# 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[1] 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

[1] 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.[2] 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.[3]

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

[3] 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** | |
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| **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.<br>**Note:** See criteria 4.K relating to required staffing of services for veterans. |

| Criteria 1.A: General Staffing Requirements | |
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| **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.<br>**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 | |
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| **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 | |
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| **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.<br>**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 | |
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| **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.<br><br>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.<br>**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 | |
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| **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. |
| **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 | |
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| **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 | |
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| **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:<br><br>• If the screening identifies an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent outpatient follow-up.<br>• 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.<br>• If the screening identifies routine needs, services will be provided and the initial evaluation completed within 10 business days.<br>• 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.<br><br>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 completed within 60 calendar days of the first request for services. 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 60 day period.<br>**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 | |
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| **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 | |
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| **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.<br>**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.<br>**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.<br>**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)[4] 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. |

[4] 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.<br>**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).<br>**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.<br>**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:<br><br>• Schools;<br>• Child welfare agencies;<br>• Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty courts);<br>• Indian Health Service youth regional treatment centers;<br>• State licensed and nationally accredited child placing agencies for therapeutic foster care service; and<br>• Other social and human services.<br><br>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:<br><br>• Specialty providers of medications for treatment of opioid and alcohol dependence;<br>• Suicide/crisis hotlines and warmlines;<br>• Indian Health Service or other tribal programs;<br>• Homeless shelters;<br>• Housing agencies;<br>• Employment services systems;<br>• Services for older adults, such as Aging and Disability Resource Centers; and<br>• Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs).<br>**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.<br>**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.<br><br>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.<br>**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.<br>**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.<br>**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.<br>**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.<br>**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 | |
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| **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:<br>• 24 hour mobile crisis teams,<br>• Emergency crisis intervention services, and<br>• Crisis stabilization.<br>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.<br>**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.<br>**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 | |
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| **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 | |
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| **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.<br>**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.<br>**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.<br>**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.<br>**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.<br>**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.<br>**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.<br><br>Current Military Personnel: Persons affirming current military service will be offered assistance in the following manner:<br><br>(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.<br><br>(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.<br><br>(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.<br><br>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).<br>**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:<br><br>(1) Regular contact is maintained with the veteran as clinically indicated as long as ongoing care is required.<br><br>(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.<br><br>(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).<br><br>(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.<br><br>(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).<br><br>(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:<br><br>• Hope<br>• Person-driven<br>• Many pathways<br>• Holistic<br>• Peer support<br>• Relational<br>• Culture<br>• Addresses trauma<br>• Strengths/responsibility<br>• Respect<br><br>(Substance Abuse and Mental Health Services Administration [2012]).<br>As implemented in VHA recovery, the recovery principles also include the following:<br><br>• Privacy<br>• Security<br>• Honor<br><br>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.<br><br>(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.<br>(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.<br><br>(1) The treatment plan includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis.<br>(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.<br>(3) As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness.<br>(4) The plan is recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments.<br>(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.<br>**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 | |
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| **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 <u>one of the following statutorily established</u> criteria:<br><br>• Is a non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code;<br>• Is part of a local government behavioral health authority;<br>• 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.);<br>• 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.).<br>**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 UPDATED 5-1-2016

Appendix A of the Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (published with the Request for Applications SM16-001 Planning Grants for CCBHCs) alerted readers that the list of required quality measures may change. This updated chart replaces the original Appendix A. The change column below identifies measures that are no longer required and modifications that were made to the required measures. Please note that experience of care is counted as one measure but collected separately for patients and families.

Appendix A contains the data and quality measures required to be reported as part of these criteria[5]. 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.

