CBHC Programs Frequently Asked Questions (FAQ) Part I

March 14, 2022

EOHHS and MBHP are thrilled with the interest and enthusiasm that providers have shown in the CBHC model. We encourage providers to participate in this transformative service delivery option. We look forward to working with selected providers to ensure successful outcomes for those clients whom the CBHC serves. EOHHS and MBHP are committed to working with CBHCs to ensure that they are successful in implementing this major enhancement to the behavioral health (BH) delivery system.

We want to emphasize that the CBHC model will enhance, not replace or disrupt, the existing service delivery system. Providers that are not CBHCs will continue to have an important role in offering services to MassHealth Members. They will continue to provide and bill for services as they currently do. CBHCs will offer increased access to integrated behavioral health treatment; better, more convenient community-based alternatives to the emergency department for behavioral health crises; and advance health equity by ensuring capacity to meet the diverse needs of all individuals in the Commonwealth. However, MassHealth Members may continue to receive services from any MassHealth-contracted BH provider they choose. EOHHS is also strengthening and supporting community BH providers through the BH Urgent Care program and increased outpatient treatment program rates.

The goal of CBHCs is to ensure a seamless, predictable, consistent experience for individuals and families, enabling them to quickly and easily get connected to the treatment they need, in one location in their community, 24/7/365. The goal is to improve the experience of the help seeker by not asking an individual to know what service they need, rather to provide a broad and inclusive set of services at a predictable and consistent location. CBHCs are intended to serve as community/mobile treatment providers for all residents of the Commonwealth, regardless of their ability to pay or insurance coverage. The CBHC is the community location where needs can be assessed, crisis and urgent services provided, and ongoing care is available and/or referred elsewhere based on preference and need. Because the CBHC is intended to provide a full set of outpatient and 24/7 crisis services to individuals and families as part of a coordinated system, organizations that apply to become a CBHC site must have the capacity to offer the full array of CBHC, AMCI, YMCI, Adult CCS, and YCCS services, as outlined in the performance specifications and in the RFP. They may provide these services directly or subcontract with another agency to offer the required set of services.

The CBHC is a site-based model. Each CBHC must provide all core services at a single location, except for Adult CCS and YCCS, where co-location is preferred but not required. Organizations that choose to provide services via subcontracting arrangements must ensure that the core (not including Adult CCS and YCCS) services are also provided at each CBHC site. Co-location could include separate buildings on the same campus within close proximity (i.e., within a short walking distance, not requiring crossing traffic or other safety concerns, and presenting no barriers for those requiring ambulatory assistance).

Our goal is to ensure the community understands the breadth of services provided at the CBHC site. Marketing and community outreach will ensure over time that communities understand the 24/7/365 nature of this site for non-hospital-based crisis treatment, police and ambulance drop-off, and connection to ongoing comprehensive services, including telehealth.

This FAQ document includes questions that were both submitted to the CBHC@beaconhealthoptions.com mailbox and that were asked during the bidders' conference on February 18. Questions have been merged, edited, and condensed for clarity, and an FAQ Part II document with additional questions will be issued in the coming weeks. Questions not directly related to the procurement documents are not included in this FAQ.

Commonly used acronyms in this document:
CBHC = Community Behavioral Health Center
AMCI = Adult Mobile Crisis Intervention (formerly known as Emergency Services Program (ESP))
YMCI = Youth Mobile Crisis Intervention (formerly known as Mobile Crisis Intervention (MCI))
Adult CCS = Adult Community Crisis Stabilization
YCCS = Youth Community Crisis Stabilization

Quick links to sections within this document:

General/Intro

1. Following this procurement and awards, do you anticipate future opportunities for agencies to apply for CBHC contracts? Is the CBHC program a rolling procurement? If not, what is the anticipated contract or service term?
   The CBHC contract is for an initial five (5) year term. There may be opportunities for a future procurement. More information will be released when it is available.

2. Are you open to creative/innovative solutions if it solves the aims?
   Yes. MBHP and EOHHS are committed to working with providers before, during, and after the contracting process to ensure that the procurement's goals of increasing access to integrated treatment in a timely and equitable fashion are achieved. Our goal is to provide a site-based location that is predicable, consistent, and serves as a hub for crisis services, crisis stabilization, triage and urgent assessment, and for connection to and opportunity for ongoing care. The CBHC site will be required to develop and maintain relationships with services provided in the communities they cover and to refer Members to services as necessary, appropriate, and clinically indicated. Bidders may offer additional context or description on how these services will support specific communities. We are open to creative/innovative solutions that may meet the unique needs of the community.

3. Is the expectation that all comprehensive services are in place effective January 1, 2023, or will there be a ramp-up time because hiring won't occur until the contract is awarded, and it will take time to recruit, train, and lead to fill the expansion of services?
   All services are expected to be in place on January 1, 2023. With the announcement of the CBHC awards in Spring 2022, the awarded agencies will have minimum of six months to ramp up. During the readiness review period, MBHP will work with providers to address any issues or concerns that may impact the implementation date.

4. Can a provider be both a CBHC site and a BH Urgent Care provider?
   If the provider site is a CBHC, services received at that site will be reimbursed at the CBHC bundled rate. However, providers are encouraged to become BH Urgent Care providers at other provider sites which meet BH Urgent Care requirements. For example, 100 Main Street is a CBHC site and bills at the CBHC bundled rate; 500 South Street and 750 North Street are BH Urgent Care provider sites and bill at the BH Urgent Care enhanced rate. To determine if you have provider sites that meet the criteria to become a BH

Urgent Care site, click here. In addition, for recent payment changes to this policy, please see download (mass.gov).

