

Certified Community Behavioral Health Clinic (CCBHC)

CERTIFICATION CRITERIA

(Draft for Public Comment)

Updated December 2022



Acknowledgments

Preparation Notice

The revised Certified Community Behavioral Health Center (CCBHC) certification criteria were developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) through the Center for Behavioral Health Financing and Integration task order (HHSS283201700031I/75S20322F42003) with Westat.

Electronic Access

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Interim Draft

Introduction

The Protecting Access to Medicare Act of 2014 (PAMA), section 223, directed the Department of Health and Human Services (HHS) to publish criteria for clinics to be certified as Certified Community Behavioral Health Clinics (CCBHCs). In 2015, HHS issued the original CCBHC Certification Criteria. The Criteria established a set of uniform standards that providers must meet to be a CCBHC. By meeting these criteria, CCBHCs across the country are transforming systems by providing comprehensive, coordinated, trauma-informed, and recovery-oriented care for mental health and substance use conditions.

These standards were used by the original eight states in the Section 223 CCBHC Demonstration to certify the first set of 67 CCBHCs in 2017. Since then, the CCBHC Section 223 CCBHC Demonstration has expanded to two additional states, HHS has supported the development of the program through an expansion grant program that was established in 2018, and states have supported the development of CCBHCs separate from the Section 223 CCBHC Demonstration. Today, there are over 500 CCBHCs across 48 U.S. states, territories, and the District of Columbia.

What is a Certified Community Behavioral Health Center?

CCBHCs provide:

- Comprehensive, coordinated mental health and substance use services appropriate for individuals across the life span
- Increased access to high-quality community mental health and substance use care, including crisis care
- Integrated person- and family-centered services, driven by the needs and preferences of clients and their families
- A range of evidence-based practices, services, and supports to meet the needs of their communities
- Services to anyone seeking help for a mental health or substance use condition, regardless of their diagnosis, place of residence, or ability to pay.



Since 2015, a lot of has been learned about implementing the CCBHC model. Developments and advancements in mental health and substance use disorder field have also created a need to update the Criteria in several areas. As a result, HHS is releasing an updated version of the Criteria.

Updates were informed by written feedback from the public, CCBHCs, and states; listening sessions where the public, people with lived experience of mental health and substance use conditions, and CCBHC stakeholders provided input; and findings from the Section 223 CCBHC Demonstration evaluation. The updated criteria will guide existing and future CCBHCs. These criteria will ensure that individuals who seek CCBHC services can expect the same quality, comprehensive, coordinated care regardless of where they reside.

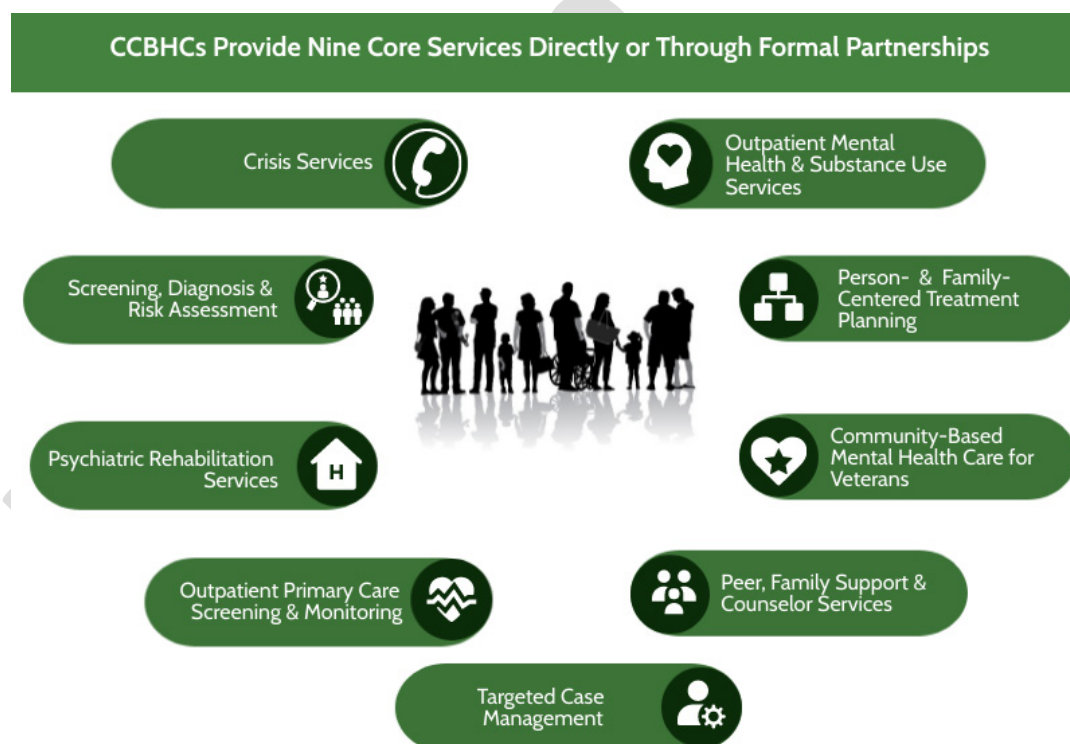
CCBHC Background and History

On April 1, 2014, PAMA was signed into law, establishing the Section 223 CCBHC Demonstration.¹ A cross-HHS partnership supports the CCBHC initiative, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare & Medicaid Services (CMS), and the Assistant Secretary of Planning and Evaluation (ASPE).

PAMA included program requirements that have served as the organizing framework for the CCBHC Certification Criteria. These requirements also guide the updated criteria and include:

1. Staffing
2. Availability and Accessibility of Services
3. Care Coordination
4. Scope of Services
5. Quality and Other Reporting
6. Organizational Authority and Governance

PAMA makes clear that, regardless of condition, CCBHCs must provide services to anyone seeking help for a mental health or substance use condition, regardless of their place of residence, ability to pay, or age. It also specifies that CCBHCs provide nine core services.



¹ [H.R.4302 - 113th Congress \(2013-2014\): Protecting Access to Medicare Act of 2014 | Congress.gov | Library of Congress](#)

Development and Expansion of the CCBHC Program

The original CCBHC Certification Criteria, released in 2015, were based primarily on the requirements in PAMA. They were informed by review of state Medicaid Plans, standards for Federally Qualified Health Centers and Medicaid Health Homes, and state quality measures. The criteria were refined and finalized through a public process that included national listening sessions; consultation with tribal, state, and federal leadership; and written public comments. The original criteria were written for states participating in the Section 223 CCBHC Demonstration.

Since then, other funding sources for CCBHCs have emerged. In 2018, SAMHSA was appropriated funding for the CCBHC-Expansion Grant Program. Unlike the Section 223 CCBHC Demonstration, which was administered through states, the CCBHC-Expansion grants are awarded directly to community provider organizations. Some states are also using existing Medicaid authorities to allow CMS-approved payments to CCBHCs that are certified by states but outside of the Section 223 CCBHC Demonstration.

As of September 2022, CCBHCs are primarily funded through three separate funding streams:

1. **CCBHCs funded by the Section 223 CCBHC Demonstration.** These CCBHCs are managed through state Section 223 CCBHC Demonstration programs. They are certified by the state as being in compliance with the certification criteria, and are reimbursed via a prospective payment system (PPS) for services they deliver that are within the scope of the criteria. These CCBHCs may also receive SAMHSA expansion grants.
 2. **CCBHC-Es funded by SAMHSA expansion grants.** These CCBHCs are supported through direct SAMHSA grants to the provider organization and the grantee self-attests to compliance with the certification criteria. There is no PPS for services provided as a part of the expansion grants and there is no required oversight by their state, tribe, or territory. These CCBHCs fund their activities using a combination of grant funds and other funding sources (e.g., Medicaid, Medicare, state and local funding, other third-party payment). In FY 2022, the expansion grant program was divided into two tracks: Planning, Development, and Implementation (PDI) grant for new CCBHCs and Improvement and Advancement (IA) grants for existing CCBHCs.
 3. **CCBHCs funded through state Medicaid programs separate from the Section 223 CCBHC Demonstration.** The states use Medicaid authority, not the Section 223 CCBHC Demonstration, to define the CCBHC array of services and payment for CCBHC services. These CCBHCs are subject to state oversight through their Medicaid programs and may also receive SAMHSA expansion grants.
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Revised CCBHC Criteria

The revised CCBHC criteria are applicable to all CCBHCs, regardless of state, tribe, territory, or funding stream. The criteria maintain the six program requirements and nine services that anchor the 2014 criteria.

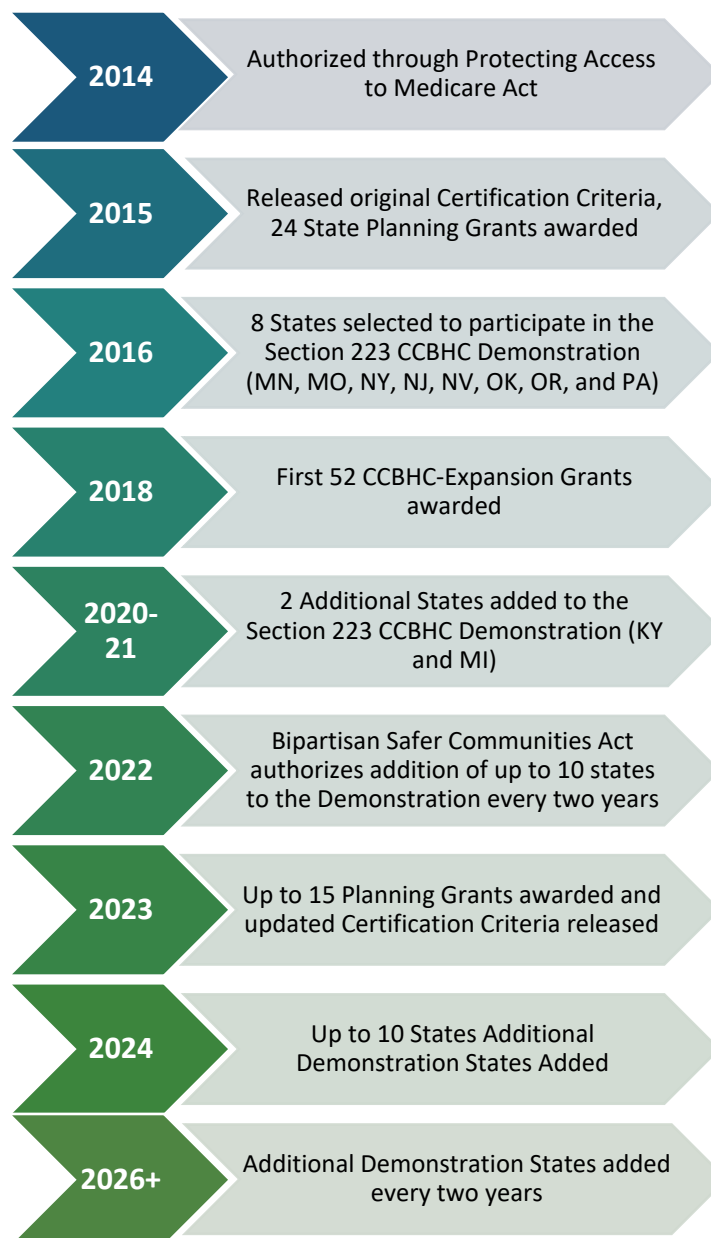
The criteria continue to emphasize the principals embedded in PAMA, including the provision of coordinated, person-and family-centered care to help individuals recover, be healthy, and live fully within their communities. These criteria are intended to empower people and families to engage with their communities in the ways that they choose. These criteria are also designed to support effective community-based care that meets the legal obligation to provide services in the least restrictive setting possible.

The revised criteria seek to strengthen and update the criteria without significantly adding to state or clinic burden. SAMHSA updated and revised the Criteria to 1) respond to developments in the field (e.g., newer terminology, 988 and the crisis continuum, emerging best practices, workforce shortages, etc.), 2) update sections of the criteria that are no longer current (e.g., reference to outdated electronic health record standards, etc.), and 3) address areas suggested by CCBHCs, states, and other stakeholders.

The Structure of the Revised Criteria

The criteria continue to use the six program requirements from PAMA as an organizing structure. At the beginning of each program requirement section, the PAMA language is included in a text box. Each of the program requirements are numbered, as in the original criteria. In some program requirement sections, the numbering of the criteria have changed due to the deletion or addition of criteria. As in the original

CCBHC Milestones



criteria, “notes” are embedded into the criteria to provide clarifications or explain how an alternative approach to meeting the requirements of the criteria may be possible.

