



**Certified Community Behavioral Health Clinics (CCBHCs):  
Clarification to Criteria and Guidance**

**Section 223 of the Protecting Access to Medicare Act of 2014 (H.R. 4302)**

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## Clarifications on Questions from States During the CCBHC Planning Grant Period

### Program Requirement 1: Staffing

Question 1-1: If a CCBHC is required by a state's law to be accredited by a state-approved accrediting body (e.g. TJC, CARF, or ACHC), could the staffing plan simply state that the CCBHC must be in compliance with the accrediting body's staffing standards? Since SAMHSA is encouraging accreditation and if a state mandates it, it seems overly-bureaucratic to add another layer of requirements.

Clarification 1-1: See **Criteria 1.a and 1.b.2**. The staffing plan is influenced by many factors including the needs assessment, services to veterans, and other state-determined criteria. States are responsible to certify that clinics meet the Criteria specific to CCBHCs.

Question 1-2: Clinics have questions about the licensure requirement. Are all clinicians required to have or to be in pursuit of their license? With the BH provider shortage, can a clinic be licensed and individuals who are supervised by a licensed clinician count?

Clarification 1-2: Please refer to the **complete Criterion 1.b.2, Licensure and Credentialing of Providers**. It reads in part, "The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state, is informed by the state's initial needs assessment, and includes clinical and peer staff...The CCBHC must have staff, either employed or available through formal arrangements, who are credentialed substance abuse specialists...CCBHCs are not precluded by anything in this criterion from utilizing providers working toward licensure, provided they are working under the requisite supervision."

Question 1-3: When developing services to be included in the CCBHC that are not already covered by the state plan, is it also allowable to look at alternative provider types that are not currently covered under the state plan? An example would be Community Health Workers. (Question is about which state providers can render demonstration services.)

Clarification 1-3: The state may contract with providers not covered by the Medicaid State Plan in order to meet the requirements of the Criteria. Refer to the **Criterion 1.b.2**, to ensure that providers meet the necessary requirements.

Question 1-4: Can you provide clarification between a contractor/subcontractor and a DCO, and what (if any) distinction lies between them?

Clarification 1-4: DCOs are not under the direct supervision of the CCBHC while contract staff members are under direct supervision of the CCBHC.

Please see the Criteria which include this definition of a "Designated Collaborating Organization (DCO): A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. The CCBHC maintains clinical responsibility for the services provided for CCBHC consumers by the DCO. To the extent that services are

required that cannot be provided either by the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for care coordination including services to which it refers consumers. Payment for those referred services is not through the PPS but is made through traditional mechanisms within Medicaid.”

See **Criterion 1.b.2** which reads in part, “The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state, is informed by the state’s initial needs assessment, and includes clinical and peer staff. In accordance with the staffing plan, the CCBHC maintains a core staff comprised of employed, and, as needed, contracted staff, as appropriate to the needs of CCBHC consumers as stated in consumers’ individual treatment plans and as required by program requirements 3 and 4 of these Criteria...”

### **Program Requirement 2: Availability and Accessibility of Services**

Question 2-1: Is it a requirement that a CCBHC provide evening and weekend hours at all of the offices of the CCBHC or can this be limited to the CCBHC’s larger locations?

Clarification 2-1: Please refer to **Criterion 2.a.2**, “The CCBHC provides outpatient clinical services during times that ensure accessibility and meet the needs of the consumer population to be served, including some nights and weekend hours.” Needs assessments should evaluate accessibility and availability for all individuals – including those served as well as those who are under-served and unserved. States have discretion about CCBHC locations and operating hours based on the needs of all individuals.

Question 2-2: Can clarity be provided with regards to specific services which can be provided in compliance with the “non-four walls” requirement of the CCBHC? Are visits to incarcerated clients, visits with clients at places such as restaurants allowed? If the site isn’t licensed, is the service billable?

Clarification 2-2: The state has the flexibility to determine which of the nine required services may be provided outside the four walls. See **Criterion 2.a.5**, “To the extent possible within the state Medicaid program and as allowed by state law, CCBHCs utilize mobile in-home, telehealth/telemedicine, and on-line treatment services to ensure consumers have access to all required services.” Services to individuals within incarceration facilities are not covered. Clinics must meet state licensure requirements and must be “certified” CCBHCs in order to bill for services. Discretion should be exercised when meeting consumers outside the four walls including in restaurants to maintain confidentiality, safety, accountability, and professionalism.

Question 2-3: For a new assessment on a client at a CCBHC, is it allowable to both schedule clients and allow walk-in availability for clients?

Clarification 2-3: Yes, as long as services comply with the certification Criteria. See **Criteria 2.B.** regarding timely access to services and initial and comprehensive evaluations.

Question 2-4: We are looking for guidance on the screening assessment and treatment planning requirements for consumers who are already receiving services from the CCBHC at the

time of certification. Can the state establish criteria for acceptable screening, etc. that were done within a certain time period prior to CCBHC certification? Can the state establish a phase-in period for CCBHCs to renew and update all assessments and treatment planning base on CCBHC Criteria?

Clarification 2-4: See **Criterion 2.b.2**, “The comprehensive person-centered and family-centered diagnostic and treatment planning evaluation is updated by the treatment team, in agreement with and endorsed by the consumer and in consultation with the primary care provider (if any), when changes in the consumer’s status, responses to treatment, or goal achievement have occurred. The assessment must be updated no less frequently than every 90 days unless the state has established a standard that meets the expectations of quality care and that renders this time frame unworkable; or state, federal, or applicable accreditation standards are more stringent.” We interpret this Criterion to mean that all existing CCBHC consumers will have a comprehensive review and update of their treatment plans within 90 days of the first day of CCBHC service implementation.

