



January 20, 2023

Miriam Delphin-Rittmon, Ph.D.  
Assistant Secretary for Mental Health and Substance Abuse  
Substance Abuse and Mental Health Services Administration  
Department of Health and Human Services  
5600 Fishers Lane  
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Dear Dr. Delphin-Rittmon,

NRHA is pleased to see SAMHSA's updated certification criteria for Certified Community Behavioral Health Clinics (CCBHCs). Overall, the increased flexibilities and clarifications will allow more facilities to be certified as CCBHCs. This is crucial for rural areas where CCBHCs have struggled to gain traction due to stringent certification criteria. NRHA broadly supports SAMHSA's proposed criteria as a step in the right direction to grow the number of CCBHCs in rural areas and thus expand access to needed behavioral health services.

**Criteria 1.a: General Staffing Requirements**

**1.a.3:**

Rural areas continue to face behavioral health professional shortages, which has historically been one barrier to CCBHC certification. CCBHCs must have a psychiatrist serving as a Medical Director and rural areas often have fewer practicing psychiatrists than urban areas.<sup>1</sup> A 2020 report on CCBHCs from the Assistant Secretary for Planning and Evaluation (ASPE) found that hiring and retaining CCBHC staff was challenging in rural or remote locations, with psychiatrists being the hardest to recruit.<sup>2</sup> While there has been an exception to the psychiatrist requirement for CCBHCs in a mental health professional shortage area (HPSA), the exception requires that the CCBHC employ a medically trained behavioral health professional that can independently prescribe and manage medications under state law in lieu of a psychiatrist.

NRHA supports SAMHSA's revision to remove the HPSA requirement to the non-psychiatrist exception. This would allow any potential CCBHC that has failed to retain a psychiatrist as a Medical Director after reasonable efforts to employ an alternative behavioral health professional that can prescribe medication. However, this change will likely have a small effect on rural facilities as many

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<sup>1</sup> C. Holly A. Andrilla, et al., *Geographic Variation in the Supply of Selected Behavioral Health Providers*, 54 AM. J. OF PREVENTIVE MEDICINE S199, S200 (2018) (65% of nonmetro counties lacked a psychiatrist compared to 27% of metro counties).

<sup>2</sup> Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, *Implementation Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration*, 12-13 (Sept. 2020) [https://aspe.hhs.gov/sites/default/files/migrated\\_legacy\\_files/196051/CCBHCImpFind.pdf](https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/196051/CCBHCImpFind.pdf).

rural areas are HPSAs. Rural mental health HPSAs account for 61% of all mental health HPSAs overall.<sup>3</sup>

For rural facilities, the more challenging aspect of the Medical Director role is finding any appropriate provider that meets the criteria, even under the non-psychiatrist exception. While this exception opens the door to more professionals able to serve as Medical Director, rural providers are likely still disadvantaged compared to urban or suburban providers. Psychiatric nurse practitioners (NPs), which would meet the exception criteria, may actually be more difficult to recruit and retain than psychiatrists in rural areas.<sup>4</sup> The lack of psychiatric NPs in some areas may be due to restrictive scope of practice laws that do not grant NPs independent practice authority. About 91% of noncore, or rural, counties lack a psychiatric nurse practitioner whereas 80% of noncore counties lack a psychiatrist. This makes the non-psychiatrist exception less meaningful for rural facilities.

Rural facilities may also use family physicians to fill the Medical Director role under the non-psychiatrist exception. However, NRHA members have expressed that the majority of family physicians are not comfortable managing behavioral health medications within their general practice. Additionally, similar to other practitioners discussed, family physicians are also difficult to recruit and retain in rural areas. NRHA encourages SAMHSA to be cognizant of the behavioral health workforce shortage and state scope of practice laws facing rural when updating CCBHC criteria in order to not unintentionally hinder rural providers from becoming CCBHCs.

NRHA requests that SAMHSA provide examples of what professionals that it would consider meeting the non-psychiatrist standard of “a medically trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law.” The ASPE report noted that where CCBHCs did not hire psychiatrists as Medical Directors, psychiatric nurse practitioners fulfilled the role.<sup>5</sup> SAMHSA should clarify with examples what other practitioners, may fill the role, like physician assistants or primary care physicians.

SAMHSA may also consider including more guidance on the Medical Director role to ease the burden of meeting staffing requirements. SAMHSA’s criteria should provide examples of Medical Director responsibilities and clarify the extent to which they are involved in the day-to-day activities of the CCBHC. SAMHSA could model these duties after 42 C.F.R. § 491.8(b) which lists the overseeing physician’s duties in rural health clinics and federally qualified health centers.<sup>6</sup> Describing the responsibilities may help CCBHCs employ a Medical Director that can perform them.

