*The National Council for Mental Wellbeing is providing this document as a resource to our members wishing to submit comments to SAMHSA on its draft revisions to the CCBHC certification criteria. Text from this document may be copied into organizations’ formal comment letters if desired. Users are welcome to customize the text, adjust it to reflect their own experiences, or share their own concerns or examples where relevant.*

**General Positive Comments**

We appreciate the revisions that advance and support the delivery of substance use services, including services related to opioid overdose. We believe these changes will bolster the availability of substance use care and recovery supports, improve access to medication-assisted treatment and ensure access to timely and appropriate services for individuals experiencing an overdose or substance-related crisis. We believe the revisions and clarifications to criteria pertaining to CCBHCs’ partnerships throughout the health care system will also support collaboration between CCBHCs and specialty substance use organizations, allowing CCBHCs and their clients to benefit from the expertise and services delivered by these organizations. Taken all together, these changes should advance the integration of mental health and substance use care and will improve individuals’ access to a wider range of treatment and support.

We support the inclusion of new elements related to ensuring health equity and addressing health disparities. The added focus on social determinants of health, the directive for CCBHCs to address the needs of populations experiencing health disparities, and the clarifications regarding CCBHCs’ responsibility to proactively reach out to under- and un-served communities, will help improve access to services for historically marginalized populations. These changes to the criteria also reinforce that CCBHCs’ allowable activities expressly include non-billable services aimed at engaging individuals in care and improving health equity—thus setting the stage to ensure these activities will be supported through the CCBHC Prospective Payment System (PPS) rate.

## **Program Requirement 1**

**Section 1.B:**

* 1.b.2: This criterion briefly mentions having staff with expertise in child/youth services, but the context of appearing in a sentence about trauma and recovery makes it unclear as to the extent of child/youth expertise required. We recommend adding clarity to this staffing requirement with a statement such as “The CCBHC must have staff, either employed or under contract, who are credentialed child/youth specialists.”

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

**Section 2.A:**

* 2.a.4: This criterion directs CCBHCs to provide transportation services or vouchers “to the extent possible within the state Medicaid program or other funding or programs.” We recommend strengthening this criterion to require transportation as a mandatory CCBHC service for clients who are unable to utilize regular NEMT services, and to work with CMS to ensure that the associated costs (to the degree they are not already covered by Medicaid or other programs) are allowable within the cost report/PPS.
* 2.a.5: We recommend expanding the list of allowable technologies by making the following revision (noted in blue): “The CCBHC utilizes technologies such as telehealth/telemedicine, video conferencing, digital therapeutics, remote patient monitoring, asynchronous interventions, and other technologies to the extent possible within the state Medicaid program…”
* 2.a.6: We support these revisions and appreciate the focus here—and throughout the revised criteria—on CCBHCs’ role in proactively reaching out to engage with underserved and unserved populations.

**Section 2.B:**

* 2.b.1:
  + We recommend modifying the comprehensive evaluation requirement in 2.b.1 as follows (changes noted in blue): “The preliminary triage and risk assessment will be followed by an initial evaluation as described in program requirement 4.d.3. Recent information incorporated into the CCBHC medical records from outside providers does not have to be reevaluated during this evaluation. The conclusion of the initial evaluation will indicate if further comprehensive evaluation is necessary to address the person’s current clinical situation and needs. Further evaluation is only required if that is the conclusion of the initial evaluation or if there are state standards stipulating further elements that must be evaluated.”
  + If SAMHSA does not accept the above recommendation, we request two alternate modifications to 2.b.1:
    - Indicating that a comprehensive evaluation is only required if the initial evaluation indicates a need for treatment at the CCBHC extending beyond 60 days.
    - Waiving the comprehensive evaluation for individuals who are only receiving medication services.
  + To reduce the paperwork burden on clinicians and clients, we also recommend allowing CCBHCs to accept a comprehensive evaluation conducted by another provider by adding the following text: “If a client is entering services as a result of a referral and has received a comprehensive evaluation from another provider within the last 60 days, unless precluded by more stringent state standards, the results of that evaluation may be used to satisfy this requirement, and the CCBHC is not obligated to conduct an additional comprehensive evaluation.”
  + Additionally, we recommend allowing flexibility for CCBHCs when states mandate different screening or evaluation processes for special populations such as youth, by adding the following sentence: “If the state has established independent screening and assessment processes for certain child and youth populations, the CCBHC has partnerships in place to engage with those processes and not duplicate existing processes.”
* 2.b.2: We recommend differentiating between the comprehensive evaluation and treatment plan, and suggest modifying this criterion to read: “The treatment plan is updated by the treatment team, in agreement with and endorsed by the client, when changes in the client’s status, responses to treatment, or goal achievement have occurred, unless the state, federal, or applicable accreditation standards are more stringent. The comprehensive evaluation does not need to be updated or repeated unless changes in the client’s status warrant revisiting any areas of the evaluation or unless mandated by more stringent state standards.”
* 2.b.3:
  + CCBHCs’ performance on the access standard for routine care is negatively affected when clients are offered – but decline – an appointment within the 10-day window. We encourage SAMHSA to consider the feasibility of modifying this standard (and the associated quality metric) such that CCBHCs are held accountable for “offering” rather than “providing” an appointment within 10 days.
  + We also recommend the addition of language indicating that same-day or open access is encouraged as a best practice.