The Criteria Apply Universally to CCBHCs Regardless of Funding Source

Some criteria include a “Notes” section. Notes are clarifications of a criterion or explain how an alternative approach to meeting the requirements of the criteria may be possible.

- A green dot identifies the few criteria, or parts of criteria, that are only relevant to states that certify CCBHCs.

Appendices offer additional guidance:

- Appendix A: Terms and Definitions
- Appendix B: Behavioral Health Clinic Quality Measures
- Appendix C: Summary of Changes

Interim

Program Requirement 1: Staffing

This section describes the requirements for:

- a. General staffing requirements, community needs assessment, and staffing plan
- b. Licensure and credentialing of providers
- c. Training related to cultural competence, trauma-informed care, and other areas
- d. Linguistic competence

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

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

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

Criteria 1.A: General Staffing Requirements

1.a.1 As part of the process leading to certification, and before certification or attestation, a community needs assessment (see Appendix A: Terms and Definitions for required components of the community needs assessment) and a staffing plan that is responsive to the community needs assessment are completed and documented. 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 client population, as determined by the community needs assessment, in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer.

Note: See criteria 4.k relating to required staffing of services for veterans.

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 community 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 provide guidance regarding behavioral health clinical service delivery, ensure the quality of the medical component of care, and provide guidance to ensure that the coordination of behavioral health and primary care are facilitated.

Note: If a CCBHC is unable, after reasonable efforts, to employ or contract with a psychiatrist as Medical Director, a medically trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law, will serve as the Medical Director. In addition, if a CCBHC is unable to hire a psychiatrist and hires another prescriber instead, psychiatric consultation will be obtained regarding behavioral health clinical service delivery, quality of the medical component of care, and coordination of behavioral health and primary care.

- 1.a.4** The CCBHC maintains liability/malpractice insurance adequate for the staffing and scope of services provided.

Criteria 1.B: Licensure and Credentialing of Providers

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

- 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 community 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 clients as stated in clients' individual treatment plans and as required by program requirements 3 and 4 of these criteria.

CCBHC staff 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 FDA-approved medications used to treat opioid, alcohol, and tobacco use disorders. This would not include methadone. If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder directly, it shall refer to an Opioid Treatment Program (OTP) (if any exist in the CCBHC service area) and provide care coordination to ensure access to methadone. The CCBHC must have staff, either employed or under contract, who are credentialed substance use treatment counselors or specialists. If the medical director is not experienced with the treatment of substance use disorders, the CCBHC must have addiction medicine physicians or specialists on staff or arrangements that ensure access to consultation on addiction medicine for the medical director and clinical staff. The CCBHC must include staff 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). Examples of staff include a combination of the following: (1) psychiatrists (including general adult psychiatrists and subspecialists), (2) nurses, (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) certified/trained peer specialist(s)/recovery coaches, (10) licensed addiction counselors, (11) certified/trained family peer specialists, (12) medical assistants, and (13) community health workers.

The CCBHC supplements its core staff, as necessary in order to adhere to the CCBHC program requirements within sections 3 and 4 and individual treatment plans, through arrangements with and referrals to other providers.

Note: *Recognizing professional shortages exist for many behavioral health providers²: (1) some services may be provided by contract or part-time as needed; (2) in CCBHC organizations comprised of multiple clinics, providers may be shared across clinics; and (3) The CCBHC may utilize telehealth/telemedicine and on-line services to alleviate shortages, provided that these services are coordinated with other services delivered by the CCBHC. The CCBHC is not precluded by anything in this criterion from utilizing providers working towards licensure, if they are working under the requisite supervision.*

- Certifying states should specify which staff disciplines they will require as part of certification.

Criteria 1.C: Cultural Competence and Other Training

1.c.1 The CCBHC has a training plan for all CCBHC employed and contract staff who work directly with CCBHC clients or their families. The training plan satisfies and includes requirements of the state behavioral health authority and any accreditation standards on training required by the state. At orientation and at reasonable intervals thereafter, the CCBHC must provide training on:

- Evidence-based practices
- Cultural competency (described below)
- Person-centered and family-centered, recovery-oriented planning and services
- Trauma-informed care
- The clinic's policy and procedures for continuity of operations/disasters
- The clinic's policy and procedures for coordination with primary care

At orientation and annually thereafter, the CCBHC must provide training on risk assessment; suicide and overdose prevention and response; and the roles of family and peer staff. If necessary, trainings may be provided on-line.

² Find Shortage Areas by State & County, see [HPSA Find \(hrsa.gov\)](https://hpsa.find.hrsa.gov/)

Training is aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS)³ to advance health equity, improve quality of services, and eliminate disparities. To the extent active-duty military or veterans are being served, such training must also include information related to military culture. Examples of training and materials that further the ability of the clinic to provide tailored training for a diverse population include, but are not limited to, those available through the HHS website, the SAMHSA website,⁴ the HHS Office of Minority Health, or through the website of the Health Resources and Services Administration.

Note: See criterion 4.k relating to cultural competency requirements in services for veterans.

- 1.c.2** The CCBHC assesses 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 for the duration of employment of each employee who has direct contact with clients.
- 1.c.3** The CCBHC documents in the staff personnel records that the training and demonstration of competency are successfully completed.
- 1.c.4** Individuals providing staff training are qualified as evidenced by their education, training, and experience.

Criteria 1.D: Linguistic Competence

- 1.d.1** The CCBHC takes reasonable steps to provide meaningful access to services, such as language assistance, for those with Limited English Proficiency (LEP) and/or language-based disabilities.
- 1.d.2** Interpretation/translation service(s) are readily available and appropriate for the size/needs of the LEP CCBHC client population (e.g., bilingual providers, onsite interpreters, language video or 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 clients with physical, cognitive, and/or developmental disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines).

³ Access standards at, [What is CLAS? - Think Cultural Health \(hhs.gov\)](https://www.hhs.gov/what-is-clas/) and Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care at [National Minority Mental Health Awareness Month — New CLAS Implementation Guide \(hhs.gov\)](https://www.hhs.gov/national-minority-mental-health-awareness-month-new-clas-implementation-guide/).

⁴ Suggested resources include the African American Behavioral Health Center of Excellence, LGBTQ+ Behavioral Health Equity Center of Excellence, Engage, Educate, Empower for Equity: E4 Center of Excellence for Behavioral Health Disparities in Aging, and Asian American, Native Hawaiian, and Pacific Islander Behavioral Health Center of Excellence.

- 1.d.4** Documents or messages vital to a client's ability to access CCBHC services (e.g., registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available online and in writing for clients in languages commonly spoken within the community served, taking account of literacy levels and the need for alternative formats. Such materials are provided in a timely manner at intake and throughout the time a person is served by the CCBHC. The requisite languages will be informed by the needs assessment and a CCBHC policy for determining threshold languages that require language assistance 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. These include, but are 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 client's family and friends, so long as the client consents. If a client is amenable and has the capacity to make health care decisions, health care providers may communicate with a client's family and friends.
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Program Requirement 2: Availability and Accessibility of Services

This section describes the requirements for:

- a. General requirements of access and availability
- b. Requirements for timely access to services and assessment
- c. Access to Crisis Management Services
- d. Provision of services regardless of ability to pay and residence

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

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

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

Criteria 2.A: General Requirements of Access and Availability

- 2.a.1** The CCBHC provides a safe, functional, clean, sanitary, and welcoming environment for clients and staff, conducive to the provision of services identified in program requirement 4.
- 2.a.2** The CCBHC ensures that services are provided during times that ensure accessibility and meet the needs of the client population to be served, including some evening and weekend hours.
- 2.a.3** The CCBHC provides services at locations that ensure accessibility and meet the needs of the client population to be served.
- 2.a.4** The CCBHC provides transportation or transportation vouchers for clients to the extent possible within the state Medicaid program or other funding or programs, in order to facilitate access to services in alignment with the person-centered and family-centered treatment plan.
- 2.a.5** The CCBHC utilizes technologies such as telehealth/telemedicine and video conferencing to the extent possible within the state Medicaid program and, as allowed by state law, in alignment with client preferences to ensure clients have access to all required services.

- 2.a.6** The CCBHC conducts outreach, engagement, and retention activities to support inclusion and access for underserved individuals and populations.⁵
- 2.a.7** Services are subject to all state standards for the provision of both voluntary and court-ordered services.
- 2.a.8** The CCBHC has a continuity of operations/disaster plan. The Plan will ensure the CCHBC is able to effectively notify staff, clients, and healthcare and community partners when a disaster/emergency occurs or services are disrupted. The CCBHC, to the extent feasible, has identified alternative locations and methods to sustain service delivery and access to behavioral health medications during emergencies and disasters. The Plan also addresses health IT systems security/ransomware protection and backup and access to these systems in case of disaster.

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

- 2.b.1** All new clients requesting or being referred for behavioral health services will, at the time of first contact, whether that contact is in-person, by telephone, or using other remote communication, receive a preliminary triage, including risk assessment, to determine acuity of needs. That preliminary triage may occur telephonically. If the triage identifies an emergency/crisis need, appropriate action is taken immediately, including safety planning and any necessary subsequent outpatient follow-up.
- If the triage identifies an urgent need, clinical services are provided, including an initial evaluation within one business day of the time the request is made.
 - If the triage identifies routine needs, services will be provided and the initial evaluation completed within 10 business days.
 - For those presenting with emergency or urgent needs, the initial evaluation may be conducted by phone or through use of technologies for telehealth/telemedicine and video conferencing, but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved the client must be seen in person at the next subsequent encounter and the initial evaluation reviewed.

The preliminary triage and risk assessment 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 must build upon what came before it. Subject to more stringent state,

⁵ Underserved individuals and populations includes communities as defined in [Executive Order 13985](#) as well as individuals or populations that have unmet needs for mental health and substance use disorder treatment and supports.

federal or applicable accreditation standards, all new clients will receive a 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 does not preclude the initiation, completion of the comprehensive evaluation, or the provision of treatment during the 60-day period.

Note: Requirements for these screenings and evaluations are specified in criteria 4.d.

- 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 client, when changes in the client's status, responses to treatment, or goal achievement have occurred. The assessment must be updated no less frequently than every 6 months unless the state, federal, or applicable accreditation standards are more stringent.
- 2.b.3** Existing CCBHC clients seeking routine outpatient clinical services must be provided an appointment within 10 business days of the request for an appointment, unless the state, federal, or applicable accreditation standards are more stringent. If an established client presents with an emergency/crisis need, appropriate action is taken immediately based on the need of the client, including immediate crisis response if necessary. If an established client presents with an urgent, non-emergency need, clinical services are generally provided within one business day of the time the request is made or at a later time if that is the preference of the client.

Criteria 2.C: 24/7 Access to Crisis Management Services

- 2.c.1** In accordance with program requirement 4.c, the CCBHC provides crisis management services that are available and accessible 24 hours a day, seven days a week.
 - 2.c.2** The methods for providing a continuum of crisis prevention, response, and postvention services are 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 planning, psychiatric advanced directives, and how to access crisis services, including the 988 Suicide & Crisis Lifeline (by call, chat, or text) and other area hotlines and warmlines, and overdose prevention, if risk is indicated, at the time of the initial evaluation meeting following the preliminary triage. Please see 3.a.4. for further information on crisis planning. 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.c).
 - 2.c.4** In accordance with program requirement 3, the CCBHC maintains a working relationship with local hospital emergency departments (EDs). Protocols are established for CCBHC staff to address the needs of CCBHC clients in psychiatric crisis who come to those EDs.
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- 2.c.5** Protocols, including those for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a behavioral health crisis. Shared protocols are designed to maximize the delivery of recovery-oriented treatment and services. The protocols should minimize contact with law enforcement and the criminal justice system, while promoting individual and public safety, and complying with applicable state and local laws and regulations.

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, in conjunction with the client, 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 client and their family.

Note: See criterion 3.a.4 where precautionary crisis planning is addressed.

