Netsmart

January 20, 2023

The Honorable Dr. Miriam E. Delphin-Rittmon
Assistant Secretary for Mental Health and Substance Use
SAMHSA – Office of the Assistant Secretary for Mental Health and Substance
5600 Fishers Lane
Rockville, MD 20857

RE: Certified Community Behavioral Health Clinic (CCBHC) CERTIFICATION CRITERIA

Dear Dr. Delphin-Rittmon,

Netsmart appreciates the opportunity to submit public comment on the provisions of the above-referenced Certified Community Behavioral Health Clinic (CCBHC) CERTIFICATION CRITERIA. As a leading supplier of clinical and management information systems in the behavioral health care realm, we believe our experience provides us with valuable insight in this area of regulation and are grateful for the ability to share that insight.

Our detailed comments align to recommendations summarized in the Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2021 to develop data systems that facilitate population health management and care coordination and to strengthen data to facilitate future monitoring and evaluation. Netsmart is highly supportive of the move to update the CCBHC program requirements. Netsmart believes this proposed draft is a step in the right direction.

Netsmart wishes to express its support and appreciation for the hard work and dedication of you and your staff behind the preparation and creation of this draft. Please do not hesitate to contact me at (631) 968-2185 if I can provide any additional information or clarification to our comments.

Sincerely,

Kevin Scalia
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Criteria 3.B.2 Care Coordination and Other Health Information Systems
Proposed Language: The CCBHC uses its existing or newly established health IT system to conduct activities such as population health management, quality improvement, reducing disparities, outreach, and for research, ensure appropriate protections are in place.
PUBLIC COMMENT: Netsmart noted the removal of the following line from the proposed draft**:** *"To the extent possible, the CCBHC will use the health IT system to report on data and quality measures as required by program requirement 5."* We ask this line to be reinserted as we feel it is extremely important to require tracking and the reporting of quality measures for CCBHC participants. Quality measures provide identifiable baselines from which to assess participation and progress of CCBHC participants. Without this standardization, it is nearly impossible to track and validate program success outside of surveys. (Please see additional comments in Section 5.) However, if there are standard metrics in place, national benchmarking and data driven analytics are achievable. To reduce the burden on CCBHCs, states and SAMHSA should support electronic submission of the required quality measures to minimize undue burden and unnecessary costs related to manual data entry. Netsmart supports the scope of activities listed in section 3.B.2. However, we ask that SAMHSA provide clarification regarding the specific metrics and mechanisms required to adequately demonstrate compliance with the referenced topical areas, specifically related to population health management. We agree that the electronic health record needs to be ONC certified, however some of the most successful CCHBCs in the country have gone beyond the use of just the EHR to manage a population and the associated social determinants of health (SDoH). These population health systems do not have an associated certification process and should not be lumped in more broadly with the EHR that does require certification. Population health management is not the same as provisioning of direct care that would take place in an EHR, and to be successful we believe there needs to be a separate platform that would complement the EHR functionality. A Population Health system calculates risk and manages a caseload for the care manager (analogous to air traffic control system references in the crisis community) and uses data such as Medicaid claims to look at high cost clients and for gaps in care. EHRs are typically not designed to do these functions, which are critical to integrating physical and behavioral health and to reducing hospital admissions. However, there is specific functionality that a population health platform must have for CCBHC program success, including 1) benchmarking across organizations and programs, 2) ability to drill down into the list of Clients needing an intervention, 3) ability to stratify risk both at the population level as well as for sub-populations such as those justice involved or with specific challenges that need more immediate actions, 4) automation to utilize real time information and present that to the clinical team versus simply pulling reports or retro reporting, 5) ability to tag the data inputs to monitor quality, validate program eligibility, etc.

