

February 18, 2015

Substance Abuse and Mental Health Services Administration  
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Submitted to: [Section223feedback@samhsa.hhs.gov](mailto:Section223feedback@samhsa.hhs.gov)

## **Re: Draft Certification Criteria for Certified Community Behavioral Health Clinics**

The National Council for Behavioral Health (National Council) welcomes the opportunity to provide comments on SAMHSA's draft criteria for Certified Community Behavioral Health Clinics (CCBHCs) to participate in the Section 223 demonstration program. This demonstration program provides an important opportunity to not only increase individuals' access to community mental health and substance use treatment services but to also set new higher standards for behavioral health providers. The National Council is a non-profit association representing 2,250 community-based mental health and addiction treatment providers. Along with our member organizations, we are dedicated to fostering clinical and operational innovation and promoting policies that ensure that all Americans have access to high quality health care services.

In addition to our written comments provided herein, please also refer to the attached red-lined version of the proposed certification criteria with our proposed edits.

## **Overarching Comments**

**The criteria are overly prescriptive, creating a disincentive for state participation.** While the National Council has long championed the creation of national standards for community behavioral health services, that must be balanced with the reality that CCBHCs are currently authorized only as a two-year demonstration program.

For example, if implemented as currently outlined, CCBHCs would have to *directly* provide a long list of service categories, including crisis (mobile crisis, emergency crisis intervention, and crisis stabilization), case management, mental health and substance use treatment, and peer specialists and recovery coaches. Many state behavioral health systems have purposefully created those as regional or standalone services. States that would have to upend their current system are unlikely to apply for the demonstration program.

We believe that SAMHSA has the statutory authority to be more flexible in its criteria, while still meeting the goal of raising the standard of care.

**The service requirements are laid out in absence of a discussion of the Prospective Payment System, or cognizant of limitations in State Medicaid Plans.** Payment by Medicaid for CCBHC services is limited to what is already allowable in a state's Medicaid program. Despite this limitation, the criteria include many services and activities which are not commonly covered in Medicaid programs (e.g., outreach and engagement).

In its future revisions to the criteria, SAMHSA should make clear which services are required for participation, and those services should align with typical state Medicaid coverage policies. Additionally, when it releases the Prospective Payment System guidance, the Centers for Medicare and Medicaid Services should notify states that they will have expedited review of State Plan and Waiver Amendments should they choose to adjust their Medicaid benefits.

**The criteria hews too closely to services required for partial hospitalization services, and does not leave room for a level of care for people with mild-to-moderate behavioral health conditions.** The National Council cautions SAMHSA from applying broad application of 42 CFR Part 485 due to its narrow application to partial hospitalization programs (PHP). Due to the acute nature of symptoms associated with the population served within PHP programs, access, (re)assessment, and staffing requirements may not be transferable across the full continuum of behavioral health services and supports. Section 4.g.1 includes a reference to "indicated community services"; we recommend that other certification requirements mirror this concept/language.

As part of our analysis of the draft criteria, we compared the proposed CCBHC criteria with existing federal guidelines for Federally Qualified Health Centers (FQHCs) which, similarly to CCBHCs, serve primarily low-income individuals in an ambulatory care setting with wide variation in clinical need. The requirements for CCBHCs were far more prescriptive and onerous than those applied to FQHCs, which we fear will only exacerbate the lack of parity between physical health and behavioral health systems and services. Our red-lined version of the proposed criteria indicates where there are particular discrepancies between FQHC requirements and the draft criteria for CCBHCs.

**Directly approving accreditation by a national body or allowing states to deem would address many of the quality issues raised by SAMHSA through its draft criteria.** Many of the statutory requirements for CCBHCs are already addressed through accreditation systems. Organizations that are nationally accredited already meet rigorous standards of business practices, such as credentialing and human resource functions, as well as clinical performance, including care

coordination. SAMHSA should either directly allow CCBHCs to be accredited by one of the nationally-recognized accrediting bodies (e.g., CARF, COA, Joint Commission), or allow states to deem CCBHCs that are accredited. SAMHSA and state agencies should not, especially during this demonstration period, create wholly independent certification criteria. Promulgation of new criteria is cumbersome and costly, whereas accrediting bodies have effective means to change standards based on field input and the evolution of best practices in the field.