Criteria 2.D: No Refusal of Services due to Inability to Pay

- 2.d.1** The CCBHC ensures: (1) no individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual's inability to pay for such services (PAMA § 223 (a)(2)(B)), and (2) any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1).
- 2.d.2** The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC proposes to offer pursuant to these criteria. Such fee schedule will be included on the CCBHC website, posted in the CCBHC waiting room and readily accessible to clients and families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP, literacy barriers, 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, homelessness, or lack of a permanent address. Please see 2.e.2 for CCBHC's obligations to serve individuals who
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are within the CCBHC service area and individuals who reside outside the service area and request on-going services.

- 2.e.2** The CCBHC has protocols addressing the needs of individuals who do not live close to the CCBHC or within the CCBHC service area as established by the state. The CCBHC is 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 the CCBHC to refer and track individuals seeking non-crisis services to the CCBHC or other clinics serving the individual's area of residence. For individuals and families who live within the CCBHC's service area but live a long distance from CCBHC clinic(s), the CCBHC should consider use of technologies for telehealth/telemedicine and video conferencing in alignment with client preferences and to the extent practical. These criteria do not require the CCBHC to provide continuous telehealth services to individuals who live outside of the CCBHC service area.

Interim Draft

Program Requirement 3: Care Coordination

This section describes the requirements for:

- a. General requirements of care coordination
- b. Health information systems
- c. Agreements to support care coordination
- d. Treatment team, planning, and care coordination activities

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:

- *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.*
- *Inpatient psychiatric facilities and substance use detoxification, post detoxification step-down services, and residential programs.*
- *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.*
- *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.*
- *Inpatient acute care hospitals and hospital outpatient clinics.”*

Criteria 3.A: General Requirements of Care Coordination

- 3.a.1** Based on a person-centered and family-centered treatment plan aligned with the requirements of Section 2402(a) of the Affordable Care Act and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services. This includes 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. The CCBHC also coordinates with other systems to meet the needs of the people they serve, including criminal and juvenile justice and child welfare.⁶

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 client’s family and friends. If a client consents and has the capacity to make health care decisions, health care providers may communicate protected health care information to a client’s family and friends. Given this, the CCBHC ensures clients’ 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-centered and family-centered care. Consent for release of information is obtained from CCBHC clients with providers outside of the CCBHC. If the CCBHC is 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.

Note: CCBHCs are encouraged to explore options for electronic documentation of consent where feasible and responsive to the needs and capabilities of the client. See standards within the Interoperability Standards Advisory.⁷

- 3.a.3** Consistent with requirements of privacy, confidentiality, and client preference and need, the CCBHC assists clients and families of children and youth referred to external providers or resources in obtaining an appointment and tracking engagement of services to ensure coordination and receipt of needed supports.

⁶ For additional information on care coordination, see [Care Coordination | Agency for Healthcare Research and Quality \(ahrq.gov\)](https://www.ahrq.gov/care-coordination/)

⁷ The Interoperability Standards Advisory (ISA) process represents the model by which the Office of the National Coordinator for Health Information Technology (ONC) will coordinate the identification, assessment, and determination of "recognized" interoperability standards and implementation specifications for industry use to fulfill specific clinical health IT interoperability needs. More information can be found at [Interoperability Standards Advisory \(ISA\) | HealthIT.gov](https://www.healthit.gov/interoperability-standards-advisory).

- 3.a.4** Care coordination activities are carried out in keeping with the client's preferences and needs for care and, to the extent possible and in accordance with the client's expressed preferences, with the client's family/caregiver and other supports identified by the client. So as to ascertain in advance the client's preferences in the event of psychiatric or substance use crisis, the CCBHC develops a crisis plan with each client. Crisis plans may support the development of a Psychiatric Advance Directive.⁸

Psychiatric Advance Directives are entered in the patient's electronic health information so that the information is available to providers in emergency care settings where those electronic health records are accessible.

- 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 clients. Upon appropriate consent to release of information, the CCBHC is also required 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 client's freedom to choose their provider with the CCBHC or its DCOs.
- 3.a.7** The CCBHC assists clients and families to access benefits, including Medicaid, and enroll in programs or supports that may be beneficial to them.

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.
- 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, outreach, and for research, ensure appropriate protections are in place.
- 3.b.3** The CCBHC demonstrates use of a required core set of health IT capabilities certified under the ONC Health IT Certification Program that align with key clinical practice and care delivery requirement in these criteria, as follows:

⁸ Psychiatric Advance Directives are legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric Advance Directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness. For more information visit [NRC PAD | National Resource Center on Psychiatric Advance Directives \(nrc-pad.org\)](https://nrc-pad.org/)

- Capture patient health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status, in a structured format consistent with widely adopted standards.⁹
- At a minimum, support care coordination by sending and receiving summary of care records.¹⁰
- Provide customers with timely electronic access to view, download, or transmit their health information.¹¹
- Provide evidence-based clinical decision support using capabilities of certified health IT.¹²
- Conduct electronic prescribing using the capabilities of certified health IT.¹³

Note: CCBHCs are not required to have all these capabilities in place when certified or when submitting their attestation but should plan to adopt and use technology meeting these requirements over time, consistent with any applicable program timeframes. In addition, CCBHCs do not need to adopt a single system that provides all these certified capabilities but can adopt either a single system or a combination of tools that provide these capabilities. Finally, CCBHC providers who successfully participate in the Promoting Interoperability performance category of the Quality Payment Program will already have health IT systems that successfully meet all the core certified health IT capabilities.

- 3.b.4** The CCBHC will work with DCOs to ensure all steps are taken, including obtaining client consent, to comply with privacy and confidentiality requirements. These include, but are not limited to, those of HIPAA (Pub. L. No. 104191, 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** The CCBHC develops a plan to be produced within two-years from CCBHC designation to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan includes 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.

⁹ United States Core Data for Interoperability (USCDI) standard at 45 CFR 170.213 and “Demographics” criterion at § CFR 170.315(a)(5).

¹⁰ “Transitions of care” criterion at § 170.315(b)(1)).

¹¹ “Application access – patient selection” criterion at § 170.315(g)(7); “Application access – all data request” criterion at § 170.315(g)(9) and “Standardized API for patient and population services” criterion at § 170.315(g)(10).

¹² “Clinical decision support” criterion at § 170.315(a)(9).

¹³ “Electronic prescribing” criterion at § 170.215(b)(3).

Criteria 3.C: Care Coordination Partnerships

- 3.c.1** The CCBHC has a partnership 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 clients who are served by other primary care providers, including but not limited to FQHC Look-Alikes and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination.

Note: *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*

- 3.c.2** The CCBHC has partnerships that establish care coordination expectations with programs that can provide inpatient psychiatric treatment, OTP services, if any exist within the CCBHC service area, medical withdrawal management services for substance use disorders, and residential substance use disorder treatment programs. The CCBHC tracks when clients 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 programs, medically monitored withdrawal management services, 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, overdose prevention, and provision for peer services.

Note: *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*

- 3.c.3** The CCBHC has partnerships with a variety of community or regional services, supports, and providers. Partnerships support joint planning for care and services, provide opportunities to identify individuals in need of services, enable the CCBHC to provide services in community settings, enable the CCBHC to provide support and consultation with a
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community partner, and support CCBHC outreach and engagement efforts. Service and support partnerships which are identified by statute include:

- Schools
- Child welfare agencies
- Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans, and other specialty courts)
- Indian Health Service¹⁴ youth regional treatment centers
- State licensed and nationally accredited child placing agencies for therapeutic foster care service
- Other social and human services

The CCBHC has partnerships with other community or regional systems, services, supports, and providers given the population served and the needs and preferences of individual clients, such as the following:

- Specialty providers of medications for treatment of opioid and alcohol use disorders
- Suicide and crisis hotlines and warmlines
- Indian Health Service or other tribal programs
- Homeless shelters
- Housing agencies
- Employment services systems
- Peer-operated programs
- Services for older adults, such as Area Agencies on Aging and Aging and Disability Resource Centers
- State and local health departments and behavioral health and developmental disabilities agencies
- Substance use prevention and harm reduction programs
- Criminal and juvenile justice, including law enforcement, courts, jails, prisons, and detention centers
- Legal aid
- Immigrant and refugee services
- Other social and human services (e.g., intimate partner violence centers, religious services and supports, grief counseling, Affordable Care Act Navigators, food and transportation programs)

In addition, the CCBHC has a care coordination partnership with the 988 Suicide & Crisis Lifeline call center serving the area in which the CCBHC is located.

¹⁴ The Indian Health Service is an Operating Division within HHS, responsible for providing federal health services to American Indians and Alaska Natives.

Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party or unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.

- 3.c.4** The CCBHC has an agreement establishing care coordination expectations with the nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department. To the extent multiple Department facilities of different types are located nearby, the CCBHC should explore care coordination agreements with facilities of each type.

Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.

- 3.c.5** The CCBHC has care coordination partnerships establishing expectations with inpatient acute-care hospitals in the area served by the CCBHC and their associated services/facilities, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical withdrawal management facilities and ambulatory medical withdrawal management providers to address the needs of CCBHC clients. This includes procedures and services, such as peer recovery specialist/coaches, to help individuals successfully transition from ED or hospital to CCBHC and community care to ensure continuity of services and to minimize the time between discharge and follow up. Ideally, the CCBHC should work with the discharging facility ahead of discharge to assure a seamless transition. The agreement is such that the CCBHC can track when their clients are admitted to facilities providing the services listed above, as well as when they are discharged. The agreement also provides for transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge.

The CCBHC will make and document reasonable attempts to contact all CCBHC clients who are discharged from these settings within 24 hours of discharge. For all CCBHC clients being discharged from such facilities who are at risk for suicide and overdose, the care coordination agreement between these facilities and the CCBHC includes a requirement to coordinate consent and follow-up services with the client within 24 hours of discharge, and continues until the individual is linked to services or assessed to be no longer at risk.

Note: *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*

Criteria 3.D: Care Treatment Team, Treatment Planning, and Care Coordination Activities

3.d.1 The CCBHC treatment team includes the client, the family/caregiver/legal guardian of child clients, the adult client's family to the extent the client desires their involvement, legal guardians, and any other person the client desires to be involved in their care. All treatment planning and care coordination activities are person- and family-centered and align 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 allows for clients to identify those persons who can receive information about their care and does not restrict communication between health care professionals and the family, friends, and guardians of clients. If the client consents, health care professionals covered by HIPAA may provide information to a client's family, friends, or anyone else identified by a client as involved in their care.

3.d.2 As appropriate for the individual's needs and preferences, the CCBHC designates an interdisciplinary treatment team that is responsible, with the client or family/caregiver, for directing, coordinating, and managing care and services for the client. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of CCBHC clients, including, as appropriate, traditional approaches to care for clients who may be American Indian or Alaska Native or from other cultural and ethnic groups.

Note: *See criteria 4.k relating to required treatment planning services for veterans.*

3.d.3 The CCBHC coordinates care and services provided by DCOs in accordance with the current treatment plan.

Note: *See program requirement 4 related to scope of service and person-centered and family-centered treatment planning.*

Program Requirement 4: Scope of Services

This section includes general requirements about service delivery and describes the services that must be provided by the CCBHC and/or a DCO through a formal agreement.

- a. Person-Centered and Family-Centered Care
- b. Crisis Services
- c. Screening, Assessment, and Diagnosis
- d. Person-Centered and Family-Centered Treatment Planning
- e. Outpatient Mental Health and Substance Use Services
- f. Primary Care Screening and Monitoring
- g. Targeted Case Management Services
- h. Psychiatric Rehabilitation Services
- i. Peer Supports and Family/Caregiver Supports
- j. Community Care for Uniformed Service Members and Veterans

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** The CCBHC organization will deliver the majority of services under the CCBHC umbrella directly rather than through DCOs (i.e., a majority of total service volume delivered across the nine required services). Whether delivered directly or through a DCO agreement, the CCBHC is responsible for the provision of all care specified in PAMA. This includes, as more explicitly provided and more clearly defined below in criteria 4.c through 4.k, crisis services; screening, assessment and diagnosis; person-centered and family-centered treatment planning; outpatient behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer and family supports; and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans.

● *Certifying states participating in the Section 223 CCBHC Demonstration, see CMS PPS guidance regarding payment.*

- 4.a.2** The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, consistent with the client's freedom to choose providers within the CCBHC and its DCOs. This requirement does not preclude the use of referrals outside the CCBHC or DCO if a needed specialty service is unavailable through the CCBHC or DCO entities.
- 4.a.3** With regard to either CCBHC or DCO services, clients will be informed of and 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 or state authorities.
- 4.a.4** DCO-provided services for CCBHC clients must meet the same quality standards as those provided by the CCBHC. 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. These reflect person-centered and family-centered, recovery-oriented care; being respectful of the individual client's needs, preferences, and values; and ensuring both client involvement and self-direction of services received. Services for children and youth are family-centered, youth-guided, and developmentally appropriate. A shared decision-making model for engagement is the recommended approach.

