Frequently Asked Questions (FAQ) for Vermont Certified Community-Based integrated Health Centers (CCBHCs)

Helpful Resources:

SAMHSA FAQ: https://www.samhsa.gov/certified-community-behavioral-health-clinics/ccbhc-faqs

SAMHSA CCBHC Certification Criteria: https://www.samhsa.gov/certified-community-behavioral-health-clinics/ccbhc-certification-criteria

National Council Needs Assessment Toolkit: https://www.thenationalcouncil.org/resources/ccbhc-community-needs-assessment-toolkit/

SAMHSA CCBHC Quality Measures Technical Specs Manual: https://www.samhsa.gov/certified-community-behavioral-health-clinics/guidance-and-webinars/quality-measures-disclaimers

Vermont-specific FAQ:

1. **Q: What is the State's anticipated development process for the DA/Provider CCBHC manual?**

   A: The high-level development process for the CCBHC manual will be for Subgroups to give feedback and updates to Manatt for inclusion in the DA/Provider manual that will be complete mid-December. State leadership will be the final decision makers on language. At this time, it is anticipated that the CCBHC manual will be separate from the DA/Provider manual.

2. **Q: How can intersectionality and representation for underrepresented groups in Vermont be addressed within peer supports and other services?**

   A: Organizations should be intentional in their hiring practices and training strategies to ensure they can provide culturally responsive services to underrepresented groups in Vermont. For more information see (relevant criterion (4.b.2, 4.J, Criteria 1.C: Cultural Competence and Other Training, 3.b.3 and 4.f.1, and 4.f.2, Criteria 4.I: Psychiatric Rehabilitation Services, and 4.k.7) or links to the SAMHSA website).

   In addition, Kheya Ganguly, M.A. (she/her) **|** Director of Trauma Prevention and Resilience Development, DMH. Kheya is available to provide consultation.

3. **Q: Please provide more information about the state's intention related to the evidence-based practices issue that came up in the last public meeting. DMH stated that agencies would be accountable to demonstrate use of their list of EBPs but in what way?**

   A: This will be part of the application process for demonstration consideration as the use of EBPs is core to the CCBHC model. At the time of the readiness assessment, it is not expected that the agency will demonstrate full compliance with all practices. When the agency is selected and reviewed for compliance to standards, agencies will need to demonstrate the capacity to provide the required EBPs with fidelity. Any additional evidence-based practices identified in the community needs assessment will require the same.

4. **Q: More information about the EBPs would be very beneficial as agencies work to implement and plan for CCBHC.**

   A: Vermont EBPs are Person-Centered Treatment Planning, Cognitive Behavior Therapy (CBT), Attachment, Regulation and Competency (ARC), Dialectical Behavioral Therapy (DBT), Collaborative Assessment and Management of Suicidality (CAMS), Motivational Interviewing, Individual Placement and Support-Supported Employment (IPS – SE) - for youth & adults to gain/maintain employment & education, Medications for Opioid Use Disorder (MOUD), Medications for Alcohol Use Disorder (MAUD), Nicotine Replacement Therapy (NRT) and Other EBPs based on site's Community Needs Assessment. As part of the DMH audit on fidelity of EBP in preparation for certification; there will be a formal fidelity check and review of training records. This may include clinical supervision notes and/ or the use of standardized fidelity review processes.

5. **Q: Is there a process for incorporating new evidence-based models into the list of accepted EBPs? If so, what is it?**

   A: Yes, if the Community Needs Assessment indicates the community is requesting or the needs of people receiving services require additional treatment modalities, new evidence-based models may be proposed and will be reviewed by the state and potentially added to the list of accepted EBPs.

6. **Q: What are the implications of CCBHC implementation as the State simultaneously pursues other major initiatives such as payment reform via the AHEAD model and COI? What impact might this have on communities?**

   A: Conflict of Interest standards do not apply to any agencies certified as CCBHC (for the services that fall under the CCBHC model - mental health and substance use). See the FAQ list from SAMHSA: https://www.samhsa.gov/certified-community-behavioral-health-clinics/ccbhc-faqs

7. **Q: How do agency designation and preferred provider status fit in? And how will CCBHC impact/align with the designation process?**

   A: The goal of the state is to have the CCBHC certification process, agency designation, and preferred provider certification happen simultaneously, ideally as components of the same review process. While we will work diligently to align in the short term, it will take time to fully integrate these processes.

8. **Q: How will the provider agreement work with some agencies being CCBHC certified and others not?**

   A: CCBHCs may need to have a different provider agreement negotiation process than non-CCBHC agencies.

9. **Q: It is our understanding that the state is working toward a regional MOU between sites and the VA. Can you provide more information on that and how agencies will be integrated into the development of the MOU.**

   A: This is not a regional MOU with the VA. The MOU pertains only to Vermont CCBHCs and the VA. Any New England-related regional collaboration with the VA would involve the State of Vermont only at present, if any regional, cross-state activities were to occur.

10. **Q: Does DMH have a description or guidelines as to what constitutes mental health urgent care, as required by the CCBHC Criteria?**

    A: Regarding urgent care/walk ins for CCBHCs, the State is not requiring a CCBHC to have a formal Mental Health Urgent Care, but to offer walk in/"urgent care" services for those experiencing crises or who need urgent assistance. Given the ongoing work of agency Crisis/Emergency Services teams, they are meeting the CCBHC certification criteria for this item.

11. **Q: How does commercial insurance pay for CCBHC services?**

    A: Commercial insurers are still going to be paying fee-for-service for any services they cover and then the CCBHC would offer a sliding fee scale for services outside of that coverage.

12. **Q: Is the Elder Care program covered/paid for under CCBHC?**

    A: Eldercare continues to be a contract outside of CCBHCs. This means the services remain the same and is not paid under a CCBHC, however, as part of CCBHC's availability and accessibility of services, they ensure no one is denied services for lack of ability to pay and they must offer a sliding scale for payment. Now that Medicare has recognized additional clinical licenses, CCBHCs could treat and bill for Vermont's aging population.

13. **Q: Why and how did Vermont choose to use the PPS1 rate?**

    A: The comparison between Daily Rate (PPS 1 or 3) and Monthly Rate (PPS 2 or 4) showed several key differences:

    1. Calculation Complexity: PPS 1 (Daily Rate) involves simpler calculations compared to PPS 2 (Monthly Rate).

    2. Special Population Rates: PPS 1 uses a single rate for all populations and services, unlike the other PPS rates which use special rates for targeted populations or crisis services. Developing special rates adds complexity.

    3. Value-Based Payments: In PPS 1, value-based payments are optional for meeting quality measures, whereas in PPS 2, they are mandatory.

4. Outlier Payments: PPS 1 does not use outlier payments, while PPS 2 has a more complex system and requires outlier payments and a methodology for establishing the corridors.

PPS 1 is well regarded by the National Council and has a proven track record, while PPS 3 and 4 are newer. The simpler calculations of PPS 1 were supported by consultants from the provider network and the state. The State may revisit the rate decision as the model develops.

14: Q: Is the H0020 the code we should/will use for MAT treatment as outlined in Hub and Spoke Model and CCBHC document on the CMH website, or if there is another code that will be added?

A: The prescribing of MOUD is often similar to other office visits for evaluating and managing chronic conditions, such as visits for high blood pressure medications, SSRIs, or other treatments. Typically, these visits are billed using E&M codes, and the PCSS offers a helpful guidance document online for additional guidance.

In Vermont, the procedure code H0020 is designated specifically for MOUD services provided at the Hubs.

It’s important for providers to use codes that align with both state-specific guidelines and national coding practices to ensure compliance.