We do not, however, anticipate that accreditation would entirely substitute for state certification; we simply recommend that accreditation be the “floor” and state certification activities overlay, and not duplicate, national accreditation standards.

### **Section 1. Staffing**

The proposed staffing requirements are far too onerous and prescriptive given (1) the wide spectrum of clinical needs to be addressed by CCBHCs, and (2) the reality of workforce shortages across the United States.

While we are supportive of highly qualified, high-performing, multidisciplinary teams, that does not mean that every patient should be assigned such a resource-intensive team of clinicians. Furthermore, the specific makeup of the interdisciplinary team should be based on a needs assessment of the clinic’s service population. Similarly, it is not the place of federal agencies to prescribe a specific training plan for individual clinics.

The personnel requirements do not reflect the reality of workforce shortages. According to the Health Resources and Services Administration (HRSA), there are currently 4,071 geographical areas in the United States that have a mental health care workforce shortage; 13 states are deemed in critical need. This includes Arizona, California, Florida, Illinois, Louisiana, Michigan, New York, Ohio, Oklahoma, Pennsylvania, Texas, Washington, and Wisconsin. 16 other states are not far behind for the highest need for mental health care professionals. A 2007 SAMHSA analysis of workforce issues noted that more than 50 percent of U.S. counties in rural areas lack practicing psychiatrists, psychologists, or social workers. HRSA estimates that about 2,800 psychiatrists, in particular, are needed to fill in the shortage areas.

We, of course, believe that CCBHCs should employ or have formal arrangements with many of the staff enumerated in draft criteria 1.b.2. But we also believe that the Act makes it clear that States should have the flexibility they need to establish certification standards regarding the exact mix of required staff that will meet their particular service delivery system needs. Many states do not require psychiatrists to be board certified; not every state has a licensure, certification, or registration process for every level of staff; and most states allow individuals working towards independent licensures to practice under supervision. For all of these reasons, we recommend that this criterion be revised to require that CCBHCs employ, or have

formal arrangements with, staff that are appropriately trained, licensed and certified to provide the services that are directly provided by the CCBHC.

In addition, we note, in particular, that many comprehensive community behavioral health providers successfully purchase psychological testing on an as needed basis from independent clinicians, and therefore that there is no need for them to employ an individual with the expertise to provide this service. We recommend that CCBHCs not be required to employ, or have a formal arrangement with, a mental health professional trained and credentialed to perform psychological testing.

## **Section 2. Availability and Accessibility of Services**

Large sections of the proposed standards for access and availability were directly copied from the Conditions of Participation for Partial Hospitalization Services, and there is nothing remotely as prescriptive for FQHCs. The proposed 30-day timeline for reassessments is neither reasonable nor, by and large, clinically appropriate for people who would be served in a CCBHC. Many consumers served by behavioral health clinics are in stable recovery to the extent that they do not require treatment or supports every month. A requirement for reassessment every 30 days would result in requested consumers coming for a visit merely to assess that they once again have not changed in just need to keep their next medication refill visit. Industry standards for reassessments more closely align to 90-days, but even this is not always necessary. We recommend deferring to clinical judgment and assuring “prompt accessibility”, rather than setting this in federal guidance.

## **Section 3. Care Coordination**

While care coordination is an essential component of delivery of high quality care, the expected reach and authority of CCBHC care coordinators is overestimated. Required FQHC case management services include counseling, referral, and follow-up services. Rather than listing ways in which CCBHCs must “ensure” that external parties share data and coordinate care, HHS – through CMS – should assure that outreach and care coordination activities are incentivized through the PPS methodology.

Additionally, the list of required “formal partnerships” is extensive and unrealistic in the timeframe of the demonstration program. We recommend that the criteria be revised to allow that if an agreement cannot be established (e.g., provider does not exist in their service area program or an agreement cannot be reached in the timeframe of the demonstration program), justification is provided to the certifying body and contingency plans are established with other providers that can offer similar services (e.g., primary care, preventive services, other medical care services).