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 clients who are American Indian or Alaska Native (AI/AN) or other cultural or ethnic groups, for whom access to traditional approaches or medicines may be part of CCBHC services, and services that respond to the needs of sexual and gender minorities. For clients who are AI/AN, these services may be provided either directly or by arrangement with tribal organizations.

Criteria 4.C: Crisis Behavioral Health Services

- 4.c.1** The CCBHC may provide crisis services directly or through a DCO agreement with existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services.

Whether provided directly by the CCBHC or by a DCO, available services must include the following:

- **Emergency crisis intervention services:** The CCBHC provides or coordinates with telephonic, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. The CCBHC should participate in any state, regional, or local air traffic control (ATC) systems which provide quality coordination of crisis care in real-time as well as any service capacity registries as appropriate. Quality coordination means that protocols have been established, are followed for referrals made from the call center to the CCBHC or its DCO crisis care provider, and are tracked to ensure the timely delivery of mobile crisis team response, crisis stabilization, and post crisis follow-up care.¹⁵
- **24-hour mobile crisis teams:** The CCBHC provide mobile crisis teams available to provide community-based behavioral health crisis intervention services twenty-four hours per day, seven days per week to adults, children, youth, and families anywhere within the service area including at home, work, or anywhere else where the crisis is experienced. Mobile crisis teams are expected to arrive in-person within one hour (2 hours in rural and frontier settings) from the time that they are dispatched. Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time. Technologies also may be used to provide crisis care to individuals when remote travel distances make the 2-hour response time unachievable, but the ability to provide an in-person response must be available when it is necessary to assure safety. The CCBHC may consider aligning their programs with the [CMS Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services](#) if they are in a state that includes this option in their Medicaid state plan.

¹⁵ For more information see [National Guidelines for Behavioral Health Crisis Care | SAMHSA](#).

- **Crisis receiving/stabilization:** The CCBHC provides crisis receiving/stabilization services as defined by the state in which the CCBHC operates and must include at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals. Urgent care/walk-in services that identify the individual's immediate needs, de-escalate the individual, and connect them to a safe and least-restrictive setting for ongoing care. Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted. The CCBHC should have a goal of expanding the hours of operation as much as possible. In addition to these activities, the CCBHC may consider the development or support of peer-run crisis respite programs. These services are available to individuals of any level of acuity, either through presentation with a concerned individual, such as a family member, or human service worker and/or law enforcement in accordance with state and local laws. Crisis receiving/stabilization services should ideally be available 24 hours per day, 7 days a week. The CCBHC is encouraged to provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care.

PAMA requires provision of these three crisis behavioral health services. As part of the certification process, certifying states and clinics will clearly define crisis stabilization as they are using it but services provided must include suicide prevention and intervention, and services capable of addressing crises related to substance use including the risk of drug and alcohol related overdose and support following a non-fatal overdose after the individual is medically stable. The CCBHC will have an established protocol specifying the role of law enforcement during the provision of crisis services. As a part of the requirement to provide training related to trauma-informed care, the CCBHC shall specifically focus on the application of trauma-informed approaches during crises.

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 inpatient or emergency department following a behavioral health crisis.

Criteria 4.D: Screening, Assessment, and Diagnosis

- 4.d.1** The CCBHC directly, or through a DCO, 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., neuropsychological testing or developmental testing and assessment), the CCBHC provides or refers the client through formal relationships with other providers, or where necessary and appropriate through telehealth/telemedicine services.

Note: See program requirement 3 regarding coordination of services and treatment planning.

- 4.d.2** Screening, assessment, and diagnosis are conducted in a time frame responsive to the individual client's needs and preferences and are of sufficient scope to assess the need for all services required to be provided by the CCBHC.
- 4.d.3** The initial evaluation (including information gathered as part of the preliminary triage 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 client or other individuals who are significantly involved; (4) identification of the client's immediate clinical care needs related to the diagnosis for mental and substance use disorders; (5) a list of all current prescriptions and over-the counter medications, herbs, and supplements and the indication for any medications; (6) a summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful; (7) the use of any alcohol and/or other drugs the client may be taking and indication for any newly started medications; (8) an assessment of whether the client is a risk to self or to others, including suicide risk factors; (9) an assessment of whether the client has other concerns for their safety; (10) assessment of need for medical care (with referral and follow-up as required); and (11) 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.
- 4.d.4** A comprehensive diagnostic and treatment planning evaluation is required for all CCBHC clients. The evaluation will depend on the individual client and on any applicable existing state, federal, or applicable accreditation standards. Clinicians may use their clinical judgment with respect to the depth of questioning within the assessment so that the assessment actively engages the client around their presenting concern and gathers the amount of information that is commensurate with the complexity of their specific needs. Throughout, the evaluation should solicit and incorporate the preferences and goals of the client.
- Evaluations shall include:
1. Reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the client's presentation to the CCBHC.
 2. An overview of relevant social supports; social determinants of health; and health-related social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status.
 3. A description of cultural and environmental factors that may affect the client's treatment plan, including the need for linguistic services or supports for people with LEP.
 4. Pregnancy and/or parenting status.
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5. Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments.
6. Relevant medical history and major health conditions that impact current psychological status.
7. A medication list including the client's prescriptions, over-the counter medications, herbal remedies, and other treatments or medications, including those identified in a Prescription Drug Monitoring Program (PDMP), that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies
8. An examination that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement-based care) and substance use disorders (including tobacco, alcohol, and other drugs).
9. Basic cognitive screening for cognitive impairment.
10. Assessment of imminent risk, including suicide risk, overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person.
11. The client's strengths, goals, preferences and other factors to be considered in treatment and recovery planning.
12. Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services).
13. Assessment of any relevant social service needs of the client, with necessary referrals made to social services and, for pediatric clients, to child welfare agencies as appropriate.
14. 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 client's primary care provider (with appropriate referral and follow-up), or (b) a basic physical assessment as required by criteria 4.g.
15. Client's preferences regarding the use technologies such as telehealth/telemedicine to receive services. All remaining necessary releases of information are obtained by this point.

4.d.5 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.6** The CCBHC uses standardized and validated screening and assessment tools and, where appropriate, brief motivational interviewing techniques to facilitate engagement.
- 4.d.7** The CCBHC uses culturally and linguistically appropriate screening tools and approaches that accommodate all literacy levels and disabilities (e.g., hearing disability, cognitive limitations), when appropriate.
- 4.d.8** If screening identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the client is provided a full assessment and provided treatment, if appropriate within the level of care of the CCBHC, or referred to a more appropriate level of care. If the screening identifies more immediate threats to the client's safety, the CCBHC will take appropriate action as described in 2.b.1.

Criteria 4.E: Person-Centered and Family Centered Treatment Planning

- 4.e.1** The CCBHC directly, or through a DCO, provides person-centered and family-centered treatment planning, 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 client involvement and self-direction.

Note: See program requirement 3 related to coordination of care and treatment planning.

- 4.e.2** The CCBHC develops an individualized plan integrating prevention, medical, and behavioral health needs, and service delivery in collaboration with and endorsed by the client, the adult client's family (to the extent the client so wishes) or family/caregivers of youth and children, and is coordinated with staff or programs necessary to carry out the plan. The plan shall support care in the least restrictive setting possible. Shared decision making is the preferred model for the establishment of treatment planning goals.

● **Note:** Certifying states may 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 client 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 client's words or ideas and, when appropriate, those of the client's family/caregiver.
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- 4.e.5** The treatment plan is comprehensive, addressing all services required, including recovery supports, 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 as needed (e.g., eating disorders, traumatic brain injury, intellectual and developmental disabilities (I/DD)).
- 4.e.7** The treatment plan documents the client's advance directives related to treatment and crisis planning. If the client does not wish to share their preferences, that decision is documented. Please see 3.a.4., requiring the development of a crisis plan with each client.
- 4.e.8** ● Consistent with the criteria in 4.e.1 through 4.e.7, certifying states should specify other aspects of person-centered and family-centered treatment planning they will require based upon the needs of the population served. Treatment planning components that certifying states might consider include: prevention; community inclusion and support (housing, employment, social supports); involvement of family/caregiver and other supports; recovery planning; crisis 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, tailored treatment to ensure cultural and linguistically appropriate services).

Criteria 4.F: Outpatient Mental Health and Substance Use Services

- 4.f.1** The CCBHC directly, or through a DCO, provides outpatient behavioral health care, including psychopharmacological treatment. The CCBHC or the DCO must provide evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for adults, children, and families. SUD treatment and services shall be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1. In the event specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of outpatient mental and substance use disorder treatment the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine, in alignment with state laws and regulations. The CCBHC also provides or makes available through a formal arrangement traditional practices/treatment as appropriate for the clients served in the CCBHC area. Where specialist providers are not available to provide direct care to a particular client, or specialist care is not practically available, the CCBHC professional staff may consult with specialized services providers for highly specialized treatment needs. For clients with potentially harmful substance use, the CCBHC is strongly encouraged to engage the client with motivational techniques and harm reduction strategies to promote safety and/or reduce substance use.

Note: See also program requirement 3 regarding coordination of services and treatment planning.

- 4.f.2** ● Based upon the findings of the community needs assessment as required in program requirement 1, certifying 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 Therapy (CBT); Dialectical Behavior Therapy (DBT); Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP); Seeking Safety; Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (FACT); FDA-approved medications for substance use disorders, including smoking cessation; Long-acting injectable medications to treat both mental and substance use disorders; Effective but underutilized medications such as clozapine; Multi-Systemic Therapy; Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); High-Fidelity Wraparound; and Parent Management Training. This list is not intended to be all-inclusive and certifying 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 client'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. When treating children and adolescents, CCBHCs must provide evidenced-based services that are developmentally appropriate, youth-guided, and family/caregiver-driven. When treating older adults, the individual client'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.
- 4.f.4** Supports for children and adolescents must comprehensively address family/caregiver, school, medical, mental health, substance use, 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. The CCBHC will provide clinically indicated primary care screening and monitoring of key health indicators as determined by the Medical Director. The CCBHC ensures that children and older adults receive age-appropriate screening and preventive interventions. Prevention is a key component of primary care screening and monitoring services provided by the CCBHC. Although the provision of primary care services is not within the scope of the CCBHC services, these criteria do not prohibit the CCBHC from providing them. The CCBHC should also refer individuals with tobacco use disorder to their local tobacco quit line for adjunctive support for smoking cessation and supportive services or provide these services directly. The CCBHC shall screen for HIV and viral hepatitis in line with the A and B recommendations of the United States Preventative Services Task Force Recommendations.
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4.g.2 Primary care screening involves (1) identification of common physical health conditions experienced by the CCBHC client population (e.g. diabetes, metabolic syndrome, high blood pressure); (2) identifying individuals with chronic diseases; (3) ensuring that the CCBHC asks the client about somatic symptoms and connects them to appropriate care following the report of symptoms; (4) assuring the individuals have access to primary care services; and (5) initial laboratory testing appropriate to the individual client, including but not limited to blood glucose, lipid status, viral hepatitis and HIV status and other commonly occurring medical conditions identified by the medical director.

4.g.3 Ongoing primary care monitoring involves (1) assuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions; (2) coordinating care with primary care and specialty health providers; and (3) promoting healthy behavior change.

Note: See also program requirement 3 regarding coordination of services and treatment planning.

- *Certifying states may elect to require specific other screening and monitoring to be provided by the CCBHCs.*

Criteria 4.H: Targeted Case Management Services

4.h.1 The CCBHC is responsible for providing directly, or through a DCO, targeted case management services that will assist individuals in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports. Targeted case management provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC. Targeted case management should include supports for persons deemed at high risk of suicide or overdose, particularly during times of transitions such as from a residential treatment, ED, or psychiatric hospitalization. Targeted case management should be used for individual with complex or serious mental health or substance use conditions and for individuals who have a short-term need for support in a critical period, such as an acute episode or care transition. Intensive case management and team-based intensive services such as through Assertive Community Treatment are strongly encouraged but not required as a component of CCBHC.

