RESOURCE

Certified Community Behavioral Health Center Implementation Recommendations

Sheila Pires
Human Service Collaborative

Shannon Robshaw
Lisa McGarrie
Institute for Innovation and Implementation
University of Maryland School of Social Work

Linda M. Callejas
College of Behavioral & Community Services
University of South Florida

Johanna Bergan
Youth M.O.V.E. National

Jane Walker
Family Run Executive Director Leadership Association

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www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

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The Protecting Access to Medicare Act of 2014 (PAMA) was signed into law in April 2014 and includes efforts and funding to improve community behavioral health services through creation of Certified Community Behavioral Health Clinics (CCBHCs). PAMA, through development of CCBHCs, is intended to increase use of evidenced-based practices, support integration of behavioral health and physical health services and improve access to quality care. Care coordination is included as a key CCBHC function. Specific criteria for CCBHCs were included in PAMA in six areas: (1) staffing, (2) availability and accessibility of services, (3) care coordination, (4) scope of services, (5) quality and other reporting, and (6) organizational authority.

On October 19, 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA), along with the Centers for Medicare & Medicaid Services (CMS) and the Assistant Secretary of Planning and Evaluation (ASPE), awarded twenty-four states Planning Grants for CCBHCs. On December 1, 2016 eight were awarded two-year demonstration grants beginning in January 2017. The eight states are: Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania.

This document is intended to support states, counties, providers, health plans and stakeholders in implementation of CCBHCs and other related system improvement efforts as it relates to children, youth and young adults with behavioral health needs. It takes the detailed PAMA Section 223 CCBCH specified criteria, and within each criteria provides recommendations or identifies opportunities to strengthen the development of CCBHCs operations and structures to most effectively serve the unique needs of children, youth and young adults with behavioral health needs and their families. The National TA Network Recommendations are in red text.

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

Introduction

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

The CCBHCs represent an opportunity for states[1] to improve the behavioral health of their citizens by: providing community based mental and substance use disorder services; advancing integration of behavioral health with physical health care; assimilating and utilizing evidence-based practices on a more consistent basis; and promoting improved access to high quality care. Care coordination is the linchpin holding these aspects of CCBHC care together and ensuring CCBHC care is, indeed, an improvement over existing services. Enhanced federal matching funds made available through this demonstration for services delivered to Medicaid beneficiaries offer states the opportunity to expand access to care and improve the quality of behavioral health services.

PAMA is clear that, regardless of condition, CCBHCs are to provide services to all who seek help, but it is anticipated the CCBHCs will prove particularly valuable for individuals with serious mental illness (SMI),

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

those with severe substance use disorders, children and adolescents with serious emotional disturbance (SED), and those with co-occurring mental, substance use or physical health disorders. Those who are most in need of coordinated, integrated quality care will receive it from CCBHCs.

The statute directs the care provided by CCBHCs be "patient-centered." It is expected CCBHCs will offer care that is person-centered and family-centered in accordance with the requirements of Section 2402(a) of the Affordable Care Act (ACA), trauma-informed, and recovery oriented, and that the integration of physical and behavioral health care will serve the "whole person" rather than simply one disconnected aspect of the individual. The criteria are infused with these expectations and states are encouraged to certify clinics providing care consistent with these principles.

Although the CCBHC demonstration program and Prospective Payment System (PPS) are designed to work within the scope of state Medicaid Plans and to apply specifically to individuals who are Medicaid enrollees, the statute also requires the CCBHCs not to refuse service to any individual on the basis of either ability to pay or place of residence. In addition to these requirements for inclusive service, CCBHCs will serve persons for whom services are court ordered.[2] These conditions, together with the fact that improving access to and the quality of health care for the Medicaid population also may positively affect the health of others through changes in overall methods of care delivery, means the CCBHC demonstration program may have long lasting and beneficial effects beyond the realm of Medicaid enrollees.

These criteria were developed based on a review of selected state Medicaid Plans, standards for Federally Qualified Health Centers and Medicaid Health Homes, and quality measures currently in use by states. The criteria were refined and finalized through a public participatory process that occurred between November 2014 and March 2015, and included a National Listening Session, consultation with tribal leaders, written public comments, and solicitation for public response on the SAMHSA website.[3]

The criteria are intended to extend quality and to improve outcomes of the behavioral health care system within the authorities of state regulations, statutes and state Medicaid Plans. These criteria establish a basic level of services at which the CCBHCs should, at a minimum, operate. They allow the states flexibility in determining how to implement the criteria in a manner best addressing the needs of the population being served. The criteria are designed to encourage states and CCBHCs to further develop their abilities to offer behavioral health services that comport with current best practices. Thus, the criteria set high expectations which are likely to require changes and adjustments to current service delivery systems. SAMHSA recognizes state behavioral health programs vary widely in structure, content, funding and organization, and state Medicaid programs also differ widely. Consequently, there will be differences in the ease with which states can meet the criteria specified for this program. Although SAMHSA, in collaboration with staff in the Centers for Medicare & Medicaid Services (CMS) and the ASPE, plans to select states for the demonstration program that can best satisfy the goals of PAMA, it also intends to consider carefully the extent to which applicant states are positioned to make substantial strides in care, using the demonstration program to improve access and quality of care.

Structure of the Criteria

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

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

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

Program Requirement 1: STAFFING

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

Criteria 1.A: General Staffing Requirements

1.a.1

As part of the process leading to certification, the state will prepare an assessment of the needs of the target consumer population and a staffing plan for prospective CCBHCs. The needs assessment will include cultural, linguistic and treatment needs. The needs assessment is performed prior to certification of the CCBHCs in order to inform staffing and services. After certification, the CCBHC will update the needs assessment and the staffing plan, including both consumer and family/caregiver input. The need assessment and staffing plan will be updated regularly, but no less frequently than every three years.

Recommendation: The needs assessment should specifically address the needs of the child, youth, and young adult (i.e. transition age, 18-26) populations and staffing requirements specific to serving children, youth, and young adult populations and their families. Preparation and updating of the needs assessment and staffing plan should include active participation from culturally diverse families, youth, and young adults with experience in the system.

1.a.2

The staff (both clinical and non-clinical) is appropriate for serving the consumer population in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer.

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

Recommendation: The size and composition of the staff should encompass a sufficient number of staff trained in child and adolescent behavioral health. The CCBHC management team should include a Director of Child and Youth Services who will ensure the implementation of a system of care approach to services and supports for children, youth, young adults and their families with experience in the system.

1.a.3

The Chief Executive Officer (CEO) of the CCBHC maintains a fully staffed management team as appropriate for the size and needs of the clinic as determined by the current needs assessment and staffing plan. The management team will include, at a minimum, a CEO or Executive Director/Project Director, and a psychiatrist as Medical Director. The Medical Director need not be a full-time employee of the CCBHC. Depending on the size of the CCBHC, both positions (CEO/Executive Director/Project Director and the Medical Director) may be held by the same person. The Medical Director will ensure the medical component of care and the integration of behavioral health (including addictions) and primary care are facilitated.

Note: If a CCBHC is unable, after reasonable and consistent efforts, to employ or contract with a psychiatrist as Medical Director because of a documented behavioral health professional shortage in its vicinity (as determined by the Health Resources and Services Administration (Health Resources and Services Administration [2015]), psychiatric consultation will be obtained on the medical component of care and the integration of behavioral health and primary care, and a medically trained behavioral

health care provider with appropriate education and licensure with prescriptive authority in psychopharmacology who can prescribe and manage medications independently pursuant to state law will serve as the Medical Director.

