Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Planning Grants for Certified Community Behavioral Health Clinics

(Initial Announcement)

(Short Title: CCBHCs Planning Grants)

Request for Applications (RFA) No. SM-16-001

Catalogue of Federal Domestic Assistance (CFDA) No.: 93.829

PART 1: Programmatic Guidance

[Note to Applicants: This document must be used in conjunction with SAMHSA's "Request for Applications (RFA): PART II – General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements". PART I is individually tailored for each RFA. PART II includes requirements that are common to all SAMHSA RFAs. Applicants must use both documents in preparing the application.]

Key Dates:

Application Deadline	**Applications are due by August 5, 2015**
Intergovernmental Review **(E.O. 12372)**	**Applicants must comply with E.O. 12372 if their state(s) participates. Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.**
Public Health System Impact Statement (PHSIS)/Single State Agency Coordination	**Applicants must send the PHSIS to appropriate state and local health agencies by application deadline. Comments from Single State Agency are due no later than 60 days after application deadline.**

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EXECUTIVE SUMMARY

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) is accepting applications for fiscal year (FY) 2016 Planning Grants for Certified Community Behavioral Health Clinics (CCBHCs) (Short Title: CCBHCs Planning Grants). The purpose of this program is to support states to certify clinics as certified community behavioral health clinics, establish prospective payment systems for Medicaid reimbursable services, and prepare an application to participate in a two-year demonstration program. Populations to be served are adults with serious mental illness, children with serious emotional disturbance, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders.

Funding Opportunity Title:	Planning Grants for Certified Community Behavioral Health Clinics
Funding Opportunity Number:	SM-16-001
Due Date for Applications:	August 5, 2015
Anticipated Total Available Funding:	Up to $24,635,000
Estimated Number of Awards:	Up to 25
Estimated Award Amount:	Up to $2,000,000
Cost Sharing/Match Required	No
Length of Project Period:	1 year
Eligible Applicants:	Eligible applicants are State Mental Health Authorities (SMHAs), or Single State Agencies (SSAs), or State Medicaid Agencies (SMAs) including the District of Columbia. [See Section III-1 of this RFA for complete eligibility information.]

Be sure to check the SAMHSA website periodically for any updates on this program.

I. FUNDING OPPORTUNITY DESCRIPTION

1. PURPOSE

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services is accepting applications for fiscal year (FY) 2016 Planning Grants for Certified Community Behavioral Health Clinics (Short Title: CCBHCs Planning Grants). The purpose of this program is to support states to certify clinics as certified community behavioral health clinics (CCBHCs), establish prospective payment systems for Medicaid reimbursable services, and prepare an application to participate in a two year demonstration program. Populations to be served are adults with serious mental illness, children with serious emotional disturbance, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders.

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (H.R. 4302) was enacted. The law included "Demonstration Programs to Improve Community Mental Health Services at Section 223 of the Act. The program requires: (1) the establishment and publication of criteria for clinics to be certified by a state as a certified community behavioral health clinic (CCBHC) to participate in a demonstration program; (2) the issuance of guidance on the development of a Prospective Payment System (PPS) for testing during the demonstration program; and (3) the awarding of planning grants for the purpose of developing proposals to participate in a time-limited demonstration program. The overall goal is to evaluate demonstration programs in up to eight states that will establish CCBHCs according to specified criteria that will make them eligible for enhanced Medicaid funding through the PPS.

SAMHSA is working collaboratively with the Centers for Medicare & Medicaid & Services (CMS) and the Assistant Secretary for Planning and Evaluation (ASPE) to implement Section 223. SAMHSA developed the certification criteria found in *Appendix II - Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics*. CMS prepared guidance to states to establish a prospective payment system, found in *Appendix III - Section 223 Demonstration Programs to Improve Community Mental Health Services Prospective Payment System (PPS) Guidance*. ASPE will direct the national evaluation of the demonstration program.

The awarding of CCBHCs Planning Grants is the first phase of a two-phase process. Phase I provides funds for one year to states to certify community behavioral health clinics, establish a PPS for Medicaid reimbursable behavioral health services provided by the certified clinics, and prepare an application to participate in a two-year demonstration program. CCBHC Planning Grantees must use the criteria found in

Appendix II to certify clinics in their states and follow the guidance found in Appendix III to establish PPS.

Up to eight states that participated in the CCBHC Planning Grants will be selected to participate in Phase II, the demonstration program. The eight selected states will bill Medicaid under an established PPS approved by CMS for behavioral health services provided to individuals eligible for medical assistance under the state Medicaid program.

Planning Grants for CCBHCs are authorized under the Protecting Access to Medicare Act of 2014, Section 223(c)(1).

This announcement addresses Healthy People 2020 Mental Health and Mental Disorders Topic Area HP 2020-MHMD and Substance Abuse Topic Area HP 2020-SA and is in support of SAMHSA's Recovery Support Strategic Initiative.

2. EXPECTATIONS

SAMHSA expects Mental Health Authorities, Single State Agencies for Substance Abuse, and State Medicaid Agencies within states to collaborate and certify clinics as community behavioral health clinics, establish a prospective payment system, and submit a proposal during the planning grant period to participate in the demonstration program.

According to the National Survey on Drug Use and Health, individuals who experience mental illness or who use illegal drugs have higher rates of tobacco use than the total population. Data from the National Health Interview Survey, the National Death Index, and other sources indicate earlier mortality among individuals who have mental and substance use disorders than among other individuals. Due to the high prevalence rates of tobacco use and the early mortality of the target population for this grant program, grantees are encouraged to promote abstinence from tobacco products (except with regard to accepted tribal traditional practices) and to integrate tobacco cessation strategies and services in the grant program.

Recovery from mental disorders and/or substance use disorders has been identified as a primary goal for behavioral health care. SAMHSA's Recovery Support Strategic Initiative is leading efforts to advance the understanding of recovery and ensure that vital recovery supports and services are available and accessible to all who need and want them. Building on research, practice, and the lived experiences of individuals in recovery from mental and/or substance use disorders, SAMHSA has developed the following working definition of recovery: *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.* See http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF for further information, including the four dimensions of recovery, and 10 guiding principles.

Individuals receiving services through the demonstration program may achieve a state of recovery through short-term or on-going medical and other treatment for symptoms of

their conditions, based on an appropriate and timely assessment of needs, and through counseling, psychosocial or on-going recovery support services that may change over time as their recovery progresses. For some, self-help, mutual aid, and/or complementary and integrative health approaches may also be helpful in reaching and sustaining recovery. These needed services may be funded through a variety of payment sources such as Medicaid, Medicare, private insurance, self-pay, block grant funds, state or local funds, or other system structures such as the Department of Veterans Affairs (VA), the Department of Defense (DoD), Department of Housing and Urban Development (HUD), the Department of Justice (DoJ), the Social Security Administration (SSA), or other operating divisions of the Department of Health and Human Services (HHS) (Health Resources and Services Administration, Indian Health Services, Center for Disease Control, Administration for Children and Families, etc.). CCBHCs are expected to have the capacity to accept, utilize, and otherwise collaborate with all services systems and fund sources necessary to meet the needs of persons with mental illness and substance use disorders presenting for services. Programs and services that incorporate a recovery approach fully involve people with lived experience (including consumers/peers/people in recovery, youth, and family members) in program/service design, development, implementation, and evaluation.

SAMHSA's standard, unified working definition is intended to advance recovery opportunities for all Americans and to help clarify these concepts for peers/persons in recovery, families, funders, providers and others. The definition and associated dimensions and guiding principles are to be used to assist in the planning, delivery, financing, and evaluation of behavioral health services. SAMHSA grantees are expected to integrate the definition, dimensions, and guiding principles of recovery into their programs to the greatest extent possible.

SAMHSA encourages all of its grantees to address the behavioral health needs of returning veterans and their families in designing and developing their programs and to consider prioritizing this population for services where appropriate. SAMHSA will encourage its grantees to utilize and provide technical assistance regarding locally-customized web portals that assist veterans and their families with finding behavioral health treatment and support.

SAMHSA encourages all of its grantees to support the training of direct-care staff in strategies for the prevention and elimination of seclusion and restraint both physical and chemical, in the treatment of people with serious mental illness or children with serious emotional disturbances and use approaches focused on consumer well-being.

2.1 Required Activities

Planning Grants for Certified Community Behavioral Health Clinics must complete the following activities:

A. Solicit input with respect to the development of such a demonstration program from consumers[1], family members, providers, tribes, and other key stakeholders. Activities should include:

1. Developing a steering committee, or using an existing committee, council, or process composed of relevant state agencies, providers, service recipients, and other key stakeholders to guide and provide input throughout the grant period.

2. Conducting outreach, recruitment, and engagement of the population of focus including adults with serious mental illness and children with serious emotional disturbances and their families, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders in the solicitation of input.

3. Coordinating activities with other local, state, and federal agencies and tribes to ensure that services are accessible and available.

B. Certify clinics as CCBHCs using the criteria in Appendix II for purposes of participating in a demonstration program. Establish procedures and necessary infrastructure to ensure clinic compliance with certification criteria for the demonstration period, to include:

1. Create and finalize application processes and review procedures for clinics to be certified as CCBHCs.

2. Certify at least two community behavioral health clinics that represent diverse geographic areas, including rural and underserved areas.

3. Assist clinics with meeting certification standards by facilitating access to training and technical assistance on topics such as: assessing gaps in staffing and services, building partnerships and formal relationships, implementing evidence-based practices with fidelity, care coordination, performance measurement and reporting, continuous quality improvement processes, and implementing and optimizing health information technology (HIT) infrastructure (telehealth, registries, or electronic health record functionality enabling users to electronically and dynamically select, sort, access, and create patient lists by a number of elements, electronic care coordination and billing systems, and electronic health records).

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[1] Consumer refers to clients, persons being treated for or in recovery from mental or substance use disorders, persons with lived experience, service recipients and patients of all ages (i.e., children, adolescents, transition aged youth, adults, and geriatric populations).

4. Facilitate cultural, procedural, and organizational changes to CCBHCs that will result in the delivery of high quality, comprehensive, person-centered, and evidence-based services that are accessible to the target population.

5. Assist CCBHCs with improving the cultural diversity and competence of their workforces.

6. Recruit and train the workforce necessary to provide high quality services through CCBHCs.

7. Verify that CCBHCs have meaningful input by consumers, persons in recovery, and family members as described in Appendix II, Program Requirement 6: Organizational Authority, Governance and Accreditation.

C. Establish a PPS for behavioral health services furnished by a CCBHC in accordance with the PPS Methodology Guidelines developed by CMS (Appendix III).

1. Implement either a Certified Clinic (CC) or Alternative CC PPS rate-setting methodology for payment made via fee for service or through managed care systems.

2. Determine the clinic-specific PPS rate by identifying all allowable costs and visit data necessary to support the delivery of CCBHC services covered by the state specified in statute.

3. Develop actuarially sound rates for payments made through managed care systems.

4. Prepare to collect CCBHC cost reports with supporting data, as specified in the PPS guidance, no later than 9 months after the end of each demonstration year.

5. Design and implement billing procedures to support the collection of data necessary to help determine PPS and evaluate the overall demonstration.

D. Establish the capacity to provide behavioral health services that meet the criteria listed in Appendix II.

E. Develop or enhance data collection and reporting capacity and provide information necessary for HHS to evaluate proposals submitted by states to participate in the demonstration program including the following activities:

1. Develop or enhance data collection and reporting capacity and provide information in support of meeting PPS requirements, quality reporting requirements, and demonstration evaluation reporting requirements listed under Program Requirement 5: *Quality and Other Reporting* in Appendix II.

2. Design or modify and implement data collection systems—including registries or electronic health record functionality that report on access, quality, and scope of services using various types of data, including, CCBHC administrative data and personnel records, claims, encounter data, patient records, and patient experience of care data.

3. Design or modify and implement data collection systems that report on the costs and reimbursement of providing behavioral health services.

4. Use a cost report format that is developed to conform to CMS guidance, collect cost reports from CCBHCs.

5. Assist CCBHCs with preparing to use data to inform and support continuous quality improvement processes within CCBHCs, including fidelity to evidence-based practices, and person-centered, and recovery-oriented care during the demonstration.

F. Prepare for Participation in the National Evaluation of the Demonstration Program.

Grantees must plan to participate in the demonstration program's national cross-site evaluation. The national evaluation, led by HHS, will compare accessibility to community-based behavioral health services in participating clinics with accessibility for patients who are not served by CCBHCs. In addition, the national evaluation will assess the cost, quality, and scope of services provided by CCBHCs and the impact of the demonstration programs on the federal and state costs for a full range of mental health and substance abuse services (including inpatient, emergency, and ambulatory services paid for through sources other than the demonstration program funding). Activities for participating in the national evaluation include:

1. Collaborate with the national evaluation planning team and provide input on the evaluation design, data sources, and performance measures.

2. Work with HHS and the evaluation planning team to construct a comparison group for an assessment of access, quality, and scope of services available to

Medicaid enrollees served by CCBHCs compared with Medicaid enrollees who access services from other community-based mental health service providers.

3. Prepare requests for an Institutional Review Board's approval to collect and report on process and outcome data (as necessary).

G. Submit a Proposal to Participate in the Demonstration Program

Submit a proposal no later than **October 31, 2016**, to participate in the two-year demonstration program that documents and verifies the completion of the above activities. The demonstration application must include, but is not limited to:

1. The target Medicaid population to include adults with serious mental illness and children with serious emotional disturbances, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders to be served under the demonstration program.

2. A list of participating CCBHCs.

3. Verification that the state has certified a participating clinic as a CCBHC.

4. A description of the scope of behavioral health services available under the state Medicaid program that will be paid for under the PPS tested in the demonstration program.

5. Verification that the state has agreed to pay for services funded under the demonstration program at the rate established under the PPS and that no payments will be made under the demonstration program for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, or to satellite facilities of CCBHCs if such facilities were established after April 1, 2014.

Selection of states participating in the demonstration program will be prioritized based on CCBHCs that:

1. Provide the most complete scope of services outlined in Appendix II to individuals eligible for medical assistance under the state Medicaid program;

2. Improve the availability of, access to, and participation in, services outlined in Appendix II for individuals eligible for medical assistance under the state's Medicaid program;

3. Improve availability of, access to, and participation in assisted outpatient mental health treatment in the state; or

4. Demonstrate the potential to expand available behavioral health services in a demonstration area and increase the quality of such services without increasing net federal spending.

H. If selected, agree to pay for services at the rate established under the PPS system during the demonstration program. Agree no payments will be made for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, or to satellite facilities of CCBHCs if such facilities were established after April 1, 2014. See Appendix IV for the Statement of Assurance.

2.2 Data Collection and Performance Measurement

All SAMHSA grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results (GPRA) Modernization Act of 2010. Grantees must document their ability to collect and report the required data in Section D: Data Collection and Performance Measurement of the application. Grantees will be required to report performance on the following performance measures:

- The number of organizations or communities implementing mental health/substance use-related training programs as a result of the grant;
- The number of people newly credentialed/certified to provide mental health/substance use-related practices/activities that are consistent with the goals of the grant;
- The number of financing policy changes completed as a result of the grant;
- The number of communities that establish management information/information technology system links across multiple agencies in order to share service population and service delivery data as a result of the grant;
- The number and percentage of work group/advisory group/council members who are consumers/family members;
- The number of policy changes completed as a result of the grant;[2]

[2] For purposes of this FOA, "policy" refers to programs and guidelines adopted and implemented by institutions, organizations and others to inform and establish practices and decisions and to achieve organizational goals. Policy efforts do not include activities designed to influence the enactment of legislation, appropriations, regulations, administrative actions, or Executive Orders ("legislation and other orders") proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, and awardees may not use federal funds for such activities. This restriction extends to both grass-roots lobbying efforts and direct lobbying. However, for state, local, and other governmental grantees, certain activities falling within the normal and recognized executive-legislative relationships or participation by an agency or officer of a state, local, or tribal government in policymaking

- The number of organizational changes made to support improvement of mental health/substance use-related practices/activities that are consistent with the goals of the grant; and

- The number of organizations collaborating/coordinating/sharing resources with other organizations as a result of the grant.

This information will be gathered using a uniform data collection tool provided by SAMHSA. Data are to be reported quarterly using the Common Data Platform (CDP) a web system. Further information on the CDP can be found at https://cdp.samhsa.gov/Home/ToolsAndInstruments. Technical assistance related to data collection and reporting will be offered.

The collection of these data will enable SAMHSA to report on key outcome measures relating to behavioral health policies and structures. Additional data regarding services and outcomes for individuals served during the demonstration program will be reported through the evaluation process.

Performance data will be reported to the public, the Office of Management and Budget (OMB) and Congress as part of SAMHSA's budget request.

2.3 Performance Assessment

Grantees must periodically review the performance data they report to SAMHSA (as required above) and assess their progress and use this information to improve management of their grant projects. The assessment should be designed to help grantees determine whether they are achieving the goals, objectives, and outcomes intended and whether adjustments need to be made to their projects. Performance assessments should be used also to determine whether the project is having/will have the intended impact on behavioral health disparities. Grantees will be required to report on progress achieved, barriers encountered, and efforts to overcome these barriers in a performance assessment report to be submitted at least quarterly.

Grantees will be required to submit written quarterly reports within 15 days from the end of the reporting quarter. The first report will be due no later than January 30, 2016. The report will describe progress on each of the required and allowable activities for which funding is provided.

At a minimum, the performance assessment for this planning grant should include the required performance measures identified above.

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and administrative processes within the executive branch of that government are not considered impermissible lobbying activities and may be supported by federal funds.

No more than 20 percent of the total grant award may be used for data collection, performance measurement, and performance assessment, e.g., activities required in Sections I-2.2 and 2.3 above.

2.4 Grantee Meetings

No grantee meetings are anticipated. SAMHSA will convene periodic voluntary and mandatory conference calls with grantees to discuss common challenges and accomplishments.

II. AWARD INFORMATION

Funding Mechanism:	Cooperative Agreement
Anticipated Total Available Funding:	$24,635,000
Estimated Number of Awards:	Up to 25
Estimated Award Amount:	Up to $2,000,000
Length of Project Period:	1 year

Proposed budgets cannot exceed $2,000,000 in total costs (direct and indirect) of the proposed project. Funding estimates for this announcement will be based on the number of applications received. Applicants should be aware that the size of the award may vary depending on the number of applications SAMHSA receives.

The up to eight states that are selected to participate in the demonstration program may request a no-cost extension beyond the project period to finalize planning activities to assist with the transition to the time-limited demonstration phase.