Question 2-5: Do states have flexibility in implementing the requirement that consumers and families have 24/7 access to mobile crisis services?

- Must clinicians be on site 24/7?
- May clinicians be on call and not on site 24/7?
- May law enforcement be the first point of contact, directing consumers to clinicians and/or consulting with clinicians as appropriate and needed?
- May law enforcement be considered members of the mobile crisis team?
- What role may local EDs, hotlines and warm-lines play in mobile crisis services?

Clarification 2-5: CCBHCs must provide robust and timely crisis behavioral health services including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization as required in statute and codified in CCBHC Criteria. The provision of these crisis behavioral health services directly by the CCBHC or through an existing state-sanctioned, certified, or licensed system or network, cannot be waived.

Police departments do not represent an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services. Reliance on police does not constitute a robust crisis behavioral health service.

States are responsible to clearly define 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization in their certification process. These services must include suicide crisis response and services capable of addressing crises related to substance abuse and intoxication, including ambulatory and medical detoxification.

There are several Criteria that affect this requirement and need to be considered as the state defines and applies the terms. The **Criteria** below underscore the importance of providing a coordinated response to behavioral health crises that promote individual recovery, reduced trauma, and lowered cost of care:

**2** - Because the emergency department (ED) is often a source of crisis care, CCBHCs must have clearly established relationships with local EDs to facilitate care coordination,

discharge and follow-up, as well as relationships with other sources of crisis care (see 3.c.5 in the Care Coordination section below).

**2.c.2** - The methods for providing a continuum of crisis prevention, response, and post-vention services are clearly described in the policies and procedures of the CCBHC and are available to the public.

**2.c.3** - Individuals who are served by the CCBHC are educated about crisis management services such as and Psychiatric Advanced Directives and how to access crisis services, including suicide or crisis hotlines and warm-lines, at the time of the initial evaluation. This includes individuals with limited English proficiencies or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels in accordance with program requirement 1).

**2.c.4** - Protocols are established for CCBHC staff to address the needs of CCBHC consumers in psychiatric crisis who come to those EDs.

**2.c.5** - Protocols for the involvement of law enforcement are in place to reduce delays for initiating services during and following a psychiatric crisis.

**2.c.6** - Following a psychiatric emergency or crisis involving a CCBHC consumer, in conjunction with the consumer, the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations with the goal of preventing future crises for the consumer and their family.

There may be other ways that clinics can provide 24-hour coverage that do not include reliance on police. The clinic may wish to consult the state to develop a solution that would comply with the criteria. SAMHSA staff members are available to consult with states on appropriate options.

Question 2-6: Our agencies who are eligible for CCBHC certification serve a number of counties or catchment areas. Knowing that the CCBHC is required to provide services to any person seeking BH services, does that apply to clients living outside the catchment area?

Clarification 2-6: See **Criteria 2.e.1 and 2.e.2**. See clarification to next question.

Question 2-7: For CCBHCs in areas that border other states, does the CCBHC have to provide services for out of state clients? Does the CCHBC have to provide only emergency services for out of state patients?

Clarification 2-7: See **Criteria 2.e.1 and 2.e.2**. CCBHCs must have protocols addressing the needs of consumers who do not live close to a CCBHC or within the CCBHC service area as determined by the state. CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place or residence. The required protocols should address management of the individual's ongoing treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing CCBHCs to refer and track consumers seeking non-crisis services to the CCBHC or other clinic serving the consumer's county of residence. For distant consumers within the CCBHC's service area, CCBHCs should consider use of

telehealth/telemedicine to the extent practicable. In no circumstances (and in accordance with PAMA § 223 (a)(2)(B)), may any consumer be refused services because of place of residence.

Question 2-8: Mobile Crisis 24/7 is one of the required four core CCBHC services that a CCBHC must provide directly. If the CCBHC does not currently have an established catchment area, and based on the requirement that a CCBHC cannot turn away anyone due to location or ability to pay, how will that affect the provision of services in a large geographical area? Would the CCBHC need to identify a catchment area? If they do, what is the distance then identified that would be outside of the catchment area?

To expand on the question above, if a CCBHC provides many community-based services (outside the four walls) and does not have an identified catchment area, would a catchment area need to be identified? If not, how would a CCBHC comply with seeing any consumer regardless of residence and ability to pay, given such a large geographical location?

Clarification 2-8: The Criteria require the state to conduct a community needs assessment for each CCBHC. The service area (we are using that term instead of catchment area) must be defined by the state in order to determine the “community” to be served by the CCBHC. The CCBHC’s staffing plan, EBPs, cultural and linguistic capabilities, and service hours should be established based on the population residing within that service area.

This will also help when CCBHCs develop “protocols addressing the needs of consumers who do not live close to a CCBHC or within the CCBHC catchment area as established by the state.” See **Criterion 2.e.2** for details.

### **Program Requirement 3: Care Coordination**

Question 3-1: The CCBHC is required to treat anyone who requests and needs service. How should the CCBHC handle care coordination in a situation in which someone comes in for a primary substance abuse service but refuses to sign consent to the release of information?

Clarification 3-1: Please see **Criterion 3.a.2** which requires “Necessary consent for release of information is obtained from CCBHC consumers for all care coordination relationships. If CCBHCs are unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program requirement 3, such attempts must be documented and revisited periodically.”