Partnerships/Subcontracting

5. Partnerships and subcontractual relationships are allowed for some services. These bullets address common questions that were submitted.
   - Each CBHC must have a lead agency that is responsible for ensuring that providers are properly credentialed and licensed.
   - Core services must be provided by the lead agency and should not be subcontracted. However, proposals in which CBHC core services are subcontracted to a youth-serving agency will be considered if the lead agency is an adult agency, provided that the Member experience is seamless and remains anchored to a site-based model where a consumer understands where to go for their needs.
   - Organizations within a geographic area can join together to create an entity to become that area's CBHC, if it results in ongoing, predictable access to care 24/7/365 within the geographic community.
   - If an agency is not awarded a contract to serve as the lead agency of a CBHC site, the agency can serve as a subcontractor to other CBHCs. We encourage organizations to explore such arrangements.
   - If a CBHC subcontracts with other providers, the only components of CBHC services that may be offered at a separate location are Adult CCS and YCCS services. All other services must be provided at the CBHC site. This supports our goal of ensuring a seamless, predictable, consistent experience for an individual, either calling or presenting in-person to the CBHC, for BH services 24/7/365, at a single location.
   - When the organization serving as the lead agency in the CBHC subcontracts with another organization for any service component, the lead agency is responsible for reimbursing the subcontracted organization for services provided by the subcontractor. The subcontracting organization will bill directly for services that are not covered by the CBHC subcontract.
   - We understand that contracts and/or MOUs may not be finalized at the time of proposal submission. MBHP expects that bidders will begin discussions about subcontracting with other providers, as necessary, and speak to these potential partnerships in their RFP responses. We do not expect subcontracts to be completed by the time RFP responses are submitted. These arrangements must be finalized prior to go-live and will be a component of readiness review activities.

Role of Independent Providers

6. Will CBHCs replace existing services for outpatient behavioral health services, or will existing providers be able to continue to provide services under their existing contracts? Can they still provide the same OP services and bill at their current rate?
   The CBHC model will enhance, not replace or disrupt, the existing service delivery system. Providers that are not CBHCs will continue to have an important role in offering services to MassHealth Members. They will continue to provide and bill for services as they currently do. Members will continue to receive services from any MassHealth-contracted BH provider they choose.

7. How will this model ensure continuity of care for BIPOC populations who desire to seek care from BIPOC-owned BH clinics, if those clinics are adversely impacted by the CBHC structure?
   The goal of CBHCs is to enhance the current service delivery system, not replace it, and to advance health equity by increasing access to culturally sensitive care. Individuals identifying as BIPOC, as well as other individuals, may continue to seek care from their preferred providers.

CBHC

8. Is there any option to apply to become a CBHC, but not yet implement the mobile crisis and CCS services?
   No, a CBHC must offer all services outlined in the CBHC, AMCI, YMCI, and Adult CCS specs in the RFP and must either provide YCCS services or have a subcontract with an organization that offers those services.

9. May an organization without a licensed mental health clinic respond to this RFP with the intention of becoming licensed under 105 CMR 140.00?
   Yes. The organization must obtain its license by January 1, 2023.

Co-location questions

10. Where providers have existing facilities including lease commitments, will there be a glide path to co-location, provided transportation is addressed in the interim?
    If a bidder has a current lease in place that makes it difficult to immediately offer co-located services on January 1, 2023, the bidder should provide details in the proposal about the timeline for co-location and a description of interim transportation arrangements for clients who require services at the other site(s).

11. There are multiple mentions of all services, except Adult CCS and YCCS, being provided in one location or co-located. How does this work for licensed clinics with outpatient offices? Is the expectation one brick-and-mortar location?
    CBHCs are a site-based model. Organizations that become a CBHC must provide all services at a single location, except for Adult CCS and YCCS, for which co-location is preferred but not required. Co-location could include separate buildings on the same campus within close proximity (i.e., within a short walking distance, not requiring crossing traffic or other safety concerns, and presenting no barriers for those requiring ambulatory assistance). Organizations that choose to provide services via subcontracting arrangements must ensure that these services are provided at the CBHC site, except Adult CCS and YCCS.

12. Are we able to provide AMCI and adult CBHC services at one site and YMCI and youth CBHC services at another location vs. all of those at the same site?
    The CBHC model requires that all CBHC, AMCI, and YMCI services must be provided at the same site. However, proposals in which CBHC core services are subcontracted to a youth-serving agency will be considered if the lead agency is an adult agency, provided that the Member experience is seamless and remains anchored to a site-based model where a consumer understands where to go for their needs.

13. Is physical separation of adults and youth required for all CBHC services, beyond MCI and CCS?
    There must be separate waiting areas for youth and adults for all CBHC services. Separate clinical spaces are preferred, but not required, as long as the services for both youth and adults can be appropriately delivered in the same space. Separate entrances for adults and youth are not required for core CBHC services. The goal is to ensure a welcoming, developmentally, and clinically appropriate setting for children and youth.

Population being served

14. An organization can bid to serve an entire catchment area or part of a catchment area. If bidding for part of a catchment area, are bidders required to specify the cities and towns they propose covering?
    Entities may submit bids on any area, defined as suggested CBHC catchment area, more than a suggested catchment area, or part of a suggested catchment area. Each proposal must specify the specific area including cities and towns the bidder intends to cover. If bidding on more than one area or defining a proposed area that is not outlined in the RFP, the bidder must clearly specify the cities and towns they

intend to cover. If bidding on more than one area, the bidder should submit a separate proposal for each area it is proposing to cover.