Cooperative Agreement

These awards are being made as cooperative agreements because they require substantial post-award federal programmatic participation in the conduct of the project. Under this cooperative agreement, the roles and responsibilities of grantees and SAMHSA staff are as follows:

Role of Grantee:

The role of the grantee is to comply with the terms of the award and all cooperative agreement rules and regulations, and satisfactorily perform activities to achieve the goals as described below:

- Seek SAMHSA approval for key positions to be filled. Key positions include, but are not limited to, the project director;

- Consult and accept guidance from SAMHSA staff on performance of programmatic and data collection activities to achieve the goals of the cooperative agreement;
- Maintain ongoing communication with SAMHSA, including a minimum of one call per month, keeping federal program staff informed of emerging issues, developments, and problems as appropriate;
- Identify barriers in the Criteria and/or the PPS that impede the grantees ability to certify and fund CCBHC and
- Work with the evaluation planning team to ensure data collection and reporting capability is sufficient for participating in the national evaluation of the demonstration program, and identify a comparison group.

Role of SAMHSA Staff:

- Approve proposed key positions/personnel;
- Meet regularly with grantees individually and in groups to assess progress, challenges, and innovations;
- Facilitate linkages to other SAMHSA and/or federal resources and help grantees access appropriate technical assistance;
- Assure that the grantee's projects are responsive to SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities;
- Coordinate activities with other Health and Human Services (HHS) Operating Divisions and Offices including the Centers for Medicaid and Medicare Services (CMS) and the Assistant Secretary for Planning and Evaluation (ASPE);
- Review, provide feedback, and approve quarterly reports submitted by the grantee;
- Identify federal reviewers for the review and selection of the eight states to participate in the demonstration program;

Work with grantees and HHS Operating Divisions and Offices to address barriers that impede the grantees ability to certify and fund CCBHCs and

- Participate in the selection process of the eight demonstration states by making recommendations to Senior Leadership.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

The statutory authority limits eligibility to states including the District of Columbia[3] (hereafter referred to as states). Eligible applicants are either the State Mental Health Authority (SMHA) or the Single State Agency for Substance Abuse Services (SSA) or the State Medicaid Agency (SMAs). If the SMHA and the SSA or the SMHA, SSA, and the SMA are one entity, applicants must include a statement to that effect in **Attachment 1**.

However, SAMHSA expects state's SMHAs, SSAs, and SMAs to collaborate and certify clinics as CCBHCs, establish a prospective payment system, and submit a proposal to participate in the demonstration program during the planning grant period. To demonstrate this collaboration, the applicant must include a signed Memorandum of Agreement (MOA) between the applicant agency and the two partnering agencies describing roles and responsibilities, and committing to collaborate for this planning grant and demonstration program in **Attachment 1**. Only one application per state can be submitted.

2. COST SHARING and MATCH REQUIREMENTS

Cost sharing/match is not required for the planning grant.

Note: In the demonstration program selected states will be required to provide a state match for federal financial participation for Medicaid eligible individuals and services as described in Appendix- III. Section 1902(a)(2) of the Social Security Act (the Act) and implementing regulations at 42 CFR 433.50(a)(1) of the Act requires states to share in the cost of medical assistance expenditures but permit the state to delegate some responsibility for the non-federal share of medical assistance expenditures to local sources under some circumstances.

IV. APPLICATION AND SUBMISSION INFORMATION

In addition to the application and submission language discussed in PART II: Section I, the applicant must include the following in the application:

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[3] (e) Definitions.(4) STATE.—The term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.). 42 U.S.C. 1396 et seq, page 3307 defines the term ''State'' to mean 1 of the 50 States or the District of Columbia.

1. ADDITIONAL REQUIRED APPLICATION COMPONENTS

- **Project Narrative and Supporting Documentation** – The Project Narrative describes the project. It consists of Sections A through D. Sections A-D together may not be longer than 30 pages. (Remember that if the Project Narrative starts on page 5 and ends on page 35, it is 31 pages long). More detailed instructions for completing each section of the Project Narrative are provided in Section V – Application Review Information of this document.

  The Supporting Documentation provides additional information necessary for the review of the application. This supporting documentation should be provided immediately following the Project Narrative in Sections E and F. There are no page limits for these sections, except for Section E, Biographical Sketches/Job Descriptions. Additional instructions for completing these sections are included in PART II – V: Supporting Documentation. Supporting documentation should be submitted in black and white (no color).

- **Attachments 1 through 4** – Use only the attachments listed below. If the application includes any attachments not required in this document, they will be disregarded. Do not use more than a total of 30 pages for Attachments 1 and 3combined. There are no page limitations for Attachment 2. Do not use attachments to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them. Please label the attachments as: Attachment 1, Attachment 2, etc.

- **Attachment 1:** A signed MOA between the Director of the State Mental Health Authority, the Director of the Single State Agency, and the Director of the State Medicaid Agency demonstrating a partnership to fulfill the requirements of the grant. In addition, if the SMHA and the SSA are one entity a confirmation letter (see Section III-1 of this document). Include Letters of Commitment from any organization(s) at the state level participating in the planning grant.

- **Attachment 2:** Data Collection Instruments/Interview protocols for the evaluation. If using standardized data collection instruments/interview protocols, do not need to include these in the application. Instead, provide a web link to the appropriate instrument/protocol. If the data collection instrument(s) or interview protocol(s) is/are not standardized, include a copy in Attachment 2.

- **Attachment 3:** Sample Consent Forms

- **Attachment 4:** Statement of Assurance (provided in Appendix IV of this announcement) signed by the Authorized Representative of the applicant organization identified on the first page (SF-424) of the application; if selected, agree to pay for services at the rate established under the prospective payment system during the demonstration program. Agree no payments will be made for inpatient care, residential treatment, room and board expenses, or any other

non-ambulatory services, or to satellite facilities of CCBHCs if such facilities were established after April 1, 2014.

2. APPLICATION SUBMISSION REQUIREMENTS

Applications are due by **11:59 PM** (Eastern Time) on **August 5, 2015**.

3. FUNDING LIMITATIONS/RESTRICTIONS

No more than 20 percent of the grant award may be used for data collection, performance measurement, and performance assessment expenses (Section 2.2 and 2.3). Be sure to identify these expenses in the proposed budget. This limitation/restriction does not apply to the purchase of electronic health record or data systems for CCBHCs.

SAMHSA grantees also must comply with SAMHSA's standard funding restrictions, which are included in PART II: Appendix D – Funding Restrictions.

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

The Project Narrative describes what applicants intend to do with the project and includes the Evaluation Criteria in Sections A-D below. The application will be reviewed and scored according to the quality of the response for each of the requirements in Sections A-D.

- In developing the Project Narrative section of the application, use these instructions, which have been tailored to this program.
- The Project Narrative (Sections A-D) together may be no longer than 30 pages.
- Applicants must use the four sections/headings listed below in developing the Project Narrative. **Applicants must indicate the Section letter and number in the response or it will not be considered, i.e., type "A-1", "A-2", etc., before the response to each question.** The application will be scored according to how well the requirements for each section of the Project Narrative are addressed.
- Although the budget and supporting documentation for the proposed project are not scored review criteria, the Review Group will consider their appropriateness after the merits of the application have been considered. (See PART II: Section V and Appendix F).
- The number of points after each heading is the maximum number of points a review committee may assign to that section of the Project Narrative. Although scoring weights are not assigned to individual bullets, each bullet is assessed in deriving the overall Section score.

Section A: Statement of Need (15 points)

1. Describe how behavioral health services are organized, funded, and provided in the state.

2. Describe the prevalence rates of adults and children with mental illness and/or substance use disorders in the state and particularly in the areas of the state being considered for CCBHCs. Include sub-populations such as adults with serious mental illness and children with serious emotional disturbances, and those with long term and serious substance use disorders and populations experiencing behavioral health disparities.

3. Describe the capacity of the current Medicaid State Plan to provide the services listed in Appendix II.

4. Describe the nature of the problem, including service gaps, and document the need (i.e., current prevalence rates or incidence data) for the population(s) of focus based on data. Identify the source of the data. Documentation of need may come from a variety of qualitative and quantitative sources. Examples of data sources for the quantitative data that could be used are local epidemiologic data, state data (e.g., from state needs assessments), and/or national data [e.g., from SAMHSA's National Survey on Drug Use and Health or from National Center for Health Statistics/Centers for Disease Control and Prevention (CDC) reports, and Census data]. This list is not exhaustive; applicants may submit other valid data, as appropriate for the program.

Section B: Proposed Approach (40 points)

1. Describe how the capacity, access and availability of services to the population of focus will be expanded. Include activities such as outreach and engagement, staff training, and workforce diversity.

2. Describe how input on the development of the demonstration program will be solicited from consumers, family members, providers, and other stakeholders including American Indian/Native Alaskans and how they will be kept informed of the activities, changes, and processes related to the project.

3. Describe how community behavioral health clinics will be selected to participate and how the state will work with them to meet or prepare to meet the requirements in Appendix II.

4. Describe how all of the services outlined in Appendix II will be provided by CCBHCs in the state.

5. Identify the evidence-based practices that CCBHCs will be required to provide and justify the selection of the evidence-based practices.

6. Describe how the state will certify community behavioral health clinics in both urban and rural areas (where applicable) in the state.

7. Describe how the state will finalize planning activities and assist with the transition to implementation of the demonstration program, if selected to participate in the demonstration program.

8. Describe and justify the selection of the PPS rate-setting methodology. Describe how CCBHCs base cost with supporting data, as specified in Appendix III will be collected.

9. Describe how the state will establish a PPS for behavioral health services provided by CCBHCs in accordance with CMS guidance in Appendix III.

10. Identify any other organization(s) that will participate in the proposed project. Describe their roles and responsibilities and demonstrate their commitment to the project. Include letters of commitment from these organizations in **Attachment 1** of the application.

11. Describe how the state will work with CCBHCs to develop a process of board governance or other appropriate opportunities for meaningful input by consumers, persons in recover, and family members as described in Appendix II, Program Requirement 6: Organizational Authority, Governance and Accreditation.

Section C: Staff, Management, and Relevant Experience (10 points)

1. Discuss the capability and experience of the applicant organization and other participating organizations with similar projects and populations, including experience in providing recovery-oriented and culturally appropriate/competent services.

2. Provide a complete list of staff positions for the project, including the Project Director and other key personnel, showing the role of each and their level of effort and qualifications.

3. Discuss how key staff have demonstrated experience and are qualified to develop the infrastructure for the population(s) to engage in activities and are familiar with their culture(s) and language(s).

Section D: Data Collection and Performance Measurement (35 points)

1. Document the ability to collect and report on the required performance measures as specified in Section I-2.2 of this RFA. Describe the plan for data collection, management, analysis, and reporting of data for the program. Specify and justify any additional measures the state plans to use for the grant project.

2. Describe how the state will support CCBHCs as they build the performance measurement infrastructure and implement continuous quality improvement processes.

3. Describe the plan for conducting the performance assessment as specified in Section I-2.3 of this RFA and document the ability to conduct the assessment.

4. Discuss the challenges that may be encountered in collecting the data required for the national evaluation and how the state will address these challenges.

5. Describe a preliminary plan on how the state will select a comparison group for an assessment of access, quality, and scope of services available to Medicaid enrollees served by CCBHCs compared with Medicaid enrollees who access community-based mental health services from other providers.

6. Describe the capacity to collect data to inform the national evaluation of the demonstration program including claims, and encounter data, patient records, chart-based/registry data, and patient experience data.

SUPPORTING DOCUMENTATION

Section E: Biographical Sketches and Job Descriptions

See PART II: Appendix E – Biographical Sketches and Job Descriptions, for instructions.

Section F: Confidentiality and SAMHSA Participant Protection/Human Subjects

Applicants must describe procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section F of the application. See Appendix I of this document for guidelines on these requirements.

2. REVIEW AND SELECTION PROCESS

SAMHSA applications are peer-reviewed according to the evaluation criteria listed above.

Decisions to fund a grant are based on:

- the strengths and weaknesses of the application as identified by peer reviewers;
- when the individual award is over $150,000, approval by the Center for Mental Health Services' National Advisory Council;
- availability of funds; and

- geographic distribution including rural and underserved areas when making funding decisions.

VI. ADMINISTRATION INFORMATION

1. REPORTING REQUIREMENTS

In addition to the data reporting requirements listed in Section I-2.3, grantees must comply with the reporting requirements listed on the SAMHSA website at http://www.samhsa.gov/grants/grants-management/reporting-requirements. Grantees will submit reports quarterly and a final report at the end of the grant period.

VII. AGENCY CONTACTS

For questions about program issues contact:

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For questions on grants management and budget issues contact:

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Appendix I – Confidentiality and SAMHSA Participant Protection/Human Subjects Guidelines

Confidentiality and Participant Protection:

Because of the confidential nature of the work in which many SAMHSA grantees are involved, it is important to have safeguards protecting individuals from risks associated with their participation in SAMHSA projects. All applicants (including those who plan to obtain IRB approval) must address the seven elements below. If some are not applicable or relevant to the proposed project, simply state that they are not applicable and indicate why. In addition to addressing these seven elements, read the section that follows entitled "Protection of Human Subjects Regulations" to determine if the regulations may apply to your project. If so, you are required to describe the process you will follow for obtaining Institutional Review Board (IRB) approval. While we encourage you to keep your responses brief, there are no page limits for this section and no points will be assigned by the Review Committee. Problems with confidentiality, participant protection, and the protection of human subjects identified during peer review of the application must be resolved prior to funding.

1. <u>Protect Clients and Staff from Potential Risks</u>

    - Identify and describe any foreseeable physical, medical, psychological, social, and legal risks or potential adverse effects as a result of the project itself or any data collection activity.

    - Describe the procedures you will follow to minimize or protect participants against potential risks, including risks to confidentiality.

    - Identify plans to provide guidance and assistance in the event there are adverse effects to participants.

    - Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you choose not to use these other beneficial treatments, provide the reasons for not using them.

2. <u>Fair Selection of Participants</u>

    - Describe the population(s) of focus for the proposed project. Include age, gender, and racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women, or other targeted groups.

    - Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, and individuals who are likely to be particularly vulnerable to HIV/AIDS.

- Explain the reasons for including or excluding participants.

- Explain how you will recruit and select participants. Identify who will select participants.

3. Absence of Coercion

- Explain if participation in the project is voluntary or required. Identify possible reasons why participation is required, for example, court orders requiring people to participate in a program.

- If you plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.). Provide justification that the use of incentives is appropriate, judicious, and conservative and that incentives do not provide an "undue inducement" which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value if an incentive paid for with SAMHSA discretionary grant funds exceed $30.

- State how volunteer participants will be told that they may receive services intervention even if they do not participate in or complete the data collection component of the project.

4. Data Collection

- Identify from whom you will collect data (e.g., from participants themselves, family members, teachers, others). Describe the data collection procedures and specify the sources for obtaining data (e.g., school records, interviews, psychological assessments, questionnaires, observation, or other sources). Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.

- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in **Attachment 2, "Data Collection Instruments/Interview Protocols,"** copies of all available data collection instruments and interview protocols that you plan to use (unless you are providing the web link to the instrument(s)/protocol(s)).

5. Privacy and Confidentiality

- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.
- Describe:
  - How you will use data collection instruments.
  - Where data will be stored.
  - Who will or will not have access to information.
  - How the identity of participants will be kept private, for example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of **Title 42 of the Code of Federal Regulations, Part II.**

6. Adequate Consent Procedures

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Identify the data that will be collected, how the data will be used and how you will keep the data private.
- State:
  - Whether or not their participation is voluntary.
  - Their right to leave the project at any time without problems.
  - Possible risks from participation in the project.
  - Plans to protect clients from these risks.
- Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, you **must** obtain written informed consent.

- Indicate if you will obtain informed consent from participants or assent from minors along with consent from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include, as appropriate, sample consent forms that provide for: (1) informed consent for participation in service intervention; (2) informed consent for participation in the data collection component of the project; and (3) informed consent for the exchange (releasing or requesting) of confidential information. The sample forms must be included in **Attachment 3, "Sample Consent Forms",** of your application. If needed, give English translations.

NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data?

- Additionally, if other consents (e.g., consents to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

7. Risk/Benefit Discussion

- Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

Protection of Human Subjects Regulations

SAMHSA expects that most grantees funded under this announcement will not have to comply with the Protection of Human Subjects Regulations (45 CFR 46), which requires Institutional Review Board (IRB) approval. However, in some instances, the applicant's proposed performance assessment design may meet the regulation's criteria for research involving human subjects.

In addition to the elements above, applicants whose projects must comply with the Human Subjects Regulations must fully describe the process for obtaining IRB approval. While IRB approval is not required at the time of grant award, these grantees will be required, as a condition of award, to provide documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP). IRB approval must be received in these cases prior to enrolling participants in the project. General information about Human Subjects Regulations can be obtained through OHRP at http://www.hhs.gov/ohrp or (240) 453-6900. SAMHSA–specific questions should be directed to the program contact listed in Section VII of this announcement.

Appendix II – Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics

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Introduction

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (hereinafter "PAMA" or "the statute") was signed into law. Among other things, PAMA requires the establishment of demonstration programs to improve community behavioral health services, to be funded as part of Medicaid (PAMA, § 223). PAMA specifies criteria for certified community behavioral health clinics to participate in demonstration programs. These criteria fall into six areas: (1) staffing, (2) availability and accessibility of services, (3) care coordination, (4) scope of services, (5) quality and other reporting, and (6) organizational authority. The criteria within this document address each of the areas. The behavioral health clinics participating in this demonstration program and meeting criteria will be known as Certified Community Behavioral Health Clinics (CCBHCs).

The CCBHCs represent an opportunity for states[4] to improve the behavioral health of their citizens by: providing community-based mental and substance use disorder services; advancing integration of behavioral health with physical health care; assimilating and utilizing evidence-based practices on a more consistent basis; and promoting improved access to high quality care. Care coordination is the linchpin holding these aspects of CCBHC care together and ensuring CCBHC care is, indeed, an improvement over existing services. Enhanced federal matching funds made available through this demonstration for services delivered to Medicaid beneficiaries offer states the opportunity to expand access to care and improve the quality of behavioral health services.

PAMA is clear that, regardless of condition, CCBHCs are to provide services to all who seek help, but it is anticipated the CCBHCs will prove particularly valuable for individuals with serious mental illness (SMI), those with severe substance use disorders, children and adolescents with serious emotional disturbance (SED), and those with co-occurring mental, substance use or physical health disorders. Those who are most in need of coordinated, integrated quality care will receive it from CCBHCs.

The statute directs the care provided by CCBHCs be "patient-centered." It is expected CCBHCs will offer care that is person-centered and family-centered in accordance with

[4] The term "State" is defined in the statute (PAMA § 233(e)(4)) as having "the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

the requirements of section 2402(a) of the Affordable Care Act (ACA), trauma-informed, and recovery-oriented, and that the integration of physical and behavioral health care will serve the "whole person" rather than simply one disconnected aspect of the individual. The criteria are infused with these expectations and states are encouraged to certify clinics providing care consistent with these principles.