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

**General comments:** CCBHCs will have to make a number of upgrades to existing EHRs and other technology tools—or adopt new tools—to meet the requirements in this section. It is our assumption that all applicable technology costs (and staff time associated with implementing and maintaining these systems) will be allowable in the cost report/PPS. Understanding that it may not be possible to address payment issues in the certification criteria, we respectfully request a clarifying note and/or supplemental guidance indicating that technology costs associated with compliance (including, but not limited to, patient portals, ADT tracking systems, information sharing with care coordination and DCO partners, and so on) are considered allowable expenditures within the program and must be incorporated into the cost report/PPS rate.

**Section 3.A:**

* 3.a.4: As worded, this criterion appears to indicate that a crisis plan must be developed for every CCBHC client. In reality, not every client (particularly those with mild to moderate conditions) may need a crisis plan. We recommend that this requirement be reworded to indicate that a crisis plan must be developed “if clinically indicated for a client based on severity of illness, previous history, or other relevant needs identified in the screening/evaluation process.”
* 3.a.5: We recommend revising this section to indicate that CCBHCs should check their state’s Prescription Drug Monitoring Program (PDMP), by adding the following text noted in blue: “Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers for CCBHC clients, including by consulting their state’s PDMP.”

**Section 3.B:**

* 3.b.4: We recommend adding the following language: “To support integrated evaluation planning, treatment and care coordination, the CCBHC will work with DCOs to ensure that that all clinically relevant treatment records generated by the DCO for CCBHC clients are incorporated into the CCBHC medical record and all clinically relevant treatment records maintained by the CCBHC are available to the DCO. Any staff time and EMR modifications required to facilitate exchange of records between a CCBHC and a DCO shall be an allowable cost on the CCBHC cost report.”

**Section 3.C:**

* We appreciate SAMHSA’s recognition of the challenges CCBHCs have encountered when attempting to execute formal written agreements with care coordination partners. We strongly support SAMHSA’s proposed modification of this requirement to allow CCBHCs other options for demonstrating that care coordination relationships and activities are in place.
* 3.c.2 and 3.c.5: These sections note that CCBHCs are responsible for tracking when clients are admitted to and discharged from certain facilities. The language implies that it is solely the CCBHC’s responsibility to engage in this tracking. While hospitals do have an obligation to make admission, discharge and transfer (ADT) records available to community providers upon request, other provider types listed here are not necessarily subject to the same obligation.
  + We recommend revising these sections to indicate that SAMHSA acknowledges both partners have a shared part to play in establishing such a notification system, and that CCBHCs may request accommodations or submit justifications when challenges on the part of the partner delay or prevent establishment of the notification system.
  + There is not a requirement that these notifications happen in real time, and there may be technical limitations that pose a challenge to real-time notifications. The 24-hour clock should start ticking after the CCBHC has been notified of a discharge. We recommend the following change, noted in blue: “The CCBHC will make and document reasonable attempts to contact all CCBHC clients who are discharged from these settings within 24 hours of being notified of the discharge.”

## **Program Requirement 4: Scope of Services**

**Section 4.A:** We appreciate the intent articulated in 4.a.1 that CCBHCs will deliver the “majority” of required services as well as the additional clarity in the Terms and Definitions section on how the collaboration between CCBHCs and DCOs goes beyond a referral or care coordination relationship. In general, we believe these changes will help break down silos between systems by facilitating partnerships and outlining expectations for integration of care across providers.