Recommendation: The CCBHC should ensure availability of psychiatric consultation from a board-certified child and adolescent psychiatrist.

1.a.4

The CCBHC maintains liability/malpractice insurance adequate for the staffing and scope of services provided.

Criteria 1.B: Licensure and Credentialing of Providers

1.b.1

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

1.b.2

The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state, is informed by the state's initial needs assessment, and includes clinical and peer staff. In accordance with the staffing plan, the CCBHC maintains a core staff comprised of employed and, as needed, contracted staff, as appropriate to the needs of CCBHC consumers as stated in consumers' individual treatment plans and as required by program requirements 3 and 4 of these criteria. States specify which staff disciplines they will require as part of certification but must include a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other medications used to treat opioid and alcohol use disorders. The CCBHC must have staff, either employed or available through normal arrangements, who are credentialed substance abuse specialists. Providers must include individuals with expertise in addressing trauma and promoting the recovery of children and adolescents with SED and adults with SMI and those with substance use disorders. Examples of staff the state might require include a combination of the following: (1) psychiatrists (including child, adolescent, and geriatric psychiatrists), (2) nurses trained to work with consumers across the lifespan, (3) licensed independent clinical social workers, (4) licensed mental health counselors, (5) licensed psychologists, (6) licensed marriage and family therapists, (7) licensed occupational therapists, (8) staff trained to provide case management, (9) peer specialist(s)/recovery coaches, (10) licensed addiction counselors, (11) staff trained to provide family support, (12) medical assistants, and (13) community health workers. The CCBHC supplements its core staff, as necessary given program requirements 3 and 4 and individual treatment plans, through arrangements with and referrals to other providers.

Note: Recognizing professional shortages exist for many behavioral health providers: (1) some services may be provided by contract or part-time or as needed; (2) in CCBHC organizations comprised of multiple clinics, providers may be shared among clinics; and (3) CCBHCs may utilize telehealth/ telemedicine and on-line services to alleviate shortages. CCBHCs are not precluded by anything in this

criterion from utilizing providers working toward licensure, provided they are working under the requisite supervision.

Recommendation: Permit CCBHCs to contract for their family and youth peer staff through a family- or youth-run organization. Require that family and youth peer specialists, if employed by the CCBHC, be connected to a family- or youth-run organization where possible for coaching and support.

Criteria 1.C: Cultural Competence and Other Training

1.c.1

The CCBHC has a training plan, for all employed and contract staff, and for providers at DCOs who have contact with CCBHC consumers or their families, which satisfies and includes requirements of the state behavioral health authority and any accreditation standards on training which may be required by the state. Training must address cultural competence; person-centered and family-centered, recovery oriented, evidence-based and trauma-informed care; and primary care/behavioral health integration. This training, as well as training on the clinic's continuity plan, occurs at orientation and thereafter at reasonable intervals as may be required by the state or accrediting agencies. At orientation and annually thereafter, the CCBHC provides training about: (1) risk assessment, suicide prevention and suicide response; (2) the roles of families and peers; and (3) such other trainings as may be required by the state or accrediting agency on an annual basis. If necessary, trainings may be provided on-line.

Cultural competency training addresses diversity within the organization's service population and, to the extent active duty military or veterans are being served, must include information related to military culture. Examples of cultural competency training and materials include, but are not limited to, those available through the website of the US Department of Health & Human Services (DHHS), the SAMHSA website through the website of the DHHS, Office of Minority Health, or through the website of the DHHS, Health Resources and Services Administration.

Note: See criteria 4.K relating to cultural competency requirements in services for veterans.

Recommendation: The training plan needs to address training specific to services and supports for the child, youth, and young adult populations. With regard to Cultural and Linguistic Competence training, the CCBHC should focus on meeting the principal standard of the CLAS Standards, specifically "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"

1.c.2

The CCBHC assess the skills and competence of each individual furnishing services and, as necessary, provides in-service training and education programs. The CCBHC has written policies and procedures describing its method(s) of assessing competency and maintains a written accounting of the in-service training provided during the previous 12 months.

1.c.3

The CCBHC documents in the staff personnel records that the training and demonstration of competency are successfully completed. If the CCBHC serves individuals with Limited English Proficiency (LEP) or with language-based disabilities, the CCBHC takes reasonable steps to provide meaningful access to their services.

1.c.4

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

Criteria 1.D: Linguistic Competence

1.d.1

If the CCBHC serves individuals with Limited English Proficiency (LEP) or with language-based disabilities, the CCBHC takes reasonable steps to provide meaningful access to their services.

1.d.2

Interpretation/translation service(s) are provided that are appropriate and timely for the size/needs of the LEP CCBHC consumer population (e.g. bilingual providers, onsite interpreters, language telephone line). To the extent interpreters are used, such translation service providers are trained to function in a medical and, preferably, a behavioral health setting.

1.d.3

Auxiliary aids and services are readily available, Americans with Disabilities Act (ADA) compliant, and responsive to the needs of consumers with disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines).

1.d.4

Documents or messages vital to a consumer's ability to access CCBHC services (for example, registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available for consumers in languages common in the community served, taking account of literacy levels and the need for alternative formats (for consumers with disabilities). Such materials are provided in a timely manner at intake. The requisite languages will be informed by the needs assessment prepared prior to certification, and as updated.

1.d.5

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

Program Requirement 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES

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

Criteria 2.A: General Requirements of Access and Availability

2.a.1

The CCBHC provides a safe, functional, clean, and welcoming environment, for consumers and staff, conducive to the provision of services identified in program requirement 4.

2.a.2

The CCBHC provides outpatient clinical services during times that ensure accessibility and meet the needs of the consumer population to be served, including some nights and weekend hours.

2.a.3

The CCBHC provides services at locations that ensure accessibility and meet the needs of the consumer population to be served.

Recommendation: To the extent possible within the state Medicaid program or other funding, CCBHCs should provide services at locations suitable for children, youth, and young adults, such as the schools and early childhood settings (e.g. Head Start).

2.a.4

To the extent possible within the state Medicaid program or other funding or programs, the CCBHC provides transportation or transportation vouchers for consumers.

2.a.5

To the extent possible within the state Medicaid program and as allowed by state law, CCBHCs utilize mobile in-home, telehealth/telemedicine, and on-line treatment services to ensure consumers have access to all required services.

2.a.6

The CCBHC engages in outreach and engagement activities to assist consumers and families to access benefits, and formal or informal services to address behavioral health conditions and needs.

Recommendation: CCBHCs should utilize family and youth peers in assisting families, youth, and young adults to access services and in the provision of informal services and supports.

2.a.7

Services are subject to all state standards for the provision of both voluntary and court ordered services.

2.a.8

CCBHCs have in place a continuity of operations/disaster plan.

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

2.b.1

All new consumers requesting or being referred for behavioral health services will, at the time of first contact, receive a preliminary screening and risk assessment to determine acuity of needs. That screening may occur telephonically. The preliminary screening will be followed by: (1) an initial evaluation, and (2) a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation, with the components of each specified in program requirement 4. Each evaluation builds upon what came before it. Subject to more stringent state, federal, or applicable accreditation standards:

- If the screening identifies an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent outpatient follow-up.

- If the screening identifies an urgent need, clinical services are provided and the initial evaluation completed within one business day of the time the request is made.

- If the screening identifies routine needs, services will be provided and the initial evaluation completed within ten business days.

- For those presenting with emergency or urgent needs, the initial evaluation may be conducted telephonically or by telehealth/telemedicine but an n-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved the consumer must be seen in person at the next subsequent encounter and the initial evaluation reviewed.

