Mississippi Department of Mental Health Certified Community Behavioral Health Clinic (CCBHC)

CERTIFICATION CRITERIA

FINAL DRAFT

NOVEMBER 2023

Table of Contents

Introduction

The Mississippi Department of Mental Health (DMH) used the Substance Abuse and Mental Health Services Administration Certified Community Behavioral Health Center (CCBHC) Certification Criteria published in February 2023. Also, DMH used data from the 2023 Mississippi Statewide Community Needs Assessment and input from the CCBHC Planning Grant Steering Committee to inform certification criteria for Mississippi's CCBHCs. The certification criteria use the six program requirements from the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93) as the basis organizing structure.

A Certified Community Behavioral Health Clinic (CCBHC) is a specially-designated clinic that provides a comprehensive range of mental health and substance use services. CCBHCs serve anyone who walks through the door, regardless of their diagnosis and insurance status. CCBHCs are responsible for providing the following nine services, which can be provided directly or through formal relationships with Designated Collaborating Organization (DCOs):

1. Crisis Services
2. Treatment Planning
3. Screening, Assessment, Diagnosis & Risk Assessment
4. Outpatient Mental Health & Substance Use Services
5. Targeted Case Management
6. Outpatient Primary Care Screening and Monitoring
7. Community-Based Mental Health Care for Veterans
8. Peer, Family Support & Counselor Services
9. Psychiatric Rehabilitation Services

Only invited applications can apply to be CCBHC Certified.

Commented [AS1]: The sections with comments are areas where states have flexibility in the CCBHC federal criteria. Additional DMH criteria is referenced in these sections.

Program Requirement 1: Staffing

Criteria 1.A: General Staffing Requirements

1.a.1. As part of the process leading to certification and recertification, and before certification or attestation, a community needs assessment *(see Appendix A: Terms and Definitions for required components of the community needs assessment)* and a staffing plan that is responsive to the community needs assessment are completed and documented. The needs assessment and staffing plan will be updated annually.

1.a.2 The staff (both clinical and non-clinical) is appropriate for the population receiving services, as determined by the community needs assessment, in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer. *Note: See criteria 4.k relating to required staffing of services for veterans.*

1.a.3 The Chief Executive Officer (CEO) of the CCBHC, or equivalent, maintains a fully staffed management team as appropriate for the size and needs of the clinic, as determined by the current community needs assessment and staffing plan. The management team will include, at a minimum, a CEO or equivalent/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 or equivalent and the Medical Director) may be held by the same person. The Medical Director will provide guidance regarding behavioral health clinical service delivery, ensure the quality of the medical component of care, and provide guidance to foster the integration and coordination of behavioral health and primary care.

If a CCBHC is unable, after reasonable efforts, to employ or contract with a psychiatrist as Medical Director, a medically trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law, may serve as the Medical Director. In addition, if a CCBHC is unable to hire a psychiatrist and hires another prescriber instead, psychiatric consultation will be obtained regarding behavioral health clinical service delivery, quality of the medical component of care, and integration and coordination of behavioral health and primary care[1].

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

Criteria 1.B: Licensure and Credentialing of Providers

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

Commented [AS2]: CCBHCs will be required to complete an annual Community Needs Assessment. DMH will supply them with a standardized Community Needs Assessment survey and CCBHCs will be required to collect and report data at the county level.

Commented [AS3]: DMH will require CCBHC staff to be trained on the 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.

Commented [AS4]: DMH allow CCBHC that are unable, after reasonable efforts, to employ or contract with a psychiatrist as Medical Director, a medically trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law, may serve as the Medical Director. In addition, if a CCBHC is unable to hire a psychiatrist and hires another prescriber instead, psychiatric consultation will be obtained regarding behavioral health clinical service delivery, quality of the medical component of care, and integration and coordination of behavioral health and primary care.

[1] While CCBHCs are not required to provide primary care services, they are required to provide Primary Care Screening and Monitoring (See 4.g). CCBHCs may not pay for primary care services under the Section 223 CCBHC Demonstration PPS beyond those defined under 4.g. CCBHCs should coordinate with primary care providers to support integrated provision of primary and behavioral health care.

necessary state-required licenses, certifications, or other credentialing. When CCBHC providers are working toward licensure, appropriate supervision must be provided in accordance with applicable state laws.

1.b.2. The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state. The staffing plan is informed by the community needs assessment and includes clinical, peer, and other staff. In accordance with the staffing plan, the CCBHC maintains a core workforce comprised of employed and contracted staff. Staffing shall be appropriate to address the needs of people receiving services at the CCBHC, as reflected in their treatment plans, and as required to meet program requirements of these criteria.

Commented [AS5]: DMH will not require any additional staff disciplines as part of certification. e

CCBHC staff must include a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other FDA-approved medications used to treat opioid, alcohol, and tobacco use disorders. This would not include methadone, unless the CCBHC is also an Opioid Treatment Program (OTP). If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder directly, it shall refer to an OTP (if any exist in the CCBHC service area) and provide care coordination to ensure access to methadone. The CCBHC must have staff, either employed or under contract, who are licensed or certified substance use treatment counselors or specialists. If the Medical Director is not experienced with the treatment of substance use disorders, the CCBHC must have experienced addiction medicine physicians or specialists on staff, or arrangements that ensure access to consultation on addiction medicine for the Medical Director and clinical staff. The CCBHC must include staff with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI). Examples of staff include a combination of the following: (1) psychiatrists (including general adult psychiatrists and subspecialists), (2) nurses, (3) licensed independent clinical social workers, (4) licensed mental health counselors, (5) licensed psychologists, (6) licensed marriage and family therapists, (7) licensed occupational therapists, (8) staff trained to provide case management, (9) certified/trained peer specialist(s)/recovery coaches, (10) licensed addiction counselors, (11) certified/trained family peer specialists, (12) medical assistants, and (13) community health workers. 4 CCBHCs should seek practitioners with experience in the assessment and diagnosis of SUD, substance intoxication and withdrawal; pharmacological management of intoxication, withdrawal, and SUDs; ambulatory withdrawal management; outpatient addiction treatment; toxicology testing; and pharmacodynamics of commonly used substances.

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

Criteria 1.C: Cultural Competence and Other Training

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

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

- Care for co-occurring mental health and substance use disorders

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

Training shall be aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality of services, and eliminate disparities. To the extent active-duty military or veterans are being served, such training must also include information related to military culture. Examples of training and materials that further the ability of the clinic to provide tailored training for a diverse population include, but are not limited to, those available through the HHS website, the SAMHSA website,7 the HHS Office of Minority Health, or through the website of the Health Resources and Services Administration. 6 Access standards at, what is CLAS? - Think Cultural Health (hhs.gov) and Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care at National Minority Mental Health Awareness Month — New CLAS Implementation Guide (hhs.gov). Suggested resources include the African American Behavioral Health Center of Excellence, LGBTQ+ Behavioral Health Equity Center of Excellence, Engage, Educate, Empower for Equity: E4 Center of Excellence for Behavioral Health Disparities in Aging, and Asian American, Native Hawaiian, and Pacific Islander Behavioral Health Center of Excellence. *Note: See criteria 4.k relating to cultural competency requirements in services for veterans.*

1.c.2 The CCBHC regularly assesses the skills and competence of each individual furnishing services and, as necessary, provides in-service training and education programs. The CCBHC has written policies and procedures describing its method(s) of assessing competency and maintains a written accounting of the in-service training provided for the duration of employment of each employee who has direct contact with people receiving services.

1.c.3 The CCBHC documents in the staff personnel record that the training and demonstration of competency are successfully completed. CCBHCs are encouraged to provide ongoing coaching and supervision to ensure initial and ongoing compliance with, or fidelity to, evidence-based, evidence-informed, and promising practices.

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

Criteria 1.D: Linguistic Competence

1.d.1 The CCBHC takes reasonable steps to provide meaningful access to services, such as language assistance, for those with Limited English Proficiency (LEP) and/or language-based disabilities.

1.d.2 Interpretation/translation service(s) are readily available and appropriate for the size/needs of the LEP CCBHC population (e.g., bilingual providers, onsite interpreters, language video or telephone line). To the extent interpreters are used, such translation service providers are trained to function in a medical and, preferably, a behavioral health setting.

1.d.3 Auxiliary aids and services are readily available, Americans with Disabilities Act (ADA) compliant, and responsive to the needs of people receiving services with physical, cognitive, and/or developmental disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines).

1.d.4 Documents or information vital to the ability of a person receiving services to access CCBHC services (e.g., registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available online and in paper format, in languages commonly spoken within the community served, taking account of literacy levels and the need for alternative formats. Such materials are provided in a timely manner at intake and throughout the time a person is served by the CCBHC. Prior to certification, the needs assessment will inform which languages require language assistance, to be updated as needed.

1.d.5 The CCBHC's policies have explicit provisions for ensuring all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider. These include, but are not limited to, the requirements of the 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.

Program Requirement 2: Availability and Accessibility of Services

This program requirement describes:

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

Criteria 2.A: General Requirements of Access and Availability

2.a.1 The CCBHC provides a safe, functional, clean, sanitary, and welcoming environment for people receiving services and staff, conducive to the provision of services identified in program requirement 4. CCBHCs are encouraged to operate tobacco-free campuses.