Question 3-2: Do states have flexibility in implementing the requirement that consumers and families have 24/7 access to mobile crisis services?

- Must clinicians be on site 24/7?
- May clinicians be on call and not on site 24/7?
- May law enforcement be the first point of contact, directing consumers to clinicians and/or consulting with clinicians as appropriate and needed?
- May law enforcement be considered members of the mobile crisis team?

- What role may local EDs, hotlines and warm-lines play in mobile crisis services?

Clarification 3-2: CCBHCs must provide robust and timely crisis behavioral health services including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization as required in statute and codified in CCBHC Criteria. The provision of these crisis behavioral health services directly by the CCBHC or through an existing state-sanctioned, certified, or licensed system or network, cannot be waived.

Police departments do not represent an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services. Reliance on police does not constitute a robust crisis behavioral health service.

States are responsible to clearly define 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization in their certification process. These services must include suicide crisis response and services capable of addressing crises related to substance abuse and intoxication, including ambulatory and medical detoxification.

There are several Criteria that affect this requirement and need to be considered as the state defines and applies the terms. The **Criteria** below underscore the importance of providing a coordinated response to behavioral health crises that promote individual recovery, reduced trauma, and lowered cost of care. (See Q2-\_ and C2-\_ above on availability and accessibility of services for additional Criteria which are pertinent to the clarification for this question.)

**3.a.4** - CCBHCs develop a crisis plan with each consumer so as to ascertain in advance the consumer's preferences in the event of psychiatric or substance use crisis. Examples of crisis plans may include a Psychiatric Advanced Directive or Wellness Recovery Action Plan.

**3.c.3** - CCBHCs must have agreements with suicide/crisis hotlines and warm-lines.

**3.c.5** - The CCBHC has an agreement establishing care coordination expectations with inpatient acute-care hospitals, including EDs, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers, in the area served by the CCBHC, to address the needs of CCBHC consumers. This includes procedures and services, such as peer bridgers, to help transition individuals from the ED or hospital to CCBHC care and shortened time lag between assessment and treatment. The agreement is such that the CCBHC can track when their consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to another entity. The agreement also provides for transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge.

There may be other ways that clinics can provide 24-hour coverage that do not include reliance on police. The clinic may wish to consult the state to develop a solution that would comply with the criteria. SAMHSA staff members are available to consult with states on appropriate options.

Question 3-3: Must DCOs purchase an EHR or change their electronic system to be the same as the CCBHC's? Do they need a HIE?

Clarification 3-3: The Criteria require that the CCBHC have an EHR but there is no requirement that a DCO have one at the time of certification. However, the CCBHC must develop a plan over the two-year demonstration program. See **Criterion 3.b.5**, "...the CCBHC will develop a plan to be produced within the two-year demonstration program time frame to focus on ways to improve care coordination between the CCBHCs and all DCOs using a health IT system..."

Question 3-4: If a state has multiple schools and multiple school districts within one CCBHC catchment area, must the CCBHC complete formal agreements with all schools or school districts?

Clarification 3-4: We suggest that you prioritize some, referring to your needs assessment to determine relative priority. After completing formal agreements with the most critical school districts or schools, during the demonstration period the CCBHC should work on increasing the number of agreements. The state may be able to help CCBHCs by asking the State Department of Education to inform school districts about the importance of these working relationships and agreements. See the **Criteria in 3.C** which address care coordination agreements and contingency plans when those cannot be established within the time frame of the demonstration period.

Question 3-5: Do CCBHCs need contracts with FQHCs or just agreements?

Clarification 3-5: **Criterion 3.c.1** is specific to FQHCs and allows an agreement initially. 3. c.1 goes on to say that "CCBHCs are expected to work toward formal contracts with entities with which they coordinate care if they are not established at the beginning of the demonstration project."

The purpose of the initial agreement – and the contract that follows – is spelled out in **Criteria 3.c.1 through 3.c.5**, to address the underlying reasons and some instances in which agreements or contracts are required, the types of entities with which CCBHCs should have agreements or contracts, and some content requirement for agreements and contracts.

Question 3-6: In regards to CCBHC service requirement **3.c.2**, a CCBHC must provide care coordination for consumers who need ambulatory detox. Our state has no category for ambulatory detox. Our current regulations/rules do not allow for off-site outpatient detox, so there would be no available programs to refer consumers to. Due to this issue, is ambulatory detox used as an example of a level of care, or is that a specific level of care that the state would need to ensure is in place? Currently the detox services the state licenses/certifies are residential in nature.

Clarification 3-6: Please review the definitions posted at [Substance Use Disorder Treatment Providers and CCBHCs on the SAMHA Section 223 website](#).

Question 3-7: **Criterion 3.c.4** requires CCBHCs to have an agreement establishing care coordination expectations with the nearest Department of Veterans' Affairs medical

center, independent clinic, drop-in center, or other facility of the Department. The nearest VA facility for many parts of our state is in a border state. How will this impact the state's demonstration program, and what should the state require from CCBHCs, related to requirements to provide services to veterans?

Clarification 3-7: Please refer to **Criterion 4.k.1** describing the requirements of the CCBHC to deliver services to veterans. There is nothing in the Criteria to prevent the CCBHC from referring consumers who are veterans to the closest VA facility if it is located in a different state. (Question and Clarification are repeated in Scope of Services section below.)