- *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 providing directly, or through a DCO, evidence-based rehabilitation services for both mental health and substance use disorders. These incorporate a wide variety of recovery support services. Psychiatric rehabilitation services

must include supported employment programs; support for clients to participate in education; support for clients to achieve social inclusion and community connectedness; and help for clients to find and maintain safe and stable housing. Other 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; facilitating engagement in substance use disorder mutual help groups and community supports; navigating healthcare systems; recovery support services including Illness Management & Recovery; financial management; and dietary and wellness education. These services may be provided or enhanced by peer providers.

Note: See program requirement 3 regarding coordination of services and treatment planning.

- Certifying states should specify which evidence-based and other psychiatric rehabilitation services they will require based upon the needs of the population served.

Criteria 4.J: Peer Supports, Peer Counseling, and Family/Caregiver Supports

- 4.j.1** The CCBHC is responsible for directly providing, or through a DCO, peer supports, including peer specialist and recovery coaches, peer counseling, and family/caregiver supports. Peer services may include: peer-run wellness and recovery centers; youth/young adult peer support; recovery coaching; peer-run crisis respites; warmlines; peer-led crisis planning; peer navigators to assist individuals transitioning between different treatment programs and especially between different levels of care; mutual support and self-help groups; peer support for older adults; peer education and leadership development; and peer recovery services. Potential family/caregiver support services that might be considered include: community resources education; navigation support; behavioral health and crisis support; parent/caregiver training and education; and family-to-family caregiver support.

Note: See program requirement 3 regarding coordination of services and treatment planning.

- Certifying states should specify the scope of peer and family services they will require based upon the needs of the population served.

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 providing directly, or through a DCO, 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 the CCBHC in providing quality clinical behavioral health services consistent with the Uniform Mental Health Services Handbook.

Note: See program requirement 3 regarding coordination of services and treatment planning.

4.k.2 All individuals inquiring about services are asked whether they have ever served in the U.S. military.

Current Military Personnel: Persons affirming current military service will be offered assistance in the following manner:

1. Active Duty Service Members (ADSM) must use their servicing MTF, and their MTF Primary Care Managers (PCMs) are contacted by the CCBHC regarding referrals outside the MTF.
2. ADSMs and activated Reserve Component (Guard/Reserve) members who reside more than 50 miles (or one hour's drive time) from a military hospital or military clinic enroll in TRICARE PRIME Remote and use the network PCM, or select any other authorized TRICARE provider as the PCM. The PCM refers the member to specialists for care he or she cannot provide and works with the regional managed care support contractor for referrals/authorizations.
3. Members of the Selected Reserves, not on Active Duty (AD) orders, are eligible for TRICARE Reserve Select and can schedule an appointment with any TRICARE-authorized provider, network or non-network.

Veterans: Persons affirming former military service (veterans) are offered assistance to enroll in VHA for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA. These include clinical guidelines contained in the Uniform Mental Health Services Handbook as excerpted below (from VHA Handbook 1160.01, Principles of Care found in the Uniform Mental Health Services in VA Centers and Clinics).

Note: See also program requirement 3 requiring coordination of care across settings and providers, including facilities of the Department of Veterans Affairs.

4.k.3 The CCBHC ensures 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 client tracking database for those veterans who need case management. The Principal Behavioral Health Provider ensures the following requirements are fulfilled:

1. Regular contact is maintained with the veteran as clinically indicated if ongoing care is required.
2. A psychiatrist or such other independent prescriber as satisfies the current requirements of the VHA Uniform Mental Health Services Handbook reviews and reconciles each veteran's psychiatric medications on a regular basis.
3. Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision maker's consent when the veteran does not have adequate decision-making capacity).
4. Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained.
5. The treatment plan is revised, when necessary.¹⁶
6. The principal therapist or Principal Behavioral Health Provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2).
7. The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the Principal Behavioral Health Provider suspects the veteran lacks the capacity to make a decision about the mental health treatment plan, the provider must ensure the veteran's decision-making capacity is formally assessed and documented. For

¹⁶ These services must still meet the basic CCBHC requirements for a treatment plan update every 6 months in Criterion 2.b.2

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.

4.k.5 Behavioral health services are recovery-oriented. The VHA adopted the National Consensus Statement on Mental Health Recovery in its Uniform Mental Health Services Handbook. SAMHSA has since developed a working definition and set of principles for recovery updating the Consensus Statement. Recovery is defined as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” The following are the 10 guiding principles of recovery:

- Hope
- Person-driven
- Many pathways
- Holistic
- Peer support
- Relational
- Culture
- Addresses trauma
- Strengths/responsibility
- Respect¹⁷

As implemented in VHA recovery, the recovery principles also include the following:

- Privacy
- Security
- Honor

Care for veterans must conform to that definition and to those principles in order to satisfy the statutory requirement that care for veterans adheres to guidelines promulgated by the VHA.

4.k.6 All behavioral health care is provided with cultural competence.

1. Any staff who is not a veteran has training about military and veterans' culture in order to be able to understand the unique experiences and contributions of those who have served their country.
2. All staff receives cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity.

¹⁷ See [SAMHSA's Working Definition of Recovery](#).

4.k.7 There is a behavioral health treatment plan for all veterans receiving behavioral health services.

1. The treatment plan includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis.
 2. The treatment plan includes approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself.
 3. As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness.
 4. The plan is recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments.
 5. The treatment plan is developed with input from the veteran and, when the veteran consents, appropriate family members. The veteran's verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1.
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Program Requirement 5: Quality and Other Reporting

This section describes the requirements for:

1. Data collection, reporting, and tracking
2. Continuous quality improvement planning

Criteria 5.A: Data Collection, Reporting, and Tracking

5.a.1 The CCBHC collects, reports, and tracks encounter, outcome, and quality data, including, but not limited to, data capturing: (1) client characteristics; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) client outcomes. Data collection and reporting requirements are elaborated below and in Appendix B. Where feasible, information about clients and care delivery should be captured electronically, using widely available standards.

Note: See section 3.b for additional technical guidance.

5.a.2 Reporting is annual and data are required to be reported for all CCBHC clients.

5.a.3 The CCBHC must collect and report the required Clinic-Collected quality measures identified in Appendix B.

- Certifying states may require certified CCBHCs to collect and report optional Clinic-Collected measures identified in Appendix B. States participating in the Demonstration must report State-Collected quality measures as required in Appendix B. Demonstration program states must advise SAMHSA and its CCBHCs which, if any, of the listed optional measures it will require (either State-Collected or Clinic-Collected). Whether the measures are state or clinic-collected, all must be reported to SAMHSA annually via a single submission from the state. Quality measure data are required to be reported for all CCBHC clients, or where data constraints exist (e.g., the measure is calculated from claims data by the state, for all Medicaid enrollees in the CCBHCs).

It is expected that state-collected measure results will be shared with their Demonstration program CCBHCs in a timely fashion. For this reason, Demonstration program states may elect to calculate their state-collected measures more frequently to share with their Demonstration program CCBHCs, to facilitate quality improvement at the clinic level.

Quality measures to be reported for the Demonstration program may relate to services CCBHC clients receive through DCOs. It is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship with DCOs. CCBHCs should ensure adequate consent as appropriate, and that releases of information are obtained for each affected client.

- 5.a.4** ● As specified above in 5.a.3 and in Appendix B, states participating in the Demonstration program are responsible for some aspects of data collecting and measure calculation (most typically measures using Medicaid claims and encounter data) and for reporting and for reporting all quality measures to SAMHSA, whether collected by clinics or the state itself.

Demonstration program states also must provide CCBHC-level Medicaid claims or encounter data to the evaluators of this Demonstration program annually for evaluation purposes. These data also must be submitted to CMS through T-MSIS in order to support the state's claim for enhanced federal matching funds made available through the Demonstration program. At a minimum, client and service-level data should include a unique client identifier, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis.

CCBHC client claim or encounter data must be linkable to the client's pharmacy claims, laboratory claims, or utilization information, inpatient and outpatient claims, and any other claims or encounter data necessary to report the measures identified in Appendix B. In addition to data specified in this program requirement and in Appendix B that the Demonstration state is to provide, the state will provide other data, including Treatment Episode Data Set (TEDS) data and data from comparison settings, as may be required for the evaluation to HHS and the national evaluation contractor annually.

To the extent CCBHCs participating in the Demonstration program are responsible for provision of data, the data will be provided to the state and as may be required elsewhere, to HHS and the evaluator. If requested, CCBHCs participating in the Demonstration program will participate in discussions with the national evaluation team.

- 5.a.5** ● CCBHCs participating in the Demonstration program annually submit a cost report with supporting data within six months after the end of each Demonstration year to the state. The Demonstration state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each Demonstration year to CMS.

Note: *In order for a clinic participating in the Demonstration Program to receive payment using the CCBHC PPS, it must be certified as a CCBHC.*

Criteria 5.B: Continuous Quality Improvement (CQI) Plan

- 5.b.1** The CCBHC develops, implements, and maintains an effective, CCBHC-wide data-driven continuous quality improvement (CQI) plan for the services provided. The CCBHC establishes a critical review process to review CQI outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance. The CCBHC should consider use of quantitative and qualitative data in their CQI activities. In addition, the CQI

plan includes an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and disaggregated data to track and improve outcomes for populations facing health disparities. The CCBHC is encouraged to incorporate measurement-based care into their service delivery and quality improvement efforts.

- 5.b.2** The CQI plan is to be developed by the CCBHC and will, at minimum, address how the CCBHC will review: (1) CCBHC client deaths by suicide or suicide attempts, and both fatal and non-fatal overdoses; (2) CCBHC client 30 day hospital readmissions for psychiatric or substance use reasons; (3) all-cause mortality; (4) results of CCBHC and state-collected quality measures that may be required as part of the Demonstration or otherwise; and (5) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.

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Program Requirement 6: Organizational Authority, Governance, and Accreditation

This section describes the requirements for:

1. Organizational Authority and Financing
2. Governance

Criteria 6.A: General Requirements of Organizational Authority and Finances

6.a.1 The CCBHC maintains documentation establishing the CCBHC conforms to at least one of the following statutorily established criteria:

- Is a non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code
- Is part of a local government behavioral health authority
- Is operated under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.)
- Is an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.)

Note: A CCBHC is considered part of a local government behavioral health authority when a locality, county, region or state maintains authority to oversee behavioral health services at the local level and utilizes the clinic to provide those services.

6.a.2 To the extent CCBHCs are not operated under the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, states 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 clients and to inform the provision of services to those clients, based upon the population the prospective CCBHC may serve. 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 that the clinic is designated as a CCBHC 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, sexual orientation, and in terms of types of disorders. The CCBHC will incorporate meaningful participation from individuals with lived experience of mental and/or substance use disorders and their families, including youth. This participation is designed to assure that the perspectives of clients, families, and people with lived experience of mental health and substance use conditions are integrated in leadership and decision-making. Meaningful participation means involving a substantial number of persons with lived experience and family members of clients or individuals with lived experience in developing initiatives; identifying community needs, goals, and objectives; providing input on service development and CQI processes; and budget development and fiscal decision making.¹⁸ CCBHCs reflect substantial participation by one of two options:

Option 1: At least fifty-one percent of the CCBHC governing board is comprised of individuals with lived experience of mental and/or substance use disorders and families.

Option 2: Other means are established to demonstrate meaningful participation in board governance involving people with lived experience (such as creating an advisory committee that reports to the board). The CCBHC provides staff support to the individuals involved in any alternate approach that are equivalent to the support given to the governing board.

Under this option, individuals with lived experience of mental and/or substance use disorders and family members of clients or individuals with lived experience must have representation in governance that assures input into:

1. Identifying community needs and goals and objectives of the CCBHC
2. Service development, quality improvement, and the activities of the CCBHC
3. Fiscal and budgetary decisions
4. Governance (human resource planning, leadership recruitment and selection, etc.)

The input from any alternate approach should be considered in a similar manner as input provided by members of the governing board of the CCBHC and representatives from the alternate approach must have formal voting power on the governing board. The governing board must establish protocols for incorporating input from the alternative arrangement developed.

6.b.2 If option 1 is chosen, the CCBHC must describe how it meets this requirement, or provide a transition plan with a timeline that indicates how it will do so.

¹⁸ For more information regarding meaningful participation, see [Participation Guidelines for Individuals with Lived Experience and Family | SAMHSA](#)

If option 2 is chosen, for CCBHCs not certified by the state, the federal grant funding agency will determine if this approach is acceptable, and, if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes.