2.a.2 Informed by the community needs assessment, the CCBHC ensures that services are provided during times that facilitate accessibility and meet the needs of the population served by the CCBHC, including some evening and weekend hours.

2.a.3 Informed by the community needs assessment, the CCBHC provides services at locations that ensure accessibility and meet the needs of the population to be served, such as settings in the community (e.g., schools, social service agencies, partner organizations, community centers) and, as appropriate and feasible, in the homes of people receiving services.

2.a.4 The CCBHC provides transportation or transportation vouchers for people receiving services to the extent possible with relevant funding or programs in order to facilitate access to services in alignment with the person-centered and family-centered treatment plan.

2.a.5 The CCBHC uses telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies, to the extent possible, in alignment with the preferences of the person receiving services to support access to all required services.

2.a.6 Informed by the community needs assessment, the CCBHC conducts outreach, engagement, and retention activities to support inclusion and access for underserved individuals and populations.

2.a.7 Services are subject to all state standards for the provision of both voluntary and court ordered services.

2.a.8 The CCBHC has a continuity of operations/disaster plan. The plan will ensure the CCBHC is able to effectively notify staff, people receiving services, and healthcare and community partners when a disaster/emergency occurs, or services are disrupted. The CCBHC, to the extent feasible, has identified alternative locations and methods to sustain service delivery and access to behavioral health medications during emergencies and disasters. The plan also addresses health IT systems security/ransomware protection and backup and access to these IT systems, including health records, in case of disaster.

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

2.b.1 All people new to receiving services, whether requesting or being referred for behavioral health services at the CCBHC, will, at the time of first contact, whether that contact is in person, by telephone, or using other remote communication, receive a preliminary triage, including risk assessment, to determine acuity of needs. That preliminary triage may occur telephonically. If the triage identifies an emergency/crisis need, appropriate action is taken immediately *(see 4.c.1 for crisis response timelines and detail about required services),* including plans to reduce or remove risk of harm and to facilitate any necessary subsequent outpatient follow-up.

- If the triage identifies an urgent need, clinical services are provided, including an initial evaluation within one business day of the time the request is made.
- If the triage identifies routine needs, services will be provided, and the initial evaluation completed within 10 business days.
- For those presenting with emergency or urgent needs, the initial evaluation may be conducted by phone or through use of technologies for telehealth/telemedicine and video conferencing, but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved, the person receiving services must be seen in person at the next subsequent encounter and the initial evaluation reviewed.

Underserved individuals and populations include communities as defined in Federal Register: Advancing Racial Equity and Support for Underserved Communities Through the Federal Government as well as individuals or populations that have unmet needs for mental health and substance use disorder treatment and supports.

The preliminary triage and risk assessment will be followed by: (1) an initial evaluation and (2) a comprehensive evaluation, with the components of each specified in program requirement 4. At the CCBHC's discretion, recent information may be reviewed with the person receiving services and incorporated into the CCBHC health records from outside providers to help fulfill these requirements. Each evaluation must build upon what came before it. Subject to more stringent state, federal, or applicable accreditation standards, all new people receiving services will receive a comprehensive evaluation to be completed within 60 calendar days of the first request for services. If the state has established independent screening and assessment processes for certain child and youth populations or other populations, the CCBHC should establish partnerships to incorporate findings and avoid duplication of effort. This requirement does not preclude 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.

2.b.2 The person-centered and family-centered treatment plan is reviewed and updated as needed by the treatment team, in agreement with and endorsed by the person receiving services. The treatment plan will be updated when changes occur with the status of the person receiving services, based on responses to treatment or when there are changes in treatment goals. The treatment plan must be reviewed and updated no less frequently than every 6 months, unless the state, federal, or applicable accreditation standards are more stringent.

2.b.3 People who are already receiving services from the CCBHC who are seeking routine outpatient clinical services must be provided an appointment within 10 business days of the request for an appointment, unless the state, federal, or applicable accreditation standards are more stringent. If a person receiving services presents with an emergency/crisis need, appropriate action is taken immediately based on the needs of the person receiving services, including immediate crisis response if necessary. If a person already receiving services presents with

an urgent, non-emergency need, clinical services are generally provided within one business day of the time the request is made or at a later time if that is the preference of the person receiving services. Same-day and open access scheduling are encouraged.

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

2.c.1 In accordance with program requirement 4.c, the CCBHC provides crisis management services that are available and accessible 24 hours a day, seven days a week.

2.c.2 A description of the methods for providing a continuum of crisis prevention, response, and postvention services shall be included in the policies and procedures of the CCBHC and made available to the public.

2.c.3 Individuals who are served by the CCBHC are educated about crisis planning, psychiatric advanced directives, and how to access crisis services, including the 988 Suicide & Crisis Certified Community Behavioral Health Clinic Certification Criteria
Lifeline (by call, chat, or text) and other area hotlines and warmlines, and overdose prevention, if risk is indicated, at the time of the initial evaluation meeting following the preliminary triage. *Please see 3.a.4. for further information on crisis planning. This includes individuals with LEP or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels in accordance with program requirement 1.d).*

2.c.4 In accordance with program requirement 3, the CCBHC maintains a working relationship with local hospital emergency departments (EDs). Protocols are established for CCBHC staff to address the needs of CCBHC people receiving services in psychiatric crisis who come to those EDs.

2.c.5 Protocols, including those for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a behavioral health crisis. Shared protocols are designed to maximize the delivery of recovery-oriented treatment and services. The protocols should minimize contact with law enforcement and the criminal justice system, while promoting individual and public safety, and complying with applicable state and local laws and regulations. *Note: See criterion 3.c.5 regarding specific care coordination requirements related to discharge from hospital or ED following a psychiatric crisis.*

2.c.6 Following a psychiatric emergency or crisis, in conjunction with the person receiving services, the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises. *Note: See criterion 3.a.4 where precautionary crisis planning is addressed.*

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

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

2.d.2 The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC offers pursuant to these criteria. Such fee schedules will be included on the CCBHC website, posted in the CCBHC waiting room and readily accessible to people receiving services and families.

The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP, literacy barriers, or disabilities.

2.d.3 The fee schedules, to the extent relevant, conform to state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable to existing clinics; absent applicable state or federal requirements, the schedule is based on locally prevailing rates or charges and includes reasonable costs of operation.

2.d.4 The CCBHC has written policies and procedures describing eligibility for and implementation of the sliding fee discount schedule. Those policies are applied equally to all individuals seeking services.

Criteria 2.E: Provision of Services Regardless of Residence

2.e.1 The CCBHC ensures no individual is denied behavioral health care services, including but not limited to crisis management services, because of place of residence, homelessness, or lack of a permanent address.

2.e.2 The CCBHC has protocols addressing the needs of individuals who do not live close to the CCBHC or within the CCBHC service area. The CCBHC is responsible for providing, at a minimum, crisis response, evaluation, and stabilization services in the CCBHC service area regardless of place of residence. The required protocols should address management of the individual's on-going treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing the CCBHC to refer and track individuals seeking non crisis services to the CCBHC or other clinics serving the individual's area of residence. For individuals and families who live within the CCBHC's service area but live a long distance from CCBHC clinic(s), the CCBHC should consider use of technologies for telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies in alignment with the preferences of the person receiving services, and to the extent practical. These criteria do not require the CCBHC to provide continuous services including telehealth to individuals who live outside of the CCBHC service area. CCBHCS may consider developing protocols for populations that may transition frequently in and out of the services area such as children who experience out-of-home placements and adults who are displaced by incarceration or housing instability.

Program Requirement 3: Care Coordination

This section describes the requirements for:

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

Criteria 3.A: General Requirements of Care Coordination

For additional information on care coordination, see Care Coordination | Agency for Healthcare Research and Quality

3.a.1 Based on a person-centered and family-centered treatment plan aligned with the requirements of Section 2402(a) of the Affordable Care Act and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services. This includes access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. The CCBHC also coordinates with other systems to meet the needs of the people they serve, including criminal and juvenile justice and child welfare. [2]*Note: See criteria 4.k relating to care coordination requirements for veterans.*

3.a.2 The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state privacy laws, including patient privacy requirements specific to the care of minors. To promote coordination of care, the CCBHC will obtain necessary consents for sharing information with community partners where information is not able to be shared under HIPAA and other federal and state laws and regulations. If the CCBHC is unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program requirement 3, such attempts must be documented and revisited periodically.
Note: CCBHCs are encouraged to explore options for electronic documentation of consent where feasible and responsive to the needs and capabilities of the person receiving services. See standards within the Interoperability Standards Advisory.

The Interoperability Standards Advisory (ISA) process represents the model by which the Office of the National Coordinator for Health Information Technology (ONC) will coordinate the identification, assessment, and determination of "recognized" interoperability standards and implementation specifications for industry use to fulfill specific clinical health IT interoperability needs.