Subject to more stringent state, federal or applicable accreditation standards, all new consumers will receive a more comprehensive person-centered and family-centered diagnostic and treatment planning evaluation to be completed within 60 calendar days of the first request for services. This requirement that the comprehensive evaluation be completed within 60 calendar days does not preclude either the initiation or completion of the comprehensive evaluation or the provision of treatment during the 60-day period.

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

Recommendation: For child, youth and young adult populations, CCBHCs should utilize screening and risk assessment instruments that are specific to these populations.

2.b.2

The comprehensive person-centered and family-centered diagnostic and treatment planning evaluation is updated by the treatment team, in agreement with and endorsed by the consumer and in consultation with the primary care provider (if any), when changes in the consumer's status, responses to treatment, or goal achievement have occurred. The assessment must be updated no less frequently than every 90 calendar days unless the state has established a standard that meets the expectation of quality care and that renders this time frame unworkable, or state, federal, or applicable accreditation standards are more stringent.

2.b.3

Outpatient clinical services for established CCBHC consumers seeking an appointment for routine needs must be provided within ten business days of the requested date for service, unless the state has established a standard that meets the expectation of quality care and that renders this time frame unworkable, or state, federal, or applicable accreditation standards are more stringent. If an established consumer presents with an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent outpatient follow-up. If an established consumer presents with an urgent need, clinical services are provided within one business day of the time the request is made.

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

Recommendation: The CCBHC should meet requirements listed below if there is no state-sanctioned, certified, or licensed crisis service system; if there is a state-sanctioned, certified, or licensed crisis service system, the CCBHC should meet all requirements – either directly or through a DCO - listed below that are not provided by the crisis service system:

- *The ability to serve children, youth, young adults, adults, members and veterans of the Armed Forces and their families, and older adults;*

- *Partnership with local law enforcement, schools, EDs, early childhood programs, and child welfare providers;*
- *Crisis Hotline, available 24 hours per day, 7 days per week, continually staffed by a trained and qualified specialist, able to triage the call to determine risk of harm and calibrate according to the level of threat, from immediate response through the mobile crisis team to a scheduled visit within 48 hours;*
- *Mobile crisis response teams who:*
  - *Are available 24 hours per day/7 days a week;*
  - *Provide face-to-face response in home- and community based settings within 1 hour of initial crisis contact;* [4]
  - *Coordinate with law enforcement as needed for safety;*
  - *Deescalate the crisis;*
  - *Assess for risk to self and others;*
  - *Identify crisis precipitants to assist in developing or revising an individualized crisis plan; and*
  - *Provide mobile crisis intervention services, for up to 72 hours, providing immediate and direct clinical intervention (in person or telephonically) and connections with the care coordinator to ensure follow-up regarding referrals to community services;*
  - *Facilitate access to CCBHC follow-up appointment with therapist within 24 hours of crisis response*
- *Crisis stabilization, including in-home services and supports, referrals to services, and medication management, available for a period of weeks after the crisis.*

2.c.1

In accordance with the requirements of program requirement 4, the CCBHC provides crisis management services that are available and accessible 24-hours a day and delivered within three hours.

2.c.2

The methods for providing a continuum of crisis prevention, response, and postvention services are clearly described in the policies and procedures of the CCBHC and are available to the public.

2.c.3

Individuals who are served by the CCBHC are educated about crisis management services and Psychiatric Advanced Directives and how to access crisis services, including suicide or crisis hotlines and warmlines, at the time of the initial evaluation. This includes individuals with LEP or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels in accordance with program requirement 1).

[4] n.b. The criteria specify 3 hours, which is too long for most jurisdictions except the most remote, frontier environments; see Shannahan & Fields (2015), which states that the target response time is within one hour.

2.c.4

In accordance with the requirements of program requirement 3, CCBHCs maintain a working relationship with local EDs. Protocols are established for CCBHC staff to address the needs of CCBHC consumers in psychiatric crisis who come to those EDs.

2.c.5

Protocols, including protocols for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a psychiatric crisis. Note: See criterion 3.c.5 regarding specific care coordination requirements related to discharge from hospital or ED following a psychiatric crisis.

2.c.6

Following a psychiatric emergency or crisis involving a CCBHC consumer, in conjunction with the consumer, the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises for the consumer and their family. Note: See criterion 3.a.4 where precautionary crisis planning is addressed.

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

2.d.1

The CCBHC ensures: (1) no individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual's inability to pay for such services (PAMA § 223 (a)(2)(B)), and (2) any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1).

Recommendation: CCBHCs should ensure access to CCBHC services for children and youth involved in the child welfare and juvenile justice systems.

2.d.2

The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC proposes to offer pursuant to these criteria. Such fee schedule will be included on the CCBHC website, posted in the CCBHC waiting room and readily accessible to consumers and families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP or disabilities.

2.d.3

The fee schedules, to the extent relevant, conform to state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable to existing clinics; absent applicable state or federal requirements, the schedule is based on locally prevailing rates or charges and includes reasonable costs of operation.

2.d.4

The CCBHC has written policies and procedures describing eligibility for and implementation of the sliding fee discount schedule. Those policies are applied equally to all individuals seeking services.

Criteria 2.E: Provision of Services Regardless of Residence

2.e.1

The CCBHC ensures no individual is denied behavioral health care services, including but not limited to crisis management services, because of place of residence or homelessness or lack of a permanent address.

Recommendation: CCBHCs should not deny services to children or youth who are involved with other public systems, such as child welfare and juvenile justice.

2.e.2

CCBHCs have protocols addressing the needs of consumers who do not live close to a CCBHC or within the CCBHC catchment area as established by the state. CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence. The required protocols should address management of the individual's ongoing treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing CCBHCs to refer and track consumers seeking non-crisis services to the CCBHC or other clinic serving the consumer's county of residence. For distant consumers within the CCBHC's catchment area, CCBHCs should consider use of telehealth/telemedicine to the extent practicable. In no circumstances (and in accordance with PAMA § 223 (a)(2)(B)), may any consumer be refused services because of place of residence.

Recommendation: CCBHCs should have protocols in place to ensure continuity of care for children in the child welfare system whose placement changes may affect CCBHC catchment area qualification. Protocols may allow the CCBHC to continue serving children even if they have been placed out of the catchment area if critical to maintaining treatment gains.

Program Requirement 3: CARE COORDINATION

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

Criteria 3.A: General Requirements of Care Coordination

3.a.1

Based on a person and family-centered plan of care aligned with the requirements of Section 2402(a) of the ACA and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services, including access to high quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person.

Note: See criteria 4.K relating to care coordination requirements for veterans.

Recommendation: CCBHCs should also coordinate with juvenile justice agencies, youth peer support organizations, family support organizations and natural supports. CCBHCs may also have to coordinate with specialty care management arrangements in states, for example, Care Management Entities designed for children and youth. Care coordination requirements should be clear that the CCBHC may use DCOs for care coordination for particular populations of children, youth and young adults, for example, Care Management Entities providing intensive care coordination using Wraparound or health homes that are using an intensive care coordination/Wraparound approach.

3.a.2

The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42CFR Part 2, and other federal and state privacy laws, including patient privacy requirements specific to the care of minors. The HIPAA Privacy Rule allows routine - and often critical - communications between health care providers and a consumer's family and friends. Health care providers may always listen to a consumer's family and friends. If a consumer consents and has the capacity to make health care decisions, health care providers may communicate protected health care information to a consumer's family and friends. Given this, the CCBHC ensures consumers' preferences, and those of families of children and youth and families of adults, for shared information are adequately documented in clinical records, consistent with the philosophy of person and family-centered care. Necessary consent for release of information is obtained from CCBHC consumers for all care coordination relationships. If CCBHCs are unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program requirement 3, such attempts must be documented and revisited periodically.