- For certifying states, if option 2 is chosen then states will determine if this approach is acceptable, and, if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes.

6.b.3 To the extent the CCBHC is comprised of a governmental or tribal organization, subsidiary, or part of a larger corporate organization that cannot meet these requirements for board membership, the CCBHC will specify the reasons why it cannot meet these requirements. The CCBHC will have or develop an advisory structure and describe other methods for individuals with lived experience and families to provide meaningful participation as defined in 6.b.1.

6.b.4 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 accounting, 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.5 ● Certifying states will determine what processes will be used to verify that these governance criteria are being met.

Criteria 6.C: Accreditation

6.c.1 A CCBHC is a qualified Medicaid provider and licensed provider of both mental health and substance use disorder services including developmentally appropriate services to children, youth, and their families, unless there is a state administrative, statutory, or regulatory framework that substantially prevents the CCBHC organization provider type from obtaining the necessary licensure, certification, or accreditation to provide these services. The CCBHC will adhere to any applicable state accreditation, certification, and/or licensing requirements. Further, the CCBHC is required to participate in SAMHSA Behavioral Health Treatment Locator.

Clinics that have submitted an attestation to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program are designated as CCBHCs only during the period for which they are authorized to receive federal funding to provide CCBHC services.

- CCBHCs certified by their state as a CCBHC and may be recertified as at the discretion of the state.
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- 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. Terms and Definitions

Terms and definitions included in this appendix are meant to guide states, territories, tribes, and existing/potential CCBHCs to understand the intent of the CCBHC certification criteria. The terms and definitions are not intended to replace state definitions that are more specific or are more broadly defined.

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”.¹⁹

Care coordination: CCBHCs establish activities within their organization and with care coordination partners that promote clear and timely communication, deliberate coordination, and seamless transition. This may include (but is not limited to):

- Establishing accountability and agreeing on responsibilities between care coordination partners.
- Engaging and supporting clients in and, subject to appropriate consent, their family and caregivers to participate in care planning and delivery and ensuring that the supports and services that the client and family receive are provided in the most seamless manner that is practical.
- Communicating and sharing knowledge and information, including the transfer of medical records and prescriptions, within care teams and other care coordination partners, as allowable and agreed upon with the individual being served.
- Coordinating and supporting transitions of care that include tracking of admission and discharge and coordination of specific services if the consumer presents as a potential suicide or overdose risk.
- Assessment of patient needs and goals to create a proactive treatment plan and linkage to community resources.
- Monitoring and follow-up, including adapting supports and treatment plans as needed to respond to changes in the needs and preferences of individuals being served.

¹⁹ SAMHSA-HRSA Center for Integrated Health Solutions. *Glossary*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. Available at [Glossary of Terms and Acronyms for SAMHSA Grants | SAMHSA](#).

- Coordinating directly with external providers for appointment scheduling and follow up after appointment for any prescription changes or care needs, ‘closing the loop.’
- Communicating and sharing knowledge and information to the full extent permissible under HIPAA, 42 CFR part 2, and ONC and CMS interoperability regulations on information blocking without additional requirements unless based on state law.

As used here, care coordination applies to activities by CCBHCs that have the purpose of coordinating and managing the care and services furnished to each consumer client 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”.²⁰ See also the definition of “targeted case management.”

Certified Community Behavioral Health Clinic (CCBHC) or Clinic: A CCBHC is a qualifying clinic that is responsible for providing all nine services in a manner that meets or exceeds CCBHC criteria described herein. The qualifying clinic may deliver the nine required services directly or through formal agreements with designated collaborating organizations.

A qualifying clinic must be one of the following: a nonprofit organization; part of a local government behavioral health authority; an entity operated under authority of the IHS, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS pursuant to the Indian Self-Determination Act; or an entity that is an urban Indian organization pursuant to a grant or contract with the IHS under Title V of the Indian Health Care Improvement Act (PL 94-437). CCBHC and Clinic are used interchangeably to refer to Certified Community Behavioral Health Clinics.

CCBHCs must be certified by their state as a CCBHC or have submitted an attestation to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program. Qualifying clinics that seek CCBHC designation and operate within the boundaries of a state that opt to certify CCBHCs must request certification from that state. State certified clinics are designated as CCBHCs for a period of time determined by the state but not longer than three years. CCBHCs must be recertified or submit a new attestation every three years. States may decertify CCBHCs if they fail to meet the criteria, if there are changes in the state CCBHC program, or for other reasons identified by the state.

²⁰ NASMHPD. *The Role of Supportive Housing, Case Management, and Employment Services in Reducing the Risk of Behavioral Health Crisis*. 2022. Accessible at [The Role of Supportive Housing, Case Management, and Employment Services in Reducing the Risk of Behavioral Health Crisis \(nasmhpd.org\)](https://nasmhpd.org/The_Role_of_Supportive_Housing_Case_Management_and_Employment_Services_in_Reducing_the_Risk_of_Behavioral_Health_Crisis).

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.

Community Needs Assessment: A systematic approach to identifying community needs and determining program capacity to address the needs of the population being served. CCBHCs will conduct or collaborate with other community stakeholders to conduct a community needs assessments. The assessment should identify current conditions and desired services or outcomes in the community, based on data and input from key community stakeholders. Specific CCBHC criteria are tied to the community needs assessment including staffing, language and culture, services, locations, service hours and evidence-based practices. Therefore, the community needs assessment must be thorough and reflect the treatment needs of those who reside in the service area. If a community needs assessment has been completed in the past year, the CCBHC may decide to augment, or build upon the information to ensure that the required components of the community needs assessment are collected.

The community needs assessment is comprised of the following elements:

1. A description of the physical boundaries and size of the service area, including identification of sites where services are delivered by the CCBHC, including through DCOs.
2. Information about the prevalence of mental health and substance use conditions and related needs in the service area, such as rates of suicide and overdose.
3. Economic factors and social determinants of health affecting the population's access to health services, such as percentage of the population with incomes below the poverty level, access to transportation, nutrition, and stable housing.
4. Cultures and languages of the populations residing in the service area.
5. The identification of the underserved population(s) within the service area.
6. A description of how the staffing plan does and/or will address findings.
7. Plans to update the community needs assessment every 3 years.
8. Input with regard to cultural, linguistic, health, and behavioral health treatment needs; evidence-based practices and behavioral health crisis services; access and availability of CCBHC services including days, times, and locations, and telehealth options; and potential barriers to care such as transportation, income, culture, workforce shortages.

Input should come from the following care coordination partners: health centers; local health departments (Note: these departments also develop community needs assessments that may be helpful); inpatient psychiatric facilities, inpatient acute care hospitals and hospital outpatient clinics; one or more Department of Veterans Affairs facilities; people with lived experience of mental health and substance use conditions and organizations operated by people with lived experience of mental health and substance use conditions; residential programs; school officials; juvenile justice agencies and facilities; criminal justice agencies and facilities; Indian Health Service or other tribal programs such as Indian Health Service youth regional treatment centers

as applicable; child welfare agencies and state licensed and nationally accredited child placing agencies for therapeutic foster care service; and crisis response partners such as hospital emergency departments, crisis stabilization settings, crisis call centers and warmlines.

Other key informants may include: specialty providers of medications for treatment of opioid and alcohol use disorders; peer-run and operated service providers; homeless shelters; housing agencies; employment services systems; services for older adults, such as Area Agencies on Aging and Aging and Disability Resource Centers; and other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs).

Client: Within this document, the term “client” refers to 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 or under an agreement between a CCBHC and a DCO. Use of the term “patient” is restricted to areas where the statutory or other language is being quoted. Elsewhere, the word “client” is used.

Cultural and linguistic competence: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse consumers.²¹

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. The formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal, legal arrangements describing the parties’ mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized. The formal relationship between CCBHCs and DCOs create the platform for seamlessly integrated services delivered across providers under the umbrella of a CCBHC. DCO agreements shall make the DCO responsible for providing any services provided as a part of the DCO relationship in accordance with the CCBHC Certification Criteria. To this end, DCOs are more than care coordination or referral partners, and there is an expectation that relationships with DCOs will include more regular, intensive collaboration across organizations than would take place with other types of care coordination partners.

From the perspective of the client and their family members, services received through a DCO should be part of a coordinated package with other CCBHC services and not simply accessing services through another provider organization. To this end, the DCO agreement shall take active steps to reduce administrative burden on clients and their family members when accessing DCOs services through

²¹ Office of Minority Health. *Cultural and Linguistic Competency*. Rockville, MD: U.S. Department of Health and Human Services, December 12, 2014. Available at: [Cultural Competency - The Office of Minority Health \(hhs.gov\)](https://www.hhs.gov/health/omh/).

measures such as coordinating intake process, coordinated treatment planning, information sharing, and direct communication between the CCBHC and DCO to prevent the client or their family from having to relay information between the CCBHC and DCO. CCBHCs are not financially responsible for DCO services unless funding streams has been specifically established to pay for DCO services that do not otherwise have a source of funding. Regardless of DCO relationships entered into, the CCBHC maintains responsibility for assuring that CCBHC clients receive all nine services in a manner that meets the requirements of the certification criteria. Within the Section 223 CCBHC Demonstration, payment for DCO services is typically included within the scope of the CCBHC PPS, and DCO encounters are treated as CCBHC encounters for purposes of the PPS (with states permitted to establish exemptions). The CCBHC retains responsibility for care coordination including coordination with services to which it refers clients.

The CCBHC must have internal capacity to directly provide mental health and substance use services, as well as developmentally appropriate mental health and substance use care for children and youth separate from any DCO relationship, unless substantially prohibited by their state because of their provider type. 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. In the Section 223 CCBHC Demonstration, 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. To the extent that services are needed by a client or family 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 clients with needed services and supporting their retention services. This involves the process of making sure clients and families are informed about and are able to access needed services. 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 client engagement.

Family: Families of both adult and child/family consumer clients are important to 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, extended family members, care givers, friends, and others as defined by the family. The CCBHC respects the individual client's view of what constitutes their 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 as developmentally

appropriate. 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".²² More recently, this concept was broadened to explicitly recognize family-centered services are both developmentally appropriate and youth guided.²³ 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.

Lived Experience: People with lived experience are individuals directly impacted by a social issue or combination of issues who share similar experiences or backgrounds and can bring the insights of their experience to inform and enhance systems, research, policies, practices, and programs that aim to address the issue(s). Because CCBHCs they are designed to serve people with mental disorders, adults with serious mental illness, children with serious emotional disturbance and their families, and individuals with substance use disorders, their individuals with lived experiences provide valuable insight to improving the delivery of CCBHC services.

Peer Support Services: Peer support services are services designed and delivered by individuals who have experienced a mental health 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. Peer providers may have titles that may differ from state to state such as certified peer specialist, peer support specialist, and recovery coach. 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

²² Health Resources and Services Administration, Maternal and Child Health Bureau. *The National Survey of Children with Special Health Care Needs Chartbook 2001*. Rockville, Maryland: U.S. Department of Health and Human Services, 2004. Available at [Chartbooks | MCHB \(hrsa.gov\)](#).

²³ American Academy of Child & Adolescent Psychiatry. *Family and Youth Participation in Clinical Decision-Making*. Washington, D.C., October 2009. Available at [Family and Youth Participation in Clinical Decision-Making \(aacap.org\)](#).

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.²⁴ 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 client 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 client to the maximum extent possible. Person-centered planning also involves self- direction, which means the consumer client 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.²⁵

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 (“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”).²⁶

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.

Satellite Facility: A satellite facility of a CCBHC is a facility that was established by the CCBHC, operated under the governance and financial control of that CCBHC and provides at a minimum:

- Outpatient mental health and substance use services
- Crisis services
- Person-and family-centered treatment planning

²⁴ 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* (June 6, 2014). Available at: [Implementing Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs | Guidance Portal \(hhs.gov\)](https://www.hhs.gov/implementation/standards-for-person-centered-planning-and-self-direction-in-home-and-community-based-services-programs/).

²⁵ Ibid.

²⁶ Substance Abuse and Mental Health Services Administration. *SAMHSA's Working Definition of Recovery*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012. Available at: [SAMHSA's Working Definition of Recovery | SAMHSA Publications and Digital Products](https://www.samhsa.gov/recovery/working-definition-recovery/).