3.a.3 Consistent with requirements of privacy, confidentiality, and the preferences and needs of people receiving services, the CCBHC assists people receiving services and the families of children and youth referred to external providers or resources in obtaining an appointment and tracking participation in services to ensure coordination and receipt of supports.

3.a.4 The CCBHC shall coordinate care in keeping with the preferences of the person receiving services and their care needs. To the extent possible, care coordination should be provided, as appropriate, in collaboration with the family/caregiver of the person receiving services and other supports identified by the person. To identify the preferences of the person in the event of psychiatric or substance use crisis, the CCBHC develops a crisis plan with each person receiving services. At

minimum, people receiving services should be counseled about the use of the National Suicide & Crisis Lifeline, local hotlines, warmlines, mobile crisis, and stabilization services should a crisis arise when providers are not in their office. Crisis plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving services. [3]Psychiatric Advance Directives, if developed, are entered in the electronic health record of the person receiving services so that the information is available to providers in emergency care settings where those electronic health records are accessible. Psychiatric Advance Directives are legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric Advance Directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.

3.a.5 Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers. To the extent that state laws allow, the state Prescription Drug Monitoring Program (PDMP) must be consulted before prescribing medications. The PDMP should also be consulted during the comprehensive evaluation. Upon appropriate consent to release of information, the CCBHC is also required to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care.

3.a.6 Nothing about a CCBHC's agreements for care coordination should limit the freedom of a person receiving services to choose their provider within the CCBHC, with its DCOs, or with any other provider.

3.a.7 The CCBHC assists people receiving services and families to access benefits, including Medicaid, and enroll in programs or supports that may benefit them.

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

3.b.1 The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records.

3.b.2 The CCBHC uses its secure health IT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct activities such as population health management, quality improvement, quality measurement and reporting, reducing disparities, outreach, and for research. When CCBHCs use federal funding to acquire, upgrade, or implement technology to support these activities, systems should utilize nationally recognized, HHS-adopted standards, where available, to enable health information exchange.[4] For example, this may include simply using common terminology mapped to standards adopted by HHS to represent a concept such as race, ethnicity, or other demographic information. While this requirement does not apply to incidental use of existing IT systems to support these activities when there is no targeted use of program funding, CCBHCs are encouraged to explore ways to support alignment with standards across data-driven activities.

[3] For more information visit NRC PAD | National Resource Center on Psychiatric Advance Directives (nrc-pad.org).

[4] Pursuant to HHS Health IT Alignment policy and Section 13112 of the HITECH Act, recipients and subrecipients of award funding which involves acquiring, upgrading and implementing health IT must utilize health IT that meets standards and implementation.

3.b.3 The CCBHC uses technology that has been certified to current criteria [5] under the ONC Health IT Certification Program for the following required core set of certified health IT capabilities (see footnotes for citations to the required health IT certification criteria and standards) that align with key clinical practice and care delivery requirements for CCBHCs:[6]

- Capture health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status (as feasible).[7]
- At a minimum, support care coordination by sending and receiving summary of care records.[8]
- Provide people receiving services with timely electronic access to view, download, or transmit their health information or to access their health information via an API using a personal health app of their choice.[9]
- Provide evidence-based clinical decision support.[10]
- Conduct electronic prescribing.[11]

3.b.4 The CCBHC will work with DCOs to ensure all steps are taken, including obtaining consent from people receiving services, to comply with privacy and confidentiality requirements. These include, but are not limited to, those of HIPAA (Pub. L. 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. existing IT systems to support these activities when there is no targeted use of program funding, CCBHCs are encouraged to explore ways to support alignment with standards across data-driven activities.

3.b.5 The CCBHC develops and implements a plan within two-years from CCBHC certification or submission of attestation to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan includes information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care. To support integrated evaluation planning, treatment, and care coordination, the CCBHC works with DCOs to integrate clinically relevant treatment records generated by the DCO for people receiving CCBHC services and incorporate them into the CCBHC health record. Further, all clinically relevant treatment records maintained by the CCBHC are available to DCOs within the confines of federal and/or state laws governing sharing of health records.

3.b.6 The CCBHC must participate with the MHA HIE (HIE) and be capable of exchanging protected health information, connecting to inpatient and ambulatory electronic health records (EHRs), connecting to care coordination information technology system records, and supporting secure messaging or electronic querying between providers, and patients. This must include but is not limited

Commented [AS6]: DMH has included draft language on CCBHC requirements for HIE.

[5] As of February 2023, current criteria are the 2015 Edition of health IT certification criteria, as updated according to the 2015 Edition Cures Update.
[6] Additional information about health IT products certified to these criteria is available on the Certified Health IT Product List (CHPL).
[7] United States Core Data for Interoperability (USCDI) standard at 45 CFR 170.213 and "Demographics" criterion at § CFR 170.315(a)(5).
[8] Transitions of care" criterion at § 170.315(b)(1)).
[9] "Clinical decision support" criterion at § 170.315(a)(9).
[10] "Application access – all data request" criterion at § 170.315(g)(9) and "Standardized API for patient and population services" criterion at § 170.315(g)(10).
[11] "Electronic prescribing" criterion at § 170.215(b)(3).

to using the HIEs for admission, discharge, and transfer (ADT) data and closing referral loops for social determinants of health (SDOH).
The CCBHC must support and facilitate its subcontractors or DCOs exchange of data with the MHA's HIE.

The Contractor must require its subcontractors or DCOs to provide ADT data to the MHA's HIE.

The CCBHC must submit annually, the following:

- A HIE Participation Report to Department of Mental Health providing the number and percentage of subcontractors or DCOs connected to the HIE and the type of participation.
- CCBHC's plan to support use of HIEs (HIE Subcontractor/DCO Support Plan), including, but not limited to, collaborative CCBHC's efforts that facilitate and support consistent and accurate data submission from subcontractors/DCOs to the HIEs.

The CCBHC's information system must support the use of HIEs and EHRs necessary for near real-time understanding of member needs and reporting metrics, such as electronic clinical quality measures (eCQMs).

Criteria 3.C: Care Coordination Partnerships

3.c.1 The CCBHC has a partnership establishing care coordination expectations with Federally Qualified Health Centers (FQHCs) (and, as applicable, Rural Health Clinics (RHCs)) to provide health care services, to the extent the services are not provided directly through the CCBHC. For people receiving services who are served by other primary care providers, including but not limited to FQHC Look-Alikes and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination. ***Note:*** *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*

3.c.2 The CCBHC has partnerships that establish care coordination expectations with programs that can provide inpatient psychiatric treatment, OTP services, medical withdrawal management facilities and ambulatory medical withdrawal management providers for substance use disorders, and residential substance use disorder treatment programs (if any exist within the CCBHC service area). These include tribally operated mental health and substance use services including crisis services that are in the service area. The clinic tracks when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity. The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric programs, medically monitored withdrawal management services, and residential or inpatient facilities that serve children and youth such as Psychiatric Residential Treatment Facilities and other residential treatment facilities, to a safe community setting. This includes transfer of health records of services received (e.g., prescriptions), active follow-up after discharge, and, as appropriate, a plan for suicide prevention and safety, overdose prevention, and provision for peer services. ***Note:*** *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint*

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

DMH has included in their FY 2026 budget request a plan to incentivize inpatient treatment facilities to partner with CCBHCs to establish protocols and procedures for transitioning individuals, including real time notification of discharge and record transfers that support the seamless delivery of care, maintain recovery, and reduce the risk of relapse and injury during transitions. These resources are contingent on the availability of state funding.

3.c.3 The CCBHC has partnerships with a variety of community or regional services, supports, and providers. Partnerships support joint planning for care and services, provide opportunities to identify individuals in need of services, enable the CCBHC to provide services in community settings, enable the CCBHC to provide support and consultation with a community partner, and support CCBHC outreach and engagement efforts. CCBHCs are required by statute to develop partnerships with the following organizations that operate within the service area:

- 988 Crisis Call Centers
- Child welfare agencies
- CHOICE housing voucher program
- Employment Services systems
- Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans, and other specialty courts)
- Indian Health Service or other tribal programs
- Mississippi Department of Rehabilitation Services
- Peer Support programs
- Other social and human services
- Recovery Housing Services
- Schools
- State licensed and nationally accredited child placing agencies for therapeutic foster care service.
- Transportation

CCBHCs may develop partnerships with the following entities based on the population served, the needs and preferences of people receiving services, and/or needs identified in the community needs assessment. Examples of such partnerships include (but are not limited to) the following:

- Specialty providers including those who prescribe medications for the treatment of opioid and alcohol use disorders
- Homeless shelters
- Services for older adults, such as Area Agencies on Aging
- Aging and Disability Resource Centers
- State and local health departments and behavioral health and developmental disabilities agencies
- Substance use prevention and harm reduction programs
- Criminal and juvenile justice, including law enforcement, courts, jails, prisons, and detention centers
- Legal aid
- Immigrant and refugee services

Commented [AS7]: This incentive area is being covered via DMH's FY 2026 budget request. DMH wants to incentivize inpatient treatment facilities to partner with CCBHCs to establish protocols and procedures for transitioning individuals, including real time notification of discharge and record transfers that support the seamless delivery of care, maintain recovery, and reduce the risk of relapse and injury during transitions.

