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Paolo del Vecchio, MSW
Director, Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
1 Cherry Choke Road
Rockville, MD 20857

RE: NASMHPD Comments on Criteria for State-Certified Behavioral Health Clinics under § 223 of the Protecting Access to Medicare Act of 2014 (Pub. L. 113-93)

Dear Mr. del Vecchio:

The National Association of State Mental Health Program Directors (NASMHPD) appreciates the opportunity to provide our comments identifying what guidelines should be established by SAMHSA for state standards for certifying community behavioral health clinics (CCBHCs) participating in the eight-state demonstration program authorized under § 223 of Pub. L. 113-93.

In this letter, NASMHPD—the member organization representing the state executives responsible for the $37 billion public mental health service delivery systems serving 7.2 million people annually in 50 states, 4 territories, and the District of Columbia—offers considerations on state standards for quality measures and other reporting, scope of services, staffing, accessibility and availability of services, care coordination, and organizational authority.

Quality Measurement and Other Reporting

NASMHPD agrees with commenters at the Listening Session that states should retain some flexibility in setting quality measures. The demonstration is a tremendous opportunity for SAMHSA to test a variety of approaches to providing comprehensive community behavioral health services, to learn which approaches prove most successful in fulfilling the objectives and realizing the promise of § 223. Although the enhanced match should help, states participating in the demonstration—in addition to meeting the many challenges of establishing a Prospective Payment System for current services—will like find themselves greatly challenged in enhancing their systems to add new services.

At the same time, we recognize that § 223 was enacted in part to establish some consistency from state to state in the approach taken to providing care through community behavioral health centers. All quality measures utilized by states in

assessing CCBHCs should be peer-reviewed, evidence-based, widely accepted and published in the behavioral health field, and sponsored by a professional measures-setting body. SAMHSA should create a small core set of consensus measures on which states can build, governing provider access and network adequacy, person-centered planning focused on recovery and self-determination, community-based service siting, integration of behavioral health and general medical care, cultural and linguistic competency, and care coordination. Measures should ensure appropriate trauma-informed care is provided across all age groups and all levels of illness, and that the care includes promotion of prevention and wellness. Measures should also ensure that institutional interventions for acute episodes or illnesses are followed by timely discharge into the community, and facilitated by transitional assistance and post-discharge continuous follow-up treatment and support, either by professional service providers or peer support specialists. In addition, the state should monitor effectiveness of care through measures of inpatient admission and readmission.

State flexibility can be afforded by what specific measures states choose to monitor these core concerns, and by allowing additional measures chosen by the state that meet the basic standards of being peer-reviewed, evidence-based, and widely accepted and published in the behavioral health field. Such additional measures could include, for example, the degree of adoption and use of health information technology and the appropriate and effective exchange by providers of patient health information, as appropriate under Federal and state law. It may also include measures of inclusion for specific types of providers or specialists deemed appropriate by the state.

However constructed, the measures used across all states should be similar and consistent enough to permit easy comparisons among the eight states participating in the demonstration project. Further, they should facilitate an evaluation of how the outcomes derived from a model more nationally uniform compare to the outcomes from the current more fragmented structure.

Scope of Services/Staffing

NASMHPD believes it is important that all services listed in § 223(a)(2)(D) be provided by each CCBHC, directly through providers employed by the center, through a network of contracted medical and behavioral health providers, or via partnerships and collaborations with allied community-based providers and service organizations. States should have the freedom and flexibility to allow CCBHC provider arrangements to be arranged through detailed memoranda of understanding or informal agreement, as opposed to mandating that executed contracts exist. SAMHSA should refrain from mandating the use of on-site providers or on-site services as is currently mandated under the federal Program of All-Inclusive Care for the Elderly (PACE) program; those restrictions have limited the positive impact and scalability of PACE.

And although peer support services are specifically mandated by statute, it is particularly important that access to peer support services be afforded on a 24/7 basis as needed to meet the immediate demand. We also agree with those witnesses who testified at the November 12 Listening Session that 24/7 suicide prevention services, and follow-up outpatient services for suicide interventions, should be a service available to all clients of the CCBHC. In addition, all behavioral health providers should be thoroughly trained in recovery principles. Finally, first episode and prodromal early intervention services should be reasonably available as optional services when requested by the client or the client's family or caregiver(s).