Although the CCBHC demonstration program and Prospective Payment System (PPS) are designed to work within the scope of state Medicaid Plans and to apply specifically to individuals who are Medicaid enrollees, the statute also requires the CCBHCs not to refuse service to any individual on the basis of either ability to pay or place of residence. In addition to these requirements for inclusive service, CCBHCs will serve persons for whom services are court ordered.[5] These conditions, together with the fact that improving access to and the quality of health care for the Medicaid population also may positively affect the health of others through changes in overall methods of care delivery, means the CCBHC demonstration program may have long lasting and beneficial effects beyond the realm of Medicaid enrollees.

These criteria were developed based on a review of selected state Medicaid Plans, standards for Federally Qualified Health Centers and Medicaid Health Homes, and quality measures currently in use by states. The criteria were refined and finalized through a public participatory process that occurred between November 2014 and March 2015, and included a National Listening Session, consultation with tribal leaders, written public comments, and solicitation for public response on the Substance Abuse and Mental Health Services Administration (SAMHSA) website.[6]

The criteria are intended to extend quality and to improve outcomes of the behavioral health care system within the authorities of state regulations, statutes and state Medicaid Plans. These criteria establish a basic level of services at which the CCBHCs should, at a minimum, operate. They allow the states flexibility in determining how to implement the criteria in a manner best addressing the needs of the population being served. The criteria are designed to encourage states and CCBHCs to further develop their abilities to offer behavioral health services that comport with current best practices. Thus, the criteria set high expectations which are likely to require changes and

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[5] This program does not extend Medicaid coverage or payment to inmates of correctional institutions.

[6] Also see guidance issued by CMS regarding the state PPS to be used as part of the demonstration program (PAMA, § 223(b)).

adjustments to current service delivery systems. SAMHSA recognizes state behavioral health programs vary widely in structure, content, funding and organization, and state Medicaid programs also differ widely. Consequently, there will be differences in the ease with which states can meet the criteria specified for this program. Although SAMHSA, in collaboration with staff in the Centers for Medicare & Medicaid Services (CMS) and the Assistant Secretary for Planning and Evaluation (ASPE), plans to select states for the demonstration program that can best satisfy the goals of PAMA, it also intends to consider carefully the extent to which applicant states are positioned to make substantial strides in care, using the demonstration program to improve access and quality of care.

Structure of the Criteria

Each program requirement corresponds to a section of PAMA, with the statutory authority for each program requirement identified at the beginning of the pertinent section. Also within the criteria, are "**Notes**." In some instances, **Notes** are clarifications of a criterion. In other instances, **Notes** provide states an opportunity to explain why a criterion may not be satisfied.

Definitions

Important terms used in these criteria are defined below. SAMHSA recognizes states may have existing definitions of the terms included here and these definitions are not intended to supplant state definitions to the extent a state definition is more specific or encompasses more than the definition used here.

Agreement: As used in the context of care coordination, an agreement is an arrangement between the CCBHC and external entities with which care is coordinated. Such an agreement is evidenced by a contract, Memorandum of Agreement (MOA), or Memorandum of Understanding (MOU) with the other entity, or by a letter of support, letter of agreement, or letter of commitment from the other entity. The agreement describes the parties' mutual expectations and responsibilities related to care coordination.

Behavioral health: Behavioral health is a general term "used to refer to both mental health and substance use" (SAMHSA-HRSA [2015]).

Care coordination: The Agency for Healthcare Research and Quality (2014) defines care coordination as "deliberately organizing consumer care activities and sharing information among all of the participants concerned with a consumer's care to achieve safer and more effective care. This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate,

and effective care to the patient." As used here, the term applies to activities by CCBHCs that have the purpose of coordinating and managing the care and services furnished to each consumer as required by PAMA (including both behavioral and physical health care), regardless of whether the care and services are provided directly by the CCBHC or through referral or other affiliation with care providers and facilities outside the CCBHC. Care coordination is regarded as an activity rather than a service.

Case management: Case management may be defined in many ways and can encompass services ranging from basic to intensive. The National Association of State Mental Health Program Directors (NASMHPD) defines case management as "a range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational and other services essential to meeting basic human services; linkages and training for patient served in the use of basic community resources; and monitoring of overall service delivery" (NASMHPD [2014]). See also the definition of "targeted case management."

CCBHC or Clinic: CCBHC and Clinic are used interchangeably to refer to Certified Community Behavioral Health Clinics as certified by states in accordance with these criteria and with the requirements of PAMA. A CCBHC may offer services in different locations. For multi-site organizations, however, only clinics eligible pursuant to these criteria and PAMA may be certified as CCBHCs.

CCBHC directly provides: When the term, "CCBHC directly provides" is used within these criteria it means employees or contract employees within the management structure and under the direct supervision of the CCBHC deliver the service.

Consumer: Within this document, the term "consumer" refers to clients, persons being treated for or in recovery from mental and/or substance use disorders, persons with lived experience, service recipients and patients, all used interchangeably to refer to persons of all ages (i.e., children, adolescents, transition aged youth, adults, and geriatric populations) for whom health care services, including behavioral health services, are provided by CCBHCs. Use of the term "patient" is restricted to areas where the statutory or other language is being quoted. Elsewhere, the word "consumer" is used.

Cultural and linguistic competence: Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse consumers (Office of Minority Health [2014]).

Designated Collaborating Organization (DCO): A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. The CCBHC maintains clinical responsibility for the services provided for CCBHC consumers by the DCO. To the extent that services are required that cannot be provided by either the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for care coordination including services to which it refers consumers. Payment for those referred services is not through the PPS but is made through traditional mechanisms within Medicaid.

Engagement: Engagement includes a set of activities connecting consumers with needed services. This involves the process of making sure consumers and families are informed about and initiate access with available services and, once services are offered or received, individuals and families make active decisions to continue receipt of the services provided. Activities such as outreach and education can serve the objective of engagement. Conditions such as accessibility, provider responsiveness, availability of culturally and linguistically competent care, and the provision of quality care, also promote consumer engagement.

Family: Families of both adult and child consumers are important components of treatment planning, treatment and recovery. Families come in different forms and, to the extent possible, the CCBHC should respect the individual consumer's view of what constitutes their family. Families can be organized in a wide variety of configurations regardless of social or economic status. Families can include biological parents and their partners, adoptive parents and their partners, foster parents and their partners, grandparents and their partners, siblings and their partners, care givers, friends, and others as defined by the family.

Family-centered: The Health Resources and Services Administration defines family-centered care, sometimes referred to as "family-focused care," as "an approach to the planning, delivery, and evaluation of health care whose cornerstone is active participation between families and professionals. Family-centered care recognizes families are the ultimate decision-makers for their children, with children gradually taking on more and more of this decision-making themselves. When care is family-centered, services not only meet the physical, emotional, developmental, and social needs of children, but also support the family's relationship with the child's health care providers and recognize the family's

customs and values" (Health Resources and Services Administration [2004]). More recently, this concept was broadened to explicitly recognize family-centered services are both developmentally appropriate and youth guided (American Academy of Child & Adolescent Psychiatry [2009]). Family-centered care is *family-driven* and *youth-driven*.

Formal relationships: As used in the context of scope of services and the relationships between the CCBHC and DCOs, a formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized. This formal relationship does not extend to referrals for services outside either the CCBHC or DCO, which are not encompassed within the reimbursement provided by the PPS.

Limited English Proficiency (LEP): LEP includes individuals who do not speak English as their primary language or who have a limited ability to read, write, speak, or understand English and who may be eligible to receive language assistance with respect to the particular service, benefit, or encounter.

Peer Support Services: Peer support services are services designed and delivered by individuals who have experienced a mental or substance use disorder and are in recovery. This also includes services designed and delivered by family members of those in recovery.

Peer Support Specialist: A peer provider (e.g., peer support specialist, recovery coach) is a person who uses their lived experience of recovery from mental or substance use disorders or as a family member of such a person, plus skills learned in formal training, to deliver services in behavioral health settings to promote recovery and resiliency. In states where Peer Support Services are covered through the state Medicaid Plans, the title of "certified peer specialist" often is used. SAMHSA recognizes states use different terminology for these providers.

Person-centered care: Person-centered care is aligned with the requirements of Section 2402(a) of the Patient Protection and Affordable Care Act, as implemented by the Department of Health & Human Services Guidance to HHS Agencies for Implementing Principles of Section 2403(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs (Department of Health & Human Services [June 6, 2014]). That guidance defines "person-centered planning" as a process directed by the person with service needs which identifies recovery goals,

objectives and strategies. If the consumer wishes, this process may include a representative whom the person has freely chosen, or who is otherwise authorized to make personal or health decisions for the person. Person-centered planning also includes family members, legal guardians, friends, caregivers, and others whom the person wishes to include. Person-centered planning involves the consumer to the maximum extent possible. Person-centered planning also involves self- direction, which means the consumer has control over selecting and using services and supports, including control over the amount, duration, and scope of services and supports, as well as choice of providers (Department of Health & Human Services [June 6, 2014]).

Practitioner or Provider: Any individual (practitioner) or entity (provider) engaged in the delivery of health care services and who is legally authorized to do so by the state in which the individual or entity delivers the services (42 CFR § 400.203).

Recovery: Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The 10 guiding principles of recovery are: hope; person-driven; many pathways; holistic; peer support; relational; culture; addresses trauma; strengths/responsibility; and respect. Recovery includes: Health (abstinence, "making informed healthy choices that support physical and emotional wellbeing"); Home (safe, stable housing); Purpose ("meaningful daily activities … and the independence, income and resources to participate in society"); and Community ("relationships and social networks that provide support, friendship, love, and hope") (Substance Abuse and Mental Health Services Administration [2012]).

Recovery-oriented care: Recovery-oriented care is oriented toward promoting and sustaining a person's recovery from a behavioral health condition. Care providers identify and build upon each individual's assets, strengths, and areas of health and competence to support the person in managing their condition while regaining a meaningful, constructive sense of membership in the broader community (Substance Abuse and Mental Health Services Administration [2015]).

Shared Decision-Making (SDM): SDM is an approach to care through which providers and consumers of health care come together as collaborators in determining the course of care. Key characteristics include having the health care provider, consumer, and sometimes family members and friends acting together, including taking steps in sharing a treatment decision, sharing

information about treatment options, and arriving at consensus regarding preferred treatment options (Schauer, Everett, delVecchio, & Anderson [2007]).

Targeted case management: Targeted case management is case management, as defined above, directed at specific groups, which may vary by state. CMS defines targeted case management as case management furnished without regard to requirements of statewide provision of service or comparability that typically apply for Medicaid reimbursement. 42 CFR § 440.169(b). Examples of groups that might be targeted for case management are children with serious emotional disturbance, adults with serious mental and/or substance use disorders, pregnant women who meet risk criteria, individuals with HIV, and such other groups as a state might identify as in need of targeted case management. See also the definition of "case management."

Trauma-informed: A trauma-informed approach to care "*realizes* the widespread impact of trauma and understands potential paths for recovery; *recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved in the system; and *responds* by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively *resist re-traumatization.*" The six key principles of a trauma-informed approach include: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues (Substance Abuse and Mental Health Services Administration [2014]).

Program Requirement 1: STAFFING

Within the bounds of state licensure and certification regulations, CCBHC staffing will include Medicaid-enrolled providers who adequately address the needs of the consumer population served. Credentialed, certified, and licensed professionals with adequate training in person-centered, family-centered, trauma-informed, culturally-competent and recovery-oriented care will help ensure this objective is attained. Care meeting these standards will further help the CCBHCs achieve integrated and high quality care.

Authority: Section 223 (a)(2)(A) of PAMA

The statute requires the published criteria to include criteria with respect to the following:

"Staffing requirements, including criteria that staff have diverse disciplinary backgrounds, have necessary State required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population."

Criteria 1.A: General Staffing Requirements	
1.a.1	As part of the process leading to certification, the state will prepare an assessment of the needs of the target consumer population and a staffing plan for prospective CCBHCs. The needs assessment will include cultural, linguistic and treatment needs. The needs assessment is performed prior to certification of the CCBHCs in order to inform staffing and services. After certification, the CCBHC will update the needs assessment and the staffing plan, including both consumer and family/caregiver input. The needs assessment and staffing plan will be updated regularly, but no less frequently than every three years.
1.a.2	The staff (both clinical and non-clinical) is appropriate for serving the consumer population in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer. **Note:** See criteria 4.K relating to required staffing of services for veterans.

Criteria 1.A: General Staffing Requirements	
1.a.3	The Chief Executive Officer (CEO) of the CCBHC maintains a fully staffed management team as appropriate for the size and needs of the clinic as determined by the current needs assessment and staffing plan. The management team will include, at a minimum, a CEO or Executive Director/Project Director, and a psychiatrist as Medical Director. The Medical Director need not be a full-time employee of the CCBHC. Depending on the size of the CCBHC, both positions (CEO/Executive Director/Project Director and the Medical Director) may be held by the same person. The Medical Director will ensure the medical component of care and the integration of behavioral health (including addictions) and primary care are facilitated. **Note:** If a CCBHC is unable, after reasonable and consistent efforts, to employ or contract with a psychiatrist as Medical Director because of a documented behavioral health professional shortage in its vicinity (as determined by the Health Resources and Services Administration (HRSA) (Health Resources and Services Administration [2015]), psychiatric consultation will be obtained on the medical component of care and the integration of behavioral health and primary care, and a medically trained behavioral health care provider with appropriate education and licensure with prescriptive authority in psychopharmacology who can prescribe and manage medications independently pursuant to state law will serve as the Medical Director.
1.a.4	The CCBHC maintains liability/malpractice insurance adequate for the staffing and scope of services provided.

Criteria 1.B: Licensure and Credentialing of Providers	
1.b.1	All CCBHC providers who furnish services directly, and any Designated Collaborating Organization (DCO) providers that furnish services under arrangement with the CCBHC, are legally authorized in accordance with federal, state and local laws, and act only within the scope of their respective state licenses, certifications, or registrations and in accordance with all applicable laws and regulations, including any applicable state Medicaid billing regulations or policies. Pursuant to the requirements of the statute (PAMA § 223 (a)(2)(A)), CCBHC providers have and maintain all necessary state-required licenses, certifications, or other credentialing, with providers working toward licensure, and appropriate supervision in accordance with applicable state law.

Criteria 1.B: Licensure and Credentialing of Providers	
1.b.2	The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state, is informed by the state's initial needs assessment, and includes clinical and peer staff. In accordance with the staffing plan, the CCBHC maintains a core staff comprised of employed and, as needed, contracted staff, as appropriate to the needs of CCBHC consumers as stated in consumers' individual treatment plans and as required by program requirements 3 and 4 of these criteria. States specify which staff disciplines they will require as part of certification but must include a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other medications used to treat opioid and alcohol use disorders. The CCBHC must have staff, either employed or available through formal arrangements, who are credentialed substance abuse specialists. Providers must include individuals with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI) and those with substance use disorders. Examples of staff the state might require include a combination of the following: (1) psychiatrists (including child, adolescent, and geriatric psychiatrists), (2) nurses trained to work with consumers across the lifespan, (3) licensed independent clinical social workers, (4) licensed mental health counselors, (5) licensed psychologists, (6) licensed marriage and family therapists, (7) licensed occupational therapists, (8) staff trained to provide case management, (9) peer specialist(s)/recovery coaches, (10) licensed addiction counselors, (11) staff trained to provide family support, (12) medical assistants, and (13) community health workers. The CCBHC supplements its core staff, as necessary given program requirements 3 and 4 and individual treatment plans, through arrangements with and referrals to other providers. **Note:** Recognizing professional shortages exist for many behavioral health providers: (1) some services may be provided by contract or part-time or as needed; (2) in CCBHC organizations comprised of multiple clinics, providers may be shared among clinics; and (3) CCBHCs may utilize telehealth/ telemedicine and on-line services to alleviate shortages. CCBHCs are not precluded by anything in this criterion from utilizing providers working towards licensure, provided they are working under the requisite supervision.

Criteria 1.C: Cultural Competence and Other Training	
1.c.1	The CCBHC has a training plan, for all employed and contract staff, and for providers at DCOs who have contact with CCBHC consumers or their families, which satisfies and includes requirements of the state behavioral health authority and any accreditation standards on training which may be required by the state. Training must address cultural competence; person-centered and family-centered, recovery-oriented, evidence-based and trauma-informed care; and primary care/behavioral health integration. This training, as well as training on the clinic's continuity plan, occurs at orientation and thereafter at reasonable intervals as may be required by the state or accrediting agencies. At orientation and annually thereafter, the CCBHC provides training about: (1) risk assessment, suicide prevention and suicide response; (2) the roles of families and peers; and (3) such other trainings as may be required by the state or accrediting agency on an annual basis. If necessary, trainings may be provided on-line. Cultural competency training addresses diversity within the organization's service population and, to the extent active duty military or veterans are being served, must include information related to military culture. Examples of cultural competency training and materials include, but are not limited to, those available through the website of the US Department of Health & Human Services (DHHS), the SAMHSA website through the website of the DHHS, Office of Minority Health, or through the website of the DHHS, Health Resources and Services Administration. **Note:** See criteria 4.K relating to cultural competency requirements in services for veterans.
1.c.2	The CCBHC assess the skills and competence of each individual furnishing services and, as necessary, provides in-service training and education programs. The CCBHC has written policies and procedures describing its method(s) of assessing competency and maintains a written accounting of the in-service training provided during the previous 12 months.
1.c.3	The CCBHC documents in the staff personnel records that the training and demonstration of competency are successfully completed.

1.c.4	Individuals providing staff training are qualified as evidenced by their education, training and experience.

Criteria 1.D: Linguistic Competence	
1.d.1	If the CCBHC serves individuals with Limited English Proficiency (LEP) or with language-based disabilities, the CCBHC takes reasonable steps to provide meaningful access to their services.
1.d.2	Interpretation/translation service(s) are provided that are appropriate and timely for the size/needs of the LEP CCBHC consumer population (e.g., bilingual providers, onsite interpreters, language telephone line). To the extent interpreters are used, such translation service providers are trained to function in a medical and, preferably, a behavioral health setting.
1.d.3	Auxiliary aids and services are readily available, Americans With Disabilities Act (ADA) compliant, and responsive to the needs of consumers with disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines).
1.d.4	Documents or messages vital to a consumer's ability to access CCBHC services (for example, registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available for consumers in languages common in the community served, taking account of literacy levels and the need for alternative formats (for consumers with disabilities). Such materials are provided in a timely manner at intake. The requisite languages will be informed by the needs assessment prepared prior to certification, and as updated.

Criteria 1.D: Linguistic Competence	
1.d.5	The CCBHC's policies have explicit provisions for ensuring all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider, including but not limited to the requirements of Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors. The HIPAA Privacy Rule allows routine – and often critical – communications between health care providers and a consumer's family and friends, so long as the consumer consents or does not object. If a consumer is amenable and has the capacity to make health care decisions, health care providers may communicate with a consumer's family and friends.