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

## UPDATED Table 1. CCBHC Reported Measures (9 Required)

| Potential Source of Data | Measure or Other Reporting Requirement | NQF Endorsed | Change | Count |
|---|---|---|---|---|
| Electronic scheduler | Number/Percent of clients requesting services who were determined to need routine care | N/A | **Not Required** | |
| 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 | | 1 |
| 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 | **Not Required** | |
| EHR, Patient records | Number of Suicide Deaths by Patients Engaged in Behavioral Health (CCBHC) Treatment | N/A | **Not Required** | |
| EHR, Patient records | Documentation of Current Medications in the Medical Records | 0419 | **Not Required** | |
| MHSIP surveys | Patient experience of care survey<br>Family experience of care survey | N/A | **Moved <u>to</u> state reported measures** | |
| EHR, Patient records | Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up | 0421 | | 2 |
| EHR, Encounter data | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (see Medicaid Child Core Set) | 0024 | | 3 |
| EHR, Encounter data | Controlling High Blood Pressure (see Medicaid Adult Core Set) | 0018 | **Not Required** | |
| EHR, Encounter data | Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention | **0028** | | **4** |
| EHR, Patient records | Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling | 2152 | | 5 |
| EHR, Patient | Initiation and engagement of alcohol and other drug dependence treatment (see Medicaid Adult | 0004 | **Moved <u>to</u> state** | |

| Potential Source of Data | Measure or Other Reporting Requirement | NQF Endorsed | Change | Count |
|---|---|---|---|---|
| records | Core Set) | | **reported measures** | |
| EHR, Patient records | Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment (see Medicaid Child Core Set) | 1365 | | 6 |
| EHR, Patient records | Adult major depressive disorder (MDD): Suicide risk assessment (use EHR Incentive Program version of measure) | **0104** | | **7** |
| EHR, Patient records | Screening for Clinical Depression and Follow-Up Plan (see Medicaid Adult Core Set) | **0418** | | 8 |
| EHR, Patient records Consumer follow-up with standardized measure (PHQ-9) | Depression Remission at 12 months | 0710 | | 9 |

## UPDATED Table 2. State Reported Measures (12 Required)

| Potential Source of Data | Measure or Other Reporting Requirement | | NQF Endorsed | Change | Count |
|---|---|---|---|---|---|
| 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 | | 1 |
| Claims data/ encounter data | Number of Suicide Attempts Requiring Medical Services by Patients Engaged in Behavioral Health (CCBHC) Treatment | | N/A | **Not Required** | |
| Claims data/encounter data | Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Dependence | Follow-Up After Emergency Department for Mental Health | 2605 | **Original Measure split** | 2 |
| | | Follow-Up After Emergency Department for Alcohol or Other Dependence | 2605 | **Original Measure split** | 3 |
| Claims data/ encounter data | Plan All-Cause Readmission Rate (PCR-AD) (see Medicaid Adult Core Set) | | 1768 | | 4 |
| Claims data/ encounter data | Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications | | 1932 | | 5 |
| Claims data/ encounter data | Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) | | 2607 | **Not Required** | |
| Claims data/ encounter data | Metabolic Monitoring for Children and Adolescents on Antipsychotics | | No | **Not Required** | |
| Claims data/ encounter data | Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications | | 1927 | **Not Required** | |
| Claims data/ encounter data | Cardiovascular health monitoring for people with cardiovascular disease and schizophrenia | | 1933 | **Not Required** | |

| Potential Source of Data | Measure or Other Reporting Requirement | NQF Endorsed | Change | Count |
|---|---|---|---|---|
| Claims data/ encounter data | Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder | 1880 | **Not Required** | |
| Claims data/ encounter data | Adherence to Antipsychotic Medications for Individuals with Schizophrenia (see Medicaid Adult Core Set) | No | | 6 |
| Claims data/ encounter data | Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (see Medicaid Adult Core Set) | 0576 | | 7 |
| Claims data/ encounter data | Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (see Medicaid Child Core Set) | 0576 | | 8 |
| Claims data/ encounter data | Follow-up care for children prescribed ADHD medication (see Medicaid Child Core Set) | **0108** | | 9 |
| Claims data/ encounter data | Antidepressant Medication Management (see Medicaid Adult Core Set) | 0105 | | 10 |
| EHR, Patient records | Initiation and engagement of alcohol and other drug dependence treatment (see Medicaid Adult Core Set) | 0004 | **Moved <u>from</u> CCBHC reported measures** | 11 |
| MHSIP Survey | Patient experience of care survey | N/A | **Moved <u>from</u> CCBHC reported measures and counted as one** | 12 |
| | Family experience of care survey | | | |