The State of Missouri offers a lesson in the limitations around requiring MOUs, MOAs, and contracts. In establishing Missouri’s CMHC Healthcare Homes, the State initially required each CMHC Healthcare Home to have “formal contracts” with the acute hospitals serving their health home enrollees. The State working with the

Missouri Hospital Association even developed a template for a memorandum of understanding that CMHCs and hospitals could use as a starting point for developing their own specific agreements. However, they soon found that such requirements are both impractical and unnecessary. They are unnecessary because, while having a good working relationship with all of the service providers and community support organizations serving an individual is critical to providing good care coordination, having a good working relationship does not require a “formal arrangement”, as defined in the draft criteria, to be effective. It is impractical to require such agreements, both because of the great number of entities that a CCBHC would have to develop such agreements with, but also because there are many more organizations willing to develop good working relationships than are willing to enter into formal agreements. Pursuing formal agreements frequently actually delayed the establishment of a good working relationship since formal agreements were always referred to the organizations risk managers and General Counsel for legal review. Lawyers and risk managers prioritized limiting potential and hypothetical liability problems over prompt delivery of service this usually resulted in significant delays and not infrequently an ultimate lack of agreement around which of the two organizations would bear what degree of liability in any joint effort which prevented any formal agreements from being signed. Most CMHC Healthcare Homes were very successful in developing good working relationships with their local hospitals, and despite the support of the Missouri Hospital Association, only a very few hospitals were willing to enter into formal agreements.

It is revealing that although the draft criteria acknowledge that it may not be possible to establish such agreements, the only example given is the situation where no provider exists for the CCBHC to develop an agreement with. This reflects an unrealistic and oversimplified view of what is possible, and actually necessary, in order to provide good coordination of care across provider systems. Developing and maintaining good working care coordination relationships with a wide range of community organizations takes time, and is a continuing and evolving process.

Therefore, we recommend that these criteria be revised to encourage the development of “formal arrangements” where desirable and feasible, but to require that, as part of the certification process, States ensure that CCBHCs have letters of support from hospitals, FQHCs, Department of Veterans Affairs facilities and programs, and other inpatient and detoxification and residential facilities directly serving residents of the CCBHCs area, indicating their willingness to participate in the coordination of care. The criteria should also allow exceptions to this requirement when a CCBHC can demonstrate a good faith effort to obtain a letter of support and, of course, when no such organization exists that directly serves the CCBHC’s area.

Because they mandate “formal agreements” rather than allowing either “formal agreements or partnerships” draft criteria 3.d.3 and 4.b.2 also exceed the statutory requirements of Section 223 (a) (2)(C) of the Act. Draft criterion 4.b.2 requires that CCBHCs have formal arrangements with hospitals “that permit the CCBHC to

coordinate any care that may be provided at those locations”; and draft criterion 3.d.3 requires that the CCBHC “ensures that care and services provided by the CCBHC and its partnering providers are provided in accordance with the active treatment plan”. Both of these draft criteria establish unrealistic expectations. While they may agree to work together in the coordination of care for shared patients, no hospital will agree to allow an outside entity to “coordinate any care” provided by the hospital. Similarly, while they may agree to work together to coordinate care provided to shared clients, partnering providers will not readily agree to give the CCBHC the authority to ensure that the care and services they provide are in accordance with another organization’s treatment plan, except when they have a contract to provide a specific service or services on behalf of the CCBHC.

Therefore we recommend that draft criterion 4.b.2 be deleted, and that draft criterion 3.d.3 be revised to require that if a CCBHC contracts with another organization to provide a required service, the contracted provider agrees to provide the contracted services in accordance with the active treatment plan.

We believe the definition provided for the term “partnerships” in the draft criteria is appropriate. However, we believe that the requirement (draft criterion 3.c.3) that CCBHCs must have either a partnership or a formal arrangement with educational systems; employment service systems; child welfare agencies; juvenile and criminal justice agencies and facilities; Indian Health Service youth regional treatment centers; State licensed and nationally accredited child placing agencies; and other social and human services, is much too broad. As noted above, developing and maintaining collaborative relationships with a wide range of community organizations takes time, and is a continuing and evolving process. It is unrealistic to expect CCBHCs to have established such relationships with all of the organizations identified in this draft criterion prior to implementation of the demonstration program.