#### Program Requirement 4: Scope of Services

Question 4-1: Are DCOs able to contract with multiple CCBHCs?

Clarification 4-1: There is nothing in the criteria to prohibit a DCO from contracting with more than one CCBHC.

Question 4-2: Would a CCBHC still meet SAMHSA's requirement of being "clinically responsible" for provision of services rendered by DCOs if the CCBHC contractually required the DCO to 1) indemnify the CCBHC against malpractice liability for CCBHC services furnished by the DCO, and 2) add the CCBHC as an insured on the DCO's medical malpractice insurance policy?

Clarification 4-2: Yes, both would be permissible.

Question 4-3: Would the CCBHC still meet SAMHSA's requirement of being "clinically responsible" for the provision of services rendered by the DCOs if the DCO's clinicians maintained charts in the DCO's own separate health record, then shared information appropriately with the CCBHC? Or are the CCBHC and DCO required to maintain charts in the same health record?

Clarification 4-3: The CCBHC and DCO are not required to maintain charts in the same health record. CCBHCs are responsible for the treatment planning. CCBHC records must reflect that services are being rendered in compliance with the treatment plan. The CCBHC record must reflect a complete and accurate depiction of services for which the CCBHC is responsible for overseeing including services provided by a DCO.

Question 4-4: Can you please provide some clarity regarding how states are able to comply with the Corporate Practice of Medicine rules as it relates to **Criterion 4.a.1** that states that "the CCBHC is ultimately clinically responsible for all care provided. The decision as to the scope of services to be provided directly by the CCBHC, as determined by the state and clinics as part of certification, reflects the CCBHC's responsibility and accountability for the clinical care of the consumers." There is some confusion regarding how are CCBHCs that do not provide primary care services, but rather contract with the DCO for the primary care services can be ultimately clinically responsible for all care provided, giving the limits set by the corporate practice of medicine rules.

Clarification 4-4: CCBHCs are responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk as well as care coordination with primary care providers. They are not responsible for the provision of primary care.

Question 4-5: We understand that the four core services must be provided by the CCBHC. Must the other five required services be provided by the CCBHC or by a DCO, or could some of these five required services be provided by another provider under contract to the CCBHC?

Clarification 4-5: The four core services must be provided by the CCBHC. Please see **Criteria 4.c.1, 4.d.1, 4.e.1, and 4.f.1** for the four core services to be provided directly by the CCBHC. The other five required services are listed in Program Requirement 4 of the Criteria and must be provided either by the CCBHC or by a DCO. Please see **Criterion 4.a.2**, “The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, consistent with the consumer’s freedom to choose providers within the CCBHC and its DCOs.”

Question 4-6: Guidance on the SAMHSA website indicates that CCBHCs are required to provide four levels of detoxification services and specifies how they are to be provided - level 1 directly; that it is preferred for CCBHCs to provide level 2 directly; that levels 3.2 and 3.7 should be provided directly, by a DCO or via a referral. **Criterion 4.c.1** indicates only that the CCBHC ensure that detoxification services are available within the CCBHC structure, which can be defined by the state. If a state does not license one of the four levels of detoxification services, so that one of the levels is not available in the state, will that service be required to be provided by a CCBHC?

Clarification 4-6: CCBHCs are required to provide the first four of five withdrawal management services for adults, and those services must be available and readily accessible as part of CCBHCs’ crisis services. These four services are levels 1, 2, 3.2, and 3.7. Visit [Substance Use Disorder Treatment Providers and CCBHCs on the SAMHSA 223 website](#), which includes a link to the American Society of Addiction Medicine, where these four ambulatory and medical detoxification services are defined:

- 1-WM: Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery. The CCBHC must directly provide 1-WM.
- 2-WM: Moderate withdrawal with all-day withdrawal management support and supervision; at night, has supportive family or living situation, likely to complete withdrawal management. The CCBHC is encouraged to directly provide 2-WM. While the CCBHC must have the 2-WM level of ambulatory withdrawal management available and accessible to eligible consumers, it is not a requirement that this service be provided directly, although it is encouraged.
- 3.2-WM: Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or

recovery. May be provided directly either by the CCBHC or through a DCO relationship or by referral.

- 3.7-WM: Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, or nursing monitoring. May be provided directly either by the CCBHC or through a DCO relationship or by referral.

See also the CCBHC Criteria Checklist of the “Guidance to Planning Grant States to Apply to Participate in the Section 223 CCBHC Demonstration Program. On pages 34 and 35 of the Checklist, **Criteria 4.C**, Crisis Behavioral Health Services, the state must rate the clinic on the following criteria: “The following services are explicitly included among CCBHC services that are provided directly or through an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services: (1) 24 hour mobile crisis teams, (2) emergency crisis intervention services, (3) crisis stabilization services, (4) suicide crisis response, and (5) services for substance abuse crisis and intoxication, including ambulatory and medical detoxification services.” If the CCBHC is unable to provide one of four levels of detoxification services directly, through a DCO, or by referral, even if the state does not license these services, you must rate the clinic accordingly and provide justification at the end of the program requirement checklist. States may use the narrative justification to explain deficiencies in services and how they will be addressed. The demonstration program intends to move services and treatment to a higher level of accessibility, availability, and quality.

Question 4-7: If a CCBHC contracts with a state-sanctioned crisis service, can that crisis service provider also become a DCO? (Question relates to whether a particular entity can become a DCO.)

Clarification 4-7: Yes.