Recommendation: CCBHCs should ensure that consent policies are consistent with the state's consent or assent policies for youth under 18 or 21.

3.a.3

Consistent with requirements of privacy, confidentiality, and consumer preference and need, the CCBHC assists consumers and families of children and youth, referred to external providers or resources, in obtaining an appointment and confirms the appointment was kept.

3.a.4

Care coordination activities are carried out in keeping with the consumer's preferences and needs for care and, to the extent possible and in accordance with the consumer's expressed preferences, with the consumer's family/caregiver and other supports identified by the consumer. So as to ascertain in advance the consumer's preferences in the event of psychiatric or substance use crisis, CCBHCs develop a crisis plan with each consumer. Examples of crisis plans may include a Psychiatric Advanced Directive or Wellness Recovery Action Plan.

Recommendation: For children, youth, and young adults, care coordination activities should be family driven and youth guided. Crisis planning should be done as a component of intensive care coordination using a high quality Wraparound practice model.

Recommendation: CCBHCs should utilize community locations convenient for families for child/youth and family team meetings as part of a high quality Wraparound practice model.

Recommendation: CCBHCs should encourage the use of natural supports for children, youth, young adults and families as part of a high quality Wraparound practice model.

3.a.5

Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers for CCBHC consumers and, upon appropriate consent to release of information, to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care.

3.a.6

Nothing about a CCBHC's agreements for care coordination should limit a consumer's freedom to choose their provider with the CCBHC or its DCOs.

Criteria 3.B: Care Coordination and Other Health Information Systems

3.b.1

The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records. The health IT system has the capability to capture structured information in consumer records (including demographic information, diagnoses, and medication lists), provide clinical decision support, and electronically transmit prescriptions to the pharmacy. To the extent possible, the CCBHC will use the health IT system to report on data and quality measures as required by program requirement 5.

Recommendation: The CCBHC health IT system should have the ability to capture structured information specific to children, youth, and young adults and their families, including standardized assessment scores, other system involvement, and have the ability to support monitoring of potential over or inappropriate prescribing of psychiatric medications to children and youth and outcomes specific to the child/youth population.

3.b.2

The CCBHC uses its existing or newly established health IT system to conduct activities such as population health management, quality improvement, reducing disparities, and for research and outreach.

Recommendation: Health IT system activities should include a discrete focus on children, youth, and young adult populations and their families.

3.b.3

If the CCBHC is establishing a health IT system, the system will have the capability to capture structured information in the health IT system (including demographic information, problem lists, and medication lists). CCBHCs establishing a health IT system will adopt a product certified to meet requirements in 3.b.1, to send and receive the full common data set for all summary of care records and be certified to support capabilities including transitions of care and privacy and security. CCBHCs establishing health IT systems will adopt a health IT system that is certified to meet the "Patient List Creation" criterion (45

CFR §170.314(a) (14)) established by the Office of the National Coordinator (ONC)7 for ONC's Health IT Certification Program.

3.b.4

The CCBHC will work with DCOs to ensure all steps are taken, including obtaining consumer consent, to comply with privacy and confidentiality requirements, including but not limited to those of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.

3.b.5

Whether a CCBHC has an existing health IT system or is establishing a new health IT system, the CCBHC will develop a plan to be produced within the two-year demonstration program time frame to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan shall include information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care.

Recommendation: The plan should include activities specific to the care coordination and care transition needs of children, youth, and young adults and their families.

Criteria 3.C: Care Coordination Agreements

3.c.1

The CCBHC has an agreement establishing care coordination expectations with Federally Qualified Health Centers (FQHCs) (and, as applicable, Rural Health Clinics [RHCs]) to provide health care services, to the extent the services are not provided directly through the CCBHC. For consumers who are served by other primary care providers, including but not limited to FQHC Look-Alikes and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination.

Note: If an agreement cannot be established with a FQHC or, as applicable, an RHC (e.g., a provider does not exist in their service area), or cannot be established within the time frame of the demonstration project, justification is provided to the certifying body and contingency plans are established with other providers offering similar services (e.g., primary care, preventive services, other medical care services).

Note: CCBHCs are expected to work toward formal contracts with entities with which they coordinate care if they are not established at the beginning of the demonstration project.

3.c.2

The CCBHC has an agreement establishing care coordination expectations with programs that can provide inpatient psychiatric treatment, with ambulatory and medical detoxification, post-detoxification step-down services, and residential programs to provide those services for CCBHC consumers. The CCHBC is able to track when consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity. The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric, detoxification, and residential settings to a safe community setting. This includes transfer of medical records of services received (e.g., prescriptions), active follow-up after discharge and, as appropriate, a plan for suicide prevention and safety, and provision for peer services. These CCBHC care coordination agreements should include a process for discharge planning beginning at the time a child or youth is admitted to a facility. The discharge planning should be conducted through a high quality community based Wraparound care coordination approach.

Note: For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided and contingency plans are developed and the state will make a determination whether the contingency plans are sufficient or require further efforts.

Recommendation: These CCBHC care coordination agreements should include a process for discharge planning beginning at the time a child or youth is admitted to a facility. The discharge planning should be conducted through a high quality community based Wraparound care coordination approach.

3.c.3

The CCBHC has an agreement establishing care coordination expectations with a variety of community or regional services, supports, and providers. Services and supports to collaborate with which are identified by statute include:

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

The CCBHC has, to the extent necessary given the population served and the needs of individual consumers, an agreement with such other community or regional services, supports, and providers as may be necessary, such as the following:

- Specialty providers of medications for treatment of opioid and alcohol dependence;
- Suicide/crisis hotlines and warm lines;
- Indian Health Service or other tribal programs;
- Homeless shelters;
- Housing agencies;
- Employment services systems;
- Services for older adults, such as Aging and Disability Resource Centers;
- Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs).

Note: For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided and contingency plans are developed and the state will make a determination whether the contingency plans are sufficient or require further efforts.

Recommendation: These CCBHC care coordination agreements should include a process for discharge planning beginning at the time a child or youth is admitted to a facility. The discharge planning should be conducted through a high quality community based Wraparound care coordination approach.

<u>Recommendation:</u> In addition to those entities specified in §223(a)(2)(C), CCBHCs should coordinate care with the following child and youth providers:

- *Psychiatric Residential Treatment Facilities;*
- *Residential Treatment Centers;*
- *Therapeutic group and therapeutic foster homes;*
- *Partial Hospitalization/Day Treatment/Intensive Outpatient Treatment Programs;*
- *Behavioral Health Diagnostic Facilities;*
- *Consumer, family, and youth/young adult peer support organizations;*
- *Programs and services for families with young children, including Infants & Toddlers, WIC, Home Visiting Programs, and Early Head Start/Head Start;*
- *State child- and family-serving agencies, including behavioral health, developmental disabilities, juvenile justice, Medicaid, child welfare, and education, and Specialized Care Management Entities*
- *Health homes*

3.c.4

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

Note: For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided and contingency plans are developed and the state will make a determination whether the contingency plans are sufficient or require further efforts.