Program Requirement 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES

CCBHC will offer services in a manner accessible and available to individuals in their community. Significant aspects of accessibility and availability include the need for access at times and places convenient for those served, prompt intake and engagement in services, access regardless of ability to pay and place of residence, access to adequate crisis services, and consumer choice in treatment planning and services. Because the emergency department (ED) is often a source of crisis care, CCBHCs must have clearly established relationships with local EDs to facilitate care coordination, discharge and follow-up, as well as relationships with other sources of crisis care. Use of peer, recovery, and clinical supports in the community and increased access through the use of telehealth/telemedicine and mobile in-home supports also will further the statutory objective of availability and access to services.

Authority: Section 223 (a)(2)(B) of PAMA

The statute requires the published criteria to include criteria with respect to the following:

"Availability and accessibility of services, including: crisis management services that are available and accessible 24 hours a day, the use of a sliding scale for payment, and no rejection for services or limiting of services on the basis of a patient's ability to pay or a place of residence."

Criteria 2.A: General Requirements of Access and Availability	
2.a.1	The CCBHC provides a safe, functional, clean, and welcoming environment, for consumers and staff, conducive to the provision of services identified in program requirement 4.
2.a.2	The CCBHC provides outpatient clinical services during times that ensure accessibility and meet the needs of the consumer population to be served, including some nights and weekend hours.

2.a.3	The CCBHC provides services at locations that ensure accessibility and meet the needs of the consumer population to be served.
2.a.4	To the extent possible within the state Medicaid program or other funding or programs, the CCBHC provides transportation or transportation vouchers for consumers.
2.a.5	To the extent possible within the state Medicaid program and as allowed by state law, CCBHCs utilize mobile in-home, telehealth/telemedicine, and on-line treatment services to ensure consumers have access to all required services.
2.a.6	The CCBHC engages in outreach and engagement activities to assist consumers and families to access benefits, and formal or informal services to address behavioral health conditions and needs.
2.a.7	Services are subject to all state standards for the provision of both voluntary and court-ordered services.
2.a.8	CCBHCs have in place a continuity of operations/disaster plan.

Criteria 2.B: Requirements for Timely Access to Services and Initial and Comprehensive Evaluation for New Consumers	
2.b.1	All new consumers requesting or being referred for behavioral health services will, at the time of first contact, receive a preliminary screening and risk assessment to determine acuity of needs. That screening may occur telephonically. The preliminary screening will be followed by: (1) an initial evaluation, and (2) a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation, with the components of each specified in program requirement 4. Each evaluation builds upon what came before it. Subject to more stringent state, federal, or applicable accreditation standards: • If the screening identifies an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent outpatient follow-up. • If the screening identifies an urgent need, clinical services are provided and the initial evaluation completed within one business day of the time the request is made. • If the screening identifies routine needs, services will be provided and the initial evaluation completed within 10 business days. • For those presenting with emergency or urgent needs, the initial evaluation may be conducted telephonically or by telehealth/telemedicine but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved the consumer must be seen in person at the next subsequent encounter and the initial evaluation reviewed. Subject to more stringent state, federal or applicable accreditation standards, all new consumers will receive a more comprehensive person-centered and family-centered diagnostic and treatment planning evaluation to be <u>completed</u> within 60 calendar days of the first request for services. This requirement that the comprehensive evaluation be completed within 60 calendar days <u>does not preclude</u> either the initiation or completion of the comprehensive evaluation or the provision of treatment during the 60 day period. **Note:** Requirements for these screenings and evaluations are specified in criteria 4.D.

Criteria 2.B: Requirements for Timely Access to Services and Initial and Comprehensive Evaluation for New Consumers	
2.b.2	The comprehensive person-centered and family-centered diagnostic and treatment planning evaluation is updated by the treatment team, in agreement with and endorsed by the consumer and in consultation with the primary care provider (if any), when changes in the consumer's status, responses to treatment, or goal achievement have occurred. The assessment must be updated no less frequently than every 90 calendar days unless the state has established a standard that meets the expectation of quality care and that renders this time frame unworkable, or state, federal, or applicable accreditation standards are more stringent.
2.b.3	Outpatient clinical services for established CCBHC consumers seeking an appointment for routine needs must be provided within 10 business days of the requested date for service, unless the state has established a standard that meets the expectation of quality care and that renders this time frame unworkable, or state, federal, or applicable accreditation standards are more stringent. If an established consumer presents with an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent outpatient follow-up. If an established consumer presents with an urgent need, clinical services are provided within one business day of the time the request is made.

Criteria 2.C: 24/7 Access to Crisis Management Services	
2.c.1	In accordance with the requirements of program requirement 4, the CCBHC provides crisis management services that are available and accessible 24-hours a day and delivered within three hours.
2.c.2	The methods for providing a continuum of crisis prevention, response, and postvention services are clearly described in the policies and procedures of the CCBHC and are available to the public.
2.c.3	Individuals who are served by the CCBHC are educated about crisis management services and Psychiatric Advanced Directives and how to access crisis services, including suicide or crisis hotlines and warmlines, at the time of the initial evaluation. This includes individuals with LEP or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels in accordance with program requirement 1).
2.c.4	In accordance with the requirements of program requirement 3, CCBHCs maintain a working relationship with local EDs. Protocols are established for CCBHC staff to address the needs of CCBHC consumers in psychiatric crisis who come to those EDs.
2.c.5	Protocols, including protocols for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a psychiatric crisis. **Note:** See criterion 3.c.5 regarding specific care coordination requirements related to discharge from hospital or ED following a psychiatric crisis.
2.c.6	Following a psychiatric emergency or crisis involving a CCBHC consumer, in conjunction with the consumer, the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises for the consumer and their family. **Note:** See criterion 3.a.4 where precautionary crisis planning is addressed.

Criteria 2.D: No Refusal of Services due to Inability to Pay	
2.d.1	The CCBHC ensures: (1) no individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual's inability to pay for such services (PAMA § 223 (a)(2)(B)), and (2) any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1).
2.d.2	The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC proposes to offer pursuant to these criteria. Such fee schedule will be included on the CCBHC website, posted in the CCBHC waiting room and readily accessible to consumers and families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP or disabilities.
2.d.3	The fee schedules, to the extent relevant, conform to state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable to existing clinics; absent applicable state or federal requirements, the schedule is based on locally prevailing rates or charges and includes reasonable costs of operation.
2.d.4	The CCBHC has written policies and procedures describing eligibility for and implementation of the sliding fee discount schedule. Those policies are applied equally to all individuals seeking services.

Criteria 2.E: Provision of Services Regardless of Residence	
2.e.1	The CCBHC ensures no individual is denied behavioral health care services, including but not limited to crisis management services, because of place of residence or homelessness or lack of a permanent address.
2.e.2	CCBHCs have protocols addressing the needs of consumers who do not live close to a CCBHC or within the CCBHC catchment area as established by the state. CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence. The required protocols should address management of the individual's on-going treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing CCBHCs to refer and track consumers seeking non-crisis services to the CCBHC or other clinic serving the consumer's county of residence. For distant consumers within the CCBHC's catchment area, CCBHCs should consider use of telehealth/telemedicine to the extent practicable. In no circumstances (and in accordance with PAMA § 223 (a)(2)(B)), may any consumer be refused services because of place of residence.

Program Requirement 3: CARE COORDINATION

Care coordination is the linchpin of the CCBHC program. The Agency for Healthcare Research and Quality (2014) defines care coordination as involving "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and this information is used to provide safe, appropriate, and effective care to the patient." CCBHCs should be guided by this definition as they provide integrated and coordinated care to address all aspects of a person's health. Person-centered and family-centered care is aligned with the requirements of Section 2402(a) of the Patient Protection and Affordable Care Act, as implemented by the Department of Health & Human Services Guidance to HHS Agencies for Implementing Principles of Section 2403(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs (Department of Health & Human Services [June 6, 2014]). Person-centered and family-centered care considers the consumer's choice in care services provided, as well as the physical, behavioral health, and social service needs of each individual as these factors influence the well-being of the whole person. Whether services are provided directly by CCBHC staff or through collaboration with medical or other service providers in the community, adequate communication and collaboration between providers are essential to best address the consumer's needs and preferences.

Authority: Section 223 (a)(2)(C) of PAMA

The statute requires the published criteria to include criteria with respect to the following:

"Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral health needs. Care coordination requirements shall include partnerships or formal contracts with the following:

(i) Federally-qualified health centers (and as applicable, rural health clinics) to provide Federally-qualified health center services (and as applicable, rural health clinic services) to the extent such services are not provided directly through the certified community behavioral health clinic.

(ii) Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs.

(iii) Other community or regional services, supports, and providers, including schools, child welfare agencies, and juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, State licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services.

(iv) Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the Department as defined in section 1801 of title 38, United States Code.

(v) Inpatient acute care hospitals and hospital outpatient clinics."

Criteria 3.A: General Requirements of Care Coordination	
3.a.1	Based on a person and family-centered plan of care aligned with the requirements of Section 2402(a) of the ACA and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services, including access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. **Note:** See criteria 4.K relating to care coordination requirements for veterans.
3.a.2	The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state privacy laws, including patient privacy requirements specific to the care of minors. The HIPAA Privacy Rule allows routine – and often critical – communications between health care providers and a consumer's family and friends. Health care providers may always listen to a consumer's family and friends. If a consumer consents and has the capacity to make health care decisions, health care providers may communicate protected health care information to a consumer's family and friends. Given this, the CCBHC ensures consumers' preferences, and those of families of children and youth and families of adults, for shared information are adequately documented in clinical records, consistent with the philosophy of person and family-centered care. Necessary consent for release of information is obtained from CCBHC consumers for all care coordination relationships. If CCBHCs are unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program requirement 3, such attempts must be documented and revisited periodically.
3.a.3	Consistent with requirements of privacy, confidentiality, and consumer preference and need, the CCBHC assists consumers and families of children and youth, referred to external providers or resources, in obtaining an appointment and confirms the appointment was kept.

Criteria 3.A: General Requirements of Care Coordination	
3.a.4	Care coordination activities are carried out in keeping with the consumer's preferences and needs for care and, to the extent possible and in accordance with the consumer's expressed preferences, with the consumer's family/caregiver and other supports identified by the consumer. So as to ascertain in advance the consumer's preferences in the event of psychiatric or substance use crisis, CCBHCs develop a crisis plan with each consumer. Examples of crisis plans may include a Psychiatric Advanced Directive or Wellness Recovery Action Plan.
3.a.5	Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers for CCBHC consumers and, upon appropriate consent to release of information, to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care.
3.a.6	Nothing about a CCBHC's agreements for care coordination should limit a consumer's freedom to choose their provider with the CCBHC or its DCOs.

Criteria 3.B: Care Coordination and Other Health Information Systems	
3.b.1	The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records. The health IT system has the capability to capture structured information in consumer records (including demographic information, diagnoses, and medication lists), provide clinical decision support, and electronically transmit prescriptions to the pharmacy. 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.
3.b.2	The CCBHC uses its existing or newly established health IT system to conduct activities such as population health management, quality improvement, reducing disparities, and for research and outreach.

Criteria 3.B: Care Coordination and Other Health Information Systems	
3.b.3	If the CCBHC is establishing a health IT system, the system will have the capability to capture structured information in the health IT system (including demographic information, problem lists, and medication lists). CCBHCs establishing a health IT system will adopt a product certified to meet requirements in 3.b.1, to send and receive the full common data set for all summary of care records and be certified to support capabilities including transitions of care and privacy and security. CCBHCs establishing health IT systems will adopt a health IT system that is certified to meet the "Patient List Creation" criterion (45 CFR §170.314(a)(14)) established by the Office of the National Coordinator (ONC)[7] for ONC's Health IT Certification Program.
3.b.4	The CCBHC will work with DCOs to ensure all steps are taken, including obtaining consumer consent, to comply with privacy and confidentiality requirements, including but not limited to those of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.
3.b.5	Whether a CCBHC has an existing health IT system or is establishing a new health IT system, the CCBHC will develop a plan to be produced within the two-year demonstration program time frame to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan shall include information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care.

[7] See Table 1 and Table 3 respectively in Certification Guidance for EHR Technology Developers Serving Health Care Providers Ineligible for Medicare and Medicaid EHR Incentive Payments, which lists specific criteria related to transitions of care and privacy and security.

Criteria 3.C: Care Coordination Agreements	
3.c.1	The CCBHC has an agreement establishing care coordination expectations with Federally-Qualified Health Centers (FQHCs) (and, as applicable, Rural Health Clinics [RHCs]) to provide health care services, to the extent the services are not provided directly through the CCBHC. For consumers who are served by other primary care providers, including but not limited to FQHC Look-Alikes and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination. **Note**: If an agreement cannot be established with a FQHC or, as applicable, an RHC (e.g., a provider does not exist in their service area), or cannot be established within the time frame of the demonstration project, justification is provided to the certifying body and contingency plans are established with other providers offering similar services (e.g., primary care, preventive services, other medical care services). **Note:** CCBHCs are expected to work toward formal contracts with entities with which they coordinate care if they are not established at the beginning of the demonstration project.

Criteria 3.C: Care Coordination Agreements	
3.c.2	The CCBHC has an agreement establishing care coordination expectations with programs that can provide inpatient psychiatric treatment, with ambulatory and medical detoxification, post-detoxification step-down services, and residential programs to provide those services for CCBHC consumers. The CCHBC is able to track when consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity. The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric, detoxification, and residential settings to a safe community setting. This includes transfer of medical records of services received (e.g., prescriptions), active follow-up after discharge and, as appropriate, a plan for suicide prevention and safety, and provision for peer services. **Note**: For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided and contingency plans are developed and the state will make a determination whether the contingency plans are sufficient or require further efforts.

Criteria 3.C: Care Coordination Agreements	
3.c.3	The CCBHC has an agreement establishing care coordination expectations with a variety of community or regional services, supports, and providers. Services and supports to collaborate with which are identified by statute include: • Schools; • Child welfare agencies; • Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty courts); • Indian Health Service youth regional treatment centers; • State licensed and nationally accredited child placing agencies for therapeutic foster care service; and • Other social and human services. The CCBHC has, to the extent necessary given the population served and the needs of individual consumers, an agreement with such other community or regional services, supports, and providers as may be necessary, such as the following: • Specialty providers of medications for treatment of opioid and alcohol dependence; • Suicide/crisis hotlines and warmlines; • Indian Health Service or other tribal programs; • Homeless shelters; • Housing agencies; • Employment services systems; • Services for older adults, such as Aging and Disability Resource Centers; and • Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs). **Note**: For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided and contingency plans are developed and the state will make a determination whether the contingency plans are sufficient or require further efforts.

Criteria 3.C: Care Coordination Agreements	
3.c.4	The CCBHC has an agreement establishing care coordination expectations with the nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department. To the extent multiple Department facilities of different types are located nearby, the CCBHC should explore care coordination agreements with facilities of each type. **Note**: For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided and contingency plans are developed and the state will make a determination whether the contingency plans are sufficient or require further efforts.

Criteria 3.C: Care Coordination Agreements	
3.c.5	The CCBHC has an agreement establishing care coordination expectations with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers, in the area served by the CCBHC, to address the needs of CCBHC consumers. This includes procedures and services, such as peer bridgers, to help transition individuals from the ED or hospital to CCBHC care and shortened time lag between assessment and treatment. The agreement is such that the CCBHC can track when their consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to another entity. The agreement also provides for transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge. The CCBHC will make and document reasonable attempts to contact all CCBHC consumers who are discharged from these settings within 24 hours of discharge. For all CCBHC consumers being discharged from such facilities who presented to the facilities as a potential suicide risk, the care coordination agreement between these facilities and the CCBHC includes a requirement to coordinate consent and follow-up services with the consumer within 24 hours of discharge, and continues until the individual is linked to services or assessed to be no longer at risk. **Note**: For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided and contingency plans are developed and the state will make a determination whether the contingency plans are sufficient or require further efforts.

Criteria 3.D: Treatment Team, Treatment Planning and Care Coordination Activities	
3.d.1	The CCBHC treatment team includes the consumer, the family/caregiver of child consumers, the adult consumer's family to the extent the consumer does not object, and any other person the consumer chooses. All treatment planning and care coordination activities are person-centered and family-centered and aligned with the requirements of Section 2402(a) of the Affordable Care Act. All treatment planning and care coordination activities are subject to HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors. The HIPAA Privacy Rule does not cut off all communication between health care professionals and the families and friends of consumers. As long as the consumer consents, health care professionals covered by HIPAA may provide information to a consumer's family, friends, or anyone else identified by a consumer as involved in their care.
3.d.2	As appropriate for the individual's needs, the CCBHC designates an interdisciplinary treatment team that is responsible, with the consumer or family/caregiver, for directing, coordinating, and managing care and services for the consumer. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of CCBHC consumers, including, as appropriate, traditional approaches to care for consumers who may be American Indian or Alaska Native. **Note:** See criteria 4.K relating to required treatment planning services for veterans.
3.d.3	The CCBHC coordinates care and services provided by DCOs in accordance with the current treatment plan. **Note:** See program requirement 4 related to scope of service and person-centered and family-centered treatment planning.

Program Requirement 4: SCOPE OF SERVICES

Person-centered care is care aligned with the requirements of Section 2402(a) of the Affordable Care Act, and is care in which the consumer is actively involved and has the ability to self-direct services received, having maximum choice and control over their services, “including the amount, duration, and scope of services and supports as well as choice of provider(s)” (Department of Health & Human Services [June 6, 2014]). CCBHCs are required by PAMA to provide directly, or provide through referral or formal relationships with other providers, a broad array of services to meet the needs of the population served and to do so in a person-centered and family-centered manner. These criteria establish the concept of DCOs with whom the CCBHC will have formal relationships to provide, in conjunction with the CCBHC, many of the requisite services. Even if, however, a DCO supplies some aspect of required services, the CCBHC is still regarded as providing the service and is clinically responsible for the services provided. Although the statute lists minimum requirements that will need to be met, states also will have flexibility to shape the scope of services within the required areas to be aligned with their state Medicaid Plans and other state regulations. There is no requirement for the state to amend its Medicaid state plan for any CCBHC service provided by a certified clinic through this demonstration program. This applies to services currently authorized in the Medicaid state plan and to additional services made available through this demonstration. The intention and expectation is that states will establish scope of service requirements which encourage CCBHCs to expand the availability of high-quality integrated person-centered and family-centered care as envisioned by the statute, and to ensure the continual integration of new evidence-based practices.

Authority: Section 223 (a)(2)(D) of PAMA

The statute requires the published criteria to include criteria with respect to the following:

"Provision (in a manner reflecting person-centered care) of the following services which, if not available directly through the certified community behavioral health clinic, are provided or referred through formal relationships with other providers:

(i) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

(ii) Screening, assessment, and diagnosis, including risk assessment.

(iii) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.

(iv) Outpatient mental health and substance use services.

(v) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.

(vi) Targeted case management.

(vii) Psychiatric rehabilitation services.