15. Will you contract with more than one CBHC if they both propose serving the same entire catchment area?
    Our intention is to ensure every community in the Commonwealth is covered by a CBHC to provide mobile and site-based crisis and other services as described in the procurement. Bidders are encouraged to submit proposals for any area(s) that they would like to cover, and EOHHS and MBHP will review all options to determine the preferred coverage arrangement.

16. Will all MassHealth-covered clients be eligible to receive all CBHC services?
    All MassHealth clients, including those in MCOs, ACOs, and fee-for-service MassHealth Members, have the opportunity to be served by a CBHC; however, it is not required that they receive services from a CBHC.

17. Will all MCEs/payers be expected to contract with CBHCs and follow the same payment methodology described in the RFP?
    All MCEs are expected to cover these services beginning January 1, 2023, with the same methodology described in the RFP. MBHP will provide information about the rate methodology during the readiness review period.

18. Will CBHC programs be required to serve non-MassHealth covered individuals?
    CBHCs must have the capacity or ability to expand capacity to serve all residents of the Commonwealth, including commercially insured and uninsured individuals.

19. Currently the Commonwealth reimburses for crisis services for uninsured, Medicare, and DMH populations. Will this practice carry forward in the new system?
    CBHCs will serve as the crisis provider for all residents in the Commonwealth. The Commonwealth will continue to be the payer of last resort for crisis services for uninsured, Medicare-only, and DMH-only populations.

20. The System Principles require “no-reject” of individuals who need treatment, including returning patients. Could this be explained more and what is this Principle specifically meant to address?
    No-reject policy means that the agency must serve all eligible MassHealth Members and complete an evaluation based on current presentation, and not on a history of treatment compliance. The CBHC must ensure that MassHealth Members can access services through other agencies, when appropriate. No individual can be turned away from treatment if they present to a CBHC. If an individual requires specialty treatment, the CBHC must provide services, appropriate referrals, and complete any necessary care coordination activities to ensure seamless care.

21. Can you clarify the expectations around services to infants and very young children?
    CBHCs should be familiar and have partnerships with the full spectrum of resources to support the needs of infants and very young children to make appropriate referrals for the parents and guardians accessing needed services. They should document these partnerships within the required Outreach Plan.

Access-related issues

22. For hours of operations, would we need to provide regularly scheduled appointments during all of these hours, or could we designate some of the hours as urgent care only (for example weekend hours)?
    All services should be provided during all hours of operation. Our goal is to increase access, particularly for clients who typically are unable to participate in treatment during traditional business hours.

23. What is the anchor for the determination of client receipt of service within specified timeframes, meaning when does the "clock start ticking"?
    It starts as soon as the client contacts the CBHC, either by phone or in person.

24. Also, could you please confirm that each CBHC needs to be staffed 24/7?
    The CBHC must have clinic coverage 24/7 to respond to established Members with an urgent need or crisis situation. See page 7 of the CBHC specs for requirements during business hours and after hours.

25. What does "facilitating access" mean in the context of connecting to specialized services?
    Facilitating access must mean that the CBHC site has formal partnerships with providers of the specialized services identified on page 15 of the CBHC specs. The CBHC must provide referrals and care coordination to ensure seamless and collaborative service delivery.

26. Relative to the access standards on page 2 of the CBHC specifications, can 14-day follow-up be a group?
    Yes, the 14-day follow-up requirement can be fulfilled by group therapy.

Staffing

27. The following are responses related to questions about specific CBHC staffing requirements.
    - The CBHC medical director can be shared across an agency's service components. The clinical program director, assistant director, and nurse manager are resources dedicated solely to the CBHC. Each of these positions should be one FTE.
    - A child psychiatrist or general psychiatrist must serve as medical director. This role cannot be filled by any other clinician type.
    - Only LICSWs or other independently licensed clinicians can act as supervisors or managers.
    - Community health workers are not specifically included in the CBHC rate bundle, but may provide services such as care coordination, which are included.
    - CBHCs are required to hire certified peer specialists. However, during the readiness review process MBHP will work with each CBHC to understand and mitigate barriers to this requirement and will consider the hiring climate with the CHBC provider to determine if flexibility is needed.
    - While the CBHC specs currently require an RN to provide nursing, a licensed practical nurse (LPN) may provide nursing services, under the supervision of an RN. The CBHC performance specs will be adjusted to reflect this.

28. Is there a role for students seeking clinical master's degrees as interns in the CBHC?
    Yes, please review the MBHP credentialing criteria at APPENDIX A-i (masspartnership.com).

Service delivery

29. What is the difference between "intake and brief assessment" and "comprehensive diagnostic assessment"?
    Intake and brief assessment are required to be completed within 24 hours. A comprehensive assessment, which includes history of treatment episodes and efficacy of prior treatment, is completed in the initial clinical visit. Both are included in the bundled payment.

30. Please explain what this means: the Assessment "must include the Child and Adolescent Needs and Strength (CANS) Tool inclusive of the comprehensive clinical assessment"?
    MassHealth requires that children up to the age of 21 receive a CANS assessment as part of a comprehensive clinical assessment. YMCI and YCCS are exempt from this requirement.

31. Can an individual or family therapy service, such as Dialectical Behavior Therapy skills module or Acceptance & Commitment Therapy, be provided at a site within the organization other than the CBHC site, or does the CBHC site need to provide these services directly?
    The CBHC must provide all of the individual and family therapy services at its site. These services will be covered by the bundled payment.

32. Which core services must be available to be provided in homes and other community settings?
    There should be an option to provide all core services in the home and other community settings where Members are comfortable, to increase chances of their engaging in treatment. Crisis services must be provided in the community as appropriate.

33. Can outpatient appointments be via telehealth when appropriate? Is there a minimum on-site requirement?
    Yes, appointments may be provided via telehealth. There is not a minimum on-site requirement, but services should be clinically appropriate for specific client needs.

