Planning Grants for Certified Community Behavioral Health Clinics (CCBHC)

(Short Title: CCBHCs Planning Grants)

RFA No. SM-16-001

Frequently Asked Questions

Following are Frequently Asked Questions (FAQs) related to the RFA which includes the CCBHC criteria and certification. CCBHC Prospective Payment System Questions and Answers may be found on the CMS website at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/223-demonstration-for-ccbhc.html

Please note that these questions and answers will accompany the RFA and are intended to inform state applicants during the application period for the planning grants. These questions and answers were formulated in anticipation of states questions and based on comments received during the public comment periods.

RFA-Related FAQs

Question 1: How can a state applicant for a planning grant make sure that necessary interests are considered in the application?

> **Answer 1:** The state applicant is expected to explicitly reach out to stakeholders with a role or interest in the development of CCBHCs. Such stakeholders might include but not be limited to other state agencies, behavioral health authorities in the state, state behavioral health councils, nonprofit and other healthcare providers that may qualify to be a CCBHC or a Designated Collaborating Organization (DCO), community organizations, organizations representing the interests of consumers, those in recovery, and families, and local tribal organizations. Consultation with these stakeholders is an important part of developing the planning grant and any subsequent certification of CCBHCs.

Question 2: We are not sure if we can organize services and funding around CCBHCs in my state. Should we apply?

> **Answer 2:** Yes, interested states should apply. The RFA, Criteria and PPS Guidance were written to be applicable to all 50 states and the District of Columbia. States are encouraged to contact the program staff identified in the RFA to discuss challenges. SAMHSA, CMS, and ASPE will work closely with states to discuss approaches to organizing services and funding that makes sense for the state and meets the goals of the program.

Question 3: My federally recognized tribe would like to apply for a planning grant in collaboration with our state. Can we apply?

Answer 3: Consistent with the statute, only the 50 states and the District of Columbia are eligible to apply for planning grants. Tribes are encouraged to work with state behavioral health authorities and state Medicaid directors to participate in the planning grant, either as collaborators or as a CCBHC if the tribe is a provider. While behavioral health agencies that are operated under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.) are not eligible to apply for a planning grant, they are eligible as CCBHCs.

Question 4: If our state received a planning grant, could we certify every community mental health center in the state?

Answer 4: Yes. States may certify every community mental health center in the state that meets certification standards. The state must however, work with HHS and the evaluation planning team to construct a comparison group for an assessment of access, quality, and scope of services available to Medicaid enrollees served by CCBHCs compared with Medicaid enrollees who access services from other community-based mental health service providers.

Question 5: The RFA says that grants of up to $2,000,000 can be made to up to 25 states. Multiplying these two amounts comes out to $50,000,000 but the RFA says that only $24,635,000 is available for funding. Should I apply for less than $2,000,000?

Answer 5: Applicants should apply for the amount of funding they feel they need to complete the goals of the planning grant that will prepare the state to participate in the demonstration program. The size of the award may vary depending on the number of applications SAMHSA receives.

CRITERIA-RELATED FAQS

Program Requirement 1 – Staffing:

Question 6: Is the Medical Director required to be a psychiatrist?

Answer 6: The Medical Director should be a psychiatrist unless there is a documented behavioral health professional shortage in the CCBHC service area determined by the Health Resources and Services Administration (Health Resources and Services Administration [2015]), and reasonable and consistent, but unsuccessful, efforts have been made to try to find a psychiatrist who is appropriate for the Medical Director position. Only then may the position be filled by a non-psychiatrist. The non-psychiatrist must be a medically trained behavioral health care provider with appropriate education and licensure, with prescriptive authority in psychopharmacology, who can prescribe and manage medications independently pursuant to state law.

Program Requirement 2 – Availability and Accessibility of Services:

Question 7: Criterion 2.b.1 says that "appropriate action" must be taken immediately if the initial evaluation reveals an emergency or crisis need, but criterion 2.c.1 says that crisis management services must be delivered within three hours. What is the actual requirement?

Answer 7: Some responses to emergency or crisis needs can be dealt with in-house immediately by the CCBHC staff and that should be the first recourse where it is appropriate. If, however, a crisis team must be involved, the relevant maximum response time of 3 hours applies, but the CCBHC staff must, while waiting, take any necessary actions to assure the consumer's safety and the safety of those around them.

Question 8: Can the preliminary screening and risk assessment or any of the evaluations be carried out by telephone?

Answer 8: The preliminary screening may be telephonic. It is preferred that the initial evaluation be conducted in-person but we recognize that is not always possible. If the preliminary screening reveals emergency or urgent needs, the initial evaluation may, if necessary, be conducted telephonically or by telehealth/telemedicine. Once the emergency is resolved, however, the next encounter must be in person and the initial evaluation reviewed.

Question 9: Why are 60 days allowed for CCBHCs to complete the comprehensive evaluation?

Answer 9: The comprehensive evaluation actually begins at intake with the preliminary screening, continues with the initial evaluation and subsequent assessment, culminating in the comprehensive and treatment planning evaluation which must be completed within 60 days of first contact. Nothing precludes earlier completion of the evaluation or the provision of any services. Sixty days is designed to allow the consumer time to build a relationship with the clinician conducting the evaluation and to develop trust to allow a complete and meaningful evaluation, and to accommodate consumers who may have difficulty completing an evaluation in a limited period of time.

