Certified Community Behavioral Health Clinics (CCBHC) FAQ Sheet

Application and Selection Process

1. Are you requiring the agency to be accredited by one of the accrediting bodies in question 4 of the application [Joint Commission (TJC), Nat'l Committee for Quality Assurance (NCQA), Council on Accreditation (COA), or the Commission on Accreditation of Rehabilitation Facilities (CARF)]?

   SAMHSA requirements have not stated accreditation is required, however it is strongly suggested.

2. Our agency meets all of the criteria, credentialing, licensing that is needed to be the CCBHC but is For Profit. Will this exclude us from applying?

   Eligible applicants must be a nonprofit organization or part of a local government behavioral health authority, established prior to April 1, 2014, and meet the following requirements:

   i. **Currently licensed to provide comprehensive behavioral health and D&A services, with mechanisms in place to ensure the provision of physical health services as well.**
   ii. **The ability to serve all individuals, across the lifespan, regardless of circumstances.**
   iii. **Demonstrated ability to be able to meet all CCBHC certification criteria.**

3. Can a for-profit be a designated collaborating organization (DCO)?

   The CCBHC must be non-profit.

4. Will the CMS assessment tool be provided to providers? Where might we find the CMS Certification guide?

   The assessment tool can be found here.

5. The application indicates that staffing requirements and services will be based on the needs assessment. Has the needs assessment occurred?

   The assessment will be completed after the clinics are selected. The assessment will be used to determine the evidence-based practices that will be used for the clinic, the staffing needs, etc.

6. For the application due February 29th, is there a requirement to have a signed MOU with a DCO for this deadline? Is there a requirement to have a signed letter of support from a local MH/SA government entity for this application?

   For the application please include your intended partner, however a signed MOU is not necessary.

Yes, letters of support are an expectation of the application process. On February 22, 2016, OMHSAS sent out clarification asking the MH/ID Programs and SCAs to submit their letters of support directly to RA-PWCCBHC@pa.gov.

7. If an agency is unable to complete the application by the deadline, will they still be given an opportunity to participate in the learning collaborative?

   Yes, DHS wants to include other agencies in order to improve care across the state.

8. Since Pennsylvania crisis services are frequently delivered by the county or under direct contract with the county, can an organization which provides all of the other services, apply to be a CCBHC and contract with the county or the county's subcontractor to be a DCO for crisis services?

   At a minimum, the clinics have to provide substance use counseling, and under crisis services, must provide level 1 detox. Due to the specifics of Pennsylvania's system, DHS has submitted a question to SAMHSA regarding the use of state sanctioned crisis centers.

9. Do the core services have to be provided by the organization, or can they contract for those services with another agency? For instance, can a CCBHC contract for D&A services to be provided on site?

   DHS discuss with DDAP.

10. Is it possible for DHS to choose more than one CCBHC from the same county?

    Yes.

11. Can an existing FQHC be as the site of a CCBHC?

    Yes, as long as they meet all the requirements.

12. I have reviewed the final application and the eligibility criteria still states that applicants must be currently licensed as both a mental health and a drug and alcohol provider in order to apply. Should I assume that means the team decided not to consider an application from a mental health provider that is in the process of obtaining licensure to deliver outpatient drug and alcohol treatment and that The Guidance Center is not eligible to submit an application?

    No, your organization can still apply. Your application should address the lack of a DDAP license, steps you would take to obtain, and when you would anticipate having it.

13. Please clarify whether all licensed OP mental health and OP substance use treatment services MUST be required at the same location to participate as a CCBHC.

    Yes.

14. If all licensed services are to be provided at the same location, will the State support the agency to “satellite” licensed services from an existing licensed location to the proposed collocated CCBHC location, or would the provider have to obtain a new OMHSAS or DDAP license for the specific service?

    The CCBHC itself has to be licensed.

15. The required “*New Integrated CCBHC Certification Criteria Readiness Tool (I-CCRT)*” references the Non-Four-Walls Design Model. Please clarify how the non-four-walls design model correlates to any requirement that CCBHC services are to be provided at a single location.

    The 4 core services need to be provided by the CCBHC. A non-four wall model allows some of the services to be provided outside of the mortar.

16. Concerning the required OP substance use services to be provided by the CCBHC – will this include only outpatient (OP) level of care or will Intensive Outpatient (IOP) also be required to be provided by the CCBHC?

    The clinic is not required to provide the full continuum of care directly. It may be beneficial to have formal arrangements with IOP.