- Screening, risk assessment and diagnosis, the four services required in the Criteria to be provided directly by a CCBHC

For CCBHCs participating in the Demonstration only, the authorization for CCBHCs stipulates that “no payment shall be made to a satellite facility of a CCBHC established after April 1, 2014, under this Demonstration.” This definition does not limit the provision of services in non-clinic settings such as shelters and schools consistent with Criteria 2.a.3.

Shared Decision-Making (SDM): Shared decision-making is an emerging best practice in behavioral and physical health that aims to help people in treatment and recovery have informed, meaningful, and collaborative discussions with providers about their health care services.

It involves tools and resources that offer objective information upon which people in treatment and recovery incorporate their personal preferences and values. Shared decision-making tools empower people who are seeking treatment or in recovery to work together with their service providers and be active in their own treatment.²⁷

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. 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.²⁸

²⁷ Substance Abuse and Mental Health Services Administration. Shared Decision-Making Tools. Available at: [Shared Decision-Making Tools | SAMHSA](#).

²⁸ Substance Abuse and Mental Health Services Administration. *SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. Available at: [SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach | SAMHSA Publications and Digital Products](#).

Appendix B. Behavioral Health Clinic Quality Measures

The Behavioral Health Clinic (BHC) quality measures that CCBHCs will use are being updated in 2023. Below is a list, divided into clinic-collected and state-collected measures, required and optional. At the point when these updated Certification Criteria are being released for public comment, at least one measure remains tentative. This list, therefore, is subject to change.

For demonstration or other state-certified CCBHCs, it is a state decision as to whether to require reporting of measures designated as optional. For later cohorts of CCBHC-Es that are required to report quality measures, only the clinic-collected required measures are mandated.

Color Key: ✓ = Required measures

Clinic-Collected Measures

Measure Name and Designated Abbreviation	Steward	CMS Medicaid Core Set (2023)	Notes
✓ Time to Services (I-SERV)	SAMHSA	n/a	Will include sub-measures of average time to: Initial Evaluation, Initial Clinical Services, Crisis Services
✓ Depression Remission at Six Months (DEP-REM-6)	MN Community Measurement	n/a	Changed from the Twelve-Month version of the measure
✓ Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	NCQA	n/a	n/a
✓ Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD)	CMS	Adult and Child	Child was added to the Medicaid Child Core Measure Set
✓ Screening for Social Drivers of Health (SDOH) ¹	Physicians Foundation	n/a	n/a
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	NCQA	n/a	n/a

Measure Name and Designated Abbreviation	Steward	CMS Medicaid Core Set (2023)	Notes
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA) (SRA-A)	Mathematica	n/a	n/a
Adult Major Depressive Disorder: Suicide Risk Assessment (SRA) (SRA-C)	Mathematica	n/a	n/a
Weight Assessment and Counseling for Nutrition and Physical Activity for children/Adolescents (WCC-CH)	NCQA	Child	Measure modified to coincide with change in Medicaid Child Core Measure Set
Controlling High Blood Pressure (CBP-AD)	NCQA	Adult	n/a

¹ The precise form, title, and steward of this measure is not finally determined at the point when these updated criteria are being disseminated for public comment.

State-Collected Measures

Measure Name and Designated Abbreviation	Steward	CMS Medicaid Core Set (2023)	Notes
✓ Patient Experience of Care Survey	SAMHSA	n/a	n/a
✓ Youth/Family Experience of Care Survey	SAMHSA	n/a	n/a
✓ Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	CMS	Adult	n/a
✓ Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)	NCQA	Adult	n/a
✓ Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)	NCQA	Child	n/a

Measure Name and Designated Abbreviation	Steward	CMS Medicaid Core Set (2023)	Notes
✓ Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)	NCQA	Adult	n/a
✓ Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD)	NCQA	Adult & Child	Child was added to the Medicaid Child Core Measure Set
✓ Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD)	NCQA	Adult & Child	Child was added to the Medicaid Child Core Measure Set
✓ Plan All-Cause Readmissions Rate (PCR-AD)	NCQA	Adult	n/a
✓ Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)	NCQA	Child	n/a
✓ Antidepressant Medication Management (AMM-BH)	NCQA	Adult	n/a
✓ Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	CMS	Adult	n/a
✓ Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	NCQA	Adult	n/a
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	NCQA	Child	n/a
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	NCQA	Child	n/a

Appendix C. Summary of Changes

Revisions to the CCBHC criteria are summarized as follows:²⁹

Significant Updates to Advance the Field: These are significant changes that correspond to updates to federal policies, national standards, evolving technologies, and/or infrastructure changes.

Other Revisions:

1. **Needed Structural Changes to the Criteria** - These changes are needed to align the delivery of service requirements with the statute, or updated regulations.
2. **Increased Flexibility** - These changes provide CCBHCs with additional flexibilities that were not available in the original criteria.
3. **Additions that Strengthen the Model** - These are changes designed to strengthen the CCBHC model.
4. **Updated Language and Examples** - These changes reflect the changing terminology in behavioral health. Examples are added to reflect emerging evidence-based services and to help identify innovations in the field that CCBHCs may choose to adopt.
5. **Clarifications**- These changes reflect clarification of the original criteria in areas where stakeholders identified ambiguities.

Significant Updates to Advance the Field

Crisis Care

Since the initial criteria were published, SAMHSA has developed guidance around the components of a comprehensive crisis system in its National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit. In addition, the national 988 Suicide & Crisis Lifeline was established. States have also been working to develop their crisis response systems. Crisis care requirements in the criteria have been amended to align with the National Guidelines and the implementation of 988 while recognizing the difference in state definitions and the varying availability of crisis services. Trauma informed approaches must be applied to crisis care services.

- 3.c.3 Required that the CCBHC have a care coordination partnership with the 988 Suicide & Crisis Lifeline call center serving the area in which the CCBHC is located.
- 4.c Updated the required response time of mobile crisis teams because and its response times are now more fully defined in 4.c.
- 4.c Described crisis stabilization and establishes a minimum threshold for stabilization services.

²⁹ Some minor language changes may not be reflected in this table.

- 4.c** Revisions address the risk of drug and alcohol related overdose and intervention support following a non-fatal overdose.

Responding to the Opioid Epidemic

In the midst of the continuing national overdose crisis, the Criteria have been strengthened in several areas to increase the focus on substance use disorders and overdose:

- 1.b.2** Clarified that the requirement that the CCBHC must have the capacity to prescribe FDA-approved medications used to treat opioid and alcohol use disorders makes an exception for Methadone. If the CCBHC does not have the ability to prescribe methadone directly, it should provide referral to an OTP with care coordination to ensure access to methadone and coordination with other services in the scope of their facility's legal ability to do so.
 - 1.b.2** Required to consult with or have addiction medicine specialist or physician on staff unless the medical director has experience with substance use disorder.
 - 1.b.2** Recognized need for the availability of Methadone. If the CCBHC does not have the ability to prescribe methadone directly, it should provide referral to an OTP with care coordination to ensure access to methadone and coordination with other services in the scope of their facility's legal ability to do so.
 - 1.b.2** Other FDA-approved medications are added to Buprenorphine in 1.b.2.
 - 2.c.3** Included focus on overdose prevention.
 - 3.c.2** Updated partnerships to include an OTPs if any exist within the CCBHC service area and included a focus on overdose prevention during transfers
 - 4.c.1** "Intoxication" including ambulatory and medical detoxification" replaced with "including risk of overdose and intervention following overdose reversal."
 - 4.d.3** Evaluation includes herbs and supplements and the indication for any newly started medications in the initial evaluation and replaced substances with "the use of any alcohol and/or other drugs."
 - 4.d.4** Included focus on overdose risk.
 - 4.d.8** (Previously 4.d.9) Clarified how CCBHCs act if unsafe substance use is identified during screening
 - 4.f.1** Added a focus on harm-reduction and motivational techniques
 - 5.b.2** Added events that require continuous quality improvement plans to address to include fatal and non-fatal overdoses, in response to the increase in overdose deaths resulting from opioid use and misuse.
-

Improving Health Equity

The Criteria have been updated to include a more intentional focus on disparities and social determinants of health.

- 1.c.1** Revised requirements to align training with National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to advance health equity, improve quality of services, and eliminate disparities.
- 2.a.6** Clarified the meaning and intent of “outreach and engagement activities” to extend behavioral health services to unserved individuals and underserved communities.
- 4.b.2** Added other cultural or ethnic groups in the recognition of particular cultural and other needs of clients and services that respond to the needs of sexual and gender minorities.
- 4.d.4** Added a focus on social determinants of health and cultural, environmental, and linguistic factors that may affect the client’s treatment plan as a part of the required comprehensive diagnostic and treatment planning evaluation.
- 5.b.1** Added the requirements for CCBHCs to have an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and disaggregated data to track and improve outcomes for populations facing health disparities.

Appendix A

Outlined requirements of the Community Needs Assessment CCBHC to assess the behavioral health needs of the entire service area and all of the people who live there, including unserved and underserved communities and also to identify social determinants of health impacting the population.

Other Revisions

#	Location of Change	Category	Change
1	Throughout	Needed structural change	The original criteria limited CCBHCs to organizations that directly provide four of the nine core services and may provide the other five services through formal agreement with designated collaborating organizations (DCOs). A recent determination by HHS concluded that CCBHCs are not required to directly provide 4 core services. This substantive change has required revisions throughout the document, including definitions of CCBHCs and DCOs, care coordination, and particularly to scope of services and expectations for CCBHCs competency in behavioral health. To avoid the types of service fragmentation that have been described in federal commissions over the past two decades, including the President's New Freedom Commission and in the interdepartmental Serious Mental Illness Coordination Committee, the criteria bolster expectations that CCBHCs are fully licensed and credentialed behavioral health providers and that they will provide a substantial proportion of the services that are required in the scope of services.
2	Throughout	Updated language	"Integration" replaced with "coordination" for CCBHC services unless the word is used in specific context.
3	Throughout	Updated language	"Consumer" replaced with "client" whenever the term referred to service recipient. In Section 6, Board Governance "consumer" was replaced "individuals with lived experience of mental and/or substance use disorders and families."
4	Throughout	Updated language	"Detoxification" replaced with "medical withdrawal management."
5	Throughout	Updated language	"Catchment area" replaced with "service area."
6	Throughout	Updated language	"State" replaced with "certifying state."
7	Throughout	Updated language	"Mental health and substance use" replaced with "behavioral health" unless the distinction is made for licensing or other purposes.
8	Throughout	Updated language	"Needs assessment" replaced with "community needs assessment."
9	Throughout	Updated language	"Abstinence" was removed from the definition of health as a non sequitur.
10	Throughout	Updated language	"States" that certify clinics replaced with "certifying states."

#	Location of Change	Category	Change
11	Throughout	Updated language	"Medicaid Demonstration" replaced with "Section 223 CCBHC Demonstration."
12	Definitions	Addition that strengthens the CCBHC model	Community Needs Assessment CCBHC staffing plans, accessibility, and scope of service depend upon the completion of an accurate assessment of the behavioral health needs of the entire service area and all of the people who live there, including unserved and underserved communities. The requirements for the community needs assessments were assembled from the SAMHSA 223 web page criteria that cites the community needs assessment, How States Can Conduct a Needs Assessment SAMHSA , the list of community partners identified in statute, requirements in SAMHSA's notice of funding availability for CCBHC Expansion grants, and the requirement that CCBHCs coordinate crisis care with law enforcement.
13	Definitions	Addition that strengthens the CCBHC model	The definition of CCBHCs makes the distinction between CCBHCs that are certified by states and those that are designated as CCBHCs after receiving SAMHSA CCBHC Expansion grants. The definition describes how long and under what circumstances certification and/or designation ends.
14	1.a.3	Increased flexibility	Removed the requirement that only CCBHCs operating within behavioral health professional shortage area were permitted to hire a non-psychiatrist as the medical director and clarified the role of the medical director and the need for consultation.
15	1.b.2	Clarification	Clarified that telehealth services delivered must be coordinated with other services delivered by the CCBHC.
16	1.c.1	Clarification	Clarified existing requirements for training and that it is specific to those staff in contact with clients. Note that criteria 4.c requires that CCBHCs specifically focus on the application of trauma-informed approaches during crises.
17	1.c.2	Addition that strengthens the CCBHC model	Adjusted duration for the maintenance of training records for staff with direct contact with clients.
18	1.d.1	Addition that strengthens the CCBHC model	Removed "if" from the expectation that CCBHCs take reasonable steps to provide meaningful access to individuals with limited English proficiency and clarified language.
19	1.d.2	Clarification	Clarified language around the availability of interpretation/translation service(s).
20	1.d.3	Clarification	Clarified that disabilities are not limited to hearing impairments.