(viii) Peer support and counselor services and family supports.

(ix) Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration."

Criteria 4.A: General Service Provisions	
4.a.1	CCBHCs are responsible for the provision of all care specified in PAMA, including, as more explicitly provided and more clearly defined below in criteria 4.B through 4.K, crisis services; screening, assessment and diagnosis; person-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 US Armed Forces and veterans. As provided in criteria 4.B through 4.K, many of these services may be provided either directly by the CCBHC or through formal relationships with other providers that are DCOs. Whether directly supplied by the CCBHC or by a DCO, the CCBHC is ultimately clinically responsible for all care provided. The decision as to the scope of services to be provided directly by the CCBHC, as determined by the state and clinics as part of certification, reflects the CCBHC's responsibility and accountability for the clinical care of the consumers. Despite this flexibility, it is expected CCBHCs will be designed so most services are provided by the CCBHC rather than by DCOs, as this will enhance the ability of the CCBHC to coordinate services. **Note:** 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 consumer'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.
4.a.3	With regard to either CCBHC or DCO services, consumers will have access to the CCBHC's existing grievance procedures, which must satisfy the minimum requirements of Medicaid and other grievance requirements such as those that may be mandated by relevant accrediting entities.
4.a.4	DCO-provided services for CCBHC consumers must meet the same quality standards as those provided by the CCBHC.
4.a.5	The entities with which the CCBHC coordinates care and all DCOs, taken in conjunction with the CCBHC itself, satisfy the mandatory aspects of these criteria.

Criteria 4.B: Requirement of Person-Centered and Family-Centered Care	
4.b.1	The CCBHC ensures all CCBHC services, including those supplied by its DCOs, are provided in a manner aligned with the requirements of Section 2402(a) of the Affordable Care Act, reflecting person and family-centered, recovery-oriented care, being respectful of the individual consumer's needs, preferences, and values, and ensuring both consumer involvement and self-direction of services received. Services for children and youth are family-centered, youth-guided, and developmentally appropriate. **Note:** See program requirement 3 regarding coordination of services and treatment planning. See criteria 4.K relating specifically to requirements for services for veterans.
4.b.2	Person-centered and family-centered care includes care which recognizes the particular cultural and other needs of the individual. This includes but is not limited to services for consumers who are American Indian or Alaska Native (AI/AN), for whom access to traditional approaches or medicines may be part of CCBHC services. For consumers who are AI/AN, these services may be provided either directly or by formal arrangement with tribal providers.

Criteria 4.C: Crisis Behavioral Health Services	
4.c.1	Unless there is an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services that dictates otherwise, the CCBHC will directly provide robust and timely crisis behavioral health services. Whether provided directly by the CCBHC or by a state-sanctioned alternative acting as a DCO, available services must include the following: • 24 hour mobile crisis teams, • Emergency crisis intervention services, and • Crisis stabilization. PAMA requires provision of these three crisis behavioral health services. As part of the certification process, the states will clearly define each term as they are using it but services provided must include suicide crisis response and services capable of addressing crises related to substance abuse and intoxication, including ambulatory and medical detoxification. States may elect to require the employment of peers on crisis teams. CCBHCs will have an established protocol specifying the role of law enforcement during the provision of crisis services. **Note:** See program requirement 2 related to crisis prevention, response and postvention services and criterion 3.c.5 regarding coordination of services and treatment planning, including after discharge from a hospital or ED following a psychiatric crisis.

Criteria 4.D: Screening, Assessment, and Diagnosis	
4.d.1	The CCBHC directly provides screening, assessment, and diagnosis, including risk assessment, for behavioral health conditions. In the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment or diagnosis (e.g., neurological testing, developmental testing and assessment, eating disorders), the CCBHC provides or refers them through formal relationships with other providers, or where necessary and appropriate, through use of telehealth/telemedicine services. **Note:** See program requirement 3 regarding coordination of services and treatment planning.
4.d.2	Screening, assessment, and diagnosis are conducted in a time frame responsive to the individual consumer's needs and are of sufficient scope to assess the need for all services required to be provided by CCBHCs.
4.d.3	The initial evaluation (including information gathered as part of the preliminary screening and risk assessment), as required in program requirement 2, includes, at a minimum, (1) preliminary diagnoses; (2) the source of referral; (3) the reason for seeking care, as stated by the consumer or other individuals who are significantly involved; (4) identification of the consumer's immediate clinical care needs related to the diagnosis for mental and substance use disorders; (5) a list of current prescriptions and over-the-counter medications, as well as other substances the consumer may be taking; (6) an assessment of whether the consumer is a risk to self or to others, including suicide risk factors; (7) an assessment of whether the consumer has other concerns for their safety; (8) assessment of need for medical care (with referral and follow-up as required); and (9) a determination of whether the person presently is or ever has been a member of the U.S. Armed Services. As needed, releases of information are obtained.

Criteria 4.D: Screening, Assessment, and Diagnosis	
4.d.4	As required in program requirement 2, a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation is completed within 60 days by licensed behavioral health professionals who, in conjunction with the consumer, are members of the treatment team, performing within their state's scope of practice. Information gathered as part of the preliminary screening and initial evaluation may be considered a part of the comprehensive evaluation. This requirement that the comprehensive evaluation be completed within 60 calendar days does not preclude either the initiation or completion of the comprehensive evaluation or the provision of treatment during the intervening 60 day period.

Criteria 4.D: Screening, Assessment, and Diagnosis	
4.d.5	Although a comprehensive diagnostic and treatment planning evaluation is required for all CCBHC consumers, the extent of the evaluation will depend on the individual consumer and on existing state, federal, or applicable accreditation standards. As part of certification, states will establish the requirements for these evaluations; factors states should consider requiring include: (1) reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the consumer's presentation to the CCBHC; (2) a psychosocial evaluation including housing, vocational and educational status, family/caregiver and social support, legal issues, and insurance status; (3) behavioral health history (including trauma history and previous therapeutic interventions and hospitalizations); (3) a diagnostic assessment, including current mental status, mental health (including depression screening) and substance use disorders (including tobacco, alcohol, and other drugs); (4) assessment of imminent risk (including suicide risk, danger to self or others, urgent or critical medical conditions, other immediate risks including threats from another person); (5) basic competency/cognitive impairment screening (including the consumer's ability to understand and participate in their own care); (6) a drug profile including the consumer's prescriptions, over-the-counter medications, herbal remedies, and other treatments or substances that could affect drug therapy, as well as information on drug allergies; (7) a description of attitudes and behaviors, including cultural and environmental factors, that may affect the consumer's treatment plan; (8) the consumer's strengths, goals, and other factors to be considered in recovery planning; (9) pregnancy and parenting status; (10) assessment of need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services, LEP or linguistic services); (11) assessment of the social service needs of the consumer, with necessary referrals made to social services and, for pediatric consumers, to child welfare agencies as appropriate; and (12) depending on whether the CCBHC directly provides primary care screening and monitoring of key health indicators and health risk pursuant to criteria 4.G, either: (a) an assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the consumer's primary care provider (with appropriate referral and follow-up), or (b) a basic physical assessment as required by criteria 4.G. All remaining necessary releases of information are obtained by this point.

Criteria 4.D: Screening, Assessment, and Diagnosis	
4.d.6	Screening and assessment by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix A of these criteria. The CCBHC should not take non-inclusion of a specific metric in Appendix A as a reason not to provide clinically indicated behavioral health screening or assessment and the state may elect to require specific other screening and monitoring to be provided by the CCBHCs beyond those listed in criterion 4.d.5 or Appendix A.
4.d.7	The CCBHC uses standardized and validated screening and assessment tools and, where appropriate, brief motivational interviewing techniques.
4.d.8	The CCBHC uses culturally and linguistically appropriate screening tools, and tools/approaches that accommodate disabilities (e.g., hearing disability, cognitive limitations), when appropriate.
4.d.9	If screening identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the consumer is provided or referred for a full assessment and treatment, if applicable.

Criteria 4.E: Person-Centered and Family-Centered Treatment Planning	
4.e.1	The CCBHC directly provides person-centered and family-centered treatment planning or similar processes, including but not limited to risk assessment and crisis planning. Person-centered and family-centered treatment planning satisfies the requirements of criteria 4.e.2 – 4.e.8 below and is aligned with the requirements of Section 2402(a) of the Affordable Care Act, including consumer involvement and self-direction. **Note:** See program requirement 3 related to coordination of care and treatment planning.
4.e.2	An individualized plan integrating prevention, medical and behavioral health needs and service delivery is developed by the CCBHC in collaboration with and endorsed by the consumer, the adult consumer's family to the extent the consumer so wishes, or family/caregivers of youth and children, and is coordinated with staff or programs necessary to carry out the plan. **Note:** States may wish to access additional resources related to person-centered treatment planning found in the CMS Medicaid Home and Community Based Services regulations at 42 C.F.R. Part 441, Subpart M, or in the CMS Medicare Conditions of Participation for Community Mental Health Centers regulations at 42 C.F.R. Part 485.
4.e.3	The CCBHC uses consumer assessments to inform the treatment plan and services provided.
4.e.4	Treatment planning includes needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the consumer's words or ideas and, when appropriate, those of the consumer's family/caregiver.
4.e.5	The treatment plan is comprehensive, addressing all services required, with provision for monitoring of progress towards goals. The treatment plan is built upon a shared decision-making approach.
4.e.6	Where appropriate, consultation is sought during treatment planning about special emphasis problems, including for treatment planning purposes (e.g., trauma, eating disorders).
4.e.7	The treatment plan documents the consumer's advance wishes related to treatment and crisis management and, if the consumer does not wish to share their preferences, that decision is documented.

Criteria 4.E: Person-Centered and Family-Centered Treatment Planning	
4.e.8	Consistent with the criteria in 4.e.1 through 4.e.7, states should specify other aspects of consumer, person-centered and family-centered treatment planning they will require based upon the needs of the population served. Treatment planning components that states might consider include: prevention; community inclusion and support (housing, employment, social supports); involvement of family/caregiver and other supports; recovery planning; safety planning; and the need for specific services required by the statute (i.e., care coordination, physical health services, peer and family support services, targeted case management, psychiatric rehabilitation services, accommodations to ensure cultural and linguistically competent services).

Criteria 4.F: Outpatient Mental Health and Substance Use Services	
4.f.1	The CCBHC directly provides outpatient mental and substance use disorder services that are evidence-based or best practices, consistent with the needs of individual consumers as identified in their individual treatment plan. In the event specialized services outside the expertise of the CCBHC are required for purposes of outpatient mental and substance use disorder treatment (e.g., treatment of sexual trauma, eating disorders, specialized medications for substance use disorders), the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine services. The CCBHC also provides or makes available through formal arrangement traditional practices/treatment as appropriate for the consumers served in the CCBHC area. **Note:** See also program requirement 3 regarding coordination of services and treatment planning.

Criteria 4.F: Outpatient Mental Health and Substance Use Services	
4.f.2	Based upon the findings of the needs assessment as required in program requirement 1, states must establish a minimum set of evidence-based practices required of the CCBHCs. Among those evidence-based practices states might consider are the following: Motivational Interviewing; Cognitive Behavioral individual, group and on-line Therapies (CBT); Dialectical Behavior Therapy (DBT); addiction technologies; recovery supports; first episode early intervention for psychosis; Multi-Systemic Therapy; Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (F-ACT); evidence-based medication evaluation and management (including but not limited to medications for psychiatric conditions, medication assisted treatment for alcohol and opioid substance use disorders (e.g., buprenorphine, methadone, naltrexone (injectable and oral), acamprosate, disulfiram, naloxone), prescription long-acting injectable medications for both mental and substance use disorders, and smoking cessation medications); community wrap-around services for youth and children; and specialty clinical interventions to treat mental and substance use disorders experienced by youth (including youth in therapeutic foster care). This list is not intended to be all-inclusive and the states are free to determine whether these or other evidence-based treatments may be appropriate as a condition of certification.
4.f.3	Treatments are provided that are appropriate for the consumer's phase of life and development, specifically considering what is appropriate for children, adolescents, transition age youth, and older adults, as distinct groups for whom life stage and functioning may affect treatment. Specifically, when treating children and adolescents, CCHBCs provide evidenced-based services that are developmentally appropriate, youth guided, and family/caregiver driven with respect to children and adolescents. When treating older adults, the individual consumer's desires and functioning are considered and appropriate evidence-based treatments are provided. When treating individuals with developmental or other cognitive disabilities, level of functioning is considered and appropriate evidence-based treatments are provided. These treatments are delivered by staff with specific training in treating the segment of the population being served.

Criteria 4.F: Outpatient Mental Health and Substance Use Services	
4.f.4	Children and adolescents are treated using a family/caregiver-driven, youth guided and developmentally appropriate approach that comprehensively addresses family/caregiver, school, medical, mental health, substance abuse, psychosocial, and environmental issues.

Criteria 4.G: Outpatient Clinic Primary Care Screening and Monitoring	
4. g.1	The CCBHC is responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk. Whether directly provided by the CCBHC or through a DCO, the CCBHC is responsible for ensuring these services are received in a timely fashion. Required primary care screening and monitoring of key health indicators and health risk provided by the CCBHC include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix A of these criteria. The CCBHC should not take non-inclusion of a specific metric in Appendix A as a reason not to provide clinically indicated primary care screening and monitoring and the state may elect to require specific other screening and monitoring to be provided by the CCBHCs. The CCBHC ensures children receive age appropriate screening and preventive interventions including, where appropriate, assessment of learning disabilities, and older adults receive age appropriate screening and preventive interventions. Prevention is a key component of primary care services provided by the CCBHC. Nothing in these criteria prevent a CCBHC from providing other primary care services. **Note:** See also program requirement 3 regarding coordination of services and treatment planning.

Criteria 4.H: Targeted Case Management Services	
4.h.1	The CCBHC is responsible for high quality targeted case management services that will assist individuals in sustaining recovery, and gaining access to needed medical, social, legal, educational, and other services and supports. Targeted case management should include supports for persons deemed at high risk of suicide, particularly during times of transitions such as from an ED or psychiatric hospitalization. Based upon the needs of the population served, states should specify the scope of other targeted case management services that will be required, and the specific populations for which they are intended.

Criteria 4.I: Psychiatric Rehabilitation Services	
4.i.1	The CCBHC is responsible for evidence-based and other psychiatric rehabilitation services. States should specify which evidence-based and other psychiatric rehabilitation services they will require based upon the needs of the population served. Psychiatric rehabilitation services that might be considered include: medication education; self-management; training in personal care skills; individual and family/caregiver psycho-education; community integration services; recovery support services including Illness Management & Recovery; financial management; and dietary and wellness education. States also may wish to require the provision of supported services such as housing, employment, and education, the latter in collaboration with local school systems. **Note:** See program requirement 3 regarding coordination of services and treatment planning.

Criteria 4.J: Peer Supports, Peer Counseling and Family/Caregiver Supports	
4.j.1	The CCBHC is responsible for peer specialist and recovery coaches, peer counseling, and family/caregiver supports. States should specify the scope of peer and family services they will require based upon the needs of the population served. Peer services that might be considered include: peer-run drop-in centers, peer crisis support services, peer bridge services to assist individuals transitioning between residential or inpatient settings to the community, peer trauma support, peer support for older adults or youth, and other peer recovery services. Potential family/caregiver support services that might be considered include: family/caregiver psycho-education, parent training, and family-to-family/caregiver support services. **Note:** See program requirement 3 regarding coordination of services and treatment planning.

Criteria 4.K: Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans	
4.k.1	The CCBHC is responsible for intensive, community-based behavioral health care for certain members of the U.S. Armed Forces and veterans, particularly those Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility (MTF) and veterans living 40 miles or more (driving distance) from a VA medical facility, or as otherwise required by federal law. Care provided to veterans is required to be consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration. The provisions of these criteria in general and, specifically, in criteria 4.K, are designed to assist CCBHCs in providing quality clinical behavioral health services consistent with the Uniform Mental Health Services Handbook. **Note:** See program requirement 3 regarding coordination of services and treatment planning.

Criteria 4.K: Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans	
4.k.2	All individuals inquiring about services are asked whether they have ever served in the U.S. military. Current Military Personnel: Persons affirming current military service will be offered assistance in the following manner: (1) Active Duty Service Members (ADSM) must use their servicing MTF, and their MTF Primary Care Managers (PCMs) are contacted by the CCBHC regarding referrals outside the MTF. (2) ADSMs and activated Reserve Component (Guard/Reserve) members who reside more than 50 miles (or one hour's drive time) from a military hospital or military clinic enroll in TRICARE PRIME Remote and use the network PCM, or select any other authorized TRICARE provider as the PCM. The PCM refers the member to specialists for care he or she cannot provide; and works with the regional managed care support contractor for referrals/authorizations. (3) Members of the Selected Reserves, not on Active Duty (AD) orders, are eligible for TRICARE Reserve Select and can schedule an appointment with any TRICARE-authorized provider, network or non-network. Veterans: Persons affirming former military service (veterans) are offered assistance to enroll in VHA for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA, including clinical guidelines contained in the Uniform Mental Health Services Handbook as excerpted below (from VHA Handbook 1160.01, Principles of Care found in the Uniform Mental Health Services in VA Centers and Clinics). **Note:** See also program requirement 3 requiring coordination of care across settings and providers, including facilities of the Department of Veterans Affairs.

Criteria 4.K: Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans	
4.k.3	In keeping with the general criteria governing CCBHCs, CCBHCs ensure there is integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both and for integration or coordination between care for behavioral health conditions and other components of health care for all veterans.
4.k.4	Every veteran seen for behavioral health services is assigned a Principal Behavioral Health Provider. When veterans are seeing more than one behavioral health provider and when they are involved in more than one program, the identity of the Principal Behavioral Health Provider is made clear to the veteran and identified in the medical record. The Principal Behavioral Health Provider is identified on a consumer tracking database for those veterans who need case management. The Principal Behavioral Health Provider ensures the following requirements are fulfilled: (1) Regular contact is maintained with the veteran as clinically indicated as long as ongoing care is required. (2) A psychiatrist, or such other independent prescriber as satisfies the current requirements of the VHA Uniform Mental Health Services Handbook, reviews and reconciles each veteran's psychiatric medications on a regular basis. (3) Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision-maker's consent when the veteran does not have adequate decision-making capacity). (4) Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained. (5) The treatment plan is revised, when necessary.

Criteria 4.K: Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans	
4.k.4 (continued)	(6) The principal therapist or Principal Behavioral Health Provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision-making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2). (7) The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the Principal Behavioral Health Provider suspects the veteran lacks the capacity to make a decision about the mental health treatment plan, the provider must ensure the veteran's decision-making capacity is formally assessed and documented. For veterans who are determined to lack capacity, the provider must identify the authorized surrogate and document the surrogate's verbal consent to the treatment plan.