17. For any CCBHC services provided by a Designated Collaborating Organization (DCO), will the CCBHC be required to provide a compliance function for any contracted services?

    Yes, the CCBHC is accountable.

18. In the “CCBHC Certification Criteria Feasibility and Readiness Tool”, on page 8, Section C. Question 9 askes: “Do you have any related parties? Can you please clarify what “related parties” means?

    <u>Related Parties</u> - Any Affiliate that is related to the Primary Contractor or its BH-MCO by common ownership or control (see definition of "Affiliate") and:

    1. **Performs some of the Primary Contractor or its BH-MCO's management functions under contract or delegation; or**
    2. **Furnishes services to Members under a written agreement; or**
    3. **Leases real property or sells materials to the Primary Contractor or its BH-MCO at a cost of more than $2,500 during any year of a HealthChoices Behavioral Health Agreement with the Department.**
    4. **<u>Affiliate</u> - Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization (hereinafter "Person"), controlled by or under common control with a Private Sector BH-MCO, including a Private Sector BH-MCO subcontracting with a county, Joinder, or a Private Sector BH-MCO's parent(s), whether such common control be direct or indirect. Without limitation, all officers, or persons, holding five (5%) percent or more of the outstanding ownership interest of the Private Sector BH-MCO's or Private Sector BH-MCO's parent(s), directors and subsidiaries of the Private Sector BH-MCO, shall be presumed to be Affiliates for purposes of this Agreement. For purposes of this definition, "control" means the possession, directly or indirectly, of the power (whether or not exercised)**

to direct or cause the direction of the management or policies of a Person, whether through the ownership of voting securities, other ownership interest, or by contract or otherwise, including but not limited to the power to elect a majority of the directors of a corporation or trustees of a trust, as the case may be.

19. In the "*CCBHC Certification Criteria Feasibility and Readiness Tool"*, on page 10, Section E, Question 8: "Does your clinic have an inter-rate reliable standardized outcome assessment tool that is used for all Medicaid clients (MH and SUD as well as children, adolescent and adults) with the capacity to report outcome results?" – Please clarify whether a single "all-inclusive" tool is intended for all populations noted, or whether a tool is being used for each distinct clinical population.

    Please specify whether you currently use an assessment tool and the populations it is intended for.

20. Is there an agreed upon set of definitions for the 9 mandated services, with particular emphasis on the requisite 4 that must be provided by an organization in order to be considered for CCBHC approval, against which we can compare our service delivery system to ensure that CMS and the State would concur with our conclusion?

    Definitions will be discussed at the CCBHC Steering Committee meeting taking place on Monday, February 29, 2016.

21. Is it permissible and productive to submit the application even though we will not possess our outpatient license until next month, March 2016? We have historically provided IDD services. Five years ago, we began providing Psychiatric Rehabilitation services and this has now expanded into multiple counties. We have applied for our Drug and Alcohol license as we continue to expand our behavioral health offerings. We would like to submit the application to become a CCBHC as this is our intended model of integrated care as we develop more services. It was stated on the Mental Health Committee phone call with RCPA last week that agencies are encouraged to apply, even if they are not yet licensed for outpatient services. We want to confirm that this is accurate. In addition, would it be preferred that we apply with our psych rehab license information included?

    Yes, you can still apply.

22. What's the definition of a substance abuse specialist?

    DHS will use a broad definition to capture Recovery Specialists when staffing prior to the needs assessment.

Cost Report

23. Is there a section for Psychiatric Rehabilitative Services (PRS) on the cost report?

    PRS information can be added under "Other CCBHC staff costs" in the cost report.

24. Does the cost report include costs for all payors or just Medicaid?

    Costs, visit and charges associated with demonstration services provided to all clinic users, not just Medicaid beneficiaries, are to be included in the cost report.

25. Are the PPS-2 Rate and Monthly Visits tabs on the cost report required?

    No, they are not required.

26. Should the "anticipated costs" tab of the workbook reflect a future time period, presumably the time period of January 1, 2017 to December 31, 2017, which would be the first year as a CCBHC if selected by DHS? Does the same hold true for the "daily visits" tab and the "monthly visits" tab?

    "Anticipated costs" should reflect any changes to the current reported costs that will occur because of the demonstration. See Tab 6 to the Cost Report and Instructions. Because of the need to connect reported costs and anticipated costs, anticipated costs need to be in the same time period as reported costs (the base year). In other words, how the reported costs would have looked if the demonstration was occurring at the same time. Please note that the "monthly visits" tab will not need to be completed for purposes of establishing the PPS-1 rate.

