Maybe that was, yes, this is just a process question. I noticed that (Tim Lee) didn't respond and say that the PowerPoint that you're presenting today will be available. Can you tell us how is this going to be available? Is there going to be a link or how do we access it?

(David DeVoursney): I think we'll be e-mailing it out to other project directors.

Woman 1: Yes.

(Chris Axford): Okay, all right, thank you.

Coordinator: Our next question is from (Marenchis). Your line is open.

(Marenchis): Okay, thanks. Did I hear you say just to clarify really quick, there's no point of care labs?

(David DeVoursney): Sorry, what was that?

((Crosstalk))

(David DeVoursney): You know, again we haven't kind of the (unintelligible) package for review of the quality measures that hasn't interfered with that work, you

know, our goal is to avoid, you know, anything that would require a blood draw so ...

(Marenchis): Okay, so then my this office that was discussed, just wanted to clarify so my question is actually in regards to the aid so we have at our site we have an outpatient clinic that's essentially around the corner but I'm not sure, it talked about, you know, if there was a military treatment facility within 50 miles or more, an hour's drive that that would be so there's an actual treatment facility in Indianapolis, we're in Bloomington, Indiana. Does that meet the expectations?

(David DeVoursney): I'd have to look in more detail to the certification criteria, I know your question so I think that's one we're going to have to just let you know in follow-up.

(Marenchis): Okay, that would be really helpful.

(David DeVoursney): Thanks.

Coordinator: Our next question is from (Donald Thompson). Your line is open.

(Donald Thompson): Thanks. My question is in relation to a DCO and the only DCO that we have here in Pennsylvania because of the way that crisis services are setup is with a mobile crisis team that is managed by another organization.

Under the grant arrangement they will continue to build for Medicaid services through the normal Medicaid process and get reimbursed for all their services in that way.

I'm just wondering in terms of the original CCBHC criteria of the relationship between the CCBHC and the DCO, where it stated that the CCBHC would be responsible - clinically responsible - for the services delivered by the DCO and in this case since we are not paying them for the service, we will not have a contractual agreement with them for payment.

Your thoughts about does the requirement for us to have clinical responsibility for the DCO service, does that still hold or how is that supposed to be handled?

(David DeVoursney): Sorry, I wish I could give you a more satisfying answer. I know that there have been kind of these kind of issues with the DCO and especially around crisis services but I'm going to have to get back with the broader you know, HHS CCBHC team to get you answer to that question so if you could send us an e-mail with the question, we'll try and get back to you.

(Donald Thompson): Okay, thanks.

(David DeVoursney): Okay, well we are at 4:31 so I just want to thank you all for your time today and also for your interest and successful applications to the grant program. We are really looking forward to working with you over the next couple of years and, you know, please let us know how we can help you so with that good luck and congratulations.

Woman 1: Thank you, everyone.

Woman 1: Thank you.

Woman 1: Bye.

Coordinator: Thank you for participating in today's conference. All lines may disconnect at this time.

END