Criteria 4.K: Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans	
4.k.5	In keeping with the general criteria governing CCBHCs, behavioral health services are recovery-oriented. The VHA adopted the National Consensus Statement on Mental Health Recovery in its Uniform Mental Health Services Handbook. SAMHSA has since developed a working definition and set of principles for recovery updating the Consensus Statement. Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The following are the 10 guiding principles of recovery: • Hope • Person-driven • Many pathways • Holistic • Peer support • Relational • Culture • Addresses trauma • Strengths/responsibility • Respect (Substance Abuse and Mental Health Services Administration [2012]). As implemented in VHA recovery, the recovery principles also include the following: • Privacy • Security • Honor Care for veterans must conform to that definition and to those principles in order to satisfy the statutory requirement that care for veterans adheres to guidelines promulgated by the VHA.

Criteria 4.K: Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans	
4.k.6	In keeping with the general criteria governing CCBHCs, all behavioral health care is provided with cultural competence. (1) Any staff who is not a veteran has training about military and veterans' culture in order to be able to understand the unique experiences and contributions of those who have served their country. (2) All staff receives cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity.
4.k.7	In keeping with the general criteria governing CCBHCs, there is a behavioral health treatment plan for all veterans receiving behavioral health services. (1) The treatment plan includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis. (2) The treatment plan includes approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself. (3) As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness. (4) The plan is recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments. (5) The treatment plan is developed with input from the veteran, and when the veteran consents, appropriate family members. The veteran's verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1.

Program Requirement 5: QUALITY AND OTHER REPORTING

Data collection, use and reporting are vital for assessment and improvement of program quality. As a condition of participation in the demonstration program, the statute requires states to collect and report on encounter, clinical outcomes, and quality improvement data. The statute also requires annual reporting by the states that will entail collection of data which can be used to assess the impact of the demonstration program on: (1) access to community-based behavioral health services "in the area or areas of a state targeted by a demonstration program compared to other areas of the state"; (2) quality and scope of services provided by CCBHCs compared with non-CCBHC providers; and (3) federal and state costs of a full range of behavioral health services (including inpatient, emergency, and ambulatory services) (PAMA § 223(d)(7)(A)). The criteria related to this program requirement are designed to elicit the data needed to ensure improved access to care, high-quality services and appropriate state reporting. States also may wish to encourage the use of consumer and family led evaluations of the CCBHCs to ensure consumers and families are involved in this aspect of service design and delivery.

Authority: Section 223 (a)(2)(E) of PAMA

The statute requires the published criteria to include criteria with respect to the following:

"Reporting of encounter data, clinical outcomes data, quality data, and such other data as the Secretary requires."

Criteria 5.A: Data Collection, Reporting and Tracking	
5.a.1	The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including but not limited to data capturing: (1) consumer 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) consumer outcomes. Data collection and reporting requirements are elaborated below and in Appendix A.
5.a.2	Reporting is annual and data are required to be reported for all CCBHC consumers, or where data constraints exist (for example, the measure is calculated from claims), for all Medicaid enrollees in the CCBHCs.
5.a.3	To the extent possible, these criteria assign to the state responsibility for data collection and reporting where access to data outside the CCBHC is required. Data to be collected and reported and quality measures to be reported, however, may relate to services CCBHC consumers receive through DCOs. Collection of some of the data and quality measures that are the responsibility of the CCBHC may require access to data from DCOs and it is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship with DCOs and to ensure adequate consent as appropriate and that releases of information are obtained for each affected consumer.

Criteria 5.A: Data Collection, Reporting and Tracking	
5.a.4	As specified in Appendix A, some aspects of data reporting will be the responsibility of the state, using Medicaid claims and encounter data. States must provide CCHBC-level Medicaid claims or encounter data to the evaluators of this demonstration program annually. At a minimum, consumer and service-level data should include a unique consumer identifier, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. These data must be reported through MMIS/T-MSIS in order to support the state's claim for enhanced federal matching funds made available through this demonstration program. For each consumer, the state must obtain and link the consumer level administrative Uniform Reporting System (URS) information to the claim (or be able to link by unique consumer identifier). CCBHC consumer claim or encounter data must be linkable to the consumer's pharmacy claims or utilization information, inpatient and outpatient claims, and any other claims or encounter data necessary to report the measures identified in Appendix A. These linked claims or encounter data must also be made available to the evaluator. In addition to data specified in this program requirement and in Appendix A that the state is to provide, the state will provide such 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 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 will participate in discussions with the national evaluation team.
5.a.5	CCBHCs annually submit a cost report with supporting data within six months after the end of each demonstration year to the state. The 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 to receive payment using the CCBHC PPS, it must be certified as a CCBHC.

Criteria 5.B: Continuous Quality Improvement (CQI) Plan	
5.b.1	The CCBHC develops, implements, and maintains an effective, CCBHC-wide data-driven continuous quality improvement (CQI) plan for clinical services and clinical management. The CQI projects are clearly defined, implemented, and evaluated annually. The number and scope of distinct CQI projects conducted annually are based on the needs of the CCBHC's population and reflect the scope, complexity and past performance of the CCBHC's services and operations. The CCBHC-wide CQI plan addresses priorities for improved quality of care and client safety, and requires all improvement activities be evaluated for effectiveness. 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 documents each CQI project implemented, the reasons for the projects, and the measurable progress achieved by the projects. One or more individuals are designated as responsible for operating the CQI program.
5.b.2	Although the CQI plan is to be developed by the CCBHC and reviewed and approved by the state during certification, specific events are expected to be addressed as part of the CQI plan, including: (1) CCBHC consumer suicide deaths or suicide attempts; (2) CCBHC consumer 30 day hospital readmissions for psychiatric or substance use reasons; and (3) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.

Program Requirement 6: ORGANIZATIONAL AUTHORITY, GOVERNANCE AND ACCREDITATION

It is envisioned the organizations meeting the CCBHC standards will be able to provide comprehensive and high quality services in a manner reflecting evidence based and best practices in the field. Combined with the other program requirements of Section 223, the criteria within this section are meant to bolster states' ability to identify and support organizations with demonstrated capacity and capability to meet the CCBHC criteria.

Authority: Section 223 (a)(2)(F) of PAMA

The statute requires the published criteria to include criteria with respect to the following:

"Criteria that a clinic be a nonprofit or part of a local government behavioral health authority or operated under the authority of the Indian Health Service, an Indian Tribe, or Tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.), or an urban Indian organization pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.)."

Criteria 6.A: General Requirements of Organizational Authority and Finances	
6.a.1	The CCBHC maintains documentation establishing the CCBHC conforms to at least one of the following statutorily established criteria: • Is a non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code; • Is part of a local government behavioral health authority; • Is operated under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.); • Is an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.). **Note:** A CCBHC is considered part of a local government behavioral health authority when a locality, county, region or state maintains authority to oversee behavioral health services at the local level and utilizes the clinic to provide those services.
6.a.2	To the extent CCBHCs are not operated under the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, states, based upon the population the prospective CCBHC may serve, should require CCBHCs to reach out to such entities within their geographic service area and enter into arrangements with those entities to assist in the provision of services to AI/AN consumers and to inform the provision of services to those consumers. To the extent the CCBHC and such entities jointly provide services, the CCBHC and those collaborating entities shall, as a whole, satisfy the requirements of these criteria.
6.a.3	An independent financial audit is performed annually for the duration of the demonstration in accordance with federal audit requirements, and, where indicated, a corrective action plan is submitted addressing all findings, questioned costs, reportable conditions, and material weakness cited in the Audit Report.

Criteria 6.B: Governance	
6.b.1	As a group, the CCBHC's board members are representative of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, and sexual orientation, and in terms of types of disorders. The CCBHC will incorporate meaningful participation by adult consumers with mental illness, adults recovering from substance use disorders, and family members of CCBHC consumers, either through 51 percent of the board being families, consumers or people in recovery from behavioral health conditions, or through a substantial portion of the governing board members meeting this criteria and other specifically described methods for consumers, people in recovery and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services.
6.b.2	The CCBHC will describe how it meets this requirement or develop a transition plan with timelines appropriate to its governing board size and target population to meet this requirement.
6.b.3	To the extent the CCBHC is comprised of a governmental or tribal entity or a subsidiary or part of a larger corporate organization that cannot meet these requirements for board membership, the state will specify the reasons why the CCBHC cannot meet these requirements and the CCBHC will have or develop an advisory structure and other specifically described methods for consumers, persons in recovery, and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services.
6.b.4	As an alternative to the board membership requirement, any organization selected for this demonstration project may establish and implement other means of enhancing its governing body's ability to insure that the CCBHC is responsive to the needs of its consumers, families, and communities. Efforts to insure responsiveness will focus on the full range of consumers, services provided, geographic areas covered, types of disorders, and levels of care provided. The state will determine if this alternative approach is acceptable and, if it is not, will require that additional or different mechanisms be established to assure that the board is responsive to the needs of CCBHC consumers and families. Each organization will make available the results of their efforts in terms of outcomes and resulting changes.

Criteria 6.B: Governance	
6.b.5	Members of the governing or advisory boards will be representative of the communities in which the CCBHC's service area is located and will be selected for their expertise in health services, community affairs, local government, finance and banking, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. No more than one half (50 percent) of the governing board members may derive more than 10 percent of their annual income from the health care industry.
6.b.6	States will determine what processes will be used to verify that these governance criteria are being met.

Criteria 6.C: Accreditation	
6.c.1	CCBHCs will adhere to any applicable state accreditation, certification, and/or licensing requirements.
6.c.2	States are encouraged to require accreditation of the CCBHCs by an appropriate nationally-recognized organization (e.g., the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities [CARF], the Council on Accreditation [COA], the Accreditation Association for Ambulatory Health Care [AAAHC]). Accreditation does not mean “deemed” status.

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Appendix A: Quality Measures and Other Reporting Requirements

Appendix A contains the data and quality measures required to be reported as part of these criteria.[8] The requirements are based on the measurement landscape as of the time the CCBHC criteria were drafted (March 2015) and, given the rapid change occurring in the measurement field, might change, particularly if altering these quality measures enables better alignment with other reporting requirements. For the same reason, Quality Bonus Measures (QBMs) are not specified in these criteria or Appendix, rather they are established by CMS as part of the PPS. Appendix A is divided into data/measures required to be reported by the CCBHCs (Table 1) and those required to be reported by the states (Table 2). Reporting is annual and data are required to be reported for all CCBHC consumers, or where data constraints exist, for all Medicaid enrollees in the CCBHCs.

In addition to these reporting requirements, the demonstration program evaluator will require the reporting of additional data to be used as part of the project evaluation. Those additional data are not specified in these criteria. All data collected and reported by the state must be flagged to distinguish the individual CCBHCs and consumers served by CCBHCs, as well as a comparison group of clinics and consumers. In addition, the consumer's unique Medicaid identifier must be attached.

Table 1. CCBHC Required Reporting = 17

Potential Source of Data	Measure or Other Reporting Requirement	National Quality Forum Measure (# if endorsed)
EHR, Patient records, Electronic scheduler	Number/Percent of clients requesting services who were determined to need routine care	N/A

[8] See also program requirement 5 for additional information on required reporting.

Potential Source of Data	Measure or Other Reporting Requirement	National Quality Forum Measure (# if endorsed)
EHR, Patient records, Electronic scheduler	Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients	N/A
EHR, Patient records, Electronic scheduler	Mean number of days before the comprehensive person-centered and family centered diagnostic and treatment planning evaluation is performed for new clients	N/A
EHR, Patient records	Number of Suicide Deaths by Patients Engaged in Behavioral Health (CCBHC) Treatment	N/A
EHR, Patient records	Documentation of Current Medications in the Medical Records	0419
MHSIP Consumer survey	Patient experience of care survey	No
MHSIP Family survey	Family experience of care survey	No
EHR, Patient records	Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up	0421
EHR, Encounter data	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (see Medicaid Child Core Set)[9]	0024
EHR, Encounter data	Controlling High Blood Pressure (see Medicaid Adult Core Set)[10]	0018

[9] The link to specifications for the Medicaid Child Core Set is http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/chipra-initial-core-set-of-childrens-health-care-quality-measures.html

[10] The link to specifications for the Medicaid Adult Core Set is: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-health-care-quality-measures.html

Potential Source of Data	Measure or Other Reporting Requirement	National Quality Forum Measure (# if endorsed)
EHR, Encounter data	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	0028
EHR, Patient records	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	2152
EHR, Patient records	Initiation and engagement of alcohol and other drug dependence treatment (see Medicaid Adult Core Set)	0004
EHR, Patient records	Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment (see Medicaid Child Core Set)	1365
EHR, Patient records	Adult major depressive disorder (MDD): Suicide risk assessment (use EHR Incentive Program version of measure)	0104
EHR, Patient records	Screening for Clinical Depression and Follow-Up Plan (see Medicaid Adult Core Set)	0418
EHR, Patient records; Consumer follow-up with standardized measure (PHQ-9)	Depression Remission at 12 months	0710

Table 2. State Required Reporting = 15

Potential Source of Data	Measure or Other Reporting Requirement	National Quality Forum Measure (# if endorsed)
URS	Housing Status (Residential Status at Admission or Start of the Reporting Period Compared to Residential Status at Discharge or End of the Reporting Period)	N/A
Claims data/encounter data	Number of Suicide Attempts Requiring Medical Services by Patients Engaged in Behavioral Health (CCBHC) Treatment	N/A
Claims data/encounter data	Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Dependence	2605
Claims data/encounter data	Plan All-Cause Readmission Rate (PCR-AD) (see Medicaid Adult Core Set)	1768
Claims data/encounter data	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications	1932
Claims data/encounter data	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	2607
Claims data/encounter data	Metabolic Monitoring for Children and Adolescents on Antipsychotics	No
Claims data/encounter data	Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications	1927
Claims data/encounter data	Cardiovascular health monitoring for people with cardiovascular disease and schizophrenia	1933

Potential Source of Data	Measure or Other Reporting Requirement	National Quality Forum Measure (# if endorsed)
Claims data/encounter data	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	1880
Claims data/encounter data	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (see Medicaid Adult Core Set)	No
Claims data/encounter data	Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (see Medicaid Adult Core Set)	0576
Claims data/encounter data	Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (see Medicaid Child Core Set)	0576
Claims data/encounter data	Follow-up care for children prescribed ADHD medication (see Medicaid Child Core Set)	0108
Claims data/encounter data	Antidepressant Medication Management (see Medicaid Adult Core Set)	0105

Appendix III - Section 223 Demonstration Programs to Improve Community Mental Health Services Prospective Payment System (PPS) Guidance

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Section 1: Introduction

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA or "the statute") was signed into law. No later than September 1, 2017, the Department of Health and Human Services (HHS) will select up to eight states to participate in a 2-year demonstration program to improve community mental health services. The behavioral health clinics, in the selected states, that meet HHS established criteria to participate in this demonstration will be known as certified community behavioral health clinics (CCBHCs).

The statute requires the use of a prospective payment system (PPS) to pay the participating clinics for provision of CCBHC services and requires the Centers for Medicare & Medicaid Services (CMS) to issue guidance to states and clinics no later than September 1, 2015, on the development of the PPS to be used for the demonstration. The CCBHC PPS applies to services delivered either directly by a CCBHC or through a formal relationship between a CCBHC (including related sites eligible to participate) and Designated Collaborating Organizations (DCOs) as that term is defined in the criteria.

Under this demonstration, participating states will select one of two PPS rate methodologies for use in the demonstration. The PPS methodology selected will be used demonstration-wide to set CCBHC-specific rates. Designated as Certified Clinic Prospective Payment System (CC PPS-1), the first option is a FQHC-like PPS that provides reimbursement of cost on a daily basis (as does the current PPS used for FQHC services reimbursement) with the addition of a state option to provide quality bonus payments to CCBHCs that meet defined quality metrics. This is not a requirement and should not be seen as changing the underlying PPS system. It would only be there as a possibility for additional bonus payments and is at the option of the state. The second option, CC PPS Alternative (CC PPS-2) uses a monthly unit of payment, provides for quality bonus and provides for rates that vary, depending on the populations served by the certified clinic (e.g. patients who are seriously mentally ill and those with substance use disorders). Under the second option the state is required to incorporate quality bonus payments as part of the payment made using CC PPS-2.

PAMA permits states to claim expenditures related to payments made for CCBHC services at the enhanced Federal Medical Assistance Percentage (FMAP) equivalent to the standard Children's Health Insurance Program (CHIP) rate as specified in section 2105(b) of the Social Security Act (the Act), not including the 23 percentage point

applicable for the period beginning on October 1, 2015 and ending on September 30, 2019. With respect to expenditures for CCBHC services provided to certified clinic users who are Medicaid beneficiaries enrolled in a Medicaid CHIP expansion program, beginning on October 1, 2015 and ending on September 30, 2019, the enhanced FMAP for CHIP expenditures as provided in section 2105(b) of the Social Security Act will be increased by 23 percentage points (not to exceed 100 percent). For expenditures related to demonstration services provided to newly eligible individuals described in paragraph (2) of section 1905(y) of the Act, the matching rate applicable under paragraph (1) of that section will apply. Expenditures for services provided by IHS clinics that are also certified clinics to American Indians and Alaskan Natives (AI/AN) are matched at 100 percent. Using demonstration authority, states may claim enhanced FMAP and do not need Medicaid state plan authority to implement payment for CCBHC services delivered by certified clinics. Enhanced FMAP applies to expenditures for CCBHC services provided to individuals enrolled in Medicaid, including Medicaid expansion CHIP programs but not separate CHIP programs. Using demonstration authority, states may claim enhanced FMAP and do not need Medicaid state plan authority to implement payment for CCBHC services delivered by certified clinics. Under the demonstration, states and localities continue to finance the non-federal share of payment and, as part of the application process, will provide information to CMS on the source(s) of funding. Although there is no statutory authority to permit states to claim additional, non Medicaid expenditures, states may claim administrative expenditures that support the development and implementation of the demonstration.

CMS developed PPS guidance for CCBHC payment in light of the criteria established by the Substance Abuse and Mental Health Services Administration (SAMHSA) with regard to requirements developed for staffing; availability and accessibility of services; care coordination; scope of services; quality and other reporting; and, organizational authority, governance, and accreditation. CMS held multiple listening sessions prior to issuing this guidance, providing a forum for all interested parties to comment on what CMS should consider in developing payment parameters for the PPS applicable to CCBHC services. CMS made available an electronic mailbox to accept public comment. The PPS guidance is based on feedback that CMS received from states, providers and other stakeholders. This final guidance also reflects our experience with other PPS payment systems, particularly those used for Federally Qualified Health Center (FQHC) services in Medicaid.

CMS will support state's efforts in developing the PPS rates by providing technical assistance (TA) to states and clinics during the planning phase of this demonstration. Requests for assistance may be submitted to CCBHC-Demonstration@cms.hhs.gov.

To assist states in determining the PPS rate for individual CCBHCs, this guidance provides information on identifying, reporting, and allocating allowable costs for the CCBHC PPS methodologies.