Program Requirement 3 – Care Coordination:

Question 10: Where can we learn more about Health Information Technology (HIT) and certification?

Answer 10: The principal federal agency coordinating the effort to develop HIT capability is The Office of the National Coordinator for Health Information Technology (ONC). ONC is responsible for the Health IT Certification Program (http://www.healthit.gov/policy-researchers-implementers/onc-health-it-certification-program) and maintains an online list of certified products, the ONC Certified Health IT Product List (CHPL) at http://oncchpl.force.com/ehrcert?q=chpl .

Program Requirement 4 – Scope of Services:

Question 11: There are multiple components to the comprehensive evaluation requirements. What is the reasoning behind the requirements?

Answer 11: The preliminary screening and risk assessment is designed to determine acuity of needs and whether the new consumer presents a risk to self or others. The information gleaned from this screening/assessment feeds into the initial evaluation which requires the gathering of very basic information designed to guide preliminary treatment and determination of other needs. The initial evaluation, in turn, feeds into the comprehensive diagnostic and treatment planning evaluation, which gathers more complete information to allow a full diagnosis and adequate basis for treatment plan development. The content of the comprehensive evaluation will vary by state-established certification requirement, individual needs, and other requirements such as accreditation to which the CCBHC may be subject.

Question 12: Must existing clients of the agency that becomes a CCBHC receive a comprehensive evaluation or will their records be exempt from such requirements?

Answer 12: No, the comprehensive evaluation is for new consumers enrolled after the date of the clinic's certification as a CCBHC.

Question 13: The criteria state that standardized and validated screening tools must be used. When is a tool considered "standardized and validated"?

Answer 13: The CCBHC should be able to provide evidence that the tool being used is reliable and valid. This may be done through studies the CCBHC has undertaken or by referencing research that has been conducted to test the reliability and validity of the tool.

Program Requirement 5 – Quality and Other Reporting/Appendix A:

Question14: What are the components of the required Continuous Quality Improvement (CQI) Plan?

Answer 14: The components of the CQI plans should be defined and implemented based on the needs of the CCBHC's client population and reflect the scope, complexity and past performance of the CCBHC's services and operations. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes, and takes actions to demonstrate improvement in CCBHC performance. An individual or team of individuals within the CCBHC should be responsible for implementing and monitoring the Plan. The Plan requires that all improvement activities be evaluated annually to determine whether adjustments should be made to improve service delivery and consumer outcomes. Among other things the CQI must address consumer suicide deaths or attempts and 30 day hospital readmissions for psychiatric or substance use reasons.

Section 6: Organizational Authority, Governance and Accreditation

Question 15: Can a private, for-profit clinic or organization be a CCBHC?

Answer 15: No, but they may be a DCO working with a CCBHC.

Question 16: Can a for-profit clinic be a CCBHC if the local behavioral health authority or the IHS pays for services received there?

Answer 16: No, for-profit organizations are not permissible owners or operators of a CCBHC.

Question 17: Can a non-profit organization with multiple clinics be a CCBHC?

Answer 17: Yes, as long as all of its components satisfy the criteria for a CCBHC. The larger organization cannot be a CCBHC if all components do not satisfy the criteria.

Question 18: Can one clinic in a larger non-profit organization be a CCBHC and another part of the non-profit organization be a DCO for the CCBHC?

Answer 18: Yes, as long as the clinic meets the CCBHC criteria and the relationship between the clinic and the other component of the non-profit meets the DCO requirements in the criteria.

For example, if a large non-profit organization has only one clinic that is a CCBHC but the non-profit also operates a state-sanctioned, certified or licensed crisis behavioral health crisis system, the crisis system may be a DCO for the CCBHC as long as the requirements of that relationship are satisfied.

Question 19: Can a state-operated clinic be a CCBHC?

Answer 19: Yes, such a clinic is considered part of a local government behavioral health authority as long as a locality, county, region or state maintains authority to oversee mental health and substance abuse services at the local level.

Question 20: Can a clinic that is owned and operated by a local behavioral health authority be a CCBHC if it meets the criteria?

Answer 20: Yes.

Question 21: Can a tribal health organization, clinic or health center be a CCBHC?

Answer 21: Yes, as long as it meets the criteria and is operated under authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS under the Indian Self-Determination Act.

Question 22: Can a clinic that if funded by a grant from the Indian Health Service as an Urban Indian Health Center be a CCBHC?

Answer 22: Yes, if the clinic meets the criteria for certification.

Question 23: Can a clinic funded by a grant from the Indian Health Service as an Urban Indian Health Center be a DCO that works with a CCBHC?

Answer 23: Yes, as long as the requirements of a CCBHC-DCO relationship are satisfied.

Question 24: What is the role of the state regarding the governing board?

Answer 24: The state must develop processes to be used in certification for determining whether the criteria are being met. The state also must be able to explain, if the CCBHC is a tribal or governmental entity or part of a corporate entity that cannot meet any of the three options for certification, why that is true.

Question 25: When can the CCBHC rely on an advisory board to satisfy the governance requirements?

Answer 25: The CCBHC can use an advisory board to satisfy the governing board requirements of representation and meaningful participation and to provide input to the governing board if the CCBHC is a governmental or tribal entity, or a subsidiary or part of a larger corporate organization that cannot meet the requirements for board membership under any of the three options. It is possible that an advisory board also might be used to help satisfy one the two options that do not include 51 percent representation.