3.c.5

The CCBHC has an agreement establishing care coordination expectations with inpatient acute-care hospitals, including EDs, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers, in the area served by the CCBHC, to address the needs of CCBHC consumers. This includes procedures and services, such as peer bridgers, to help transition individuals from the ED or hospital to CCBHC care and shortened time lag between assessment and treatment. The agreement is such that the CCBHC can track when their consumers are admitted to providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to another entity. The agreement also provides for transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge. The CCBHC will make and document reasonable attempts to contact all CCBHC consumers who are discharged from these settings within 24 hours of discharge. For all CCBHC consumers being discharged from such facilities who presented to the facilities as a potential suicide risk, the care coordination agreement between these facilities and the CCBHC includes <u>a requirement</u> to coordinate consent and follow-up services with the consumer within 24 hours of discharge, and continues until the individual is linked to services or assessed to be no longer at risk.

Note: For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided and contingency plans are developed and the state will make a determination whether the contingency plans are sufficient or require further efforts.

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

3.d.1

The CCBHC treatment team includes the consumer, the family/caregiver of child consumers, the adult consumer's family to the extent the consumer does not object, and any other person the consumer chooses. All treatment planning and care coordination activities are person-centered and family-centered and aligned with the requirements of Section 2402(a) of the Affordable Care Act. All treatment planning and care coordination activities are subject to HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors. The HIPAA Privacy Rule does not cut off all communication between health care professionals and the families and friends of consumers. As long as the consumer consents, health care professionals covered by HIPAA may provide information to a consumer's family, friends, or anyone else identified by a consumer as involved in their care.

Recommendation: Child and Family teams should be established through a high quality Wraparound practice model for treatment planning for children and youth and their families with significant behavioral health needs. The CCBHC requirements should be clear that treatment team, treatment planning, and care coordination activities may be contracted to a DCO, such as a Care Management Entity that is already providing these functions for certain populations of children and youth, such as those with significant behavioral health challenges.

3.d.2

As appropriate for the individual's needs, the CCBHC designates an interdisciplinary treatment team that is responsible, with the consumer or family/caregiver, for directing, coordinating, and managing care and services for the consumer. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of CCBHC consumers, including, as appropriate, traditional approaches to care for consumers who may be American Indian or Alaska Native.

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

Recommendation: In states with high quality Wraparound care coordination structures, CCBHCs should use this capacity for care coordination and treatment planning for designated subpopulations of children and youth through specific DCO arrangements.

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 3: CARE COORDINATION

Person-centered care is care aligned with the requirements of Section 2402(a) of the Affordable Care Act, and is care in which the consumer is actively involved and has the ability to self-direct services received, having maximum choice and control over their services, "including the amount, duration, and scope of services and supports as well as choice of provider(s)" (Department of Health & Human Services [June 6, 2014]). CCBHCs are required by PAMA to provide directly, or provide through referral or formal relationships with other providers, a broad array of services to meet the needs of the population served

and to do so in a person-centered and family-centered manner. These criteria establish the concept of DCOs with whom the CCBHC will have formal relationships to provide, in conjunction with the CCBHC, many of the requisite services. Even if, however, a DCO supplies some aspect of required services, the CCBHC is still regarded as providing the service and is clinically responsible for the services provided. Although the statute lists minimum requirements that will need to be met, states also will have flexibility to shape the scope of services within the required areas to be aligned with their state Medicaid Plans and other state regulations. There is no requirement for the state to amend its Medicaid state plan for any CCBHC service provided by a certified clinic through this demonstration program. This applies to services currently authorized in the Medicaid state plan and to additional services made available through this demonstration. The intention and expectation is that states will establish scope of service requirements which encourage CCBHCs to expand the availability of high quality, integrated, person-centered and family-centered care as envisioned by the statute, and to ensure the continual integration of new evidence-based practices.

Criteria 4.A: General Service Provisions

4.a.1

CCBHCs are responsible for the provision of all care specified in PAMA, including, as more explicitly provided and more clearly defined below in criteria 4.B through 4.K, crisis services; screening, assessment and diagnosis; person-centered treatment planning; outpatient behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer and family supports; and intensive community based outpatient behavioral health care for members of the US Armed Forces and veterans. As provided in criteria 4.B through 4.K, many of these services may be provided either directly by the CCBHC or through formal relationships with other providers that are DCOs. Whether directly supplied by the CCBHC or by a DCO, the CCBHC is ultimately clinically responsible for all care provided. The decision as to the scope of services to be provided directly by the CCBHC, as determined by the state and clinics as part of certification, reflects the CCBHC's responsibility and accountability for the clinical care of the consumers. Despite this flexibility, it is expected CCBHCs will be designed so most services are provided by the CCBHC rather than by DCOs, as this will enhance the ability of the CCBHC to coordinate services.

Note: See CMS PPS guidance regarding payment.

Recommendation: CCBHCs serving children, youth and young adults should include providing (directly or through a DCO), at a minimum the following services, and incentivize the provision of services in the home, school and community based settings:

- *Intensive Care Coordination using a high quality Wraparound practice model;*
- *Parent/Family and Youth Peer Support Services, provided by individuals with lived experience;*
- *Intensive In-Home Services;*
- *Respite Services;*
- *Mobile Crisis Response and Stabilization Services;*
- *Flexible/Discretionary Funds (Customized Goods & Services);*
- *Trauma-informed, evidence-based practices to address mental health and substance use disorders, including co-occurring disorders, Autism Spectrum Disorder, and first episode psychosis.*

4.a.2

The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, consistent with the consumer's freedom to choose providers within the CCBHC and its DCOs. This requirement does not preclude the use of referrals outside the CCBHC or DCO if a needed specialty service is unavailable through the CCBHC or DCO entities.

4.a.3

With regard to either CCBHC or DCO services, consumers will have access to the CCBHC's existing grievance procedures, which must satisfy the minimum requirements of Medicaid and other grievance requirements such as those that may be mandated by relevant accrediting entities.

4.a.4

DCO-provided services for CCBHC consumers must meet the same quality standards as those provided by the CCBHC.

Recommendation: DCO child and adolescent providers must, at a minimum, have the same quality standards as the CCBHC and may have higher quality standards.

4.a.5

The entities with which the CCBHC coordinates care and all DCOs, taken in conjunction with the CCBHC itself, satisfy the mandatory aspects of these criteria.

Criteria 4.B: Requirement of Person-Centered and Family-Centered Care

4.b.1

The CCBHC ensures all CCBHC services, including those supplied by its DCOs, are provided in a manner aligned with the requirements of Section 2402(a) of the Affordable Care Act, reflecting person and family-centered, recovery oriented care, being respectful of the individual consumer's needs, preferences, and values, and ensuring both consumer involvement and self-direction of services received. Services for children and youth are family-centered, youth guided, and developmentally appropriate.

Note: See program requirement 3 regarding coordination of services and treatment planning. See criteria 4.K relating specifically to requirements for services for veterans.

Recommendation: CCBHC services for youth and families should be family driven and youth guided.

4.b.2

Person-centered and family-centered care includes care which recognizes he particular cultural, and other needs of the individual. This includes but is not limited to services for consumers who are American Indian or Alaska Native (AI/AN), for whom access to traditional approaches or medicines may be part of CCBHC services. For consumers who are AI/AN, these services may be provided either directly or by formal arrangement with tribal providers.

Recommendation: CCBHC services for youth and families should be family driven and youth guided and culturally and linguistically competent.

Criteria 4.C: Crisis Behavioral Health Services

4.c.1

Unless there is an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services that dictates otherwise, the CCBHC will directly provide robust and

timely crisis behavioral health services. Whether provided directly by the CCBHC or by a state-sanctioned alternative acting as a DCO, available services must include the following:

- 24-hour mobile crisis teams,
- Emergency crisis intervention services,
- Crisis stabilization.