Question 4-8: If a state has state-sanctioned crisis services, may those be used as long as they provide the required level one withdrawal meet the other crisis services requirements?

Clarification 4-8: Please refer to **Criterion 4.c.1**: “Unless there is an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services that dictates otherwise, the CCBHC will directly provide robust and timely crisis behavioral health services. Whether provided directly or by the CCBHC or by a state-sanctioned alternative acting as a DCO, available services must include the following:

- 24-hour mobile crisis teams,
- Emergency crisis intervention services, and
- Crisis stabilization.”

Question 4-9: Must crisis response services be provided directly by the CCBHC or by a DCO? What if a state directly operates the crisis response services?

Clarification 4-9: **Criterion 4.c.1** states, “Unless there is an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services that dictates otherwise, the CCBHC will **directly** provide robust and timely crisis behavioral health services. Whether provided directly by the CCBHC or by a state-sanctioned alternative acting as a DCO, available services must include the following:

- 24-hour mobile crisis teams,
- Emergency crisis intervention services, and
- Crisis stabilization.

Crisis services directly operated by a state can be provided through a DCO arrangement, documented by contract, MOA, or MOU describing mutual expectations, accountability, and funding.

Question 4-10: What does the required medical detoxification service look like? If detoxification can be provided by a DCO, does the CCBHC need to provide anything else?

Clarification 4-10: **Criterion 4.c.1** refer to ambulatory and medical detoxification. The clarification on the SAMHSA website refers to these discrete levels of care:

1-WM: Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery.

- The CCBHC must directly provide 1-WM.

2-WM: Moderate withdrawal with all-day withdrawal management support and supervision; at night, has supportive family or living situation, likely to complete withdrawal management.

- The CCBHC is encouraged to directly provide 2-WM.
- May be provided through a DCO relationship or by referral.

3.2-WM: Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.

- May be provided by the CCBHC, through a DCO relationship or by referral.
- If residential, it is not part of the PPS.

3-7-WM: Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, or nursing monitoring.

- May be provided by the CCBHC, through a DCO relationship or by referral.
- As a residential service, it is not part of the PPS.

Question 4-11: Must a CCBHC have registered a patient, screened him/her for eligibility for the sliding fee discount schedule, and conducted the required CCBHC clinical screening, before the individual can access a service rendered by a DCO?

Clarification 4-11: Yes. This is one of four core services that must be provided directly by the CCBHC. The CCBHC will provide this service, develop the treatment plan and refer the individual to needed services within the CCBHC and to any DCOs as warranted.

Question 4-12: Would a CCBHC meet SAMHSA’s definition of being “financially responsible” for the provision of DCO services if the CCBHC contractually delegated to the DCO the following functions: (1) Verifying patients’ insurance status, collecting cost-sharing, and apply the sliding fee discount, and (2) Filing claims with Medicaid and other payers on behalf of the CCBHC?

Clarification 4-12: A state may choose to permit CCBHCs to delegate responsibility to DCOs for the activities in (1) above. The CCBHC may not delegate filing claims to the DCO as in (2) above. The CCBHC bills the state Medicaid office and reimburses the DCO for services rendered.

Question 4-13: Can court-ordered SUD and SUD without counseling be included as allowable costs? (The State Medicaid Plan requires counseling for SUD.)

Clarification 4-13: These services would be allowable costs to the extent that they fall under one of the nine services required by the criteria, excluding services provided in an institutional setting.

Question 4-14: If the CCBHC site provides all the four core services directly can a DCO also be used for some of those services (basically an extension for certain specialties or for capacity purpose)? Most of these arrangements are already in place. (In addition to a CCBHC DCO being able to provide some or all the four core services as an extension, we also have the issue of certain CCBHC services like home-based, TCM, ACT, and Wraparound where EBP fidelity requires them to do assessment and outpatient services including the person-centered planning. Since many of these services can be done by DCOs they would need the ability to provide some of the four core services. Additionally, at least in the case of certain CBPs and DCOs, it doesn’t seem right to have to split treatment providers by the four core services.)

Clarification 4-14: CCBHC outpatient services are based on the needs assessment of the community and determine the staffing expectations for outpatient services provided directly by the CCBHC. We understand that there may be certain conditions that require outpatient care that is so specialized that the CCBHC may not be able to provide it directly. The CCBHC is still responsible to assess, diagnose, develop a service plan and coordinate care. Outpatient care to treat behavioral health disorders that are mild or moderate does not fall into the category of specialized services and so must be provided by the CCBHC directly.

We also understand that the CCBHC may experience surges in demand based on a particular disaster, traumatic incident, or other event that has significant impact on a community. When surges do occur, CCBHCs should have the flexibility to react appropriately to meet needs. Surges are time limited and cannot be the basis to extend the use of DCOs for outpatient treatment indefinitely.

The state should accurately assess and rate whether the “CCBHCs directly provide outpatient mental health and substance use services” across the life span to the community in the State’s Compliance with CCBHC Criteria Checklist under **Criterion 4.F. Outpatient Mental Health and Substance Use Services.**

Question 4-15: This is about crisis services, specifically ambulatory and medical detoxification requirements, specifically Level 1 withdrawal with daily or less than daily outpatient monitoring of the withdrawal. Are CCBHCs required to provide this service directly, or are CCBHCs allowed to make referrals to specialty clinics for this service?

Clarification 4-15: The CCBHC must directly provide 1-WM: Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery.