#	Location of Change	Category	Change
21	1.d.4	Additions that strengthen the CCBHC model	Updated the ways that clients can access information about CCBHC services by adding “online” and clarified that resources should be available throughout the time the client is served. Added that the CCBHC defines threshold for languages that require language assistance.
22	2.a.1	Addition that strengthens the CCBHC model	Added “sanitary” to the expectations of the CCBHC environment.
23	2.a.2	Clarification	Removed unnecessary qualifying language about outpatient clinical services.
24	2.a.4	Clarification	Clarifying the intent behind transportation services.
25	2.a.5	Addition that strengthens the CCBHC model	Included focus on client preferences.
26	2.a.6	Clarification	Clarified intent of outreach and engagement.
27	2.a.8	Clarification	Clarified the meaning of a continuity of operations/disaster plan in reference to client services and access to medication as well as health IT systems (both security/ransomware protection and backup) and access to these systems in case of disaster.
28	2.b.1	Clarification	Clarified that first contact with clients may include other remote forms of communication and changed terminology so that preliminary screening is referred to as preliminary triage.
29	2.b.1 and 2.b.3	Clarification	Clarified the difference between new clients in 2.b.1 and existing clients in 2.b.3 and that each must have timely access to services, including safety planning if appropriate
30	2.b.2	Increased flexibility	Requirement for primary care consultation removed and language simplified.
31	2.b.2	Increased flexibility	CCBHC’s staff and clients may now reduce the frequency of reviewing treatment plans from four times per year (every 90 days) to two times per year (every 6 months).
32	2.b.3	Clarification	Clarified language related to timely access to services for existing clients.
33	2.c.1	Clarification	Clarified that crisis management services shall be available 7 days a week.
34	2.c.3	Updated language	Updated crisis planning by including 988 and clarified language.

#	Location of Change	Category	Change
35	2.c.5	Clarification	Clarified the purpose of establishing protocols with law enforcement.
36	2.d.2	Addition that strengthens the CCBHC model	Included focus on literacy barriers.
37	2.e.1	Clarification	Clarified options for clinics to address ongoing needs of individuals based on residence.
38	2.e.2	Clarification	Clarified that CCBHCs are not required to provide continuous telehealth services to individuals who live outside of the CCBHC service area.
39	2.e.2	Addition that strengthens the CCBHC model	Included focus on client preferences.
40	3	Increased flexibility	Care coordination partnerships- Demonstration states and participating clinics complained that time, energy, and legal resources were spent in futile attempts to obtaining legal documents from other organizations to document care coordination agreements. Other organizations likewise complained that they were under no obligation to spend their time, energy and legal resources to comply. As a result, CCBHCs have been unable to obtain care coordination agreements. The criteria have been revised to allow CCBHCs to achieve meaningful partnerships with community partners and expanded the means by which they can be documented. Criteria 3.c is renamed from "Care Coordination Agreements" to "Care Coordination Partnerships" and establish alternatives forms of agreement to allow CCBHCs and its partner agencies to coordinate care. Partnerships are supported by a formal agreement or jointly developed partnership protocols and tailored to the relationship and roles of the CCBHC and the entity it is partnering with. This change also prompted the removal of "agreement" and "formal agreement" in definitions.
41	3.a.1	Clarification	Clarified that CCBHCs also coordination with other systems outside of the health system (criminal and juvenile justice and child welfare).
42	3.a.2	Clarification	Clarifies that consent for release of information is obtained from CCBHC clients with providers outside of the CCBHC.
43	3.a.2	Updated language	Added note that CCBHCs are encouraged to explore options for electronic documentation of consent where feasible and responsive to the needs and capabilities of the client. See standards within the Interoperability Standards Advisory.

#	Location of Change	Category	Change
44	3.a.4	Addition that strengthens the CCBHC model	Required psychiatric advance directives to be entered in the patient's electronic health information so that the information is available to providers in emergency care settings where electronic health records are accessible.
45	3.a.7	Addition that strengthens the CCBHC model	Added new sub-criterion: The CCBHC shall assist clients and families to access benefits, including Medicaid, and enroll in programs or supports that may be beneficial to them.
46	3.b.1	Clarification	Health information technology systems was clarified.
47	3.b.2	Clarification	Added qualifying language related to research protections.
48	3.b.3	Needed Structural Change	Updated required core set of health IT capabilities to align with current ONC Health IT Certification Program.
49	3.a.3	Clarification	Clarified the intent of the criteria to coordinate services rather than monitor clients.
50	3.b.1	Addition that strengthens the CCBHC model	Added that CCBHC establishes or maintains a health information technology (IT) system that includes electronic health records.
51	3.b.3	Addition that strengthens the CCBHC model	Added that the CCBHC demonstrates use of a required core set of health IT capabilities certified under the ONC Health IT Certification Program that align with key clinical practice and care delivery requirement in these criteria.
52	3.c.3	Addition that strengthens the CCBHC model	Added a focus on client preferences and suggested other systems for potential partnership.
53	3.c.5	Clarification	Clarified that CCBHCs need to follow clients being discharged from facilities who are at risk for suicide and overdose and clarified language about the timing of transitions to community-based services.
54	3.d.1	Clarification	Clarified that the members of the adult client's family whom the client "desires" (replacing "does not object to") may be included in the treatment team.
55	3.d.1	Clarification	Added legal guardian to family/caregiver members of the treatment team. Clarified that the members of the adult client's family whom the client "desires" (replacing "does not object to") may be included in the treatment team and that HIPAA allows for clients to identify those persons who can receive information about their care.

#	Location of Change	Category	Change
56	3.d.2	Addition that strengthens the CCBHC model	Added psychiatry to the interdisciplinary treatment team and referenced traditional approaches for cultural and ethnic groups beyond AI/AN.
57	4.a.1	Clarification	Clarifies the expectation that CCBHCs directly provide a majority of services of as this will enhance the ability of the CCBHC to provide a coordinated service package.
58	4.a.3	Clarification	Clarifies that clients must be informed of grievance procedures and makes reference to state requirements.
59	4.b.1	Clarification	Added that shared decision-making is the recommended approach for engagement.
60	4.b.2	Addition that strengthens the CCBHC model	Adds focus on other cultural and ethnic groups and specifically mentions services that respond to the needs of sexual and gender minorities.
61	4.c.1	Updated language	"Psychiatric" replaced with "behavioral health" crisis.
62	4.d.3	Addition that strengthens the CCBHC model	Included herbs and supplements among substances clients may be taking and a summary of treatment history and success of past treatments to the requirements for the initial evaluation.
63	4.d.4	Clarification	4.d.4 was eliminated because it repeated the requirement stated in 2.b.1 for a comprehensive person- and family-centered diagnostic and treatment planning evaluation. Subsequent items in section 4.d were renumbered.
64	4.d.4 (previously 4.d.5)	Updated language	The language and expectations for the comprehensive screening and assessment were updated so that the client's preferences; relevant social supports; social determinants of health; and cultural, environmental, and health-related social needs are more clearly identified and included.
65	4.d.6 (previously 4.d.7)	Clarification	Clarified purpose of motivational interviewing.
66	4.d.7 (previously 4.d.8)	Addition that strengthens the CCBHC model	Included a focus on literacy.
67	4.d.8 (previously 4.d.9)	Addition that strengthens the CCBHC model	Added that if screening identifies more immediate threats to the client's safety, the CCBHC will take appropriate action as described in 2.b.1.

#	Location of Change	Category	Change
68	4.e.2	Addition that strengthens the CCBHC model	Adds requirements that the treatment plan supports care in the least restrictive setting possible and that shared decision making is the preferred model of establishing goals.
69	4.e.5	Addition that strengthens the CCBHC model	Added that treatment plans address special needs including developmental and cognitive abilities of clients in the delivery of treatment and support services, and includes recovery supports
70	4.e.6	Clarification	Clarified language related to consultation.
71	4.e.7	Updated language	Clarified that treatment plans include development of a crisis plan with each client.
72	4.f.1	Addition that strengthens the CCBHC model	To ensure consistency of CCBHC outpatient services and to clarify expectations, a minimum floor of outpatient services has been outlined in 4.f.1. Services must include the delivery of evidence based and best practices (as determined from the community needs assessment) in individual, family and medication therapies as well as substance use treatment services that align with ASAM level 1 outpatient and 2.1 intensive outpatient services. Added detail about referral to more intensive services and consultation.
73	4.f.2	Updated language	Updated examples of evidence-based and best practices.
74	4.f.2	Updated language	Updated the listing of evidence-based practices in outpatient services.
75	4.f.4	Updated language	Removed duplicative language.
76	4.g.1	Updated language	Updated the expectations for primary care screening because quality measures for health conditions have been revised. Medical directors will consult the list of screenings that have been reviewed by the U.S. Preventive Services Task Force list of A and B Recommendations for evidence of effectiveness in making their determinations. Both CCBHCs and certifying states are directed to review the required and optional quality measures described in Criteria 5 Quality Measures and listed in Appendix B.

#	Location of Change	Category	Change
77	4.g.1	Clarification	Split 4.g.1 into three sub-criteria for clarity. Clarifies that CCBHCs will provide clinically indicated and age-appropriate primary care screening and monitoring of key health indicators as determined by the Medical Director. Directs the referral of tobacco users to the tobacco quit line. Requires CCBHCs to screen for HIV and viral hepatitis. Also clarified that the delivery of primary care is not within the scope of these criteria but that CCBHCs are not prohibited from providing them.
78	4.g.2	Addition that strengthens the CCBHC model	Describes primary care screening and monitoring and emphasizes screening. Requires initial laboratory testing of blood glucose, lipid status, viral hepatitis, and HIV status and other commonly occurring conditions medical conditions.
79	4.g.3	Addition that strengthens the CCBHC model	This sub-criterion describes the requirements for ongoing primary care monitoring, coordinating care, and promoting healthy behavior change.
80	4.h.1	Clarification	Included more definition around the definition of targeted case management. Recommended use of intensive case management and models such as Assertive Community Treatment.
81	4.i.1	Addition that strengthens the CCBHC model	Psychiatric rehabilitation services are now more clearly defined and require the provision of supported employment services and services that will support individuals to find and keep safe and permanent housing, educational opportunities, and improve social inclusion and community connectedness.
82	4.i.1	Updated language	Updated the definition of psychiatric rehabilitation services and types of services that can be provided.
83	4.j.1	Updated language	Updated the definition of peer support and description of peer services.
84	5.a.1	Clarification	Clarified that data are captured electronically when feasible.
85	5.a.4	Increased flexibility	Removed requirement for linking with URS data.
86	5.b.1	Addition that strengthens the CCBHC model	Recommended the use of qualitative and quantitative data and encouraged the use of measurement-based care.
87	5.b.2	Addition that strengthens the CCBHC model	Added events that require continuous quality improvement plans to address to include fatal and non-fatal overdoses, in response to the increase in overdose deaths resulting from opioid use and misuse.

#	Location of Change	Category	Change
88	6.a.3	Clarification	Clarified that an independent financial audit is performed annually for all CCBHCs for the duration that they are designated CCBHCs.
89	6.b.1 and 6.b.2	Clarification	Clarified requirements for board composition, the meaning of “meaningful participation” by people.
90	6.b.1, 6.b.2, 6.b.3, and 6.b.4	Clarification	Clarified the options for incorporating meaningful participation using plain language as described by SAMHSA’s 223 guidance web pages and SAMHSA’s Participation Guidelines for Individuals with Lived Experience and Family.
91	6.b.4, 6.b.5, and 6.b.6	Clarification	6.b.4 was folded into 6.b.1 and eliminated. Subsequent sub-criteria in 6.b. were renumbered.
92	6.c.1	Addition that strengthens the CCBHC model	Added the period of time CCBHCs can be certified and/or designated as CCBHCs.
93	6.c.1	Needed structural change	The CCBHC must be a qualified Medicaid provider and licensed provider of both mental health and substance use disorder services including developmentally appropriate services to children, youth, and their families unless there is a state administrative, statutory, or regulatory framework that prevents or substantially prevents the CCBHC organization provider type from obtaining the necessary licensure, certification, or accreditation to provide these services.