For reasons similar to those described above regarding formal arrangements, we recommend that this criterion be revised to encourage the development of “formal arrangements” where desirable and feasible with the identified community or regional services, supports and providers; but to require that, as part of the certification process, States ensure that CCBHCs have letters of support from a variety of such community organizations directly serving residents of the CCBHCs area, indicating their willingness to participate in the coordination of care. The criteria should also allow exceptions to this requirement when a CCBHC can demonstrate a good faith effort to obtain letters of support and, of course, when no such organization exists that directly service the CCBHC’s area.

#### **Section 4. Scope of Services**

Our greatest concern regarding the scope of services is the long list of service categories which must be provided *directly by* CCBHCs, including crisis (mobile

crisis, emergency crisis intervention, and crisis stabilization), case management, mental health and substance use treatment, and peer specialists and recovery coaches. Many state behavioral health systems have purposefully created those as regional, county-operated, or standalone services. For example, in Massachusetts, emergency crisis management services and targeted case management are both provided by their Department of Mental Health; in Minnesota, all targeted case management is delivered by the country; and in Michigan, peer services are provided by standalone peer-run agencies. States that would have to upend their current system are unlikely to apply for the demonstration program.

The clinical rationale for why some services should be provided directly by the CCBHC, versus through a formal partnership, is not clear. Why, for instance, must ACT services be delivered directly by the CCBHC, whereas psychiatric rehabilitation services are not? FQHCs do not carry any requirements that mandate certain services be delivered directly by the FQHC.

We recommend that SAMHSA allow CCBHCs to deliver its required services either directly or through a formal partnership, as is allowed in the authorizing legislation. SAMHSA has the statutory authority to be more flexible in its criteria, while still meeting the goal of raising the standard of care.

We recommend that the certified CCBHC be responsible for 60% of services, and that any services provided by partnering organizations be provided as if they were delivered by the CCBHC, i.e., the CCBHC certifies that the services provided by a partnering organization rises to the standards that the CCBHC would be held to. The threshold of 60% should be derived by direct service labor categories. This approach will allow for state flexibility to choose whether or not certain services should be considered “core” services for all CCBHCs in that state. Additionally, use of the labor categories instead of another marker such as encounters weights level of effort and incorporates activities like care coordination, rather than incentivizes face-to-face encounters.

Our second biggest concern regarding the scope of services is the extent to which components of evaluations are prescribed. These types of highly detailed evaluations are appropriate for a small subgroup of people seeking mental health and substance use treatments. Most people seeking help have very specific things that would like to have addressed. Delving into this broader array of possible issues can hurt the formation of an alliance with the person you are seeing.

In addition, many people require shorter durations of treatment. Doing lengthy evaluations on people who may or may not come back is a poor use of staff resources. Some people need only a few visits to get back on track with their lives.

Rather than a prescriptive one-size-fits-all approach, best use of federal authority would be to develop guidelines that facilitate the use of clinical judgment to evaluate

whether a person will need short or longer-term treatment, and encourage the use of more focused, value-added interventions.

Lastly, the criteria should do more to encourage tele health and the use of technology. One of the brief mentions of telehealth is, “some States do not include telehealth or limit telehealth within their State Medicaid Plans. Therefore, requiring use of telehealth for all States is not possible.” If the position of SAMHSA is that the criteria represent their idealized state, then telehealth should be figured more prominently. If the position of SAMHSA is that the criteria are a realistic presentation of what is possible in today’s system, then SAMHSA should not discredit telehealth while simultaneously promoting/requiring care coordination activities that are not included in State Medicaid Plans.

CMS and SAMHSA recently issued a joint informational bulletin (January 26, 2015) on [Coverage of Behavioral Health Services for Youth with Substance Use Disorders](#) that has a section dedicated to Technological Support Services and found that, “research demonstrates the feasibility of implementing technology-based recovery supports for youth with SUDs and that the use of technology to deliver elements of treatment and recovery may result in resource (e.g., money, time) savings.” We hope the final criteria incorporate such possibilities for CCBHCs.