Commented [AS8]: In addition to the minimum required formal partnerships with: Schools; Child welfare agencies; Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans, and other specialty courts); Indian Health Service; youth regional treatment centers; State licensed and nationally accredited child placing agencies for therapeutic foster care service; and other social and human services, Mississippi's CCBHCs will be required to have formal partnerships with the following programs in their service area: 988 Crisis Call Centers; MS Department of Rehabilitation Services; CHOICE Housing Voucher Program; Recovery Housing Services; employment services systems; and transportation.

- SUD Recovery/Transitional housing
- Programs and services for families with young children, including Infants & Toddlers, WIC, Home Visiting Programs, Early Head Start/Head Start, and Infant and Early Childhood Mental Health Consultation programs
- Coordinated Specialty Care programs for first episode psychosis
- Other social and human services (e.g., intimate partner violence centers, religious services and supports, grief counseling, Affordable Care Act Navigators, food and transportation programs)

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

3.c.4 The CCBHC has partnerships 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 work to establish care coordination agreements with facilities of each type. ***Note:*** *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*

3.c.5 The CCBHC has care coordination partnerships establishing expectations with inpatient acute-care hospitals in the area served by the CCBHC and their associated services/facilities, including emergency departments, hospital outpatient clinics, urgent care centers, and residential crisis settings. This includes procedures and services, such as peer recovery specialist/coaches, to help individuals successfully transition from ED or hospital to CCBHC and community care to ensure continuity of services and to minimize the time between discharge and follow up. Ideally, the CCBHC should work with the discharging facility ahead of discharge to assure a seamless transition. These partnerships shall support tracking when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged. The partnerships shall also support the transfer of health records of services received (e.g., prescriptions) and active follow-up after discharge. CCBHCs should request of relevant inpatient and outpatient facilities, for people receiving CCBHC services, that notification be provided through the Admission-Discharge-Transfer (ADT) system.

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

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

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

3.d.1 The CCBHC treatment team includes the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, and any other people the person receiving services desires to be involved in their care. All treatment planning and care coordination activities are person- and family-centered and align with the requirements of Section 2402(a) of the Affordable Care Act. All treatment planning and care coordination activities are subject to HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR

Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.

3.d.2 The CCBHC designates an interdisciplinary treatment team that is responsible, with the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, for directing, coordinating, and managing care and services. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of the people receiving services, including, as appropriate and desired by the person receiving services, traditional approaches to care for people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups. ***Note:*** *See criteria 4.k relating to required treatment planning services for veterans.*

3.d.3 The CCBHC coordinates care and services provided by DCOs in accordance with the current treatment plan. ***Note:*** *See program requirement 4 related to scope of service and person-centered and family-centered treatment planning.*

Program Requirement 4: Scope of Services

These nine services will be delivered by the CCBHC director or through its DCOS, in a manner reflecting person-centered and family-centered care.

I. Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
II. II. Screening, assessment, and diagnosis, including risk assessment.
III. III. Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
IV. Outpatient mental health and substance use services.
V. Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
VI. Targeted case management.
VII. Psychiatric rehabilitation services.
VIII. Peer support and counselor services and family supports.
IX. Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration."

Criteria 4.A: General Service Provisions

4.a.1 Whether delivered directly or through a DCO agreement, the CCBHC is responsible for ensuring access to all care specified in PAMA. This includes, as more explicitly provided and more clearly defined below in criteria 4.c through 4.k the following required services: crisis services; screening, assessment and diagnosis; person-centered and family-centered treatment planning; outpatient behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer and family supports; and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans. The CCBHC organization will deliver directly the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through DCOs.

4.a.2 The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, consistent with the freedom of the person receiving services 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, people receiving services will be informed of and have access to the CCBHC's existing grievance procedures, which must satisfy the minimum requirements of Medicaid and other grievance requirements such as those that may be mandated by relevant accrediting entities or state authorities.

4.a.4 DCO-provided services for people receiving CCBHC services must meet the same quality standards as those provided by the CCBHC. The entities with which the CCBHC coordinates care and all DCOs, taken in conjunction with the CCBHC itself, satisfy the mandatory aspects of these criteria.

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

4.b.1 The CCBHC ensures all CCBHC services, including those supplied by its DCOs, are provided in a manner aligned with the requirements of Section 2402(a) of the Affordable Care Act. These reflect person-centered and family-centered, recovery-oriented care; being respectful of the needs, preferences, and values of the person receiving services; and ensuring both involvement of the person receiving services and self-direction of services received. Services for children and youth are family-centered, youth-guided, and developmentally appropriate. A shared decision-making model for engagement is the recommended approach. ***Note:*** *See program requirement 3 regarding coordination of services and treatment planning. See criteria 4.k relating specifically to requirements for services for veterans.*

4.b.2 Person-centered and family-centered care is responsive to the race, ethnicity, sexual orientation and gender identity of the person receiving services and includes care which recognizes the particular cultural and other needs of the individual. This includes, but is not limited to, services for people who are American Indian or Alaska Native (AI/AN) or other cultural or ethnic groups, for whom access to traditional approaches or medicines may be part of CCBHC services. For people receiving services who are AI/AN, these services may be provided either directly or by arrangement with tribal organizations.

Criteria 4.C: Crisis Behavioral Health Services

4.c.1 The CCBHC shall provide crisis services directly or through a DCO agreement with existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services. HHS recognizes that state-sanctioned crisis systems may operate under different standards than those identified in these criteria. If a CCBHC would like to have a DCO relationship with a state-sanctioned crisis system that operates under less stringent standards, they must request approval from HHS to do so.

Commented [AS9]: DMH agrees to request HHS approval to certify CCBHCs in their states that have or seek to have a DCO relationship with a state-sanctioned crisis system with less stringent standards than those included in these criteria. If an entity seeking CCBHC certification makes this request, DMH will review and submit to HHS for approval.

PAMA requires provision of these three crisis behavioral health services, whether provided directly by the CCBHC or by a DCO:

- *Emergency crisis intervention services:* The CCBHC provides or coordinates with telephonic, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. The CCBHC should participate in any state, regional, or local air traffic control (ATC)23 systems which provide quality coordination of crisis care in real-time as well as any service capacity registries as appropriate. Quality coordination means that protocols have been established to track referrals made from the call center to the CCBHC or its DCO crisis care provider to ensure the timely delivery of mobile crisis team response, crisis stabilization, and post crisis follow-up care.
- *24-hour mobile crisis teams*: The CCBHC provides community-based behavioral health crisis intervention services using mobile crisis teams twenty-four hours per day, seven days per week to adults, children, youth, and families anywhere within the service area including at home, work, or anywhere else where the crisis is experienced. Mobile crisis teams are expected to arrive in-person within one hour (2 hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed 3 hours. Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time. Technologies also may be used to provide crisis care to individuals when remote travel distances make the 2-hour response time unachievable, but

the ability to provide an in-person response must be available when it is necessary to assure safety. The CCBHC should consider aligning their programs with the CMS Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services if they are in a state that includes this option in their Medicaid state plan.

- *Crisis receiving/stabilization*: The CCBHC provides crisis receiving/stabilization services that must include at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals. Urgent care/walk-in services that identify the individual's immediate needs, de-escalate the crisis, and connect them to a safe and least-restrictive setting for ongoing care (including care provided by the CCBHC). Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted. The CCBHC should have a goal of expanding the hours of operation as much as possible. Ideally, these services are available to individuals of any level of acuity; however, the facility need not manage the highest acuity individuals in this ambulatory setting. Crisis stabilization services should ideally be available 24 hours per day, 7 days a week, whether individuals present on their own, with a concerned individual, such as a family member, or with a human service worker, and/or law enforcement, in accordance with state and local laws. In addition to these activities, the CCBHC may consider supporting or coordinating with peer-run crisis respite programs. The CCBHC is encouraged to provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care.

For questions about this process, please email ccbhc@samhsa.hhs.gov. 23 Air traffic control (ATC) serves as a conceptual model for real-time coordination of crisis care and linkage to crisis response services. It may involve real-time connection to GPS-enabled mobile teams, true system-wide access to available beds, and outpatient appointment scheduling through the integrated crisis call center. For more information see National Guidelines for Behavioral Health Crisis Care | SAMHSA.

Services provided must include suicide prevention and intervention, and services capable of addressing crises related to substance use including the risk of drug and alcohol related overdose and support following a non-fatal overdose after the individual is medically stable. Overdose prevention activities must include ensuring access to naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to their family members. The CCBHC or its DCO crisis care provider should offer developmentally appropriate responses, sensitive de-escalation supports, and connections to ongoing care, when needed. The CCBHC will have an established protocol specifying the role of law enforcement during the provision of crisis services. As a part of the requirement to provide training related to trauma-informed care, the CCBHC shall specifically focus on the application of trauma-informed approaches during crises. *Note: See program requirement 2.c regarding access to crisis services and criterion 3.c.5 regarding coordination of services and treatment planning, including after discharge from a hospital inpatient or emergency department following a behavioral health crisis.*

For information on crisis services for children and youth, please see National Guidelines for Child and Youth Behavioral Health Crisis Care (samhsa.gov) and A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth (samhsa.gov)

Criteria 4.D: Screening, Assessment, and Diagnosis

4.d.1 The CCBHC directly, or through a DCO, provides screening, assessment, and diagnosis, including risk assessment for behavioral health conditions. In the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment, or diagnosis (e.g., neuropsychological testing or developmental testing and assessment), the CCBHC refers the person to an appropriate provider. When necessary and appropriate screening, assessment and diagnosis can be provided through telehealth/telemedicine services. *Note: See program requirement 3 regarding coordination of services and treatment planning.*

4.d.2 Screening, assessment, and diagnosis are conducted in a time frame responsive to the needs and preferences of the person receiving services and are of sufficient scope to assess the need for all services required to be provided by the CCBHC.