34. Will there be a "prior authorization process" for any CBHC services?
    There will be no prior authorization process for any CBHC service.

35. To facilitate development of formal communication agreements, would MBHP in partnership with relevant state agencies provide a directory with contact info for all entities in each of the communication categories that are listed on pages 15-16 of the CBHC specs?
    Bidders should be able to access information on relevant providers serving the areas that they are bidding to serve via state agency websites, advocacy agencies, and payer networks. If there are challenges or needs raised during the readiness review period, MBHP and relevant state agencies can provide support in connecting services.

36. Question 8.1 in Section D appears to contain a typo, as there is no list of providers in Section II. "8.1. Describe the formal communication agreements you have or will have with these providers listed in Section II." Should this read Section IV?
    Yes, this should refer to Section IV. We will make the appropriate changes.

37. Please expound on "ensuring there are no disincentives for providing the full array of services required under this model."
    CBHC sites should ensure that staff productivity requirements do not create barriers to providing the full array of services that CBHCs are required to offer. Additionally, CBHCs are encouraged to utilize salaried staff as opposed to a fee-for-service model to allow clients to receive the full array of services with minimal disruption.

38. If one of your partners has an OTP (methadone clinic), can administration of methadone be included as part of the bundled rate?
    Per page 15 of the CBHC performance specifications, services provided by OTPs are not part of the bundled rate and should be billed in the same way that they are currently billed.

39. Seeking further clarification on Question 9.3 in Section D which asks bidders to "provide an overview of the cultural and linguistic make up of your agency's staff including support staff and senior leadership." Are bidders expected to provide this overview organization-wide or limited to their CBHC staff?
    Please provide an overview of the organization-wide cultural and linguistic makeup. You may also provide a CBHC-specific breakout.

40. Many of our psychopharmacology clients are in maintenance specialty treatment, with appointments every three or six months. Would it be acceptable to time the vitals monitoring and review side effects with the person's clinically indicated appointment frequency? Are specific monitors required?
The requirement is currently being modified from "monthly" to "minimally every six months, and more frequently as clinically indicated." The CBHC must conduct screenings for health indicators based on Member presentation and refer Members to primary care and/or specialized providers for further assessment of treatment as clinically appropriate. There is no requirement for the use of specific monitors.

41. The procurement notes we can provide on-site lab work or order services through a formal partnership. If we choose to order work through another company, would we still need a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver?
Page 4 of the CBHC performance specifications indicate that the CBHC must offer on-site toxicology screenings. Therefore, a CLIA certificate of waiver is required.

42. How will the 24/7 Behavioral Health Help Line interface with all the CBHC components?
- The Behavioral Health Help Line will be a statewide centralized call center that will receive all crisis calls from all regions in the Commonwealth and triage each call to the appropriate CBHC for local crisis response.
- The 24/7 Behavioral Health Help Line is planned for go live on January 1, 2023.
- It will have the ability to connect to the CBHC network to provide warm hand-off/access to all services provided by the CBHC. Individuals may also contact the CBHC directly as well to reach afterhours assessment, triage, and crisis support as outlined in the procurement.

43. Can the CBHC transfer all after-hours calls to be answered by the AMCI and/or YMCI?
The CBHC may propose a model whereby after-hours calls are adequately staffed by the AMCI or the YMCI.

44. How does the Behavioral Health Community Partners (BHCP) program link to CBHC? Does a BHCP have to be a part of a CBHC in order to be considered for the next MassHealth 1115 Extension Waiver as a part of the BHCP Program?
No, the BHCP does not have be a part of the legal structure of a CBHC, but CBHCs and BHCPs must have defined relationships to serve Members who are receiving services from both entities. Per the CBHC performance specifications, the CBHC must assist Members and families of children and youth referred to external providers or resources in obtaining an appointment and confirm the appointment was completed. The CBHC will ensure timely access, bidirectional communication, and referral pathways through an MOU or affiliation agreement with BHCPs, Community Services Agencies (CSAs), and other care coordination entities.

45. When creating the client transition plan, is the CBHC or BHCP responsible for creating and disseminating the transition plan to stakeholders?
When an individual is working with a BHCP, the BHCP is expected to serve as the main point of contact and "first line" coordinator for the Member and the Member's family. The BHCP is responsible for creating the transition plan. The BHCP must communicate and collaborate with the CBHC on all care coordination services, including transition plans.

46. Does every client in a CBHC require a care coordinator, whether it be external or provided by the CBHC?
No, care coordination is based on need. Page 9 of the CBHC program specifications states, "For Members who do not have an existing BHCP, care coordination services, ICC, do not meet the requirements, or refuse to receive those supports, it will be the CBHC's responsibility to provide a robust set of care coordination services, as appropriate, to ensure Member needs are met." Care coordination services provided by CBHC staff are included in the bundled payment and do not have to be provided on the same day as other services.

47. Do CBHCs need to have a primary care physician round on-site, or can that be handled through a community partnership?
    It is not required that a PCP round at the CBHC site; those services can be offered through a community partnership.

48. Are all CBHC components expected to operate in the same EHR?
    While it would be beneficial that all components of the CBHC are on the same EHR, it is not required. Regardless of whether all components are on the same EHR, it is critical that information about the Member is shared to ensure coordinated care.

Training

49. Are there specific metrics we are expected to meet for the requirements listed in 10.1.1 "describe how your training will incorporate person- and family-centered, recovery-oriented, evidence-based, and trauma-informed care, as well as coordination with primary care?"
    Per the CBHC performance specifications, the CBHC will be responsible for oversight across all services provided by the CBHC system and all locations where these services are provided. These are inclusive of training. MBHP will support CBHC providers with training activities through the readiness review period. We anticipate a statewide training clearinghouse to support CBHCs in accessing the required training modules to meet CBHC performance specifications. More information will be available soon.

