

Section 223 Demonstration Program for Certified Community Behavioral Health Clinics (CCBHCs)

Clarifications to Guidance – May 1 - 31, 2016

SAMHSA, CMS, and ASPE have provided the following responses to questions from states and clinics regarding the Section 223 Demonstration Program and CCHBC certification process. For more information on the program and to access helpful resources and guides, please visit SAMHSA's [Section 223 website](#).

Question 1: 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 behavioral health services, does that apply to clients living outside the catchment area?

Clarification: **See Criteria 2.e.1 and 2.e.2. CCBHCs have 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. CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence. The required protocols should address management of the individual's on-going 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 catchment 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: 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: **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 3: In regards to CCBHC service requirement 3.C.2, a CCBHC has to 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 is residential in nature.

Clarification: **Please see definitions at <http://www.samhsa.gov/section-223/care-coordination/substance-use-disorder-treatment-providers>**

Question 4: Must DCOs purchase an EHR or change their electronic system to be the same as the CCBHC's? Do they need a HIE?

Clarification: **The criteria require that the CCBHC have an EHR but there's no requirement that a DCO have one at the time of certification. However, the CCBHC has to 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 CCBHC and all DCOs using a health IT system. .."**

Question 5: 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: **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 6: This question is about crisis services, specifically about ambulatory and **medical detoxification** requirements. Level 1 is 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: **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 7: 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: **The Criteria at 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 8: Please clarify whether it is the intent to actually include all “Demonstration-covered services” previously billed as FQHC services in the CCBHC PPS and that the CCBHC/FQHC be paid the CCBHC PPS rate rather than the FQHC rate for these services, and confirm that if a state follows this guidance it would have no impact on an FQHC’s scope of services, UDS reporting, or HRSA grants.

Clarification: **CMS confirms that FQHCs dually certified as CCBHCs should bill the CCBHC PPS rate for services that are covered under the demonstration, even when they overlap the FQHC scope of services. The state should pay the FQHC PPS rate to the health center for the provision of non-demonstration services covered under the FQHC’s Medicaid scope of services. Please note the following:**

- **This method of billing for demonstration and FQHC services does not modify the scope of services recognized under the Medicaid FQHC scope of service.**
- **Clinics will continue to report all services in UDS that are part of their HRSA-approved scope of project; the delivery of services through the demonstration will have no effect on UDS reporting.**
- **HRSA confirms there will be no effect on grant awards made under section 330 of the Public Health Act as a result of participation in the CCBHC demonstration.**

Question 9: 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: **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 according to 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 A1c (HbA1c) 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.