**Section 4.C:**

* 4.c.1:
  + Re: ability of DCOs to meet CCBHC requirements: When a state-sanctioned crisis network is in place that operates under different parameters and with different oversight—or when a state uses different designations, terms or standards for its licensed/certified crisis providers—it may be impossible for the CCBHC to mandate that that network comply with the CCBHC requirements as a DCO. At the same time, it may not be feasible or desirable for the CCBHC to launch its own crisis services in order to meet the SAMHSA requirements, when an existing network is already in place. We recommend that SAMHSA include language that would allow flexibility for CCBHCs to align or work with existing systems even when those systems may not exactly match the CCBHC requirements.
  + Re: emergency crisis intervention: We recommend adding the following sentence: “The CCBHC or its DCO crisis care provider should offer developmentally appropriate assessment, sensitive de-escalation supports, and connections to ongoing care, when needed.”
  + Re: mobile crisis services: When the CCBHC’s service area is large enough, travel times for mobile crisis response may exceed 2 hours. We recommend clarifying this language as follows: “but the ability to provide an in-person response as quickly as travel distances allow must be available when it is necessary to assure safety. CCBHCs may consider implementing partnerships or protocols with local first responder entities, supported by the CCBHC via a telehealth platform, to speed the in-person response when necessary.”
  + Re: crisis stabilization:
    - Implementing the urgent care/walk-in requirements may be a very heavy lift for CCBHCs that do not already have facilities and staff equipped to provide this service. To support CCBHCs in meeting this requirement:
      * We appreciate the statement that while 24/7 accessibility of urgent care/walk-in services is “ideal,” it is encouraged rather than required of all CCBHCs. We encourage SAMHSA to retain this approach in the final criteria.
      * We note that establishing urgent care/walk-in capacity may require clinics to renovate or upgrade their facilities in order to create a clinically appropriate environment for individuals with highly acute needs while segregating them from the general population of clients accessing routine care. Facility features like a separate door and waiting area, a home-like environment, safe furnishings, observation spaces for staff, and heightened safety protocols are critical features of an urgent care/walk-in program. We fear that CMS may not permit the upfront costs of these facility upgrades to be included in the CCBHC cost report, essentially making this service an unfunded mandate for CCBHCs. We ask that SAMHSA work with CMS to ensure all costs associated with this required activity are allowable in the cost report/PPS. In the event a determination is made that such expenditures are absolutely not allowable, we urge SAMHSA to reconsider the inclusion of this requirement in the criteria, allow exemptions for CCBHCs that are unable to meet it, or establish additional flexibility around this requirement that would enable clinics to come into compliance.
  + CCBHCs may be delivering additional crisis services aligned with but not strictly required by the criteria (e.g., operating a 988 call center, embedding staff with 911 call centers, etc.). We encourage SAMHSA to add a note for demonstration states (or work with CMS to issue payment guidance) clarifying that states may accept or require additional CCBHC crisis services and that the costs of these additional services may be included in the cost report/PPS.

**Section 4.D:**

* 4.d.4: As noted in our comments on 2.b.1 above, we continue to urge additional flexibility around the comprehensive evaluation requirement. Our suggested revisions to the comprehensive evaluation requirement are noted under 2.b.1; if accepted, they may require additional updates to 4.d.4 to align language accordingly.
* 4.d.6: We recommend the addition of the following text: “For child, youth and young adult populations, CCBHCs utilize standardized and validated screening and risk assessment tools designed for these populations.”

**Section 4.F:**

* We support the revisions here that add clarity on the required ASAM levels of care. Use of ASAM criteria for assessment of level of care and needed treatment is a recognized best practice in the treatment of SUD. We appreciate the flexibility that has been provided for CCBHCs to work with DCOs to deliver any services they do not directly provide, and note the importance of developing DCO relationships aligned with the description in the Terms and Definitions to ensure that such services remain integrated even when provided by different organizations.
* 4.f.4: Include young adults in this criterion, as follows (changes marked in blue): “Supports for children, adolescents, and young adults…”

**Section 4.G:**

* 4.g.1-2:
  + Blood pressure and weight/BMI are absent from the list of required screenings, although CCBHCs near-universally screen for these: 97% of CCBHCs reported screening for blood pressure and 98% are screening for weight in the National Council’s [2022 CCBHC Impact Survey](https://www.thenationalcouncil.org/wp-content/uploads/2022/10/2022-CCBHC-Impact-Report.pdf). We recommend adding these items to the list of required primary care screenings in 4.g.1.
  + We suggest inserting language that clarifies screening must be completed when clinically indicated based on the client’s risks or health conditions identified in the initial or comprehensive evaluation, that screenings conducted by another provider (e.g., the client’s primary care provider) satisfy this requirement, and that the medical director shall be responsible for developing organizational screening protocols based on these considerations.