27. We need clear guidance on how to determine cost for a CCBHC in one location vs services provided at satellite locations. Does the application require one cost report for the agency or separated by cost center?

    Please see Section 2 Instructions to the cost report – Provider Information Tab. Part 1 of the cost report includes information about single sites or, for clinics filing under consolidated cost reporting, about the central office. Only clinics filing under consolidated reporting need to fill out Part 2 – it is for site-specific information.

28. Can support services like Mobile Psychiatric Rehabilitation be included if they are licensed at another address but mobility can be provided at the CCBHC?

    You can include it in the cost report. Some pieces may be provided on site, but community-based service like MPR and peer and other kinds of services are certainly encouraged. In fact, one of the things they are looking for on the Federal level is for people to think outside of the box and expand their services as much as possible based on the needs assessment.

29. What is the purpose of the reallocation column?

    There are several examples in the cost report instructions. For example, if there is a staff psychiatrist, and part of his/her time is spent doing administrative duties, you would want to reallocate/reclassify some of those costs to admin.

30. Regarding the CCBHC Cost Report specific to the Provider Information Tab, Line 11: Does the site operate other than a CCBHC - the answer is yes because we are not a CCBHC yet correct?

    Yes.

31. Regarding the CCBHC Cost Report specific to the Provider Information Tab, Line 13: Should we respond to the hours operating as a CCBHC as the hours that we anticipate operating in this capacity since we are not yet a CCBHC or should we skip this section?

    The cost report instructions for Line 13 state that the applicant should "Enter the hours of operation and the total hours for each day of the week that the site operates as a CCBHC. Clinic hours, outside of the 24-hour mobile crisis team, should be reported to help evaluate access to care.

32. Regarding the CCBHC Cost Report specific to the Provider Information Tab, Line 14: I understand that we should not include the 24-hour crisis services we currently provide in the hours of operation, correct? Do you want just the hours we provide services at the physical clinic or are you also interested in the hours of operation of mobile services provided such as wrap around/BHRS, Family Based, peer support, blended case management etc.?

    Per the instructions, if the answer to Line 11 is Yes (operates as other than a CCBHC), enter the hours of operation and total hours for each day of the week that the site operates as other than a CCBHC. See also answer to previous question regarding crisis hours to be reported.

33. Are mobile mental health treatment services such as BHRS considered broadly as part of outpatient services by SAMHSA and should these services be included in the cost report?

    Yes, those services would be considered outpatient. Services which are not covered are inpatient and residential.

34. When calculating the primary care-does that include blood work costs? Specialists? What if inpatient is the required level of care?

    Section 11 of the cost report instructions outlines the types of practitioners to be included. If the CCBHC plans to cover additional costs, they should be entered on Line 17. Specialists are not required. Specialists are not covered.

35. Pa 1A trail balance tab line 20a states that mobile crisis can be contracted out-we thought it was one of the core services? Is crisis a core CCBHC service or not?

    DHS has reached out to SAMHSA regarding the interpretation based on the PA crisis services model.

36. I heard today that if an organization is selected that they will have another opportunity to do a cost report later in the process-that is not what RCPA has heard or been told.

    Please provide your best estimates in the cost report. After the needs assessment, there may be a need for you to amend the cost report for any

material changes.

37. What do we base our DCO cost on, for example per week per month per how many clients?

DCO costs should be calculated based on the same staffing, compensation and adjusted items as CCBHC costs and shown in the "Other" column. Section 11 of the cost report instructions regarding Part 1B – CCBHC Services Under Agreement provides additional information. Please note that there is no need to separately identify staffing and compensation for DCOs as the CCBHC will not be paying for those directly.

Rates

38. Will every facility use PPS-1?

Each CCBHC and approved satellite locations will receive the PPS-1 rate.

39. What does payment include?

The PPS-1 payment is intended to cover all direct and indirect allowable costs required to provide CCBHC services. The unique rate will be based on each CCBHC's allowable costs established in the base year.

40. Are optional services included in the rate?

If the applicant anticipates providing additional services beyond the set of required services, they should be included in the cost report.

41. How much will the Quality Incentive Payments be?

This is still under discussion.

42. Is there cost settlement/cost reconciliation at the end of the base period? What if the estimated costs are not correct? Is there a chance to change the rate?

The Department plans to require the BH Managed Care Organizations to pay the CCBHC the full PPS rate. There is no requirement to provide a supplemental payment above the PPS rate, although the state may elect to do so. The Department may provide a reconciliation payment, which is under discussion.