Section 2: CCBHC PPS Rate-Setting Methodology Options

For the purposes of this demonstration, CMS offers states the option of using either the Certified Clinic Prospective Payment System (CC PPS-1) or CC PPS Alternative (CC PPS-2) rate methodology, as described below. A state must elect one methodology demonstration-wide for use in determining the uniform per clinic rate it will use to pay for CCBHC services delivered by a clinic, including those delivered by qualified satellite facilities established prior to April 1, 2014. CMS expects states to develop rates using actuarially sound principles with respect to the data, assumptions, and calculation methodology used.[11]

Table 1. Rate Elements of CC PPS-1 and CC PPS-2

Rate Element	CC PPS-1	CC PPS-2
Base rate	Daily rate	Monthly rate
Payments for services provided to clinic users with certain conditions[12]	NA	Separate monthly PPS rate to reimburse CCBHCs for the higher costs associated with providing all services necessary to meet the needs of special populations
Update factor for demonstration year 2	Medicare Economic Index (MEI)[13] or rebasing	MEI or rebasing
Outlier payments	NA	Reimbursement for portion of participant costs in excess of threshold
Quality bonus payment	Optional bonus payment for CCBHCs that meet quality	Bonus payment for CCBHCs that meet quality measures detailed

[11] Actuarial soundness defined in 42 CFR 438.6(c)

[12] Examples of clinic users with certain conditions:

- Adults with serious mental illness
- Adults with serious mental illness and co-occurring substance use disorders
- Children and adolescents with serious emotional disturbance
- Individuals with a recent history of frequent hospitalizations related to behavioral health conditions
- Adults with significant substance abuse disorders (SUDs)

[13] CMS Medicare Program Rates and Statistics, Market Basket Data. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html

Rate Element	CC PPS-1	CC PPS-2
	measures detailed on page 7	on page 7

Abbreviations: CCBHC, certified community behavioral health center; CC PPS, Certified Clinic Prospective Payment System; NA, not applicable; PPS, prospective payment system

Section 2.1: Certified Clinic PPS (CC PPS-1)

The CC PPS-1 is a cost-based, per clinic rate that applies uniformly to all CCBHC services rendered by a certified clinic, including those delivered by qualified satellite facilities established prior to April 1, 2014. It pays CCBHCs a daily rate that is a fixed amount for all CCBHC services provided on any given day to a Medicaid beneficiary. In demonstration year one (DY1), the state will use cost and visit data from the demonstration planning phase, updated by the Medicare Economic Index (MEI) to create the rate for DY1. The DY1 rate will be updated again for DY2 by the MEI or by rebasing of the PPS rate. CMS requires the use of one full year of cost data and visit data, unless a state can justify the use of a shorter period of time. The CC PPS-1 rate is based on total annual allowable CCBHC costs divided by the total annual number of CCBHC daily visits and results in a uniform payment amount per day, regardless of the intensity of services or individual needs of clinic users on that day. In developing the rates, states may include estimated costs related to services or items not incurred during the planning phase but projected to be incurred during the demonstration. States also should include in CC PPS-1 the cost of care associated with Designated Collaborating Organizations (DCOs). A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. Services of a DCO are distinct from referred services in that the CCBHC is not financially and clinically responsible for referred services.

CC PPS-1	
2.1a	The state must implement CC PPS-1 as a daily rate. The following formula is used for calculating the DY1 rate for the CC PPS-1: $$\frac{\textbf{Total annual allowable CCBHC costs}^{*}}{\textbf{Total number of CCBHC daily visits per year}}$$ ***Note: For DY1, the total annual allowable CCBHC costs collected during the demonstration planning phase must be trended forward by the MEI to reflect changes due to inflation. The DY1 rate will be updated again for DY2 by the MEI or by rebasing of the**

CC PPS-1	
	PPS rate. To assist states in identifying and documenting allowable costs, CMS provides guidance in this document on cost principles, documentation requirements and select items of cost (See section 4).

The example in Table 2 illustrates the CC PPS-1 rate mechanics, in which the total allowable annual costs of $10,000 are divided by 100 total annual daily visits. This calculation results in a payment rate of $100 per visit. The state would pay this per visit base rate, regardless of the participant type, CCBHC services provided, or overall costs associated with the visit. Again, the daily payment cap of one per day for each clinic user pertains only to CCBHC services, not other types of care that also may be provided by a certified clinic.

Table 2. CC PPS-1 Rate Calculation Example

Participant	Number of Daily Visits in a Year	Trended Annual Costs[1], $	CC PPS-1 Payment Per Daily Visit[2], $	CC PPS-1 Payment[3,4], $
A	25	2,250	100	2,500
B	15	450	100	1,500
C	10	600	100	1,000
D	5	750	100	500
E	35	2,350	100	3,500
F	8	3,000	100	800
G	2	600	100	200
Total	**100**	**10,000**		**10,000**

[1]Annual costs may be determined for each participant.

[2] CC PPS-1 Payment Per Daily Visit = Annual Costs ($10,000) / Number of Daily Visits in a Year (100) = $100

[3] CC PPS-1 Payment = Participant Number of Daily Visits in a Year * CC PPS-1 Payment Per Daily Visit ($100)

*Note: Table 2 is included for illustrative purposes only, and does not reflect actual facility based costs. In determining actual base rates, a facility must meet reasonable credibility standards, to be established by the state, in accordance with Substance Abuse and Mental Health Services Administration guidance.

Abbreviations: CC PPS, Certified Clinic Prospective Payment System

CC PPS-1	
2.1b	**CC PPS-1 Quality Bonus Payment**

CC PPS-1	
	Under the CC PPS-1 rate methodology, a state may elect to offer Quality Bonus Payment (QBP). For the state to make QBP, the CCBHC must demonstrate that it has achieved all of the required quality measures shown below. The state can make QBP using the additional measures provided in this guidance but only after the certified clinic has met performance goals for the required set of bonus measures. States may propose additional quality measures for QBP; however, CMS approval is required. The QBP measures included in this guidance are derived primarily from the Medicaid adult and child core set measures. In applying to participate in this demonstration, the state must demonstrate how it plans to implement QBP if it plans to make such payments. . States have flexibility in determining the level of payment but must use a comprehensive methodology that specifies: (1) the factors that trigger payment (e.g., the percentage of improvement in a quality metric within a particular period), (2) the methodology for making the payment (e.g., on a per claim basis or a lump sum payment; and how often payment is made), and, (3) the amount of payment. When calculating the PPS rate, the QBP is not treated as revenue offset against cost. CMS is making QBP TA available to states in collecting, reporting, and using measures for the adult and child core sets of Medicaid/CHIP quality measures. States may submit requests to: MACQualityTA@cms.hhs.gov.

Table 3. Quality Bonus Payment Medicaid Adult and Core Set Measures

For the state to make QBP the CCBHC must demonstrate that it has achieved all of the required quality measures shown in Table 3. The state can make QBP using the additional measures provided in this guidance but only after the certified clinic has met performance goals for the required set of measures. States may propose quality measures for QBP; however, CMS approval is required. The QBP measures included in this guidance are derived primarily from the Medicaid adult and child core set measures. In applying to participate in this demonstration the state must demonstrate how it plans to implement QBP if it plans to make such payments.

Acronym[1]	Measure	Measure Steward[2]	QBP Eligible Measures	Required QBP Measures
FUH-AD	Follow-Up After Hospitalization for Mental Illness (adult age groups)	NCQA/HEDIS	Yes	Yes
FUH-CH	Follow-Up After Hospitalization for Mental Illness (child/adolescents)	NCQA/HEDIS	Yes	Yes

Acronym[1]	Measure	Measure Steward[2]	QBP Eligible Measures	Required QBP Measures
SAA-AD	Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA/HEDIS	Yes	Yes
IET-AD	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA/HEDIS	Yes	Yes
NQF-0104	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	Yes	Yes
SRA-CH	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	Yes	Yes
ADD-CH	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA/HEDIS	Yes	No
CDF-AD	Screening for Clinical Depression and Follow-Up Plan	CMS	Yes	No
AMM-AD	Antidepressant Medication Management	NCQA/HEDIS	Yes	No
PCR-AD	Plan All-Cause Readmission Rate	NCQA/HEDIS	Yes	No
NQF-0710	Depression Remission at Twelve Months-Adults	MPC	Yes	No

[1]CMS-developed acronyms, except NQF-0104 and NQF-0710. CH refers to measures in the 2015 Medicaid Child Core Set, AD refers to measures in the 2015 Medicaid Adult Core Set.

[2] The measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities of the measure steward include updating the codes that are tied to technical specifications and adjusting measures as the clinical evidence changes. This list may change based on the current measurement landscape. The steward websites are provided below:

- http://www.ncqa.org
- www.usqualitymeasures.org
- http://www.ama-assn.org/ama/pub/physician-resources/physician-consortium-performance-improvement.page

Abbreviations: AMA, American Medical Association; CMS, Centers for Medicare & Medicaid Services; HEDIS, Healthcare Effectiveness Data and Information Set; MPC, Measurement Policy Council; NCQA, National Committee for Quality Assurance; PCPI, Physician Consortium for Performance Improvement

Section 2.2: CC PPS Alternative (CC PPS-2)

The CC PPS-2 is a cost-based, per clinic monthly rate that applies uniformly to all CCBHC services rendered by a certified clinic, including all qualifying sites of the certified clinic established prior to April 1, 2014. CC PPS-2 includes these required elements: (1) a monthly rate to reimburse the CCBHC for services, (2) separate monthly PPS rates to reimburse CCBHCs for higher costs associated with providing all services needed to meet the needs of clinic users with certain conditions, (3) cost updates from the demonstration planning period to DY1 using the MEI and from DY1 to DY2 using the MEI or by rebasing, (4) outlier payments made in addition to PPS for participant costs in excess of a threshold defined by the state, and (5) QBP made in addition to the PPS

rates. A CCBHC receives the monthly rate whenever at least one CCBHC service is delivered during the month to a Medicaid beneficiary by the CCBHC; states may pay this rate only after a CCBHC service has been delivered.

Under this methodology states will develop a standard monthly rate and also will develop monthly PPS rates that vary according to users' clinical conditions. For example, states could set different rates for adults with serious mental illness and co-occurring substance use disorders and children and adolescents with serious emotional disturbance who require higher intensity services. The state has flexibility in determining how PPS rates could vary. An outlier payment is part of the CC PPS-2 and reimburses clinics for costs above a state-defined threshold. This helps to enssure that clinics are able to meet the cost of serving their users. Finally, the CC PPS-2 rate methodology requires the state to select quality measure(s) as permitted and make bonus payments to incentivize improvements in quality of care.

States should include in CC PPS-2 the cost of care associated with DCOs. A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. Services of a DCO are distinct from referred services in that the CCBHC is not financially and clinically responsible for referred services.

This guidance contains information to help states develop these rates and CMS is available to provide state-specific technical assistance on this topic.

CC PPS-2	
2.2a	**CC PPS-2 Base Rate and Outlier Payment** **Step1:** Determine the base PPS rate, excluding costs for services to any clinic users with certain conditions and outlier payment (section 2.2c). The base PPS formula is: $$\frac{\textbf{Total annual allowable CCBHC costs}^{*} \textbf{ excluding costs for services to clinic users with certain conditions and outlier payments}}{\textbf{Total number of CCBHC unduplicated monthly visits per year}}$$

CC PPS-2	
	excluding* clinic users with certain conditions** ***The number of unduplicated monthly visits per year equals the total number of months that a member received at least one service in a month from a clinic. The state may count up to 12 monthly visits over the course of the year for each clinic user. A qualifying service is one defined in Section 223 (a)(2)(D) Scope of Services. CMS requires the use of 1 full year of cost data and visit data, unless a state can justify a shorter period of time. **Step 2:** Determine PPS rates for special populations using the formula below. **Total annual allowable CCBHC costs ***including only* clinic users with certain conditions *excluding* outlier payments** **Total number of CCBHC monthly visits per year *including only* clinic users with certain conditions** *The total annual allowable CCBHC costs collected during the demonstration planning phase must be updated by the MEI to reflect changes due to inflation. The DY1 rate will be updated again for DY2 by the MEI or by rebasing of the PPS rate. Key considerations in determining PPS for special populations are: (1) identifying the population(s), (2) assessing utilization, and (3) allocating cost. States have flexibility in designating the clinic users with certain conditions for which separate PPS rates will be determined. **Step 3:** Determine the outlier payment, which provides reimbursement in excess of a threshold defined by a state not to exceed 100 percent of cost. The outlier payment may be calculated monthly or annually, depending on the state's ability to accurately determine the payment. The threshold can be expressed as an absolute dollar amount (e.g., $10,000) or as a function of the facility's distribution of costs (e.g., three standard deviations above the mean facility costs). The state has flexibility in setting the threshold for outlier payment. Section 2.3 contains a sample calculation that demonstrates the CC PPS-2 methodology. This example includes considerations for both clinic users with certain conditions and outlier payments.
2.2b	**CC PPS-2 Quality Bonus Payments** Under the CC PPS-2 rate methodology, a state must make a QBP whenever a CCBHC has demonstrated that it has achieved all of the required quality measures shown on page 7 of this guidance. The state can make payment using additional measures provided in this guidance but only after the certified clinic

CC PPS-2	
	has met performance goals for the required set of measures. The QBP measures, shown on page 7, are derived primarily from the Medicaid adult and child core set measures. States may propose additional quality measures, but CMS approval must be obtained. In applying to participate in this demonstration the state must demonstrate how it plans to implement QBP. States have flexibility in determining the level of payment but must use a comprehensive methodology that specifies: (1) the factors that trigger payment (e.g., the percentage of improvement in a quality metric within a particular period), (2) the methodology for making the payment (e.g., on a per claim basis or a lump sum payment; and how often payment is made), and (3) the amount of the payment. In applying to participate in this demonstration, the state must demonstrate how they plan to implement QBP. When calculating the PPS rate, the QBP is not treated as revenue offset against cost. CMS is making available TA and analytic support to states in collecting, reporting, and using measures for the adult and child core sets of Medicaid/CHIP quality measures. States may submit requests for QBP TA and analytic support to the TA mailbox: MACQualityTA@cms.hhs.gov.

Section 2.3: CCBHC CC PPS-2 Rate Example

CCBHC CC PPS-2 Rate Example	
2.3	The following example demonstrates the CC PPS-2 method calculations for a small sample facility with seven participants per year. Table 4 illustrates how aggregate monthly allowed costs are translated into base and separate monthly PPS rates to reimburse CCBHCs for the higher costs associated with providing all services necessary to meet the needs of special populations. It also shows how funds are allocated or reserved to pay for outliers. Data to set these rates will be collected during the planning phase of the demonstration and should be adjusted by MEI to reflect changes in the underlying costs to provide treatment between the data collection period and the DY1 period. Payment rates for DY2 can be adjusted by MEI or by rebasing. In the example in Table 4, participants are categorized on the basis of criteria the

CCBHC CC PPS-2 Rate Example	
	state has used to define the base population and any other clinic users with certain conditions. These categorizations should be made at the participant level— not tied to services delivered. In our example, three distinct base rates are calculated —one for the participants not in the special population (Standard) and two for the different special population groups (Special Population A and Special Population B). A state can choose to make outlier payments on either a monthly or an annual basis. The methodology used to define outlier payments should include planning phase cost experience that spans all populations. Outlier payments are commonly calculated by setting a threshold above which a certain percentage of costs should be kept in reserve to account for anticipated outlier costs during the demonstration. This threshold should be set based on statistically and actuarially sound principles, by studying the distribution of costs at the facility level. Some portion of costs above the outlier threshold is captured in the rates for the different populations. In all cases, the cost data should be fully attributed between the Standard or Special Population payment rate calculation and the amount reserved to pay for outliers. For this facility, the monthly outlier threshold is set at $1,000. Therefore, in the rate setting period, 80 percent of the anticipated costs above the $1,000 threshold would be held in reserve to make outlier payments in during the demonstration period. Participants A, E, and F each experience 1 month with costs that exceed the established threshold. Therefore, in addition to a base rate for each participant type, the facility will be paid a varying additional outlier payment. For instance, Participant A in March has a $1,250 service that is above the outlier threshold. The amount of cost used in the base rate calculation would be $1,050; $1,000 (up to the threshold), plus $50 (20 percent of the remaining amount above the threshold). The remaining $200 should be held back as a reserve to pay for future anticipated outlier payments. Finally, payment rates for each of the populations are calculated by dividing the population-specific portion of the trended allowed annual costs, by the participant months for the population. For the Standard population, this rate is $250 per participant month (calculated as $1,500/6 participant months).

Table 4. CC PPS-2 Rates, Special Population Rates and Outlier Payments Calculation Example

Participant	Month	Outlier?	Participant Type	Participant Months	*Trended* Allowed Monthly Costs, $	Non-outlier Payment Portion	Outlier Payment Reserve	Payment Per Monthly Visit, $
A	Jan		Standard	1	50	50	-	250
A	Feb		Standard	1	150	150	-	250
A	Mar	Yes	Standard	1	1,250	1,050	200	250
B	June		Standard	1	50	50	-	250
C	Aug		Standard	1	100	100	-	250
D	Sept		Standard	1	100	100	-	250
Standard Population Subtotal			*Standard*	*6*	*1,700*	*1,500*	*200*	*1,500*
E	Nov		Special Population A	1	300	300	-	700
E	Dec	Yes	Special Population A	1	1,500	1,100	400	700
Special Population A Subtotal			*Special Population A*	*2*	*1,800*	*1,400*	*400*	*1,400*
F	Apr	Yes	Special Population B	1	2,000	1,200	800	900
G	Aug		Special Population B	1	600	600	-	900
Special Population B Subtotal			*Special Population B*	*2*	*2,600*	*1,800*	*800*	*1,800*
Total			Total	**10**	**6,100**	**4,700**	**1,400**	**4,700**

Note: Table 4 is included for illustrative purposes only, and does not reflect actual facility based costs. In determining actual base rates, a facility must meet reasonable credibility standards, to be established by the state, in accordance with Substance Abuse and Mental Health Services Administration guidance.

If an annual outlier threshold were used, the calculation would be nearly the same. The total annual allowed participant costs would be used to compare against a higher annual threshold. The outlier reserve would be calculated as the total annual costs for a participant over the annual threshold multiplied by the set percentage that applies to the outlier.

Section 3: Payment to CCBHCs That Are FQHCs, Clinics, or Tribal Facilities

In some instances a CCBHC may already participate in the Medicaid program as an FQHC, clinic services provider or Indian Health Service (IHS) facility that receives payment authorized through the Medicaid state plan. This guidance provides information on how these Medicaid providers would be paid when a clinic user receives a service authorized under both the state plan and this demonstration.