4.d.3 The initial evaluation (including information gathered as part of the preliminary triage and risk assessment, with information releases obtained as needed), 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 person receiving services or other individuals who are significantly involved
4. Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services
5. A list of all current prescriptions and over-the counter medications, herbal remedies, and dietary supplements and the indication for any medications
6. A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful
7. The use of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications
8. An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors
9. An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence
10. Assessment of need for medical care (with referral and follow-up as required)
11. A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services
12. For children and youth, whether they have system involvement (such as child welfare and juvenile justice)

4.d.4 A comprehensive evaluation is required for all people receiving CCBHC services. Subject to applicable state, federal, or other accreditation standards, clinicians should use their clinical judgment with respect to the depth of questioning within the assessment so that the assessment actively engages the person receiving services around their presenting concern(s). The evaluation should gather the amount of information that is commensurate with the complexity of their specific needs, and prioritize preferences of people receiving services with respect to the depth of evaluation and their treatment goals. The evaluation shall include:

1. Reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the presentation to the CCBHC of the person receiving services.

2. An overview of relevant social supports; social determinants of health; and healthrelated social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status.
3. A description of cultural and environmental factors that may affect the treatment plan of the person receiving services, including the need for linguistic services or supports for people with LEP.
4. Pregnancy and/or parenting status.
5. Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments.
6. Relevant medical history and major health conditions that impact current psychological status.
7. A medication list including prescriptions, over-the counter medications, herbal remedies, dietary supplements, and other treatments or medications of the person receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies.
8. An examination that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement based care) and substance use disorders (including tobacco, alcohol, and other drugs).
9. Basic cognitive screening for cognitive impairment.
10. Assessment of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person.
11. The strengths, goals, preferences, needs and other factors to be considered in treatment and recovery planning of the person receiving services.
12. Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services).
13. Assessment of any relevant social service needs of the person receiving services, with necessary referrals made to social services. For children and youth receiving services, assessment of systems involvement such as child welfare and juvenile justice and referral to child welfare agencies as appropriate.
14. An assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the primary care provider (with appropriate referral and follow-up) of the person receiving services.
15. The preferences of the person receiving services regarding the use technologies such as telehealth/telemedicine, video conferencing, remote patient monitoring, and asynchronous interventions.

Commented [AS10]: In addition to capturing these elements, DMH is requiring the capture of "needs" as well as the minimum requirements.

4.d.5 Screening and assessment conducted by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix B of these criteria. The CCBHC should not take non-inclusion of a specific metric in Appendix B as a reason not to provide clinically indicated behavioral health screening or assessment.

4.d.6 The CCBHC uses standardized and validated and developmentally appropriate screening and assessment tools appropriate for the person and, where warranted, brief motivational interviewing techniques to facilitate engagement.

4.d.7 The CCBHC uses culturally and linguistically appropriate screening tools and approaches that accommodate all literacy levels and disabilities (e.g., hearing disability, cognitive limitations), when appropriate.

4.d.8 If screening identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the person receiving services is provided a full assessment and treatment, if appropriate within the level of care of the CCBHC, or referred to a more appropriate level of care. If the screening identifies more immediate threats to the safety of the person receiving services, the CCBHC will take appropriate action as described in 2.b.1.

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

4.e.1 The CCBHC directly, or through a DCO, provides person-centered and family-centered treatment planning, including but not limited to, risk assessment and crisis planning (CCBHCs may work collaboratively with DCOs to complete these activities). 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 person receiving services involvement and self-direction. *Note: See program requirement 3 related to coordination of care and treatment planning.*

4.e.2 The CCBHC develops an individualized treatment plan based on information obtained through the comprehensive evaluation and the person receiving services' goals and preferences. The plan shall address the person's prevention, medical, and behavioral health needs. The plan shall be developed in collaboration with and be endorsed by the person receiving services; their family (to the extent the person receiving services so wishes); and family/caregivers of youth and children or legal guardians. Treatment plan development shall be coordinated with staff or programs necessary to carry out the plan. The plan shall support care in the least restrictive setting possible. Shared decision making is the preferred model for the establishment of treatment planning goals. All necessary releases of information shall be obtained and included in the health record as a part of the development of the initial treatment plan.

4.e.3 The CCBHC uses the initial evaluation, comprehensive evaluation, and ongoing screening and assessment of the person receiving services to inform the treatment plan and services provided.

4.e.4 Treatment planning includes needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the words or ideas of the person receiving services and, when appropriate, those of the family/caregiver of the person receiving services.

4.e.5 The treatment plan is comprehensive, addressing all services required, including recovery supports, with provision for monitoring of progress towards goals. The treatment plan is built upon a shared decision-making approach.

4.e.6 Where appropriate, consultation is sought during treatment planning as needed (e.g., eating disorders, traumatic brain injury, intellectual and developmental disabilities (I/DD), interpersonal violence and human trafficking).

4.e.7 The person's health record documents any advance directives related to treatment and crisis planning. If the person receiving services does not wish to share their preferences, that decision is documented. Please see 3.a.4., requiring the development of a crisis plan with each person receiving services.

Commented [AS11]: DMH has decided not to add additional requirements for other aspects of person-centered and family-centered treatment planning does DMH want to require based upon the needs of the population served.

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

4.f.1 The CCBHC directly, or through a DCO, provides outpatient behavioral health care, including psychopharmacological treatment. The CCBHC or the DCO must provide -based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for adults, children, and families. SUD treatment and services shall be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 and include treatment of tobacco use disorders. In the event specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of outpatient mental and substance use disorder treatment the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine, in alignment with state and federal laws and regulations. The CCBHC also provides or makes available through a formal arrangement traditional practices/treatment as appropriate for the people receiving services served in the CCBHC area. Where specialist providers are not available to provide direct care to a particular person receiving CCBHC services, or specialist care is not practically available, the CCBHC professional staff may consult with specialized services providers for highly specialized treatment needs. For people receiving services with potentially harmful substance use, the CCBHC is strongly encouraged to engage the person receiving services with motivational techniques and harm reduction strategies to promote safety and/or reduce substance use. *Note: See also program requirement 3 regarding coordination of services and treatment planning.*

Based upon the findings of the community needs assessment, input from the CCBHC Planning Grant Steering Committee, and research from all CCBHC Demonstration States DMH has identified the following minimum set of evidence-based practices required and recommended of the CCBHCs.

Commented [AS12]: Based upon the findings of the community needs assessment, input from the CCBHC Planning Grant Steering Committee, and research from all CCBHC Demonstration States DMH has identified the following minimum set of evidence-based practices required and recommended of the CCBHCs.

Required EBPs
CBT -Cognitive Behavioral Therapy
IMR - Illness Management Recovery
MI- Motivational Interviewing
SBIRT-Screening Brief Intervention and Referral
WRAP- Wellness Recovery Action Planning

Recommended EBPs
ACT- Assertive Community Treatment
CPT - Cognitive Processing Theory
DBT- Dialectical Behavior Therapy
EMDR - Eye Movement Desensitization and Reprocessing
IPS - Individual Placement and Support
TF-CBT - Trauma Focused Cognitive Behavioral Therapy
12 Step Facilitation Therapy
WHAM - Whole Health Action Management

4.f.2 Treatments are provided that are appropriate for the phase of life and development of the person receiving services, specifically considering what is appropriate for children, adolescents, transition-age youth, and older adults, as distinct groups for whom life stage and functioning may affect treatment. When treating children and adolescents, CCBHCs must provide evidenced-based services that are developmentally appropriate, youth guided, and family/caregiver-driven. When treating older adults, the desires and functioning of the individual person receiving services 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. CCBHCs are encouraged to use evidence-based strategies such as measurement-based care (MBC)25 to improve service outcomes.

4.f.3 Supports for children and adolescents must comprehensively address family/caregiver, school, medical, mental health, substance use, psychosocial, and environmental issues.

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

4.g.1 The CCBHC is responsible for outpatient 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. Prevention is a key component of primary care screening and monitoring services provided by the CCBHC. The Medical Director establishes protocols that conform to screening recommendations with scores of A and B, of the United States Preventive Services Task Force Recommendations (these recommendations specify for which populations screening is appropriate) for the following conditions:

- HIV and viral hepatitis
- Primary care screening pursuant to CCBHC Program Requirement 5 Quality and Other Reporting and Appendix B
- Other clinically indicated primary care key health indicators of children, adults, and older adults receiving services, as determined by the CCBHC Medical Director and based on environmental factors, social determinants of health, and common physical health conditions experienced by the CCBHC person receiving services population.