Question 4-16: Does Medication Assisted Treatment (MAT) services need to be provided directly by the CCBHC as part of the outpatient substance abuse services or can MAT be provided through a DCO arrangement?

Clarification 4-16: CCBHCs are required to directly provide substance abuse outpatient services as part of the four core services, however, if a consumer has been assessed and determined to need a specialized outpatient service, such as MAT, this service may be provided either directly by the CCBHC or through a DCO arrangement.

Question 4-17: Is Medication Assisted Treatment a required service?

Clarification 4-17: No, MAT is not a required service unless the State defines it as an outpatient service under **Criterion 4.f.2**. This addresses “...evidence-based medication evaluation and management (including but not limited to medications for psychiatric conditions, medication assisted treatment for alcohol and opioid substance use disorders (e.g., buprenorphine, methadone, naltrexone (injectable and oral), acamprosate, disulfiram, naloxone), prescription long-acting injectable medications for both mental and substance use disorders, and smoking cessation medications); community wrap-around services for youth and children; and specialty clinical interventions to treat mental and substance use disorders experienced by youth (including youth in therapeutic foster care).” This list is not intended to be all-inclusive and the states are free to determine whether these or other evidence-based treatments may be appropriate as a condition of certification.

Question 4-18: Our state is seeking guidance from SAMHSA about one of the nine required services, “Outpatient clinic primary care screening and monitoring of key health indicators and health risk.” As our state plans for primary care screening and monitoring, we need more guidance about what is allowable, what is billable, and how we should define primary care screening; monitoring of key health indicators and health risks; and monitoring of further evaluations, referrals, and follow-up via care coordination under the treatment plan.

Clarification 4-18: SAMHSA and CMS issued the following clarification about screening services:

As specified in the section 223(a)(2)(D)(v) of the Protecting Access to Medicare Act and detailed in section **4.G of the Criteria**, CCBHCs are required to provide outpatient clinic primary care screening and monitoring. In interpreting this requirement to develop the PPS rate SAMHSA recommends that states adopt the Medicaid definition of screening services at 42 CFR 440.130 (b): “the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.” This definition will assist states in determining which services constitute primary care screening and monitoring for purposes of coverage and payment under this demonstration.

Regarding the required primary care screening and monitoring services to be provided under this demonstration, in **Criterion 4.g.1** SAMHSA states, “The CCBHC is responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk. Whether directly provided by the CCBHC or through a DCO, the CCBHC is responsible for ensuring these services are received in a timely fashion. Required primary care screening and monitoring of key health indicators and health risk provided by the CCBHC include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix A of these criteria.” There are five primary care screening services which are required and are covered services as part of the demonstration program:

1. Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up
2. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (see Medicaid Child Core Set)
3. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
4. Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling
5. Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications

States may elect to cover additional primary care screening and monitoring services including those associated with quality measures for which reporting is no longer required per guidance issued by SAMHSA by e-mail to project directors 4/11/2016. The following four services are linked to those measures:

- Diabetes Care for People with Serious Mental Illness: Hemoglobin Alc (HbAlc) Poor Control (>9.0%)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
- Cardiovascular health monitoring for people with cardiovascular disease and schizophrenia

**Criterion 4.g.1** indicates, “The CCBHC should not take non-inclusion of a specific metric in Appendix A as a reason not to provide clinically indicated primary care screening and monitoring and the state may elect to require specific other screening and monitoring to be provided by the CCBHCs.” Further, **Criterion 4.g.1** specifies, “The CCBHC ensures children receive age appropriate screening and preventive interventions including, where appropriate, screening of learning disabilities and older adults receive age appropriate screening and preventive interventions. Prevention is a key component of primary care services provided by the CCBHC. Nothing in these criteria prevents a CCBHC from providing other primary care screening and monitoring services.”

In addition, the state will determine how CCBHC consumers are screened. **Criterion 4.d.5** states “...depending on whether the CCBHC directly provides primary care screening and monitoring of key health indicators and health risk pursuant to criteria **4.G**, either: (a) an assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the consumer’s primary care provider (with appropriate referral and follow-up), or (b) a basic physical assessment as required by criteria **4.G**.”

Question 4-19: Is there any guidance available regarding how to ensure that duplicate primary care services are not received and billed for? For example, if a patient comes to the CCBHC for outpatient substance use disorder therapy and already has their own primary care provider whom the individual sees regularly, what is the guidance regarding how to make sure that the individual does not receive the additional/redundant primary care services at the CCBHC? As well, how do we fiscally account for that - if the individual’s independent primary care provider has already billed for the primary care services, and now the individual is in the CCBHC, how do we account for the primary care service costs that are included in the CCBHC PPS? Would it be possible to use the special rate option for primary care services?

Clarification 4-19: Please see **Criterion 4.g.1**. Only outpatient clinic primary care screening and monitoring are CCBHC services.