Criteria 3.B.3 Care Coordination and Other Health Information Systems
Proposed Language: The CCBHC demonstrates use of a required core set of health IT capabilities certified under the ONC Health IT Certification Program that align with key clinical practice and care delivery requirement in these criteria, as follows: • Capture patient health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status, in a structured format consistent with widely adopted standards. • At a minimum, support care coordination by sending and receiving summary of care records. • Provide customers with timely electronic access to view, download, or transmit their health information. • Provide evidence-based clinical decision support using capabilities of certified health IT. • Conduct electronic prescribing using the capabilities of certified health IT. Note: CCBHCs are not required to have all these capabilities in place when certified or when submitting their attestation but should plan to adopt and use technology meeting these requirements over time, consistent with any applicable program timeframes. In addition, CCBHCs do not need to adopt a single system that provides all these certified capabilities but can adopt either a single system or a combination of tools that provide these capabilities. Finally, CCBHC providers who successfully participate in the Promoting Interoperability performance category of the Quality Payment Program will already have health IT systems that successfully meet all the core certified health IT capabilities.
PUBLIC COMMENT: We recommend that SAMHSA be more specific in the references to certified capabilities to prevent potential confusion around identification of acceptable certified products and criteria. We recommend that SAMHSA streamline the language to specify the Office of the National Coordinator (ONC) certification criteria rather than just “certified capabilities”. We note that each bullet point in the proposed language correlates directly with an ONC certification criteria and ask that the criteria be called out. We also urge SAMHSA to explicitly reference the required certification criteria by name in the body of the text, rather than via footnote. For example, • Capture patient health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status, in accordance with § 170.315 (a)(5) Demographics.

- At a minimum, support care coordination by sending and receiving summary of care records, in accordance with § 170.315 (b)(1) Transition of care.
- Provide Clients with timely electronic access to view, download, or transmit their health information, in accordance with § 170.315 (e)(1) View, download, and transmit to 3rd party.
- Provide evidence-based clinical decision support using capabilities of certified health IT, in accordance with § 170.315 (a)(9) Clinical decision support (CDS).
- Conduct electronic prescribing using the capabilities of certified health IT, in accordance with § 170.315(b)(3) Electronic prescribing.

We ask for clarification on the following bullet point: "Provide customers with timely electronic access to view, download, or transmit their health information.[11]"

The language in this bullet, mirrors the language in the 170.315(e)(1) View, Download & Transmit (VDT) to a third party ONC certification criteria. But footnote #11 references the ONC criteria related to APIs. We ask SAMHSA to clarify whether it is your intention to require CCBHC participants to meet the (g)(7)-(g)(10) requirements, and not the (e)(1) VDT requirements. Or is it SAMHSA's intent to require both the (g)(7) - (g)(10) API requirements, as well as the (e)(1) VDT requirement? We recommend requiring both criteria.

We reiterate our request to explicitly reference already existing ONC certification criteria and tying the criteria CCBHC participants are required to comply with that certification criteria to avoid further confusion by participants.

We urge SAMHSA to state that the most recent version of the ONC Certified Electronic Health Record Technology (CERHT) is required to meet CCBHC Criteria 3.B.3. The 2015 Edition Cures Update is now the most recent version and is required for programs like MIPS, which you mention in the note included in this section. To ensure there is no confusion pertaining to versioning we recommend SAMHSA include the following language: "CCBHC participants must use an Electronic Health Record (EHR) that meets the 2015 Edition Cures Update certification criteria, or the most recent version of the certification program." Finally, we feel an additional reference to the Certified Health IT Product List (CHPL) is further warranted to direct CCBHC participants to the correct resource to check vendor qualifications. ONC Certification is a milestone achievement for vendors and provides numerous benefits to healthcare organizations who utilize certified products. The requirement to utilize certified criteria under a certified product should be upheld in the new version of the CCBHC criteria.

Criteria 4.A. General Services Provisions
Proposed Language: 4.A.1 The CCBHC organization will deliver the majority of services under the CCBHC umbrella directly rather than through DCOs (i.e., a majority of total service volume delivered across the nine required services). Whether delivered directly or through a DCO agreement, the CCBHC is responsible for the provision of all care specified in PAMA. This includes, as more explicitly provided, and more clearly defined below in criteria 4.c through 4.k, crisis services; screening, assessment and diagnosis; person-centered and family-centered treatment planning; outpatient behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer and family supports; and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans. *Certifying states participating in the Section 223 CCBHC Demonstration, see CMS PPS guidance regarding payment. 4.A.2 The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, consistent with the client's freedom to choose providers within the CCBHC and its DCOs. This requirement does not preclude the use of referrals outside the CCBHC or DCO if a needed specialty service is unavailable through the CCBHC or DCO entities.
PUBLIC COMMENT: Netsmart applauds the inclusion of DCOs to aid in the provision of services. However, we ask SAMHSA to provide additional clarity regarding interpretation of the phrase "a majority of total service volume delivered across nine required services." Netsmart recommends the inclusion of language to ensure appropriate and robust electronic referral solutions are in place to facilitate Clients being connected to care that is outside of the scope of the nine core services but that has been identified as part of the assessing process of the provision of care of a CCBHC organization. This is important to ensuring that persons experiencing health disparities are connected with appropriate care services. Netsmart recommends the inclusion of language requiring that electronic transmission of referral data, including Client clinical data, be utilized to reduce friction on the Client and help prevent clinical errors in referrals to outside entities. We also recommend requiring that clinical and quality data be electronically transmitted from the DCO back to the CCBHC for national and state reporting purposes.