Measurement-based care (MBC) is the systematic use of patient-reported information to inform clinical care and shared decision-making among clinicians and patients and to individualize ongoing treatment plans: Measurement-Based Mental Health Care (va.gov).

4.g.2 The Medical Director will develop organizational protocols to ensure that screening for people receiving services who are at risk for common physical health conditions experienced by CCBHC populations across the lifespan. Protocols will include:

- Identifying people receiving services with chronic diseases;
- Ensuring that people receiving services are asked about physical health symptoms; and
- Establishing systems for collection and analysis of laboratory samples, fulfilling the
- requirements of 4.g.

In order to fulfill the requirements under 4.g.1 and 4.g.2 the CCBHC should have the ability to collect biologic samples directly, through a DCO, or through protocols with an independent clinical lab organization. Laboratory analyses can be done directly or through another arrangement with an

organization separate from the CCBHC. The CCBHC must also coordinate with the primary care provider to ensure that screenings occur for the identified conditions. If the person receiving services' primary care provider conducts the necessary screening and monitoring, the CCBHC is not required to do so as long as it has a record of the screening and monitoring and the results of any tests that address the health conditions included in the CCBHCs screening and monitoring protocols developed under 4.g.

4.g.3 The CCBHC will provide ongoing primary care monitoring of health conditions as identified in 4.g.1 and 4.g.2., and as clinically indicated for the individual. Monitoring includes the following:

- ensuring individuals have access to primary care services;
- ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions;
- coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and
- promoting a healthy behavior lifestyle.

Note: The provision of primary care services, outside of primary care screening and monitoring as defined in 4.g., is not within the scope of the nine required CCBHC services. CCBHC organizations may provide primary care services outside the nine required services, but these primary care services cannot be reimbursed through the Section 223 CCBHC demonstration PPS.

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

Criteria 4.I: Psychiatric Rehabilitation Services

4.i.1 The CCBHC is responsible for providing directly, or through a DCO, evidence-based rehabilitation services for both mental health and substance use disorders. Rehabilitative services include services and recovery supports that help individuals develop skills and functioning to facilitate community living; support positive social, emotional, and educational development; facilitate inclusion and

For more information, see Social Determinants of Health (SDOH) State Health Official (SHO) Letter (medicaid.gov).

Commented [AS13]: DMH will not require any additional ongoing primary care monitoring of health conditions identified in 4.g.1 and 4.g.2. Please note: 4.g.1 requirement of Primary care screening pursuant to CCBHC Program Requirement 5 Quality and Other Reporting and Appendix B is still required.

Commented [AS14]: DMH will not require any specific CCBHC populations for targeted case management services.

Commented [AS15]: DMH will not require any specific evidence-based or other psychiatric rehabilitation services.

integration; and support pursuit of their goals in the community. These skills are important to addressing social determinants of health and navigating the complexity of finding housing or employment, filling out paperwork, securing identification documents, developing social networks, negotiating with property owners or property managers, paying bills, and interacting with neighbors or coworkers. Psychiatric rehabilitation services must include supported employment programs designed to provide those receiving services with on-going support to obtain and maintain competitive, integrated employment (e.g., evidence-based supported employment, customized employment programs, or employment supports run in coordination with CCBHC targeted case management services are separate from and do not follow state targeted case management rules under the Medicaid state plan or waivers.

Vocational Rehabilitation or Career One-Stop services. Psychiatric rehabilitation services must also support people receiving services to:

- Participate in supported education and other educational services;
- Achieve social inclusion and community connectedness;
- Participate in medication education, self-management, and/or individual and family/caregiver psycho-education; and
- Find and maintain safe and stable housing.

Other psychiatric rehabilitation services that might be considered include training in personal care skills; community integration services; cognitive remediation; facilitated engagement in substance use disorder mutual help groups and community supports; assistance for navigating healthcare systems; and other recovery support services including Illness Management & Recovery, financial management, and dietary and wellness education. These services may be provided or enhanced by peer providers. *Note: See program requirement 3 regarding coordination of services and treatment planning.*

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

4.j.1 The CCBHC is responsible for directly providing, or through a DCO, peer supports, including: peer builders; peer specialist and recovery coaches; peer counseling; and family/caregiver supports. Peer services may include: peer-run wellness and recovery centers; youth/young adult peer support; recovery coaching; peer-run crisis respites28; warmlines; peer-led crisis planning; peer navigators to assist individuals transitioning between different treatment programs and especially between different levels of care; mutual support and self-help groups; peer support for older adults; peer education and leadership development; and peer recovery services. Potential family/caregiver support services that might be considered include: community resources education; navigation support; behavioral health and crisis support; parent/caregiver training and education; and family-to-family caregiver support. *Note: See program requirement 3 regarding coordination of services and treatment planning.*

Commented [AS16]: In addition to the federal CCBHC minimum requirements for peer supports, DMH will require peer bridgers as well to the other peer supports listed.

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

4.k.1 The CCBHC is responsible for providing directly, or through a DCO, intensive, community-based behavioral health care for certain members of the U.S. Armed Forces and veterans, particularly those Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility (MTF) and veterans living 40 miles or more (driving distance) from a VA medical facility, or as otherwise required by federal law. Care provided to veterans is required to be consistent with minimum clinical mental health guidelines promulgated by the Veterans Health

Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration. The provisions of these criteria in general and, specifically in criteria 4.k, are designed to assist the CCBHC in providing quality clinical behavioral health services consistent with the Uniform Mental Health Services Handbook. ***Note:*** *See program requirement 3 regarding coordination of services and treatment planning.*

4.k.2 All individuals inquiring about services are asked whether they have ever served in the U.S. military. Current Military Personnel: Persons affirming current military service will be offered assistance in the following manner:

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

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

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

4.k.3 The CCBHC ensures there is integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both, and for integration or coordination between care for behavioral health conditions and other components of health care for all veterans.

4.k.4 Every veteran seen for behavioral health services is assigned a Principal Behavioral Health Provider. When veterans are seeing more than one behavioral health provider and when they are involved in more than one program, the identity of the Principal Behavioral Health Provider is made clear to the veteran and identified in the health record. The Principal Behavioral Health Provider is identified on a tracking database for those veterans who need case management. The Principal Behavioral Health Provider ensures the following requirements are fulfilled:

1. Regular contact is maintained with the veteran as clinically indicated if ongoing care is required.
2. A psychiatrist or such other independent prescriber as satisfies the current requirements of the VHA Uniform Mental Health Services Handbook reviews and reconciles each veteran's psychiatric medications on a regular basis.
3. Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses

adequate decision-making capacity or with the veteran's surrogate decision maker's consent when the veteran does not have adequate decision-making capacity).

4. Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained.
5. The treatment plan is revised, when necessary.29
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. 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 Behavioral health services are recovery-oriented. The VHA adopted the National Consensus Statement on Mental Health Recovery in its Uniform Mental Health Services Handbook. SAMHSA has since developed a working definition and set of principles for recovery updating the Consensus Statement. Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The following are the 10 guiding principles of recovery:

- Hope
- Person-driven
- Many pathways
- Holistic
- Peer support
- Relational
- Culture
- Addresses trauma
- Strengths/responsibility
- Respect (See SAMHSA's definition of Recovery)

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

- Privacy
- Security
- Honor

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

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

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

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

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

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) characteristics of people receiving services;
(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) outcomes of people receiving services. Data collection and reporting requirements are elaborated below and in

Appendix B. Where feasible, information about people receiving services and care delivery should be captured electronically, using widely available standards. ***Note:*** *See criteria 3.b for requirements regarding health information systems. This is information recommended for updating in Care Coordination requirements in the current DMH Operational Standards: Part 2: Chapter 17: Individual Planning of Treatment, Services and Supports*

5.a.2 Both Section 223 Demonstration CCBHCs, and CCBHC-Es awarded SAMHSA discretionary CCBHC-Expansion grants beginning in 2022, must collect and report the Clinic-Collected quality measures identified as required in Appendix B. Reporting is annual and, for Clinic-Collected quality measures, reporting is required for all people receiving CCBHC services. CCBHCs are to report quality measures nine (9) months after the end of the measurement year as that term is defined in the technical specifications. Section 223 Demonstration CCBHCs report the data to their states and CCBHC-Es that are required to report quality measure data report it directly to SAMHSA.

Commented [AS17]: DMH required quality measures for clinic and state-level are located in Appendix B.

CCBHCs are required to report on quality measures through DCOs as a result of participating in a state CCBHC program separate from the Section 223 Demonstration, such as a program to support the CCBHC model through the state Medicaid plan.

5.a.3 In addition to data specified in this program requirement and in Appendix B, the CCBHC is to provide, other data as may be required for the evaluation to HHS and the national evaluation contractor annually. To the extent CCBHCs participating in the Section 223 Demonstration program are responsible for the provision of data, the data will be provided to the state and, as may be required, to HHS and the evaluator. CCBHCs participating in the Section 223 Demonstration program will participate in discussions with the national evaluation team and participate in other evaluation-related data collection activities as requested.