Question 4-20: The following excerpts from Appendix II – Criteria for the Demonstration Program to Improve Behavioral Health Clinics contain many sections that indicate CCBHCs are required to provide primary care services. However, Section 223 (a) (2)(D)(V) of PAMA states that, “Outpatient clinic primary care screening and monitoring of key health indicators and health risk” is the minimum required CCBHC primary care service. Further, **Criterion 4.g.1** states that, “Nothing in these criteria prevent a CCBHC from providing other primary care services.” However, Appendix III – Section 223 Demonstration Programs to Improve Community Mental Health Services Prospective Payment System (PPS) Guidance, Section 4.2.c states that, “States must identify and remove all non-CCBHC allowable costs in order to determine PPS. The statute implementing this demonstration prohibits payment for the following non-CCBHC services: inpatient care, residential treatment, room and board, or any other non-ambulatory expenses, as determined by the Secretary.” The section goes on to say, “Examples of additional types of costs incurred for non-CCBHC services include costs to

support the provision of dental and optometry services.” Although it is clear that CCBHCs are required to provide primary health care services, either directly or through agreements with Designated Collaborating Organizations (DCOs), it is not clear which of the primary care services a state can consider to be “CCBHC services.” This distinction between “CCBHC services” and “non-CCBHC services” is important for purposes of identifying costs which can or cannot be included in the cost report as an allowable cost to calculate a PPS rate. Can states determine whether the following services can be considered “CCBHC” services for purposes of calculating the PPS?

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

Clarification 4-20: As specified in the section 223(a)(2)(D)(v) of the PAMA\* and detailed in section **4.G** of the Criteria, CCBHCs are required to provide outpatient clinic primary care screening and monitoring. In interpreting this requirement to develop the PPS rate SAMHSA recommends that states adopt the Medicaid definition of screening services at 42 CFR 440.130 (b): “the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.” This definition will assist states in determining which services constitute primary care screening and monitoring for purposes of coverage and payment under this demonstration.

\*Protecting Access to Medicare Act

Question 4-21: In looking at the CCBHC services criteria, does **4.h.1** imply states need to create a population of focus for case management, if it does not already exist, for “persons deemed at high risk for suicide, particularly during times of transitions such as from an ED or psychiatric hospitalization”?

Clarification 4-21: Yes. Regardless of other diagnoses those deemed at high risk of suicide are specified to receive targeted case management (TCM). The duration of TCM for these individuals may be time limited, for example until no longer deemed at high risk. The CCBHC can establish appropriate utilization criteria to dictate length of service for TCM, but should ensure continuity of service during transitions in care. An important function of the needs assessment is identifying and clearly specifying other populations for TCM and the appropriate scope of their services. These may vary locally among different CCBHCs. Please see CCBHC **Criterion 4.h.1**, “The CCBHC is responsible for high quality targeted case management services that will assist individuals in sustaining recovery, and gaining access to needed medical, social, legal, educational, and other services and supports. Targeted case management should include supports for persons deemed at high risk of suicide, particularly during times of transitions such as from an ED or psychiatric hospitalization. Based upon the needs of the population served, states

should specify the scope of other targeted case management services that will be required, and the specific populations for which they are intended.”

Question 4-22: Is supported employment allowable under psychiatric rehabilitation?

Clarification 4-22: Yes, supported employment is allowable as an evidence-based practice. See **Criterion 4.i.1.**

Question 4-23: Can day treatment be an allowable cost?

Clarification 4-23: States should consider which of the nine services required by the Criteria would include day treatment. It would be an allowable cost only if it fell under one of the nine services required by the Criteria, and if it were not provided in an institutional setting.

Question 4-24: **Criterion 3.c.4** requires CCBHCs to have an agreement establishing care coordination expectations with the nearest Department of Veterans’ Affairs medical center, independent clinic, drop-in center, or other facility of the Department. The nearest VA facility for many parts of our state is in a border state. How will this impact the state’s demonstration program, and what should the state require from CCBHCs, related to requirements to provide services to veterans?

Clarification 4-24: Please refer to **Criterion 4.k.1** describing the requirements of the CCBHC to deliver services to veterans. There is nothing in the Criteria to prevent the CCBHC from referring consumers who are veterans to the closest VA facility if it is located in a different state. (Question and Clarification are repeated in Care Coordination section above.)

Question 4-25: Are members of the National Guard or Reserves considered in this service requirement? Our understanding is that they are not considered members of the Armed Forces, and are considered Veterans only if they have served abroad. Is this accurate? Are such individuals to be considered for the Armed Forces or Veterans services?

Clarification 4-25: Army and Air Guard are indeed part of the reserve branches that make up the U.S. Armed Forces. State Guard members, who serve under the leadership of the Adjutant General and the Governor as a soldier or airman for their state military departments, are not considered by many service systems Veterans for the purpose of benefits. They serve the state’s need first and stand ready to be activated by the POTUS under Title 10. Title 10 Guard members with active duty service are considered Veterans in the traditional use of the word and are eligible for VA and other Tricare programming, or those who were previously on active duty and have transitioned to Guard or Reserves. For more details on which Guard members are eligible for its benefits, access [Summary of VA Benefits for National Guard and Reserve Members and Veterans from the VA website](#).

Question 4-26: The CCBHC service requirement for Veterans and members of the Armed Forces requires that the services be consistent with the Uniform Mental Health Services Handbook. However, when reviewing the Handbook, we find several services that do not line up with the CCBHC scope of services. For example, inpatient services are required

in the handbook, but are clearly not a CCBHC service. Can such services be identified as “specialty services” that would not be provided by the CCBHC, and would require a collaboration agreement for such services, with such agreements addressing referrals for such specialty services?

Clarification 4-26: The array of VHA services and resources are organized differently than those of states and communities and do not make a perfect match. In consultation with VHA, we extracted the principles from the UMHS handbook which were taken, coincidentally from SAMHSA. States do not need to do more than what is in the Criteria.

Question 4-27: Will a CCBHC be required to obtain a copy of an individual’s DD-214 to verify their status as a Veteran, or should the CCBHC simply accept the individual’s answer to the question “Are you now, or have you ever, served in the U.S. Armed Forces?” as sufficient to document the individual’s status?