**Section 4.I:**

* 4.I.1:
  + We recommend adding medication education, self-management and psychoeducation to the list of required psychiatric rehabilitation services, as these are basic standard elements of psychiatric rehabilitation.
  + The list of required services appears to allow for a number of services and activities (particularly supported housing, employment, and education) that are not always fully reimbursable by Medicaid, depending on what types of interventions are in place. We request that SAMHSA work with CMS to ensure that costs associated with these activities will be allowable in the cost report/PPS. In the event a determination is made that such expenditures are absolutely not allowable, we urge SAMHSA to reconsider the inclusion of this requirement in the criteria or add a note that the requirement does not obligate CCBHCs to deliver specific services that are not allowable in the cost report.

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

**Section 5.A:**

* 5.a.1: We recommend revising 5.a.1 encouraging states to adopt a common CCBHC data platform/warehouse that draws on Medicaid claims data and allows states and clinics access to real-time information about their activities and performance.
* 5.a.3 Note (marked with a green dot): If the criteria do not express a clear expectation, we are concerned states will not have the ability to share claims-derived data with clinics on a frequent enough basis to allow clinics to utilize the information in their own performance monitoring, population health management, and CQI efforts. Therefore, we recommend deleting the phrase “may elect” and replacing it with “are expected to.”

**Section 5.B:**

* 5.b.2: While we fully support the intent behind articulating these required elements of the CQI plan, it is important to note that CCBHCs are not likely to have ready access to a data source or sources that would enable them to track the specified data for all clients. Data on client deaths by suicide, fatal and non-fatal overdoses, and all-cause mortality may be particularly challenging for CCBHCs to regularly access on a timeline that would enable them to use the data for CQI efforts. Moreover, to the degree that clinics are expected to collect data on the metrics indicated in this criterion, listing them only here in 5.b.2 (rather than as part of the required quality metrics) serves to mask the full extent of CCBHCs’ quality measurement obligations. It also creates confusion as to whether there is any state obligation to provide this data via claims reporting, in contrast to the clearly defined state and clinic roles outlined in the Quality Measures appendix. Finally, if CCBHCs are required to collect data to inform clinical quality improvement—but there is no reporting of such data—there is no way for clinics and states to demonstrate their impact on these measures. The National Council requests that SAMHSA either modify 5.b.2 to reflect that these data are encouraged (but not required) elements of the CQI plan, or include them in the Quality Measures appendix as proposed required measures for additional public comment.

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

**Section 6.B:**

* 6.b.1: For CCBHCs that choose to establish advisory boards to meet this requirement, the text makes the following statement which is neither practicable nor consistent with the concept of an advisory board (emphasis added): “The input from any alternate approach should be considered in a similar manner as input provided by members of the governing board of the CCBHC and representatives from the alternate approach must have formal voting power on the governing board.” The advice of an advisory board—particularly on fiduciary matters—does not and cannot have the same weight as a decision by a governing board, and an advisory board that has “formal voting power on the governing board” is no longer advisory. We recommend deleting this sentence.

**Section 6.C:**

* 6.c.2: We recommend adding the following sentence: “To the degree future CCBHC-specific accreditation products are developed that align with the full SAMHSA CCBHC certification criteria, states may opt to use CCBHC accreditation as “deemed” certification status. Accreditation products that are not CCBHC-specific may not be used for deemed status.”

## **Terms and Definitions**

**“Designated Collaborating Organization”**

* We thank SAMHSA for deleting the reference to “clinical responsibility” in the definition of a DCO and replacing it with a description of specific ways in which CCBHCs and DCOs are expected to work together, along with a statement that the CCBHC retains responsibility for ensuring the CCBHC clients receive all nine services “in a manner that meets the requirements of the certification criteria.” The removal of the term “clinical responsibility” eliminates a source of confusion that led many CCBHCs to fear legal, compliance and malpractice risks from the DCO partnership, and instead creates clarity on the nature of the DCO-CCBHC relationship that can more easily be translated into a formal contractual arrangement.

**Community Needs Assessment**

* In the first paragraph, we recommend the following addition to the description of the community needs assessment (changes noted in blue): “Therefore, the community needs assessment must be thorough and reflect the treatment needs of those who reside in the service area, including child, youth and young adult populations and their families.”
* In item #2, we recommend the following addition (noted in blue): “Information about the prevalence of mental health and substance use conditions and related needs among all populations to be served by the CCBHC—including children, youth, and young adults—in the service area, such as rates of suicide and overdose.
* In the list of partners that must be consulted in the development of the needs assessment, we recommend the following addition (noted in blue): “…people with lived experience of mental health and substance use conditions (including children, youth, young adults and their families) and organizations operated by people with lived experience of mental health and substance use conditions;…”