Payment to CCBHCs That Are FQHCs, Clinics, or Tribal Facilities	
3.0a	**FQHCs** A clinic that participates in the Medicaid program as both a FQHC and CCBHC should receive the CCBHC PPS rate whenever it provides any of the services covered by this demonstration, even if there is an overlap with services included in the clinic's FQHC PPS rate. The state should continue to pay the health center its established FQHC PPS rate and does not need to modify the payment amount. If a clinic user received a CCBHC service and FQHC service during one encounter/visit the provider is eligible to receive both the CCBHC PPS and the FQHC PPS.
3.0b	**Clinics** A clinic that is dually certified as a CCBHC and provides clinic services in the Medicaid program should be paid the CCBHC PPS rate whenever a demonstration-covered service is provided. The state should continue to pay the clinic services rate authorized through the Medicaid state plan whenever a non-CCBHC service is delivered. The provider is eligible for payment of the CCBHC PPS and the clinic services rate, depending on the type of service provided. States will follow the established process for reporting expenditures for Medicaid clinic services. CMS plans to provide technical assistance to states on reporting Medicaid clinic services provided by clinics that also are CCBHCs.
3.0c	**Tribal Facilities** The statute at subsection (a)(2)(F) Organizational Authority establishes criteria for the types of clinics that may become CCBHCs. Among the various eligible providers specified in the statute are clinics operated under the authority of the Indian Health Service (his) or an Indian tribe or tribal organization pursuant to a

Payment to CCBHCs That Are FQHCs, Clinics, or Tribal Facilities	
	contract, grant, cooperative agreement, or contract with the IHS. With respect to tribal facilities that become CCBHCs, IHS facilities and 638 clinics may be paid an encounter rate by the Medicaid program under an approved state plan. That encounter rate is determined based on national cost data and not individual facility data. To the extent that an IHS clinic provides CCBHC services, it is paid the CCBHC rate. Federal financial participation (FFP) will be available at the 100 percent matching rate for services furnished to Medicaid-eligible American Indians or Alaskan Natives by an IHS facility or a 638 clinic.

Section 4: Cost Reporting and Documentation Requirements

To determine CCBHC PPS rates, states must identify allowable costs necessary to support the provision of services. States must use a cost report that adheres to the cost principles and documentation requirements described in this section. CMS expects states to use a uniform cost report demonstration-wide. In reporting cost, the state and providers must adhere to 45 CFR §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards[14] and 42 CFR §413 Principles of Reasonable Cost Reimbursement.[15]

Pursuant to 45 CFR §75.302(a), a state must have proper fiscal control and accounting procedures in place to permit the tracing of funds to a level of expenditures adequate to establish that such funds have not been used in violation of applicable statutes. Additionally, the cost report package and source documentation (e.g., invoices, patient records, cancelled checks) must adhere to federal and state record retention requirements.[16] To demonstrate how costs will be assigned to the different cost centers, the state may elect to provide a trial balance that is reconciled to the cost centers on the cost report.

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[14] Administrative requirements and cost principles for Medicaid grants formerly were defined at 45 CFR §92 and OMB A-87.

[15] Additional guidance on Medicare principles of reasonable cost reimbursement can be found in the Medicare Provider Reimbursement Manual (PRM), which is used to guide Medicaid policy. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html

[16] See 45 CFR §75.361 Retention Requirements for Records and 42 CFR §433.32 Fiscal Policies and Accountability for the Federal Requirements. http://www.msha.gov/regs/fedreg/informationcollection/1219-0088.pdf

Section 4.1: Treatment of Select Costs

Treatment of Select Costs	
4.1a	**Uncompensated Care** Section 223 (a)(2)(B) requires that CCBHCs not reject or limit services based on a participant's ability to pay but does not authorize Medicaid expenditures for services furnished to individuals who are not eligible for Medicaid. Under this demonstration, federal financial participation will continue to be provided only when there is a corresponding state expenditure for a covered Medicaid service provided to a Medicaid recipient.
4.1b	**Telehealth** If a state chooses to provide CCBHC services via telehealth, costs related to those services should be included in the PPS. We note that individual Medicaid MCOs may have policies that offer reimbursement that differs from the fee-for-service system reflected in state Medicaid policy documents. Therefore, states must consider the implications of managed care service coverage in rate calculation. For more information about telehealth see: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html.
4.1c	**Interpretation and Translation** States may claim federal matching funds for translation or interpretation service costs either as an administration expense or as a medical assistance-related expense. This means the PPS rate may include the costs of interpretation and translation services. If the translation or interpretation service was provided by a Medicaid agency employee, a contractor of the Medicaid agency, or the provider of the medical service using a separate unit or separate employees performing solely translation or interpretation functions, then such costs may be claimed as administration. An increased matching rate is available under the Children's Health Insurance Program Reauthorization Act (CHIPRA) for translation and interpretation services claimed as administration that are provided to "children or families for whom English is not their primary language," and family members of these children. For Medicaid, the increased CHIPRA matching rate is 75 percent. For CHIP, the increased CHIPRA match is 75 percent, or the state's enhanced FMAP plus 5 percent, whichever is higher. Expenditures associated with the provision of translation and interpretation services to Medicaid enrollees

Treatment of Select Costs	
	that do not fit into the CHIPRA category are still reimbursable at the standard 50 percent Medicaid administrative matching rate. If, however, the state builds the costs of translation or interpretation services into the rate paid for the covered benefit, then the expenditure is matched at the state's applicable federal medical assistance percentage rate. In State Health Official (SHO) letter #10-007, CMS provides more detailed guidance on how states may claim these costs which support use of services by beneficiaries for whom English is not their primary language: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO10007.pdf.

Section 4.2: CCBHC Cost Report Elements and Data Essentials

The statute requires payment of PPS for behavioral health services provided under this demonstration. This means states must have cost reports to determine the uniform rate paid for CCBHC services delivered by a clinic, including those delivered by qualified satellite facilities established prior to April 1, 2014. Program Requirement 5.A of the CCBHC criteria for a clinic to participate as a CCBHC in this demonstration also specifies annual submission of a cost report with supporting data by no later than 6 months after the end of each demonstration year. The purpose of this document is to describe all of the types of data that must be reported. States will submit their cost report packages when applying to participate in the demonstration. They should include the cost report template, instructions, sample data sources such as a trial balance, and any narratives explaining the calculations included in determining the PPS rate.

The cost report template and instructions must contain the following key elements:

a. Provider Information
b. Direct and Indirect Cost-Identification
c. Direct and Overhead Cost-Allocations
d. Number of Visits
e. Rate Calculations

Additional details are in the chart below.

Key Elements in a Cost Report	
4.2a	**Provider Information** *This first section should contain following identifying attributes:* a. CCBHC name b. Organizational authority (non-profit organization, Part of a local government behavioral health authority, Tribal) c. State-assigned Medicaid ID and National Provider Identifier (NPI) (if available) for identifying the CCBHC as a whole, regardless of the number of satellite facilities d. Cost report period with start and end dates e. Whether there are non-CCBHC covered activities performed by the facility or providers f. Whether the CCBHC is dually- certified as a FQHC, clinic or operates under the authority of the IHS g. CCBHC services provided for which the PPS rate will be calculated h. Whether the cost report contains consolidated satellite facilities or not i. Whether each satellite facility was in existence prior to April 1, 2014 ii. Operating hours of each satellite facility iii. CCBHC services provided at each satellite facility i. Positions for which direct salary and fringe benefits are claimed j. Licensed or credentialed practitioners who provide CCBHC services and their full-time equivalents (FTEs) k. Certification statement
4.2b	**Direct and Indirect Cost – Identification** To support the cost centers shown, the submitted narrative should explain how expenses are mapped to the cost centers from the trial balance that is provided. Cost centers should be grouped by: a. Direct costs – staff b. Direct costs – other c. Overhead costs – facility and administrative

Key Elements in a Cost Report	
	d. Costs incurred for non-CCBHC services e. Costs incurred that are not reimbursable by Medicaid[17] As necessary, costs must be reclassified and adjusted to accurately reflect the cost of providing CCBHC services. An example of a reclassified cost is salary and fringe cost for a psychiatrist who provides direct services and performs administrative tasks. In this instance, a portion of total compensation must be reclassified from direct staffing costs under the psychiatrist cost center to indirect staffing costs. Examples of adjustments include: a rebate or refund, rental income and allocated home office costs. **Direct Costs – Staff** Staffing includes costs for those practitioner types identified in the state staffing plan pursuant to CCBHC criteria Program Requirement 1.A. Additional support staff may also be considered direct, including interpreters or linguistic counselors, case managers, and care coordinators. Adjustments and reclassifications of cost center expenses should be reflected in this section to detail changes to the adjusted cost center balances. Individual support for each adjustment and reclassification should also be provided in accompanying documents. The direct staff costs would contain all the cost centers, reclassifications, and adjustments. Supporting schedules would contain information pertaining to reclassifications and adjustments. An example of a reclassification might be a psychiatrist who performs administrative duties. The appropriate portion of his/her compensation, payroll taxes, and fringe benefits must be reclassified from direct staffing costs under the Psychiatrist cost center to indirect staffing costs. An example of an adjustment is recovery of an expense item, such as a refund of health insurance premiums. Cost reclassifications and adjustments should be included in the cost report and narrative that supports the entire cost report.

[17] The PRM 15-1 and 45 CFR Part 75 Subpart E further defines various types of allowable and non-allowable costs

Key Elements in a Cost Report	
4.2c	**Direct Costs – Other** Non personnel costs for providing CCBHC services may include the following items: supplies, training, telehealth, translation or interpretation services, transportation, depreciation on equipment used to provide CCBHC services, liability insurance and other costs incurred as a direct result of providing CCBHC services. If a state is claiming translation or interpretation services as an administrative expenditure, these costs should be reflected in the cost report as costs incurred for *non-CCBHC services*. See Item 4.1c for more information about translation and interpretation cost. **Overhead Costs – Facility and Administrative** Overhead facility costs are costs incurred by the CCBHC but not directly attributable to providing CCBHC services. Facility costs include rent, property insurance, interest on mortgage or loans, utilities, maintenance, property tax, and depreciation on the building or furniture. Overhead administrative expenses include costs of running the business such as legal, accounting, telephone, depreciation on office equipment, and general office supplies. Corporate overhead allocations are considered indirect administrative expenses, should be scrutinized to ensure that costs are reimbursable by Medicaid, and accounted for by including the amount as a home office costs adjustment. **Costs Incurred for non-CCBHC Services** States must identify and remove all non-CCBHC allowable costs in order to determine PPS. The statute implementing this demonstration prohibits payment for the following non-CCBHC services: inpatient care, residential treatment, room and board, or any other non-ambulatory expenses, as determined by the Secretary. The statute also excludes the cost of any satellite facility of a CCBHC established after April 1, 2014. Guidance provided in Item 4.2a confirms that the cost of uncompensated care may not be treated as an allowable CCBHC cost. Examples of additional types of costs incurred for non-CCBHC services include costs to support the provision of dental and optometry services.

Key Elements in a Cost Report	
	Cost Incurred that are not Reimbursable by Medicaid Certain overhead costs must be excluded from the PPS rate calculation. For more information about specific exclusions see 45 CFR §75.420-475. Examples of non reimbursable costs include those related to lobbying expenses, organization costs, or entertainment costs.
4.2d	**Direct and Overhead Cost – Allocations** This section should contain worksheets that detail the necessary allocations of costs between the direct CCBHC, direct non-CCBHC, and overhead cost centers. The statistics and methodologies used should match the narrative submitted. If an indirect cost rate (IDR) has been established, the rate and authorization may be used to allocate indirect expenses. At the facility level, providers can elect to directly assign indirect costs to cost centers. To do this, allocations may be done through a statistical measure including, but not limited to: square feet, dollar value, meals served, time spent, number housed, or pounds of laundry. Other methods of allocation could include worker day logs or random moment time studies. These two methods also can be used to allocate direct care workers costs to CCBHC.
4.2e	**Number of Visits** CC PPS-1 – Requires the total number of CCBHC daily visits per year CC PPS-2 • Total number of unduplicated monthly visits per year excluding clinic users with certain conditions • Total number of CCBHC monthly visits per year including only clinic users with certain conditions
4.2f	**Rate Calculations** There must be a summary worksheet that demonstrates how the rate was calculated using either the CC PPS-1 or the CC PPS-2 methodology. The rate may include only those costs necessary to support the provision of CCBHC services.

Section 5: Managed Care Considerations

The statute requires payment of PPS and allows such payment to be made fee for service and through managed care systems for demonstration services. Further, the state may claim enhanced FMAP for the portion of managed care payment attributable to CCBHC services. To meet the requirement of PPS payment and properly claim CCBHC expenditures eligible for enhanced federal matching funds, the state first must understand how behavioral health services are treated in existing managed care payments. This entails a state-specific review of managed care arrangements to determine which services are covered and the level of payment being made. Review of managed care arrangements is outside the scope of this guidance. In implementing managed care payment, we assume states already have an understanding of behavioral health services within their Medicaid programs.

Managed Care Considerations	
5.0a	The first consideration in determining managed care payment is to identify which PPS methodology the state will use in its managed care delivery system. CMS requires the state to use the same PPS methodology demonstration-wide for FFS and managed care payment. • ***CC PPS-1*** pays providers a daily rate for all CCBHC services and requires rate updates from the demonstration planning phase to DY1 using the MEI and from DY1 to DY2 using the MEI or by rebasing. • ***CC PPS-2*** includes these required elements: (1) a monthly rate to reimburse the CCBHC for services, (2) separate monthly PPS rates to reimburse CCBHCs for higher costs associated with providing all services needed to meet the needs of clinic users with certain conditions, (3) cost updates from the demonstration planning period to DY1 using the MEI and from DY1 to DY2 using the MEI or by rebasing; (4) outlier payments made in addition to PPS for participant costs in excess of a threshold defined by the state, and (5) QBP made in addition to the PPS rates.

5.0b	**Building CCBHC PPS Rates Into Managed Care Capitation** The state has two options for incorporating the CCBHC rate into the managed care payment methodology: (1) fully incorporate the PPS payment into the managed care capitation rate, or (2) use a reconciliation process to make a wraparound supplemental payment to ensure that the total payment is equivalent to CCBHC PPS. The first option—incorporation of the PPS payment into the managed care capitation rate—gives the state greater budget predictability for CCBHC expenditures at the beginning of the demonstration. The state will need to provide adequate oversight in the following areas: • **Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP) contract with CCBHCs** The state will need to develop and implement processes to ensure that managed care enrollees have access to services provided by CCBHCs. To satisfy this requirement, managed care contracts may need to include specific network adequacy requirements or explicit requirements allowing out-of-network access to other CCBHCs. • **PPS rates incorporated into managed care payments to CCBHCs** The state will need to ascertain the size and timing of payments to CCBHCs. Managed care plans will be required to pay CCBHCs the actual, or the actuarial equivalent of, PPS rates. The state will need to review managed care rates throughout the demonstration period to ensure that payments are sufficient compared with actual utilization. Managed care plans should be required contractually to compensate for any shortfall between rates and actual utilization. The second option—a wraparound reconciliation process—will require oversight related to reconciling managed care payments with full PPS rates: • **Reconciliation of payments to ensure actuarial equivalence of PPS rates** If the state chooses a supplemental or wraparound payment for CCBHC services, it will reconcile managed care payments to CCBHCs with the full

	PPS rates for covered services to determine whether the minimum payment was achieved. If the minimum payment was not achieved, the state (or the managed care entity, as a pass-through from the state) will make payments to CCBHCs to make up the shortfall. The frequency of wraparound payments to CCHBCs during each demonstration year is not dictated by any statutory requirement. However, we suggest that states consider making supplemental/wraparound payment at least every four months and reconciling annually, similar to the process used for Federally Qualified Health Center (FQHC) wraparound payments. Regardless of whether the state chooses the full PPS methodology or a supplemental or wraparound payment methodology, it will use PPS rate development guidelines (see section 2) to determine the minimum reimbursement to CCBHCs under the demonstration project. The state should take into account any CCBHC demonstration services that are already included in managed care capitation rates and the state's strategies for avoiding duplication of payment. The state also will need to account for any duplication in the actuarial certification(s) of the rates paid to MCOs, PIHPs, or PAHPs delivering services to enrollees included in the demonstration. Any change in services delivered under the capitation that would change the rates paid to MCOs, PIHPs, and PAHPs may require either a new or amended actuarial certification of the capitation rates to CMS demonstrating how the CCBHC services are represented in the methodology.

5.0c	**PIHP and PAHP Coverage Areas in Managed Care States** Several states contract with PIHPs and PAHPs that specialize in behavioral health services. Medicaid enrollees may be members of a PIHP or PAHP *and* an MCO at the same time. As such, a CCBHC may not be aware which entity is responsible for payment of behavioral health services. To make transparent which payer is responsible and to meet reporting requirements of this demonstration, CMS recommends that states consider assigning all CCBHCs to one managed care entity that is capable of collecting all of the data pertinent to demonstration payment. Use of a single managed care provider could help states reduce duplicate payment. States must account for duplicate services provided through these different entities. If one entity is chosen to provide CCBHC services, the capitation rate may need to be adjusted upward, and the remaining entities may need to adjust the capitation downward. Any resulting new rates must be determined to be actuarially sound. A state that chooses not to include all demonstration services under one contractor will need to define clearly how it will ensure that (1) services between contractors will be delineated, and (2) no duplication of services or payments will occur. The rate development guidelines (section 2) explain the requirements for ensuring that states develop rates without duplicating expenses. States with PHIP or PHAP arrangements should take additional steps to avoid duplicative payments.
5.0d	**Data Reporting and Managed Care Contract Requirements** The state's contract with the managed care entity must contain requirements for reporting CCBHC data. We recommend the state include the following items in its contract: (1) data to be reported; (2) the period during which data must be collected; (3) the method to meet reporting requirements; and, (4) the entity responsible entity for data collection. The data that must be reported for this demonstration is specified in Appendix A of SAMHSA's *Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish CCBHCs*. Further requirements also may be found in Program Requirement 5.A of those criteria. States also must collect data to allow for oversight of managed care contract

	execution with CCBHCs and to remedy performance issues.
5.0e	**Identification of Expenditures Eligible for Enhanced Federal Medical Percentage (FMAP)** To ensure proper claiming of enhanced FMAP, the state will need to revise its actuarial certification letters to show how much of the capitation payment(s) is associated with CCBHC services for the new adult group rate cells and for the existing managed care population rate cells. At agreed-upon intervals, the state or the managed care entity will provide actual encounter data or other adequate data sources to verify services that are eligible for enhanced FMAP. The state should report CCBHC services in a separate section for payments through managed care. The claims should attribute the actual portion of managed care rates to CCBHC services.

Appendix IV – Statement of Assurance

If selected, as the Authorized Representative of [insert name of applicant state] _____, I agree to pay for services at the rate established under the prospective payment system during the demonstration program. I agree that no payments will be made for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, or to satellite facilities of CCBHCs if such facilities were established after April 1, 2014.

_____ _____

Signature of Authorized Representative Date