Criteria 5.A: Data Collection, Reporting, and Tracking
Proposed Language: 5.a.1 The CCBHC collects, reports, and tracks encounter, outcome, and quality data, including, but not limited to, data capturing: (1) client characteristics; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) client outcomes. Data collection and reporting requirements are elaborated on below and in Appendix B. Where feasible, information about clients and care delivery should be captured electronically, using widely available standards. Note: See section 3.b for additional technical guidance. 5.a.2 Reporting is annual, and data are required to be reported for all CCBHC clients. 5.a.3 The CCBHC must collect and report the required Clinic-Collected quality measures identified in Appendix B. Certifying states may require certified CCBHCs to collect and report optional Clinic Collected measures identified in Appendix B. States participating in the Demonstration must report State-Collected quality measures as required in Appendix B. Demonstration program states must advise SAMHSA and its CCBHCs which, if any, of the listed optional measures it will require (either State-Collected or Clinic-Collected). Whether the measures are state or clinic-collected, all must be reported to SAMHSA annually via a single submission from the state. Quality measure data are required to be reported for all CCBHC clients, or where data constraints exist (e.g., the measure is calculated from claims data by the state, for all Medicaid enrollees in the CCBHCs). It is expected that state-collected measure results will be shared with their Demonstration program CCBHCs in a timely fashion. For this reason, Demonstration program states may elect to calculate their state-collected measures more frequently to share with their Demonstration program CCBHCs, to facilitate quality improvement at the clinic level. Quality measures to be reported for the Demonstration program may relate to services CCBHC clients receive through DCOs. It is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship with DCOs. CCBHCs should ensure adequate consent as appropriate, and that releases of information are obtained for each affected client. 5.a.4 As specified above in 5.a.3 and in Appendix B, states participating in the Demonstration program are responsible for some aspects of data collecting and measure calculation (most typically measures using Medicaid claims and encounter data) and for reporting and for reporting all quality measures to SAMHSA, whether collected by clinics or the state itself. Demonstration program states also must provide CCHBC-level Medicaid claims or encounter data to the evaluators of this Demonstration program annually for evaluation purposes. These data also must be submitted to CMS through T-MSIS in order to support the state's claim for enhanced federal matching funds made available through the Demonstration program. At a minimum, client and service-level data should include a unique client identifier, unique clinic identifier, date of service,

CCBHC-covered service provided, units of service provided and diagnosis. CCBHC client claim or encounter data must be linkable to the client's pharmacy claims, laboratory claims, or utilization information, inpatient and outpatient claims, and any other claims or encounter data necessary to report the measures identified in Appendix B. In addition to data specified in this program requirement and in Appendix B that the Demonstration state is to provide, the state will provide other data, including Treatment Episode Data Set (TEDS) data and data from comparison settings, as may be required for the evaluation to HHS and the national evaluation contractor annually. To the extent CCBHCs participating in the Demonstration program are responsible for provision of data, the data will be provided to the state and as may be required elsewhere, to HHS and the evaluator. If requested, CCBHCs participating in the Demonstration program will participate in discussions with the national evaluation team.

5.a.5 CCBHCs participating in the Demonstration program annually submit a cost report with supporting data within six months after the end of each Demonstration year to the state. The Demonstration state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each Demonstration year to CMS. Note: In order for a clinic participating in the Demonstration Program to receive payment using the CCBHC PPS, it must be certified as a CCBHC.

PUBLIC COMMENT:

Netsmart recommends SAMHSA to require states and CCBHCs to submit a core set of quality measures across all states and CCBHCs. The absence of a core set of quality measures significantly impedes the ability to aggregate and provide accurate and reportable metrics across the nation. We believe the addition of this requirement is critical to improving the quality and sharing of best practices nationwide. We also recognize that each state may have their own unique measures for their population. These measures should be appended to the core measures and should not modify them. These fixed, core measures would be the CCBHC version of the UDS measures found in FQHCs. We recommend that states and clinics work with SAMHSA to define and implement a common data set, and we encourage states to adopt a common CCBHC data platform/warehouse that includes Medicaid claims data and allows states and clinics access to real-time information about their activities and performance

Our experience has shown that CCBHCs that have access to claims data have better outcomes in large part because the data can be used to identify gaps in care, and "rising risk" Clients. We recommend that SAMHSA require that states provide Medicaid claims data to the CCBHCs in an electronic format no less than once per month.