Clarification 4-27: There is nothing in the Criteria or the checklist that require verification of Veteran status.

#### **Program Requirement 5: Quality and Other Reporting**

Question 5-1: Is the national evaluation taking place over the two demonstration years or is it for a longer period?

Clarification 5-1: Yes, it is for the two-year demonstration program.

Question 5-2: How should a state choose its control groups?

Clarification 5-2: The state is not responsible for choosing its control groups. The national evaluation team will select a group after the start of the demonstration and after the certified clinics have been established. The evaluation team may select a comparison group that includes comparison clinics, or a comparison group that is comprised of comparable individuals to those using CCBHCs. In either case, after a comparison group is defined, the state will be responsible for providing claims or encounter data for the comparison group of individuals (either selected by being clients of a comparison clinic, or being an identified group). A state may recommend comparison groups to the national evaluation team if the state would like to do so.

#### **Program Requirement 6: Organizational Authority, Governance and Accreditation**

Question 6-1: Many questions have arisen about the 51% consumer/family board representation requirement. Please clarify. What is SAMHSA's expectation for CCBHCs meeting the 51% requirement or providing a plan and timeline to meet this requirement? Can a CCBHC demonstrate "meaningful consumer participation" in organizational governance in other ways to meet the requirement without 51% consumer participation and without having a plan and timeline for 51% participation?

Clarification 6-1: See all of **Criteria 6.B: Governance. 6.b.1** refers to “...a substantial portion of the governing board members meeting this criteria and other specifically described methods for consumers, people in recovery and family members to provide meaningful

input to the board about the CCBHC’s policies, processes, and services.” **6.b.2** says, “The CCBHC will describe how it meets this requirement or develop a transition plan with timelines appropriate with timelines appropriate to its governing board size and target population to meet this requirement.” **Criteria 6.b.3 and 6.b.4** address challenges with meeting the requirement and alternatives to the requirement. **6.b.6** states, “States will determine what processes will be used to verify that these governance criteria are being met.”

Question 6-2: Trained peer specialists often work part time. They are valuable resources who we would like to maintain on governing and advisory boards. Please confirm that these individuals would not be subject to the “health care industry” limitation which states that “No more than one half (50%) of the governing board members may derive more than 10% of the annual income from the healthcare industry.”

Clarification 6-2: The requirement that “No more than one half (50%) of the governing board members may derive more than 10% of the annual income from the healthcare industry” applies to all members of CCBHC governance.

### **General Questions and Clarifications**

Question 7-1: Is there additional guidance about the recommended radius or region for the needs assessment?

Clarification 7-1: The state-prepared needs assessment will have a significant impact on many criteria, including staffing plans, EBPs, and cultural requirements. The needs assessment defines geographic service areas. CCBHCs *or* community behavioral health provider service areas conform to the needs assessment.

Question 7-2: May we have more than one CCBHC in a service area, providing the full array of services, but each serving fewer individuals? The intention is to increase choice, access, and availability. The two CCBHCs would be operated by the same provider.

Clarification 7-2: Yes, if the needs assessment documents the need.

Question 7-3: Can you please clarify the populations of focus for a CCBHC? It is clear that SED and SMI are two populations of focus, however, what is intended by additional language specific to SUD, chronic SUD, long term and serious SUD, others with mental illness and SUD, and “others”?

Clarification 7-3: Terminology describing duration and severity of substance use disorders should be understood per current criteria most widely used in the diagnosis and treatment of such disorders (i.e., DSM V, ICD 10). Terms such as “chronic,” “long term,” and “severe” SUD should be understood as communicating the intent that CCBHCs shall manage and use the full scope of clinical resources needed to successfully treat those who are most severely impacted by substance use disorders. CCBHCs may provide a full array of SUD treatment either through direct provision of services or services provided through a DCO. “Others with mental illness and substance use disorders” communicates the intent that CCBHCs will serve all those with mental illness and/or substance use disorders who seek treatment, rather than limit treatment exclusively to individuals with

SMI/SED /chronic SUD. Additional populations of focus may be identified based on state priorities, especially as derived from the needs assessment.

Question 7-4: When a site becomes a CCBHC, will it be a state or federal certification?

Clarification 7-4: State

Question 7-5: Can a for-profit serve as a DCO?

Clarification 7-5: Please review [Who Can and Cannot Be a CCBHC? on the SAMHSA Section 223 website](#).

Question 7-6: Which specific services may be provided in compliance with the “non-four walls” requirement of the CCBHC?

Clarification 7-6: The state has the flexibility to determine which services can be provided outside the four walls and enumerated.

Question 7-7: We are seeking clarification regarding CCBHCs that operate from multiple sites. Does each clinic have to offer all the required services? What is the proximity requirement for sites? May a large entity under one management structure offer SUD services at one location, MH services at another, and crisis services from still another location?

Clarification 7-7: The CCBHCs will be multiple site organizations in some communities. The purpose of the CCBHC is to improve quality and access; these are key determinants for consideration when states are selected for the demonstration program. All nine services must be available to everyone in the community served by the CCBHC. Please refer to [Certification Resources and Guides on the SAMHSA Section 223 website](#).

Question 7-8: If a CCBHC has multiple sites, do all outpatient services for all age groups need to be provided at each site?

Clarification 7-8: CCBHCs can use multiple sites or offices that focus on a specific population. The full array of services should be equally accessible to all people, regardless of age, who live in the service area.