50. How will we be funding and providing all of these newly required staff trainings and certifications?
    It is anticipated that the training clearinghouse mentioned in Q.49 will support training, as well as the DSRIP funding opportunity described within the RFP which is available for training and adoption of evidenced-based practices. More information about the training clearinghouse will be available soon.

51. Do we need to show evidence of "certification" in all these practices, or simply demonstrate that staff have received training?
    The CBHC site must be able to demonstrate that all staff have received trainings that are required for their positions.

AMCI/YMCI

52. Is there preference for existing Emergency Services Programs (ESPs) and CCS providers? How important is current experience providing ESP in evaluating responses?
    There is not a preference for existing ESP and CCS providers. It is more important that the bidder demonstrate an understanding of how community and mobile crisis services should function, both philosophically and operationally, as well as their capability to effectively deliver these services as intended, through their response to the RFP.

Staffing

53. The following are responses related to questions about specific AMCI staffing requirements.
    - The clinical program director should be one FTE and will share responsibility with the medical director for the clinical and administrative oversight and quality of care across all AMCI services.
    - The AMCI medical director, who must be a board-certified or board-eligible psychiatrist, should be in-house and may be a shared position across programs within the CBHC or other parts of the agency.
    - A board-eligible or board-certified child psychiatrist may also work as an AMCI psychiatrist.

54. The following are responses related to questions about specific YMCI staffing requirements.
    - Like AMCI, the YMCI triage clinician must be a master's-level clinician. The YMCI performance specifications will be modified to reflect this.
    - Bachelor's-level clinicians and certified peer specialists are two separate roles, recognizing that there may be peers who have BA degrees and would like to work as a bachelor's-level clinician.

55. Is it acceptable to share qualified staff across AMCI, YMCI, Adult CCS, and YCCS?
    Qualified staff may work in different programs, if they are not scheduled for the same shift in more than one program. For example, a YMCI clinician scheduled for a 3-11 p.m. shift on Friday may not also be scheduled for an AMCI shift at the same time. However, they may be scheduled for an AMCI shift when they are not scheduled for a YMCI shift, in accordance with the agency's scheduling policies.

56. Services for children and youth will be provided by a specialized team for youth and families; does this mean we need staff who only see adults and staff who only see youth and families?
    The intention is to ensure there are appropriately trained staff to provide evidenced-based practice treatment specifically with the pediatric population.

57. Will all individual sites be required to have security staff? Are clerical/security staff allowed to be shared across all service lines? Is there an expectation for who is hired for security staff or is that up to CBHC discretion?
    Security staff are required for all components of the CBHC, except for Adult CCS and YCCS. Security staff, as well as clerical staff, can be shared across all service lines. The specifics of who should be hired as security staff is at the discretion of the CBHC. However, training and oversight of security staff and operations must be consistent with appropriate practices for a behavioral health setting.

58. Will there be any waivers or other flexibility allowed for positions that require independently licensed clinicians where there is difficulty staffing?
    Our goal is to ensure the CBHC system is able to meet the needs of the community, and we will work with the CBHC network providers on barriers or challenges as they arise. During the readiness review period, MBHP will review these requests on a case-by-case basis.

59. The RFP indicates that the AMCI and YMCI are to operate as unique entities. In areas where staffing is particularly challenging, will EOHHS and MBHP consider some shared positions, especially in the hard-to-recruit areas, of medical director, psychiatrist, APRN, and other high-level clinical positions and roles?
    Please submit a proposal for your recommended staffing model and rationale for any deviation from the specifications, and your proposal will be evaluated.

Service delivery

60. The YMCI specifications state that all calls are triaged through the CBHC and must be answered by a live person. AMCI specs do not have the same specification. Can you confirm if needed for AMCI as well?
    Yes, that is required for the AMCI as well; the performance specifications will be amended.

61. Can the YMCI renew for multiple seven-day follow-up periods, if needed, in order to stay engaged with the family until aftercare services are in place?
    If the YMCI is unable to facilitate access to the appropriate service, then the YMCI should contact the appropriate MCE for assistance and/or to discuss extending the follow-up period.

62. For AMCI and YMCI urgent psychopharmacology appointments, the RFP indicates that these can be provided through the CBHC urgent psychopharmacology service. If the urgent psychopharm appointment is scheduled through the CBHC component for an individual served by the AMCI/YMCI, would this service be billable through the CBHC component separately from the AMCI/YMCI evaluation?
Yes, any services provided through the CBHC separate from AMCI/YMCI should be billed through the CBHC bundled payment.

63. Since there was not an ESP RFP process separate from the CBHC RFP, how were the AMCI rates determined, given that the staffing model and expectations are expanded from the current model with no corresponding increase in rate?
The current adult ESP rate structure is based on encounter rates with no mechanism for follow-up billing. In the future, there will be a mechanism for providers to bill for follow-up services (next day and beyond) using 15-minute units. The same rate structure will apply to YMCI. In this way, the new rate structure creates mechanisms for providers to bill for follow-up services unlike the current rate structure. The initial encounter rate and 15-minute units for follow-up services account for updated AMCI requirements for staffing model and other expectations.

64. Please clarify the process for those providers who do not currently have contracted rates with MBHP or other MCEs.
Under the current system, MBHP and the other MCEs have standardized rates for mobile, ED, and evaluations performed at the AMCI and YMCI locations. For those providers who do not currently have contracted rates, MCEs will contract with them at the established MCE rates once they are CBHCs.