43. What if the funding put into the BH-MCO rates is not sufficient?

The HealthChoices Behavioral Health agreements with the Department are full risk. The HealthChoices contractors are responsible for making payments to providers according to the terms of their contracts.

44. Can you provide link to the section in the RFA from CMS on PPS rate setting, and also link to the National Council Website?

National Council - CCBHC

CMS on PPS Rate Setting

45. How will TPL work with different payment structures? For example, Medicare pays a Fee For Service rate.

    DHS is working to confirm, however believes that the visit code fee will offset other payments as you would in any other TPL situation, such as Medicare or any third party resource would pay.

46. Will each organization/site have its own individual rate?

    The PPS-1 rate established will depend upon whether a consolidated cost report including satellite sites is submitted, or a separate cost report for each site is submitted. See Section 2 of the Cost Report instructions for filing options.

47. Will providers be bound by the proposed rate to be submitted with the application packet or will there be the ability to negotiate the proposed PPS rate after the submission date?

    The cost report is the first step in determining what the final PPS rate will be. The cost report will be reviewed for accuracy and completeness before the rate is determined to be final. It is anticipated that there will be interaction between the applicant and the DHS prior to finalizing the PPS rate.

48. Will some services remain fee for service with managed care as well as some being PPS if all are not included in the CCBHC?

    Only the CCBHC qualifying services will be in the PPS right now. There will be other services that, for example, Medicare might cover that Medicaid does not.

49. The PPS will be set based upon cost report submitted. The increases will be then indexed annually. What will be done when an entirely new program is developed? Can it be incorporated into the CCBHC or is it to be added to the managed care fee for service?

    Once the clinics are selected, there will be an opportunity to update the cost report for material changes. However, while there may be some back and forth as the cost report is reviewed; you should be as specific as possible in your initial cost report.

50. Will the rate impact the decision on which providers are selected to participate?

    The applicants will be evaluated based on the CMS Criteria Guide.

51. Will the CCBHCs be able to provide mobile or off-site (or in-home) services (especially care management or peer support services) as an eligible service under the PPS?

    Yes.

Provision of Service

52. Will the provider be at risk?

    The provider will be at risk in the sense that they should be providing efficient care so that increases in their costs of care do not outpace inflation over time.

53. Will the CCBHC that records profits be required to return those funds?

    No.

54. What qualifies as a billable visit: face to face only?

    The visit must include at least one of the nine required services. Care management is not a billable visit. It can be provided as part of the visit but it is an indirect cost that is included in the rate, but is not billable on its own.

55. Is telehealth included in billable visits?

    Telehealth is strongly encouraged.

56. Do DCO visits on the same day as a clinic visit count as 1 visit or 2 visits?

    If a client receives a service at both the clinic and the DCO on the same day, only one visit can be billed.

57. If a program participant chooses to receive a service outside of the CCBHCs direct or indirect services, will that participant still be considered a CCBHC participant and will the clinic be obligated to pay the outside provider for that service under the PPS rate?

    No. In that circumstance, it would follow the usual practice.

58. What is the definition of an "inter-operable" EHR, from your perspective?

    Interoperability means that within your walls, you're able to communicate among clinicians as needed with regards to the care of an individual, but interoperability also means that you will be able to share that data with the outside.

59. It was determined that since Allegheny County has crisis services, CCBHCs don't need to provide this service directly. Does this mean that the central crisis service can provide the level-1 detox?

    At a minimum, the clinics have to provide substance use counseling, and under crisis services, must provide level 1 detox.

60. Can you offer more clarification in regards to licensed clinicians providing services, as MA currently accepts masters level clinicians providing services?

    An individual who is not licensed but is in pursuit of their license can be providing services. Currently within the outpatient psychiatric clinic license which is one of the base licenses for the CCBHCs to have, there is the ability to use masters-level

clinicians that may not be separately licensed within that clinic.

61. Can you touch on governance requirements? Is the 51% community board membership a requirement?

    The 51% is a preference that SAMHSA has indicated, however if a clinic does not have that 51%, they must demonstrate how they would obtain substantial and significant input from consumers and their families.

62. Will adult and child/adolescent services be required to be provided at the same location?

    Yes.

63. Please clarify the required services for members of the armed services and veterans. If an agency is location in close proximity to an existing VA Medical Center (within the same city) what services will the CCBHC be required to provide? Is this a requirement primarily for rural areas without close proximity to a VA medical center?

    DHS will talk to VA partners.