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<sup>3</sup> Bureau of Health Workforce, Health Resources and Services Administration, First Quarter of Fiscal Year 2023 Designated HPSA Quarterly Summary (Dec. 31, 2022), 3 <https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport>.

<sup>4</sup> Andrilla, et al., *supra* note 1 at S201.

<sup>5</sup> Assistant Secretary for Planning and Evaluation, *supra* note 2, at 9.

<sup>6</sup> “(1) Except for services furnished by a clinical psychologist in an FQHC, which State law permits to be provided without physician supervision, provides medical direction for the clinic's or center's health care activities and consultation for, and medical supervision of, the health care staff. (2) In conjunction with the physician assistant and/or nurse practitioner member(s), participates in developing, executing, and periodically reviewing the clinic's or center's written policies and the services provided to Federal program patients. (3) Periodically reviews the clinic's or center's patient records, provides medical orders, and provides medical care services to the patients of the clinic or center.”

Additionally, SAMHSA should consider allowing the Medical Director to perform some duties via telehealth, where appropriate. Given the low numbers of psychiatrists and other medically trained behavioral health professionals in rural areas, telehealth may allow more practitioners to serve as Medical Director. Another strategy to ease the burden on rural CCBHCs would be to allow Medical Directors to be employed and provide oversight over more than one CCBHC especially considering that Medical Directors do not have to be fulltime employees.

1.b.2:

NRHA supports the requirement that CCBHCs must have a provider on staff that can prescribe medications to treat opioid, alcohol, and tobacco use disorders, except for methadone. Methadone is often more burdensome to administer therefore it would be inappropriate to require rural CCBHCs to provide this service. NRHA also supports the new criterion requiring that if a provider at the CCBHC cannot prescribe methadone, the client must be referred to an opioid treatment program if one exists in the area. This signifies the importance of methadone and other medications for opioid use disorder.

**Criteria 2.a.: General Requirements of Access and Availability**

2.a.5:

Telehealth is a valuable tool for rural residents that otherwise must travel long distances to the nearest provider or face other transportation challenges. NRHA applauds the inclusion of client preferences when utilizing telehealth because rural clients may be more likely to choose remote services over in-person services.

As the COVID-19 public health emergency (PHE) comes to an end, NRHA would like to ensure that CCBHCs continue to use telehealth to the greatest extent possible. The proposed criteria do not explicitly require CCBHCs to use telehealth to provide services to client and NRHA recognizes that the PHE has made the option more widely available at CCBHCs. NRHA is concerned that telehealth access may diminish for rural clients of CCBHCs when the PHE ends. SAMHSA should ensure that CCBHC funds are able to be used to support the implementation and maintenance of telehealth programs.

**Criteria 2.b.: General Requirements for Timely Access to Services and Initial and Comprehensive Evaluation**

2.b.1:

Rural residents rely upon telehealth to access care. NRHA appreciates that SAMHSA is retaining the ability for an emergency initial evaluation to be performed via telehealth. However, NRHA believes that the caveat that “an in-person evaluation is preferred” is out of date. The growth of telehealth during the COVID-19 pandemic has made it a key part of health care delivery, particularly in rural areas. Telehealth services are an operational issue and Medical Directors should decide whether their CCBHC is comfortable providing intake services via telehealth. SAMHSA should allow intake evaluations to be furnished as each CCBHC independently determines and without prejudice towards remote evaluations in the criteria.

2.b.2:

NRHA supports the proposed revision to decrease the required frequency of treatment plan updates from at least every 90 days to at least every 6 months. This flexibility may ease workloads of CCBHCs that face staffing shortages or challenges.

### **Criteria 2.c: 24/7 Access to Crisis Management Services**

#### **2.c.3:**

NRHA also applauds the new language requiring that CCBHC clients be educated on how to access the new 988 Suicide and Crisis Lifeline. Knowing where to receive behavioral health services is one major barrier to seeking care for rural adults.<sup>7</sup> Adding another tool in clients' toolboxes for accessing behavioral health care is extremely important.

### **Criteria 2.E: Provision of Services Regardless of Residence**

#### **2.e.2:**

NRHA is concerned with the note in this section that CCBHCs are not required to provide continuous telehealth services to individuals who live outside of the service area. This is a new clarification that is not included in the current criteria. CCBHCs largely define their own service areas through measures like community health needs assessments. If certain areas fall outside of the service area of a CCBHC, and do not fit within another CCBHC's service area, these residents will not have access to telehealth through the CCBHC. This is antithetical to the mission of CCBHCs to make behavioral health services accessible and potentially most harmful for rural residents. If a CCBHC is the most geographically and financially accessible provider of needed behavioral health services, clients outside of the service area should be able to receive care through telehealth rather than travel further distances to receive services in-person. Clients inside and outside of the service area should have parity in telehealth access at a CCBHC.