5.a.4 CCBHCs participating in the Section 223 Demonstration program annually submit a cost report with supporting data within six months after the end of each Section 223 Demonstration year to the state. The Section 223 Demonstration state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each Section 223 Demonstration year to CMS. ***Note****: In order for a clinic participating in the Section 223 Demonstration Program to receive payment using the CCBHC PPS, it must be certified by a Section 223 Demonstration state as a CCBHC.*

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

5.b.1 In order to maintain a continuous focus on quality improvement, the CCBHC develops, implements, and maintains an effective, CCBHC-wide continuous quality improvement (CQI) plan for the services provided. The CCBHC establishes a critical review process to review CQI outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance. The CQI plan should also focus on improved patterns of care delivery, such as reductions in emergency department use, rehospitalization, and repeated crisis episodes. The Medical Director is involved in the aspects of the CQI plan that apply to the quality of the medical components of care, including coordination and integration with primary care.

5.b.2 The CQI plan is to be developed by the CCBHC and addresses how the CCBHC will review known significant events including, at a minimum: (1) deaths by suicide or suicide attempts of people receiving services; (2) fatal and non-fatal overdoses; (3) all-cause mortality among people receiving CCBHC services; (4) 30 day hospital readmissions for psychiatric or substance use reasons; and (5) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.

5.b.3 The CQI plan is data-driven and the CCBHC considers use of quantitative and qualitative data in their CQI activities. At a minimum, the plan addresses the data resulting from the CCBHC-collected and, as applicable for the Section 223 Demonstration, State-Collected, quality measures that may be required as part of the Demonstration. The CQI plan includes an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and addresses how the CCBHC will use disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health disparities.

Program Requirement 6: Organizational Authority, Governance, and Accreditation

6.a.1 The 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. 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.)

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, CCBHCs shall 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 tribal members and to inform the provision of services to tribal members. 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 by an independent auditor (C.P.A.) for the duration that the clinic is designated as a CCBHC in accordance with federal audit requirements, and, where indicated, a corrective action plan is submitted addressing all findings, questioned costs, reportable conditions, and material weakness cited in the Audit Report.

6.a.4. Publish and distribute the Office of the Attorney General Medicaid Fraud Control Unit's Informational Brochure on the CCBHC's website; CCBHC facilities, and to all CCBHC engaged clients.

Publicize the way to report fraud, waste and abuse to:
Toll-free: 800-880-5920
Phone: 601-576-4162
Fax: 601-576-4161
Mailing address:
ATTN: Office of Program Integrity
550 High Street, Suite 1000
Jackson, MS 39201
Report fraud and abuse by submitting a secure online form

6.a.5. Establish written policies, procedures, and standards of conduct that articulate the CCBHC's commitment to comply with all applicable Federal and State standards subject to approval by the Department of Mental Health (DMH).

6.a.6. Comply with all federal and state requirements regarding Fraud, waste, and Abuse including but not limited to 42 C.F.R. § 455, Section 1902 (a)(68) of the Social Security Act and 42 C.F.R. § 438.608.

Commented [AS18]: DMH requirement for CCBHCs above and beyond the CCBHC federal criteria.

Commented [AS19]: DMH requirement for CCBHCs above and beyond the CCBHC federal criteria.

Commented [AS20]: DMH requirement for CCBHCs above and beyond the CCBHC federal criteria.

6.a.7. Not knowingly be owned by, hire or contract with an individual who has been debarred, suspended, or otherwise excluded from participating in federal procurement activities or has an employment, consulting, or other Agreement with a debarred individual for the provision of items and services that are related to the entity's contractual obligation with the State, in accordance with 42 C.F.R. § 438.610.

Commented [AS21]: DMH requirement for CCBHCs above and beyond the CCBHC federal criteria.

6.a.8. The CCBHC shall assign a staff member who reports directly to the Chief Executive Officer and/or the board of directors, to:

Commented [AS22]: DMH requirement for CCBHCs above and beyond the CCBHC federal criteria.

- Be responsible for all fraud and abuse detection activities, including the fraud and abuse compliance plan.
- Participate in meetings of the Division of Medicaid (DOM) Office of Program Integrity.
- Notify in writing the Division of Medicaid Office of Program Integrity in writing within thirty (30) days of the discovery of any Overpayments made by Medicaid caused by billing errors, system errors, human error, etc.
- Serve as contact for CCBHC staff who want to report any concerns with fraud, waste, and abuse.
- Be available for onsite DMH and DOM reviews, investigations related to suspected provider Fraud, Waste, and Abuse cases, and comply with requests from the Division of Medicaid to supply documentation and record

6.a.9. Annually review and submit an updated Fraud and Abuse compliance plan to DMH for approval. The CCBHC must submit its compliance plan, including Fraud and Abuse policies and procedures to the Office of Program Integrity for written approval within thirty (30) days before those plans and procedures are implemented. The compliance plan must include:

Commented [AS23]: DMH requirement for CCBHCs above and beyond the CCBHC federal criteria.

- Policies and procedures for completing annual fraud, wase, and abuse training and education for the CCBHC staff.
- Designated compliance staff and reporting procedures.
- Procedures that the CCBHC will take to monitor, audit and respond to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements.
- Effective annual training and ongoing education. CCBHC's can use resources at: Medicaid Program Integrity Educational Resources | CMS
- Lines of communication and reporting.
- Internal monitoring and auditing procedures, including service verification letters issued, collected and analyzed for 5% of Medicaid and non-Medicaid clients served.
- Enforcement of standards through well-publicized disciplinary guidelines.
- Prompt response to detected problems through corrective actions

Criteria 6.B: Governance

6.b.1 CCBHC governance must be informed by representatives of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, sexual orientation, and in terms of health and behavioral health needs. The CCBHC will incorporate meaningful participation from individuals with lived experience of mental and/or substance use disorders and their families, including youth. This participation is designed to assure that the perspectives of people receiving services, families, and people with lived experience of mental health and substance use conditions are integrated in leadership and decision-making. Meaningful participation means involving a substantial number of people with lived experience and family members of people receiving services or individuals with lived experience in developing initiatives; identifying community needs, goals, and objectives; providing input on service development and CQI processes; and budget development and fiscal decision making.

6.b.2. CCBHCs are required to submit their CCBHC governance plan to DMH annually for approval. CCBHCs will also be required to submit quarterly reporting to DMH on outcomes and results of their governance plan. DMH will evaluate the CCBHC's plan on the following criteria to ensure meaningful participation in the CCBHC's governance involving people with lived experience.

- A formal advisory committee/working group made up of a majority individuals with lived experiences, including two youth members.
- The CCBHC provides dedicated staff support to support the formal advisory committee/working group that are equivalent to the support given to the governing board.
- The formal advisory committee/working group gathers input on:
  - Community needs and goals and objectives of the CCBHC
  - Service development, quality improvement, and the activities of the CCBHC
  - Fiscal and budgetary decisions
  - Governance (human resource planning, leadership recruitment and selection, etc.)
- Protocols exist for incorporating input from the formal advisory committee/working group to the CCBHC governance.
- Governing board meeting summaries are shared with those participating and entered into the formal CCBHC governance board record.
- Members must be invited to board meetings; and representatives of the formal advisory committee/working group must have the opportunity to regularly address the board directly, share recommendations directly with the board, and have their comments and recommendations recorded in the board minutes.
- Meeting notices, recommendations and an annual summary of the recommendations from the formal advisory committee/working group on the CCBHC's website.
- Meaningful participation means involving a substantial number of people with lived experience and family members of people receiving services or individuals with lived experience in developing initiatives; identifying community needs, goals, and objectives; providing input on service development and CQI processes; and budget development and fiscal decision making.

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

Commented [AS24]: DMH selected Option 2 of the federal criteria. Under option 2, the governing board must establish protocols for incorporating input from individuals with lived experience and family members. Board meeting summaries are shared with those participating in the alternate arrangement and recommendations from the alternate arrangement shall be entered into the formal board record; a member or members of the arrangement established under option 2 must be invited to board meetings; and representatives of the alternate arrangement must have the opportunity to regularly address the board directly, share recommendations directly with the board, and have their comments and recommendations recorded in the board minutes. The CCBHC shall provide staff support for posting an annual summary of the recommendations from the alternate arrangement under option 2 on the CCBHC website.

Commented [AS25]: If option 2 is chosen, for CCBHCs not certified by the state, the federal grant funding agency will determine if this approach is acceptable, and, if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes.

6.b.4 Members of the governing or advisory boards will be representative of the communities in which the CCBHC's service area is located and will be selected for their expertise in health services, community affairs, local government, finance and accounting, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. No more than one half (50 percent) of the governing board members may derive more than 10 percent of their annual income from the health care industry.