65. Is it expected that if an individual is not ready for an evaluation that they are to stay at the AMCI community site until they are determined to be ready?
Unless there is an apparent safety risk, the Member should be able to remain at the AMCI until an evaluation can be performed. However, there are ancillary functions that may be started such as gathering information from collaterals and reviewing prior records. If someone is assessed in an acute emergency, then appropriate transfer should be facilitated. Our intention is to ensure CBHC providers are successful in providing crisis and other services in the community. We are committed to ongoing work with CBHC providers if additional staffing or other barriers or challenges arise.

66. What is the specific timeline for ED/ESP redesign? The RFP says 2023 but will it co-occur with CBHC services?
The expected start date for ED/ESP redesign is early 2023.

67. What process does EOHHS envision for medical clearance for police or ambulance drop-off to CCS?
MBHP will work with EOHHS to convene key stakeholders and implement a system-wide strategy around the police department and ambulance transportation and drop-off expectations.

Adult CCS/YCCS

Number of beds/programs/age groups

68. How many beds should an Adult CCS and a YCCS plan for?
Adult CCS should have a minimum of six beds in each catchment area. YCCS beds are regional, and EOHHS anticipates nine beds for youth up to age 12, and 12 beds for youth 13-18 per region.

69. Are you expecting CBHCs to subcontract with regional YCCS providers and not establish a YCCS in each catchment area?
CBHCs may provide YCCS for one or both age groups, subcontract to another provider, or have an MOU with other CBHC/YCCS providers to access those beds. CBHCs offering services for both age groups must

ensure that they are separate and distinct programs. Our intention is to have YCCS services available as locally as possible across the Commonwealth.

70. Is there any flexibility in the total number of beds at an Adult CCS and YCCS?
    If proposing any variance in the number of beds, please include your intent and rationale when describing the proposed number of beds for each service. For YCCS, please keep in mind that there must be a 3:1 staffing ratio.
71. While there are upper age limits for YCCS, what is the expectation for the youngest age children who should be accepted into the YCCS, and how do CBHCs address mixing younger children and older adolescents?
    The youngest-aged children who should be admitted are commensurate with the program's licensed age; at times there may be youth as young as 3 or 4. Younger children and adolescents will be separated because there will be unique YCCS programs for youth up to age 12, and youth 13 to 18.

72. Is there an opportunity to have flexibility with the age range? If a provider chooses to have a 13-18 YCCS program, can they also accept 12-year-olds if clinically appropriate and licensing permits this?
    DMH licensing may consider age-related waivers on a case-by-case basis.

73. Can the latency and adolescent YCCS be co-located or are two separate units required?
    They may be co-located but not integrated. If there are shared common areas (group rooms, dining area, recreation areas, etc.), they cannot be occupied by the two age groups concurrently. Bedrooms and bathrooms must be separate.

Co-location with other services

74. Is it allowable for a YCCS to be co-located with a Community-Based Acute Treatment (CBAT) program?
    YCCS may be co-located within the same campus or building as a CBAT as long as the YCCS is in a physical space that is distinct, and each program complies with the requirements of its licensure.

75. How would a YMCI determine whether YCCS is the appropriate disposition for a Member, as opposed to CBAT?
    YCCS is a different clinical model that provides intensive services for youth who are anticipated to stabilize quickly with intervention and return to their home.

Licensure

76. How will Adult CCS and YCCS beds be licensed?
    Adult CCS and YCCS will be licensed by DMH. DMH is finalizing the CCS and YCCS licensing regulations, which will be posted on the DMH website as soon as they are available. The Department of Early Education and Care will not license YCCS programs.

77. Do we need a Bureau of Substance Addiction Services (BSAS) license for YCCS to provide MAT for clients 16+?
    No, YCCS programs are not required to obtain a BSAS license to provide MAT for clients 16+.

78. Can you confirm that the Adult CCS and YCCS will not fall under the Medication Assistance Program (MAP) regulations for medication administration that is usually consistent with DPH/DMH licensing?
    Adult CCS and YCCS are not anticipated to require MAP certification as there will be 24-hour nursing coverage. DMH licensing regulations will provide further guidance on this issue.

Subcontracting for YCCS services

79. Assuming a bidder provides transportation and a seamless admission from the YMCI to the YCCS, is there any limitation on the YCCS being located outside the proposed catchment area but within the same region?
YCCS may be located outside of the proposed catchment area, as long as transportation is provided and the CBHC/YCCS provides adequate support to allow ongoing family/caregiver engagement in treatment during the admission.

80. Can a CBHC contract for YCCS with a CBHC in a bordering region if it is a similar distance away from the closest YCCS within the CBHC's region?
The preferred model is to subcontract within the region, though a CBHC may subcontract for YCCS in a bordering region if there is clear rationale for doing so.

Staffing

81. The following are responses related to questions about specific YCCS staffing requirements.
- The medical director must be a board-certified or board-eligible child psychiatrist; an APRN cannot serve as medical director.
- The medical director should be on-site or provide telehealth, based on the clinical needs of clients.
- The YCCS program director is a one FTE, on-site position.
- The board-certified child and adolescent psychiatrist or APRN with child/youth training must be on staff, rather than a consultant.
- The psychiatric APRN is supervised by the medical director or another attending child psychiatrist.
- The RN and nurse manager must be two separate positions.
- The overnight RN/LPN is required to be on-site.

82. The following are responses related to questions about specific Adult CCS staffing requirements.
- The medical director is responsible for supervising all psychiatrists and psychiatric APRNs in any of the AMCI service components.
- The clinical program manager and nurse manager have joint management of the program with accountability to the AMCI director.
- Peer supervision is required for all peer services in all components of the CBHC.
- The nurse manager position is one FTE.
- Mental health counselors are required to be on-site 24/7/365.