All CCBHCs should be encouraged to integrate behavioral health and general medical services and facilitate the exchange of patient data—electronic and otherwise—among mental health, substance

use treatment, and medical health providers serving the same client, to the maximum extent permitted by state and federal laws and regulations. Finally, we know that SAMHSA will ensure that states are mandated to ensure that all providers of services are culturally and linguistically competent in serving the various ethnic, racial, cultural, and disability populations residing within the state, using the same standards as are mandated for Medicaid managed care organizations operating within the state.

As to licensing and certification standards, NASMHPD would suggest that states should be able to maintain flexibility in this area, utilizing the existing licensing and certification standards applicable to providers of services in the CCBHC that are applicable in other venues, as well as existing standards for monitoring, reporting, and maintaining provider compliance with those standards.

Accessibility and Availability of Services

As we note above, SAMHSA should refrain from mandating the use of on-site providers or on-site services as is currently mandated under the federal Program of All-Inclusive Care for the Elderly (PACE) program. States should be asked, as part of the application to participate in the demonstration, to describe how they plan to assure service accessibility and availability; they will have already incorporated such measures into their certification standards for CCBHCs. Standards should not only incorporate travel times, but also recognize barriers presented by the state's unique geographic and demographic characteristics, and provider locations. Reasonable standards should be imposed for wait times for non-urgent care that align with wait times under the Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, but with no wait time for non-urgent care exceeding 30 days. A separate wait time standard should be set for emergent care that conditions waits on the severity of the specific emergency, and complies with the statutory language mandating that behavioral health crisis management services be made available and accessible 24/7 through means that include mobile crisis teams and crisis stabilization services.

As we also noted previously, it is especially important that peer support services be afforded and available on a 24/7 basis as needed to meet the immediate demand. The Secretary should give preference to proposals that provide the most complete scope of peer support services available. Where peer support is in short supply, CCBHCs should be prepared and qualified to provide the necessary training to boost their peer support workforce or obtain such training from an external provider of training.

Care Coordination

NASMHPD believes that the statutory language is generally specific enough to define care coordination needs. However, we would add a mandate that evidence-based institutional discharge transition procedures be adopted that include the use of teams constituting both pre-discharge institutional and post-discharge community-based providers. Post-discharge transition procedures should be mandated to include pre-discharge home, family, and community environmental scans and monthly follow-up with the client and, where client-authorized, with the client's family or caregivers.

All CCBHCs should be encouraged to integrate behavioral health and general medical services through the use of health home-like teams. In addition, as we mentioned previously, all CBHCS should be encouraged to facilitate the exchange of patient data—electronic and otherwise—among

mental health, substance use treatment, and medical health providers serving the same client to the maximum extent permitted by state and federal laws and regulations. Electronic health records (EHRs) containing the client's person-centered plan and input from all of the patient's CCBHC providers should be maintained at the CCBHC facility itself or through electronic means that make those EHRs readily available 24/7.

NASMHPD urges SAMHSA not to mandate or limit the types of care coordination or care coordination providers utilized in each state, preserving the state's flexibility to regulate care coordination within the parameters and confines defined by the state's past experiences with care coordination and the availability of care coordination entities. However, to the extent possible, the use of duplicative or repetitive care coordination systems should be discouraged.

Organizational Authority

NASMHPD urges SAMHSA to allow states to set their own criteria for which entities may participate in their demonstration operations as CCBHCs. We do urge that the Secretary give preference to states that require CCBHCs to meet the standards set by the Health Resources and Services administration (HRSA) for Federally Qualified Health Centers (FQHCs) and FQHC-lookalikes, including that participating CCBHCs be required to offer a sliding fee scale and have an ongoing quality assurance program. The one exception to this general rule should be that—given the abbreviated time for implementation—rather than mandate the FQHC requirement that governing body membership be 51 percent consumer members, SAMHSA should require applicant states only to describe in detail the extent to which CCBHCs will be expected to include consumers as participants within their governing bodies. We would also urge SAMHSA to mandate that FQHCs, FQHC-look-alikes, and tribal organizations recognized by HRSA and already present and operating within the state as state-certified be deemed to meet state criteria for participation in the § 223 program.

Finally, as mentioned previously, we would urge that CCBHCs operate within principles of recovery and self-determination, utilizing patient-centered plans.

Thank you for your attention to our comments. If you have additional questions regarding the issues raised in this correspondence, please feel free to contact NASMHPD's Director of Policy and Health Care Reform, Stuart Gordon, at stuart.gordon@nasmhpd.org or 703-682-7552.

Sincerely,

Robert W. Glover, Ph.D.
Executive Director
National Association of State Mental Health Program Directors