PAMA requires provision of these three crisis behavioral health services. As part of the certification process, the states will clearly define each term as they are using it but services provided must include suicide crisis response and services capable of addressing crises related to substance abuse and intoxication, including ambulatory and medical detoxification. States may elect to require the employment of peers on crisis teams. CCBHCs will have an established protocol specifying the role of law enforcement during the provision of crisis services.

Note: See program requirement 2 related to crisis prevention, response and postvention services and criterion 3.c.5 regarding coordination of services and treatment planning, including after discharge from a hospital or ED following a psychiatric crisis.

Recommendation: The CCBHC should meet requirements listed below if there is no state-sanctioned, certified, or licensed crisis service system; if there is a state-sanctioned, certified, or licensed crisis service system, the CCBHC should meet all requirements listed below – either directly or through a DCO --that are not provided by the crisis service system:

- *The ability to serve children, youth, young adults, adults, members and veterans of the Armed Forces and their families, and older adults;*
- *Partnership with local law enforcement, schools, EDs, early childhood programs, and child welfare providers;*
- *Crisis Hotline, available 24 hours per day, 7 days per week, continually staffed by a trained and qualified specialist, able to triage the call to determine risk of harm and calibrate according to the level of threat, from immediate response through the mobile crisis team to a scheduled visit within 48 hours;*
- *Mobile crisis response teams who:*
  - *Are available 24 hours per day/7 days a week;*
  - *Provide face-to-face response in home- and community based settings within 1 hour of initial crisis contact;* [5]
  - *Coordinate with law enforcement as needed for safety;*
  - *Deescalate the crisis;*
  - *Assess for risk to self and others;*
  - *Identify crisis precipitants to assist in developing or revising an individualized crisis plan;*

[5] n.b. The criteria specify three hours, which is too long for most jurisdictions except the most remote, frontier environments; see Shannahan & Fields (2015), which states that the target response time is within one hour.

- *Provide mobile crisis intervention services, for up to 72 hours, providing immediate and direct clinical intervention (in person or telephonically) and connections with the care coordinator to ensure follow-up regarding referrals to community services;*
- *Provide mobile crisis intervention services, for up to 72 hours, providing immediate and direct clinical intervention (in person or telephonically) and connections with the care coordinator to ensure follow-up regarding referrals to community services;*
- *Facilitate access to CCBHC follow-up appointment with therapist within 24 hours of crisis response*

- *Crisis stabilization, including in-home services and supports, referrals to services, and medication management, available for a period of weeks after the crisis.*

Criteria 4.D: Screening, Assessment, and Diagnosis

4.d.1

The CCBHC directly provides screening, assessment, and diagnosis, including risk assessment, for behavioral health conditions. In the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment or diagnosis (e.g., neurological testing, developmental testing and assessment, eating disorders), the CCBHC provides or refers them through formal relationships with other providers, or where necessary and appropriate, through use of telehealth/telemedicine services.

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

Recommendation: If the state has established independent screening and assessment processes for certain child and youth populations, the CCBHC should have partnerships in place to engage with those processes and not duplicate existing processes.

4.d.2

Screening, assessment, and diagnosis are conducted in a time frame responsive to the individual consumer's needs and are of sufficient scope to assess the need for all services required to be provided by CCBHCs.

4.d.3

The initial evaluation (including information gathered as part of the preliminary screening and risk assessment), as required in program requirement 2, includes, at a minimum, (1) preliminary diagnoses; (2) the source of referral; (3) the reason for seeking care, as stated by the consumer or other individuals who are significantly involved; (4) identification of the consumer's immediate clinical care needs related to the diagnosis for mental and substance use disorders; (5) a list of current prescriptions and over-the-counter medications, as well as other substances the consumer may be taking; (6) an assessment of whether the consumer is a risk to self or to others, including suicide risk factors; (7) an assessment of whether the consumer has other concerns for their safety; (8) assessment of need for medical care (with referral and follow-up as required); and (9) a determination of whether the person presently is or ever has been a member of the U.S. Armed Services. As needed, releases of information are obtained.

Recommendation: The assessment for children, youth, and young adults should include identification of whether the child is involved in the child welfare, juvenile justice or special education systems and/or is homeless.

4.d.4

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

Recommendation: For children and youth, a comprehensive family driven, youth guided treatment plan that is responsive to the cultural and linguistic needs of children, youth and families should be developed within 30 days of enrollment.

4.d.5

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

4.d.6

Screening and assessment by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix A of these criteria. The CCBHC should not take non-inclusion of a specific metric in Appendix A as a reason not to provide clinically indicated behavioral health screening or assessment and the state may elect to require specific other screening and monitoring to be provided by the CCBHCs beyond those listed in criterion 4.d.5 or Appendix A.

4.d.7

The CCBHC uses standardized and validated screening and assessment tools and, where appropriate, brief motivational interviewing techniques.

Recommendation: For children, youth and young adults, CCBHCs should use standardized and validated screening and assessment tools designed for the child and youth populations. Tools used should be administered in the primary language of children, youth and young adults to ensure accurate screening and assessment.

4.d.8

The CCBHC uses culturally and linguistically appropriate screening tools, and tools/approaches that accommodate disabilities (e.g., hearing disability, cognitive limitations), when appropriate.

4.d.9

If screening identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the consumer is provided or referred for a full assessment and treatment, if applicable.

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

4.e.1

The CCBHC directly provides person-centered and family-centered treatment planning or similar processes, including but not limited to risk assessment and crisis planning. Person-centered and family-centered treatment planning satisfies the requirements of criteria 4.e.2 - 4.e.8 below and is aligned with the requirements of Section 2402(a) of the Affordable Care Act, including consumer involvement and self-direction.

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

4.e.2

An individualized plan integrating prevention, medical and behavioral health needs and service delivery is developed by the CCBHC in collaboration with and endorsed by the consumer, the adult consumer's family to the extent the consumer so wishes, or family/caregivers of youth and children, and is coordinated with staff or programs necessary to carry out the plan.

Note: States may wish to access additional resources related to person-centered treatment planning found in the CMS Medicaid Home and Community Based Services regulations at 42 C.F.R. Part 441, Subpart M, or in the CMS Medicare Conditions of Participation for Community Mental Health Centers regulations at 42 C.F.R. Part 485.

Recommendation: For children, youth, and young adults and their families, treatment plans should include natural and social supports.

4.e.3

The CCBHC uses consumer assessments to inform the treatment plan and services provided.

Recommendation: Treatment plans and services for children, youth and young adults should be informed by assessments tailored to families, youth and young adults.

4.e.4

Treatment planning includes needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the consumer's words or ideas and, when appropriate, those of the consumer's family/caregiver.

4.e.5

The treatment plan is comprehensive, addressing all services required, with provision for monitoring of progress toward goals. The treatment plan is built upon a shared decision-making approach.

4.e.6

Where appropriate, consultation is sought during treatment planning about special emphasis problems, including for treatment planning purposes (e.g., trauma, eating disorders).

4.e.7

The treatment plan documents the consumer's advance wishes related to treatment and crisis management and, if the consumer does not wish to share their preferences, that decision is documented.

4.e.8

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

Recommendation: States should consider specifying the use of high quality Wraparound as a practice model for intensive care coordination for children and youth.