Service delivery

<u>Adult CCS</u>

83. Is telehealth acceptable for the in-person psychiatric assessment?
Telehealth is acceptable for the psychiatric assessment when clinically appropriate and agreed to by the client.

84. Can Adult CCS be used for people who need stabilization while escalating in residential services?
Yes, Adult CCS can be used for stabilizing clients who have residential services.

85. Does induction for buprenorphine need to be on-site at the Adult CCS?
Yes, this is required to be on-site.

86. Must Adult CCS receive clients from AMCI to provide MOUD-only services after CBHC hours? Does the CCS daily rate cover this service?
Yes, the Adult CCS covers after hours MOUD-only services, and the rate covers these services.

YCCS

87. Is CANS required for YCCS admissions?
    CANS is not required for YCCS admissions.

88. What extent of medical co-morbidity would a YCCS be expected to have the ability to serve?
    YCCS is expected to serve youth with co-morbidities that can be managed by the staffing in the YCCS, which includes 24-hour nursing coverage. This includes management of stable chronic conditions such as asthma and diabetes, which would otherwise be managed at home. More complex medical needs should be considered on a case-by-case basis.

89. If a clinician requests that a psychiatrist meet with a youth within 60 minutes of the request and the psychiatrist is not on-site, can the psychiatrist meet with the youth via telehealth?
    Yes, the psychiatrist can meet with the youth via telehealth in this situation, as long as clinically appropriate and the client/guardian is in agreement.

90. Can a youth at YCCS level of care be transferred to CBAT if a longer stay is needed or otherwise clinically indicated?
    Yes, a youth may be transferred to a CBAT when it is clinically indicated.

91. Does placement into YCCS require prior approval from the MCE for the initial admission? What is the process if a youth requires a longer stay at the YCCS?
    No prior approval is required. Utilization management timeframes will be further outlined during the readiness review period.

92. Can a bidder apply to be a YCCS without also applying to be a CBHC, or does such a YCCS proposal need to be part of a CBHC proposal, as a subcontract?
    A provider may not apply to be a YCCS independent of a CBHC. YCCS must be provided by a CBHC or subcontracted by a CBHC.

93. Is there a day option for YCCS?
    YCCS is not a day option; it is a 24-hour level of care. The language will be clarified in the YCCS specs.

94. Who conducts the subsequent review if the Member is initially denied admission by a YCCS?
    YMCI may request that an MD or medical director review the request for admission if initially denied.

Reimbursement/Billing

95. Please provide clarification around what services are covered by the bundled rate.
    - There is no time limit on how long the bundled rate can be billed, as long as services are clinically indicated. Providers can bill the encounter rate for each day that they provide services that are covered under the bundled encounter. A client day is based on a calendar day.
    - The bundled rate will apply for any client who receives services at the CBHC site that are included in the bundle. Volume and intensity of services does not matter in terms of the rates that are billed. All services identified in Appendix 3 are covered by the bundled encounter rate.
    - Care coordination, medical screens, and connection with primary care are covered under the bundled rate when provided at the CBHC site.
    - Billing requirements are not changing for services outside the bundle. These services will remain fee-for-service. Billing for services outside the bundle should be based on standard billing parameters and medical necessity for those services.
    - Certified peer specialist (CPS), recovery coaches (RCs), and recovery support navigator (RSN) services are not included in the bundled rate and will be billed separately. Codes are being finalized for CPSs.

96. If a provider has multiple outpatient sites, will the bundled rate apply to covered services provided at each location?
CBHC is a site-based program. For any sites that are contracted as a CBHC, the bundled rate can be billed. For services provided at any sites that are not contracted as a CBHC site, the provider should continue to bill fee-for-service, or as they normally would.

97. When a CBHC has subcontractors, can the subcontractors bill MBHP for CBHC programs services directly?
No, subcontractors cannot bill MBHP directly. Per section VII, the CBHC will bill MBHP for services provided by the subcontractor and is responsible for reimbursing the subcontracted organization for services provided by the subcontractor.

98. Please provide clarifications related to the Adult CCS and YCCS rate.
- The CBHC can bill for the first day of Adult CCS or YCCS if the client already received AMCI, YMCI, or CBHC services on the same day.
- There is no separate reimbursement for transportation from the CBHC to the Adult CCS or YCCS.
- The Adult CCS daily rate is $505.53 for all MCEs.

99. Please provide clarifications related to the AMCI and YMCI rate.
- The follow-up rate for AMCI is billed for 15-minute units, up to a three-day episode of care.
- The follow-up rates for AMCI and YMCI do not change based on location of service delivery.
- The AMCI can bill the applicable follow-up rate for up to three days, as clinically needed.
- For AMCI, bed searches are included in the rate. However, clinical interventions outside the specifications for MCI may be billed as follow-up services.
- If a client received CBHC services and AMCI services in the same day, the CBHC would receive the CBHC bundled rate and the AMCI reimbursement rate for those services.

100. Why will CBHCs be required to submit claims for all services provided, when reimbursement is made based on the bundled rate?
CBHCs will be required to bill with existing codes for services provided under the bundle, which will be zero paid, in addition to billing for the bundled encounter rate. The reason for this is to provide the information that will enable us to understand the utilization of services that clients receive that are covered as part of the bundle. All services that the Member received for the same date of service should be included on the same claim. This includes the code for the bundled encounter rate and the specific procedure codes that will be zero paid.

101. Why is information on billing Medicare and other insurance included as part of the bidder's proposal (Question 2.1.2 on Page 31)?
This information is requested to understand the organization's other sources of revenue. Please indicate N/A if not applicable.