SAMHSA’s position on PPS payment for respite and crisis residential services is inconsistent with the statute. PPS is not allowable for inpatient services. However, non-ambulatory care settings are allowed in many states. For example, many FQHCs see patients at home or in NFs. Crisis and respite care are exactly the services that should be covered, in lieu of residential treatment and acute care.

## **Section 5. Quality and Appendix A: CCBHC Quality Measures**

The quality measures included are too extensive, often lack specificity, and are exceptionally labor intensive. Rather than develop entirely new criteria that require chart and personnel record reviews, we propose the following approach:

The Uniform Data System (UDS) is a core set of information appropriate for reviewing the operation and performance of FQHC and RHC clinics. The UDS tracks a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. The UDS Reporting Package contains twelve UDS forms that are part of the current UDS reporting package.

UDS data are collected from health center programs which include Program Grantees and Look-Alikes as defined in Section 330 of the Public Health Service Act. All new health centers that receive Health Center grant awards before October 1 of the reporting year are required to submit UDS reports. Data are reported annually in the first quarter of the year. The UDS submission deadline is February 15 every year.

The FQHC/RHC UDS has a great deal of relevance for CCBHCs and we are recommending utilizing this framework, with a set of behavioral health related adjustments for the CCBHC Program. The key to the FQHC Clinical Measures tables is that HRSA has zeroed in on a relatively small number of high value measures and require every FQHC and RHC to report on them annually. This includes an analysis of 34 diagnoses, 11 quality of care measures, and 3 outcome measures.

Because of the historical challenges identifying and implementing high priority behavioral health clinical measures, we strongly recommend that the clinical measures tables be developed collaboratively with the states that have received planning grants (not pre-selected by SAMHSA). The clinical measures in the Draft Criteria Required Measures and Optional Measures sections are a starting point, as are the Health Home quality measures.

Many of the measures included in the draft criteria appear to be included for demonstration program evaluation purposes. We recommend that in future communications regarding the criteria that SAMHSA distinguish between measures it is collecting for evaluation purposes, versus outcomes for CCBHCs.

## **Section 6. Organizational Authority and Governance**

While we support a SAMHSA requirement for a family and consumer presence on the governing board of the CCBHCs we believe draft criterion 6.b.2, which requires 51% consumer representation on the CCBHC board, sets an unrealistic standard in the timeframe of the demonstration program. It seems to us to be an unrealistic expectation for an organization to radically change its governance process for participation in a two year demonstration program.

We, instead, recommend that this criterion be revised to require that the CCBHC governing board include as members adult consumers with serious mental illness who are receiving (or have received) behavioral health services, and family members of children with serious emotional disturbance who are receiving (or have received) behavioral health services, without specifying a percentage for participation.

To help meet the goal of family and consumer presence on the board, we recommend that family and consumer representation should be broadly defined to include, but not be limited to, family members of individuals with mental illness or substance use disorders, individuals who are currently receiving services, individuals who at some point received services but are no longer receiving services from the CCBHC, or individuals who received some kind of behavioral health service from an agency other than the CCBHC at some point in their lives. For the demonstration, the states should be allowed time to implement this change gradually as board governance is always a challenge to find willing and able servants. At the end of the demonstration, state-certified CCBHCs should

demonstrate significant family and consumer governance with an aspirational goal of up to 51%.

Thank you for the opportunity provide comments as SAMHSA and HHS moves forward with implementation of this exciting program, which will ultimately improve the quality and availability of services for people with behavioral health conditions. Should you have any questions about our comments, the attached red-lined version of the criteria, or other topics under consideration, please contact Charles Ingoglia at [chucki@thenationalcouncil.org](mailto:chucki@thenationalcouncil.org) or (202) 684-7457.

Sincerely,



Linda Rosenberg, MSW  
President and CEO

*Encl:* Draft certification criteria, red-lined version, National Council for Behavioral Health