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

4.f.1

The CCBHC directly provides outpatient mental and substance use disorder services that are evidence-based or best practices, consistent with the needs of individual consumers as identified in their individual treatment plan. In the event specialized services outside the expertise of the CCBHC are required for purposes of outpatient mental and substance use disorder treatment (e.g., treatment of sexual trauma, eating disorders, specialized medications for substance use disorders), the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine services. The CCBHC also provides or makes available through formal arrangement traditional practices/treatment as appropriate for the consumers served in the CCBHC area. CCBHCs should provide outpatient evidence-based and promising practices designed for child, youth and young adult populations or ensure availability through arrangements with DCOs and other providers.

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

Recommendation: CCBHCs should provide outpatient evidence-based and promising practices designed for children, youth and young adult populations or ensure availability through arrangements with DCOs and other providers.

4.f.2

Based upon the findings of the needs assessment as required in program requirement 1, states must establish a minimum set of evidence-based practices required of the CCBHCs. Among those evidence-based practices states might consider are the following: Motivational Interviewing; Cognitive Behavioral individual, group and on-line Therapies (CBT); Dialectical Behavior Therapy (DBT); addiction technologies; recovery supports; first episode early intervention for psychosis; Multi-Systemic Therapy; Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (F-ACT); evidence-based medication evaluation and management (including but not limited to medications for psychiatric conditions, medication assisted treatment for alcohol and opioid substance use disorders (e.g., buprenorphine, methadone, naltrexone (injectable and oral), acamprosate, disulfiram, naloxone), prescription long-acting injectable medications for both mental and substance use disorders, and smoking cessation medications); community wrap-around services for youth and children; and specialty clinical interventions to treat mental and substance use disorders experienced by youth (including youth in therapeutic foster care). This list is not intended to be all-inclusive and the states are free to determine whether these or other evidence-based treatments may be appropriate as a condition of certification.

4.f.3

Treatments are provided that are appropriate for the consumer's phase of life and development, specifically considering what is appropriate for children, adolescents, transition age youth, and older adults, as distinct groups for whom life stage and functioning may affect treatment. Specifically, when treating children and adolescents, CCHBCs provide evidenced-based services that are developmentally appropriate, youth guided, and family/caregiver driven with respect to children and adolescents. When treating older adults, the individual consumer's desires and functioning are considered and appropriate evidence-based treatments are provided. When treating individuals with developmental or other cognitive disabilities, level of functioning is considered and appropriate evidence-based treatments are provided. These treatments are delivered by staff with specific training in treating the segment of the population being served.

4.f.4

Children and adolescents are treated using a family/caregiver driven, youth guided and developmentally appropriate approach that comprehensively addresses family/caregiver, school, medical, mental health, substance abuse, psychosocial, and environmental issues.

Criteria 4.G: Outpatient Clinic Primary Care Screening and Monitoring

4.g.1

The CCBHC is responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk. Whether directly provided by the CCBHC or through a DCO, the CCBHC is responsible for ensuring these services are received in a timely fashion. Required primary care screening and monitoring of key health indicators and health risk provided by the CCBHC include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix A of these criteria. The CCBHC should not take non-inclusion of a specific metric in Appendix A as a reason not to provide clinically indicated primary care screening and monitoring and the state may elect to require specific other screening and monitoring to be provided by the CCBHCs. The CCBHC ensures children receive age appropriate screening and preventive interventions including, where appropriate, assessment of learning disabilities, and older adults receive age appropriate screening and preventive interventions. Prevention

is a key component of primary care services provided by the CCBHC. Nothing in these criteria prevent a CCBHC from providing other primary care services.

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

Criteria 4.H: Targeted Case Management Services

4.h.1

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

Recommendation: In states that have specialty Targeted Case Management arrangements for child and youth populations (for example, through Care Management Entities), CCBHCs should develop partnerships with these entities. For CCBHCs providing Targeted Case Management directly, CCBHCs should provide intensive care coordination using a high quality Wraparound practice model for children and youth with complex needs.

Criteria 4.I: Psychiatric Rehabilitation Services

4.i.1

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

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

Recommendation: Psychiatric rehabilitation services for children and youth may include intensive in-home services, behavioral management consultation, therapeutic mentoring and adjunctive therapies, among others.

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

4.j.1

The CCBHC is responsible for peer specialist and recovery coaches, peer counseling, and family/caregiver supports. States should specify the scope of peer and family services they will require based upon the needs of the population served. Peer services that might be considered include: peer-run drop-in centers, peer crisis support services, peer bridge services to assist individuals transitioning between residential or inpatient settings to the community, peer trauma support, peer support for older adults or youth, and other peer recovery services. Potential family/caregiver support services that might be considered include: family/caregiver psycho-education, parent training, and family-to-family/caregiver support services.

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

Recommendation: In states where the development of family and youth peer support capacity is lodged with another entity – for example, a family-run or youth-run organization – CCBHCs should enter into partnerships with those entities for provision of peer support.

Criteria 4.K: Intensive, Community Based Mental Health Care for Members of the Armed Forces and Veterans

Recommendation: The CCBHC should be responsible for intensive, community based behavioral health care for certain members of the U.S. Armed Forces and veterans and their families, to include spouses and dependent children.

4.k.1

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

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

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 orders, are eligible for TRICARE Reserve Select and can schedule an appointment with any TRICARE-authorized provider, network or non-network.

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

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

4.k.3

In keeping with the general criteria governing CCBHCs, CCBHCs ensure there is integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both and for integration or coordination between care for behavioral health conditions and other components of health care for all veterans.

4.k.4

Every veteran seen for behavioral health services is assigned a Principal Behavioral Health Provider. When veterans are seeing more than one behavioral health provider and when they are involved in more than one program, the identity of the Principal Behavioral Health Provider is made clear to the veteran and identified in the medical record. The Principal Behavioral Health Provider is identified on a consumer tracking database for those veterans who need case management. The Principal Behavioral Health Provider ensures the following requirements are fulfilled:

(1) Regular contact is maintained with the veteran as clinically indicated as long as ongoing care is required.

(2) A psychiatrist, or such other independent prescriber as satisfies the current requirements of the VHA Uniform Mental Health Services Handbook, reviews and reconciles each veteran's psychiatric medications on a regular basis.

(3) Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision- maker's consent when the veteran does not have adequate decision-making capacity).

(4) Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained.

(5) The treatment plan is revised, when necessary.

(6) The principal therapist or Principal Behavioral Health Provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision-making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2).

(7) The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the Principal Behavioral Health Provider suspects the veteran lacks the capacity to make a decision about the mental health treatment plan, the provider must ensure the veteran's decision-making capacity is formally assessed and documented. For veterans who are determined to lack capacity, the provider must identify the authorized surrogate and document the surrogate's verbal consent to the treatment plan.

4.k.5

In keeping with the general criteria governing CCBHCs, behavioral health services are recovery oriented. The VHA adopted the National Consensus Statement on Mental Health Recovery in its Uniform Mental Health Services Handbook. SAMHSA has since developed a working definition and set of principles for recovery updating the Consensus Statement. Recovery is defined as "a process of change through which

individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The following are the ten guiding principles of recovery:

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

(SAMHSA [2012]).

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

- Privacy
- Security
- Honor

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

4.k.6

In keeping with the general criteria governing CCBHCs, all behavioral health care is provided with cultural competence.

(1) Any staff who is not a veteran has training about military and veterans' culture in order to be able to understand the unique experiences and contributions of those who have served their country.

(2) All staff receives cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity.

4.k.7

In keeping with the general criteria governing CCBHCs, there is a behavioral health treatment plan for all veterans receiving behavioral health services.