Criteria 5.B.1 Continuous Quality Improvement (CQI) Plan
Proposed Language: The CCBHC develops, implements, and maintains an effective, CCBHC-wide data-driven continuous quality improvement (CQI) plan for the services provided. The CCBHC establishes a critical review process to review CQI outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance. The CCBHC should consider use of quantitative and qualitative data in their CQI activities. In addition, the CQI plan includes an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and disaggregated data to track and improve outcomes for populations facing health disparities. The CCBHC is encouraged to incorporate measurement-based care into their service delivery and quality improvement efforts.
PUBLIC COMMENT: Netsmart recommends the utilization of population health management technology that provides care coordination, interoperability, analytics, outcomes, and risk stratification. Population health management coordinates care across multiple organizations providing treatment and services to the Client. The ability to share data and manage the Client journey is not the same as the provisioning of care that takes places in an EHR inside a single organization. In our experience, the most successful CCBHCs collaborate over this separate platform that complements EHR functionality but is more robust to include data such as Medicaid claims and other integrations not typically done in an EHR. Examples of these integrations include social services organizations, food banks, emergency department alerting systems, claims systems, housing providers, and justice settings. For full optimization, we recommend that population health management technology should incorporate data from all the different EHRs that are related to the Client, as well as from organizations that do not use an EHR, such as a housing provider or food bank. However there is specific functionality that a population health platform must have for CCBHC program success, including 1) benchmarking across organizations and programs, 2) ability to drill down into the list of Clients needing an intervention, 3) ability to stratify risk both at the population level as well as for sub-populations such as those justice involved or with specific challenges that need more immediate actions, 4) automation to utilize real time information and present that to the clinical team versus simply pulling reports or retro reporting, 5) ability to tag the data inputs to monitor quality, validate program eligibility, etc.

Appendix B: Behavioral Health Clinical Quality Measures
Proposed Language: The Behavioral Health Clinic (BHC) quality measures that CCBHCs will use are being updated in 2023. Below is a list*, divided into clinic-collected and state-collected measures, required and optional. At the point when these updated Certification Criteria are being released for public comment, at least one measure remains tentative. This list, therefore, is subject to change. For demonstration or other state-certified CCBHCs, it is a state decision as to whether to require reporting of measures designated as optional. For later cohorts of CCBHC-Es that are required to report quality measures, only the clinic-collected required measures are mandated. **List excluded.
PUBLIC COMMENT: Netsmart recommends that SAMHSA require states and CCBHCs to submit a core set of quality measures across all states and CCBHCs. The absence of a core set of quality measures significantly impedes the ability to aggregate and provide accurate and reportable metrics across the nation. We believe the addition of this requirement is critical to improving the quality and sharing of best practices nationwide. We believe this is critical to improve the quality and sharing of best practices across the nation. We also recognize that each state may have their own unique measures for their population. These measures should be appended to the core measures and should not modify them. These fixed, core measures would be the CCBHC version of the UDS measures found in FQHCs, or the Electronic Clinical Quality Measures (eCQMs) Medicaid Promoting Interoperability Program To reduce undue burdens on CCBHCs and states, Netsmart recommends that SAMHSA require CCBHC clinical quality measure specifications be revised at the frequency in which the Measure Steward updates the specification. All measure specifications and calculations must follow the definition established by the Measure Steward exactly and no deviations or modifications from the specification are permitted. Clarity should be provided as to the delivery timeline requirements for incorporating the proposed new measures (SDOH) and revised measures (I-SERV, DEP-REM-6) into CCBHC clinic and state reporting periods. Netsmart recommends reporting of new and revised measures should begin in FY2024, to allow CCBHCs and states appropriate time to incorporate the clinical documentation workflows in their health IT systems. Since the program specifications for measures have not been updated since 2016 there should also be guidance provided as to the versioning that will be supported or required. Example CMS 2v10 is the most recent specification for Preventive Care and Screening: Depression follow up plan. It should be clarified if this and other versions of measures are to follow a specific version of the measure, from the Measure Steward.