### **Criteria 3.c: Care Coordination Partnerships**

#### **3.c.1:**

Rural CCBHCs have faced challenges with executing formal care coordination agreements with Designated Collaborating Organizations (DCOs) such as federally qualified health centers (FQHCs) and rural health clinics (RHCs). This may be because the other providers have been unwilling or unable to engage in formal agreements that are not required under their program and could be difficult if their staff are already stretched thin. Providers may also be unwilling because of the liability that they may take on as a DCO. Softening the language surrounding care coordination agreements from "agreements" to "partnerships" will address issues that CCBHCs face when working with FQHCs, RHCs, and other rural providers. By not requiring formal agreements with DCOs, SAMHSA will give rural providers more flexibility and opportunity to become certified as a CCBHC.

Related to partnerships, NRHA asks that SAMHSA speak to co-location and dual certification of CCBHCs and other providers, like FQHCs. The Centers for Medicare and Medicaid Services (CMS) currently allows existing FQHCs to also become certified as a CCBHC but does not explain whether

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<sup>7</sup> Per Ostmo & Jessica Rosencrans, *Rural Health Research Recap: Rural Mental Health*, Rural Health Research Gateway (Sept. 2022) <https://www.ruralhealthresearch.org/assets/4960-22209/rural-mental-health-recap.pdf>.

the provider should receive CCBHC and FQHC payments for a client on the same day if provided services overlap. SAMHSA does not have any guidance on either co-locating or dual certification and payment and NRHA suggests that SAMHSA allow both of these practices. SAMHSA should coordinate with CMS and HRSA to align requirements and provide clarity around dual certification and payment.

### 3.c.3:

Again, NRHA supports softening the language around care coordination partnerships from “agreements” to “partnerships.” NRHA further supports a care coordination partnership between the CCBHC and the 988 Lifeline call center within the CCBHC’s service area, where possible. This partnership has the potential to expand lifesaving behavioral health services to rural areas.

## **Criteria 4.c: Crisis Behavioral Health Services**

### 4.c.1:

Some CCBHC criteria for providing care are challenging for rural facilities to meet. One such requirement is that crisis management services must be available 24/7. We understand that this is a statutory requirement for the program; however, NRHA suggests that SAMHSA provide waivers and/or relaxed requirements for rural CCBHCs that account for the resources available in rural communities if 24/7 crisis standards cannot be met.

NRHA is troubled by SAMHSA’s proposed revision to remove the requirement that crisis management services be delivered within 3 hours. While rural or frontier areas would now have a 2-hour timeframe for mobile team response compared to 1 hour for other settings, NRHA is concerned about both staffing the team and their ability to respond within 2 hours in some settings given distance and/or weather concerns. Additional rural exceptions to this 24/7 requirement may be necessary for rural providers to be certified as a CCBHC.

The flexibility to use telehealth for crisis care when a 2-hour response time is unachievable is extremely important for rural, and particularly frontier, areas. Nonetheless, the proposed criteria implies that telehealth or other technology is not a replacement for an in-person response, but rather a stand-in option before the crisis team arrives. NRHA urges SAMHSA to explicitly allow telehealth in place of an in-person crisis response for situations in which the crisis is determined to be non-life threatening.

SAMHSA should explicitly allow for audio-only telehealth for crisis management services. The lack of broadband infrastructure in many rural areas, along with the technology capabilities of rural households, may make audio/video telehealth unusable. Audio-only must be available as an alternative option for crisis management services.

A DCO may help provide mobile crisis management services for the CCBHC. For some facilities, this could ease staffing and response time concerns. But staffing issues likely still remain an issue in rural areas even when a DCO is contracted to provide these services. In rural areas, a DCO likely faces the same workforce challenges that the partnering rural CCBHC faces. A CCBHC could work with an RHC or rural hospital as a DCO but that does not guarantee appropriate staffing levels for a mobile crisis response team at those providers. Rural CCBHCs need more flexibility outside of telehealth and DCOs to be able to comply with this section.



Thank you for the chance to offer comments on the proposed CCBHC criteria and for your consideration of our comments. We very much look forward to continuing our work together to ensure our goal of improving quality and access to care for rural residents. If you would like additional information, please contact Alexa McKinley at [amckinley@ruralhealth.us](mailto:amckinley@ruralhealth.us).

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan", is written over a light gray, textured background.

Alan Morgan  
Chief Executive Officer  
National Rural Health Association