(1) The treatment plan includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis.

(2) The treatment plan includes approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself.

(3) As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness.

(4) The plan is recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments.

(5) The treatment plan is developed with input from the veteran, and when the veteran consents, appropriate family members. The veteran's verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1.

Program Requirement 5: QUALITY AND OTHER REPORTING

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

Criteria 5.A: Data Collection, Reporting and Tracking

5.a.1

The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including but not limited to data capturing: (1) consumer characteristics; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) consumer outcomes. Data collection and reporting requirements are elaborated below and in Appendix A.

Recommendation: Data collection should include measures specific to children, youth, and young adults, including living at home with family, involvement with juvenile justice, placement stability within child welfare system, educational progress, employment and housing status.

5.a.2

Reporting is annual and data are required to be reported for all CCBHC consumers, or where data constraints exist (for example, the measure is calculated from claims), for all Medicaid enrollees in the CCBHCs.

5.a.3

To the extent possible, these criteria assign to the state responsibility for data collection and reporting where access to data outside the CCBHC is required. Data to be collected and reported and quality measures to be reported, however, may relate to services CCBHC consumers receive through DCOs. Collection of some of the data and quality measures that are the responsibility of the CCBHC may require access to data from DCOs and it is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship with DCOs and to ensure adequate consent as appropriate and that releases of information are obtained for each affected consumer.

5.a.4

As specified in Appendix A, some aspects of data reporting will be the responsibility of the state, using Medicaid claims and encounter data. States must provide CCHBC-level Medicaid claims or encounter data

to the evaluators of this demonstration program annually. At a minimum, consumer and service-level data should include a unique consumer identifier, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. This data must be reported through MMIS/T-MSIS in order to support the state's claim for enhanced federal matching funds made available through this demonstration program. For each consumer, the state must obtain and link the consumer level administrative Uniform Reporting System (URS) information to the claim (or be able to link by unique consumer identifier). CCBHC consumer claim or encounter data must be linkable to the consumer's pharmacy claims or utilization information, inpatient and outpatient claims, and any other claims or encounter data necessary to report the measures identified in Appendix A. These linked claims or encounter data must also be made available to the evaluator. In addition to data specified in this program requirement and in Appendix A that the state is to provide, the state will provide such other data, including Treatment Episode Data Set data and data from comparison settings, as may be required for the evaluation to HHS and the national evaluation contractor annually. To the extent CCBHCs are responsible for provision of data, the data will be provided to the state and, as may be required elsewhere, to HHS and the evaluator. If requested, CCBHCs will participate in discussions with the national evaluation team.

5.a.5

CCBHCs annually submit a cost report with supporting data within six months after the end of each demonstration year to the state. The state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each demonstration year to CMS.

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

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

5.b.1

The CCBHC develops, implements, and maintains an effective, CCBHC-wide data-driven CQI plan for clinical services and clinical management. The CQI projects are clearly defined, implemented, and evaluated annually. The number and scope of distinct CQI projects conducted annually are based on the needs of the CCBHC's population and reflect the scope, complexity and past performance of the CCBHC's services and operations. The CCBHC-wide CQI plan addresses priorities for improved quality of care and client safety, and requires all improvement activities be evaluated for effectiveness. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes, and takes actions to demonstrate improvement in CCBHC performance. The CCBHC documents each CQI project implemented, the reasons for the projects, and the measurable progress achieved by the projects. One or more individuals are designated as responsible for operating the CQI program.

Recommendation: The annual CCBHC CQI plan should include projects specific to children, youth and young adults and their families.

5.b.2

Although the CQI plan is to be developed by the CCBHC and reviewed and approved by the state during certification, specific events are expected to be addressed as part of the CQI plan, including: (1) CCBHC consumer suicide deaths or suicide attempts; (2) CCBHC consumer 30-day hospital readmissions for psychiatric or substance use reasons; and (3) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.

Recommendation: Specific events indicators should be broken out by child/youth versus adult populations. Psychiatric Residential Treatment Facility (PRTF) placement of more than 4 months for

children and youth, readmission to PRTF, and detention by the juvenile justice agency should be included as specific events to be addressed by the CQI plan.

Program Requirement 6: ORGANIZATIONAL AUTHORITY, GOVERNANCE AND ACCREDITATION

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

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

6.a.1

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

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

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

6.a.2

To the extent CCBHCs are not operated under the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, states, based upon the population the prospective CCBHC may serve, should require CCBHCs to reach out to such entities within their geographic service area and enter into arrangements with those entities to assist in the provision of services to AI/AN consumers and to inform the provision of services to those consumers. To the extent the CCBHC and such entities jointly provide services, the CCBHC and those collaborating entities shall, as a whole, satisfy the requirements of these criteria.

6.a.3

An independent financial audit is performed annually for the duration of the demonstration in accordance with federal audit requirements, and, where indicated, a corrective action plan is submitted addressing all findings questioned costs, reportable conditions, and material weakness cited in the Audit Report.

Criteria 6.B: Governance

6.b.1

As a group, the CCBHC's board members are representative of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, and sexual orientation, and in terms of types of disorders. The CCBHC will incorporate meaningful participation by adult consumers with mental illness, adults recovering from substance use disorders, and family members of CCBHC consumers, either through 51 percent of the board being families, consumers or people in recovery from behavioral health conditions, or through a substantial portion of the governing board members meeting this criteria and other specifically described methods for consumers, people in recovery and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services.

6.b.2

The CCBHC will describe how it meets this requirement or develop a transition plan with timelines appropriate to its governing board size and target population to meet this requirement.

6.b.3

To the extent the CCBHC is comprised of a governmental or tribal entity or a subsidiary or part of a larger corporate organization that cannot meet these requirements for board membership, the state will specify the reasons why the CCBHC cannot meet these requirements and the CCBHC will have or develop an advisory structure and other specifically described methods for consumers, persons in recovery, and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services.

6.b.4

As an alternative to the board membership requirement, any organization selected for this demonstration project may establish and implement other means of enhancing its governing body's ability to insure that the CCBHC is responsive to the needs of its consumers, families, and communities. Efforts to insure responsiveness will focus on the full range of consumers, services provided, geographic areas covered, types of disorders, and levels of care provided. The state will determine if this alternative approach is acceptable and, if it is not, will require that additional or different mechanisms be established to assure that the board is responsive to the needs of CCBHC consumers and families. Each organization will make available the results of their efforts in terms of outcomes and resulting changes.

6.b.5

Members of the governing or advisory boards will be representative of the communities in which the CCBHC's service area is located and will be selected for their expertise in health services, community affairs, local government, finance and banking, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. No more than one half (50 percent) of the governing board members may derive more than 10 percent of their annual income from the health care industry.

Recommendation: CCBHCs should have a balanced number of board members representing a range of ages (young child, adolescent, young adult, adult, older adult) for both the consumer/family representatives and the non-consumer members, ensuring there is balanced expertise on the board. CCBHCs should include diverse youth consumers and families/caregivers of children with lived experience, who represent the populations the CCBHCs serve.

6.b.6

States will determine what processes will be used to verify that these governance criteria are being met.

Criteria 6.C: Accreditation

6.c.1

CCBHCs will adhere to any applicable state accreditation, certification, and/or licensing requirements.

6.c.2

States are encouraged to require accreditation of the CCBHCs by an appropriate nationally-recognized organization (e.g., the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities [CARF], the Council on Accreditation [COA], the Accreditation Association for Ambulatory Health Care [AAAHC]). Accreditation does not mean "deemed" status.