Quality and Reporting

102. The Behavioral Health Roadmap indicates that this model will include pay-for-performance metrics at some point. Will this happen and how soon?
During the first year of the CBHC contract, data on a number of quality and access measures will be collected and evaluated by EOHHS to establish baselines and set benchmarks. Once baselines and benchmarks are established, data will be collected, and the payment model may include a pay-for-performance component based on CBHCs' performance on these metrics. The specific time frame has not yet been determined.

103. Will there be a metric to review service utilization/whether census is being met for new services, and will requirements end for these services if they are not utilized by the public?
MBHP and EOHHS are in the process of identifying metrics and data collection processes to understand service utilization.

104. Will EOHHS identify and require a specific suicide risk assessment for adult and child/adolescent to be measured by the measure/reporting requirement?
There is not a specific required tool to identify suicide risk assessment. The CBHC must identify an evidence-based, universally accepted tool to utilize.

105. Will EOHHS identify and require a specific client satisfaction survey tool to be used by the CBHCs?
A standardized client satisfaction tool will be provided for the CBHCs to use.

106. Will CBHCs be responsible for reporting on "ED visits for individuals with mental illness, addiction, or co-occurring conditions," or will EOHHS collect that information from claims data?
Such data will be collected in claims by EOHHS.

107. Can the use of Healthcare Effectiveness and Data Information Set (HEDIS®)[1] measures be clarified for the monthly performance review meeting?
The CBHC review and oversight team will meet with the CBHCs on a monthly cadence. Use of HEDIS measures, as well as other data, will be used to understand performance, identify barriers, and develop strategies to address them.

108. What will the denominator be for the measures described in Section V? Will it be all MassHealth Members in the catchment areas or just Members billed the bundled rate by the CBHCs?
The denominator would be MassHealth Members who received services that are billed by the CBHC under the bundled rate.

DSRIP

109. If an agency receives a CBHC award for more than one catchment area, is the DSRIP award based on a single agency as the contractor ($750,000 for the entire award), or is each catchment area considered a "contract" (i.e., $750,000 for each defined catchment area awarded)?
Yes, a separate DSRIP proposal should be submitted for each CBHC site for which they are bidding. The specific amount of funding will be determined based on the proposals received, as there is a maximum of $10,000,000 available for these awards.

110. Please confirm when DSRIP funds will be awarded and distributed and the timeframe in which the funds must be used.
The DSRIP awards will be announced at the time that the CBHC sites are announced. The funds will be distributed in the following months, after the provider has completed the contract to participate as a CBHC. The deadline for using the funds is June 30, 2023.

111. We intend to raise salaries to recruit and retain a qualified workforce as part of the implementation of the CBHC bundled rate. Can DSRIP funds be used for an increase of base salaries as part of capacity building during the start-up phase?
DSRIP bidders may propose to use funding for the allocation of staff time toward the projects. Bidders who propose to use funding for staff time should describe their intended cost allocation to staff time in their budget narrative. If salaries are adjusted in order to retain staff as described in this question, details should be included in the budget.

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

112. Based on awards anticipated being made late June 2022, should providers use a start date of July 1, 2022, as the earliest start date for the two-year budget (or longer as indicated) to include a start-up phase and DSRIP funding?
Yes, use of DSRIP funding can begin at the earliest, July 1, 2022.

Details about Responses/Formatting

113. Can you please clarify if bidders need to submit copies of subcontracts? If so, can you please identify the section of the RFP where this is indicated?
Bidders are not required to submit copies of subcontracts when they submit their response to the RFP. Boilerplate agreements are sufficient for the proposal submission. CBHCs will be required to submit copies of subcontracts during the readiness review period.

114. How will MBHP score a proposal submitted with multiple catchment areas? Would MBHP prefer a proposal submitted for each catchment area?
Bidders should submit separate proposals for each catchment area or part of a catchment area that the bidder would like to cover. Each proposal will be scored separately and considered relative to other proposals in the same catchment area(s).

115. Please provide clarity related to formatting requirements and documents that should be included.
- Budget documents, including budget and narrative, should include AMCI, YMCI, Adult CCS, and YCCS components, along with the CBHC information.
- Charts and tables can be a smaller font; a font as low 9 point is acceptable for charts and tables.
- Sample staffing schedules should be referenced in the narrative and included as attachments.
- In Sections B2.1 and C1.12, when providing "evidence of," please describe in the body of narrative. Examples can be included as attachments. These can include descriptions of contracts for the provision of these services at various levels of care, clinical tools used to complete a crisis assessment of children and families, and/or data reflecting the number of children and adolescents served in the past year.
- Section XIII.H should be included in the Narrative Response (75 page limit for entire Narrative Response, Sections A-H) and Section XIII.I should be included in the Fiscal Response (no page limit for Fiscal Response).
- The page limit for RFP response is 75 pages, single-sided, not including DSRIP response. The cover page and divider pages are not included in the page count. The page limit for completed DSRIP Program Response Forms is 10 pages. Any supporting documentation to the DSRIP Program Response Form will not be counted in calculating the DSRIP bidder's page limits.
- The staffing plan sample schedules can be considered attachments and are not included in the page count.
- Resumes in Section B.1.6.1 are not included in the page count, and there is no page limit for resumes.
- Job descriptions and the organization chart (D.9.1) do not count against the page count and should be included as attachments.
- It is preferred that the DSRIP submission responses should be submitted attached to the end of the general bid response, after the attachments. If the DSRIP proposal is submitted separately, it should be submitted electronically, and a bound hard copy and an unbound hard copy should also be submitted.
- For the DSRIP Funding Response Form, printout of the Excel form is sufficient.