Criteria 6.C: Accreditation

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

6.c.2 CCBHCs must be certified by DMH as a CCBHC or have submitted an attestation to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program. Clinics that have submitted an attestation to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program are designated as CCBHCs only during the period for which they are authorized to receive federal funding to provide CCBHC services. CCBHC expansion grant recipients are encouraged to seek state certification if they are in a state that certifies CCBHCs. *NOTE: State-certified clinics are designated as CCBHCs for a period of time determined by the state but not longer than three years before recertification.* DMH will decertify CCBHCs if they fail to meet the criteria, if there are changes in the state CCBHC program, or for other reasons identified by the state. DMH can use an independent accrediting body as a part of their certification process as long as it meets state standards for the certification process and assures adherence to the CCBHC Certification Criteria.

Commented [AS26]: DMH have included language on decertifying CCBHCs if they are not meeting their requirements.

6.c.3 States are encouraged to require accreditation of the CCBHCs by an appropriate independent accrediting body (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.

Appendix A. Terms and Definitions

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

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

Behavioral health: Behavioral health is a general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for mental and/or substance use disorders. [12]

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

- Establishing accountability and agreeing on responsibilities between care coordination partners.
- Engaging and supporting people receiving services in and, subject to appropriate consent, their family and caregivers, to participate in care planning and delivery and ensuring that the supports and services that the person receiving services and family receive are provided in the most seamless manner that is practical.
- Communicating and sharing knowledge and information, including the transfer of health records and prescriptions, within care teams and other care coordination partners, as allowable and agreed upon with the individual being served.
- Coordinating and supporting transitions of care that include tracking of admission and discharge and coordination of specific services if the person receiving services presents as a potential suicide or overdose risk.
- Assessment of the person receiving services needs and goals to create a proactive treatment plan and linkage to community resources.
- Monitoring and follow-up, including adapting supports and treatment plans as needed to respond to changes in the needs and preferences of individuals being served.
- Coordinating directly with external providers for appointment scheduling and follow up after appointment for any prescription changes or care needs, 'closing the loop.'
- Communicating and sharing knowledge and information to the full extent permissible under HIPAA, 42 CFR part 2, and ONC and CMS interoperability regulations on information blocking without additional requirements unless based on state law.

As used here, care coordination applies to activities by CCBHCs that have the purpose of coordinating and managing the care and services furnished to each person receiving services as required by PAMA (including both behavioral and physical health care), regardless of whether the care and services are provided directly by the CCBHC or through referral or other affiliation with care

[12] Available at Glossary of Terms and Acronyms for SAMHSA Grants | SAMHSA.

providers and facilities outside the CCBHC. Care coordination is regarded as an activity rather than a service.

Case management: Case management may be defined in many ways and can encompass services ranging from
basic to intensive. The National Association of State Mental Health Program Directors (NASMHPD) defines case management as "a range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational and other services essential to meeting basic human services; linkages and training for patient served in the use of basic community resources; and monitoring of overall service delivery". [13]See also the definition of "targeted case management."

Certified Community Behavioral Health Clinic (CCBHC) or Clinic: A CCBHC is a qualifying clinic that is responsible for providing all nine services in a manner that meets or exceeds CCBHC criteria described herein. The qualifying clinic may deliver the nine required services directly or through formal agreements with DCOs. The CCBHC must have the capacity to directly provide mental health and substance use services to people with serious mental illness and serious emotional disorders as well as developmentally appropriate mental health and substance use care for children and youth separate from any DCO relationship, unless substantially prohibited by their state because of their provider type.

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

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

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

Community Needs Assessment: A systematic approach to identifying community needs and determining program capacity to address the needs of the population being served. CCBHCs are required to collaborate with other community stakeholders to conduct an annual community needs assessment. CCBHC's are required to use, at a minimum, a standardized community needs assessment survey. CCBHCs are required to collect and report data at the county level.

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

The assessment should identify current conditions and desired services or outcomes in the community, based on data and input from key community stakeholders. Specific CCBHC criteria are tied to the community needs assessment including staffing, language and culture, services, locations, service hours and evidence- based practices. Therefore, the community needs assessment must be thorough and reflect the treatment and recovery needs of those who reside in the service area across the lifespan including children, youth, and families. If a separate community needs assessment has been completed in the past year, the CCBHC may decide to augment, or build upon the information to ensure that the required components of the community needs assessment are collected.

The community needs assessment is comprised of the following elements:

1. A description of the physical boundaries and size of the service area, including identification of sites where services are delivered by the CCBHC, including through DCOs.
2. Information about the prevalence of mental health and substance use conditions and related needs in the service area, such as rates of suicide and overdose.
3. Economic factors and social determinants of health affecting the population's access to health services, such as percentage of the population with incomes below the poverty level, access to transportation, nutrition, and stable housing.
4. Cultures and languages of the populations residing in the service area.
5. The identification of the underserved population(s) within the service area.
6. A description of how the staffing plan does and/or will address findings.
7. Plans to update the community needs assessment every 3 years.

Input with regard to:

- cultural, linguistic, physical health, and behavioral health treatment needs;
- evidence-based practices and behavioral health crisis services;
- access and availability of CCBHC services including days, times, and locations, and telehealth options; and
- potential barriers to care such as geographic barriers, transportation challenges, economic hardship, lack of culturally responsive services, and workforce shortages.

Input should come from the following entities if they are in the CCBHC service area:

- People with lived experience of mental and substance use conditions and individuals who have received/are receiving services from the clinic conducting the needs assessment;
- Health centers (including FQHCs in the service area);
- Local health departments (Note: these departments also develop community needs assessments that may be helpful);
- Inpatient psychiatric facilities, inpatient acute care hospitals, and hospital outpatient clinics;
- One or more Department of Veterans Affairs facilities;
- Representatives from local K-12 school systems; and
- Crisis response partners such as hospital emergency departments, emergency responders, crisis stabilization settings, crisis call centers and warmlines.

CCBHCs must engage also with other community partners, especially those who also work with people receiving services from the CCBHC and populations that historically are not engaging with health services, such as:

- Organizations operated by people with lived experience of mental health and substance use conditions;

- Other mental health and SUD treatment providers in the community;
- Residential programs;
- Juvenile justice agencies and facilities;
- Criminal justice agencies and facilities;
- Indian Health Service or other tribal programs such as Indian Health Service youth regional treatment centers as applicable;
- Child welfare agencies and state licensed and nationally accredited child placing agencies for therapeutic foster care service; and
- Crisis response partners such as hospital emergency departments, crisis stabilization settings, crisis call centers and warmlines.
- Specialty providers of medications for treatment of opioid and alcohol use disorders;
- Peer-run and operated service providers;
- Homeless shelters and housing agencies;
- Employment services systems;
- Services for older adults, such as Area Agencies on Aging;
- Aging and Disability Resource Centers; and
- Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs).

Cultural and linguistic competence: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse consumers.[14]

Designated Collaborating Organization (DCO): A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC to deliver one or more (or elements of) of the required services as described in criteria 4. CCBHC services provided through a DCO must conform to the relevant applicable CCBHC criteria. The formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal, legal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized. The formal relationship between CCBHCs and DCOs creates the platform for seamlessly integrated services delivered across providers under the umbrella of a CCBHC. DCO agreements shall include provisions that assure that the required CCBHC services that DCOs provide under the CCBHC umbrella are delivered in a manner that meets the standards set in the CCBHC certification criteria. To this end, DCOs are more than care coordination or referral partners, and there is an expectation that relationships with DCOs will include more regular, intensive collaboration across organizations than would take place with other types of care coordination partners.

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

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

treatment planning, information sharing, and direct communication between the CCBHC and DCO to prevent the person receiving services or their family from having to relay information between the CCBHC and DCO. CCBHCs and their DCOs are further directed to work towards inclusion of additional integrated care elements (e.g., including DCO providers on CCBHC treatment teams, collocating services). Regardless of DCO relationships entered into, the CCBHC maintains responsibility for assuring that people receiving services from the CCBHC receive all nine services as needed in a manner that meets the requirements of the CCBHC certification criteria.

In the Section 223 CCBHC Demonstration, payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. To the extent that services are needed by a person receiving services or their family that cannot be provided by either the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for care coordination including services to which it refers consumers. Payment for those referred services is not through the PPS but is made through traditional mechanisms within Medicaid or other funding sources.

Engagement: Engagement includes a set of activities connecting people receiving services with needed services and supporting their retention services. This involves the process of making sure people receiving services and families are informed about and are able to access needed services. Activities such as outreach and education can serve the objective of engagement. Conditions such as accessibility, provider responsiveness, availability of culturally and linguistically competent care, and the provision of quality care also promote consumer person receiving services engagement.

Family: Involvement of families of both adults and children receiving services is important to treatment planning, treatment, and recovery. Families come in different forms and, to the extent possible, the CCBHC should respect the individual consumer's view of what constitutes their family. Families can be organized in a wide variety of configurations regardless of social or economic status. Families can include biological parents and their partners, adoptive parents and their partners, foster parents and their partners, grandparents and their partners, siblings and their partners, extended family members, care givers, friends, and others as defined by the family. The CCBHC respects the view of what constitutes the family of the individual person receiving services.

Family-centered: The Health Resources and Services Administration defines family-centered care, sometimes referred to as "family-focused care," as "an approach to the planning, delivery, and evaluation of health care whose cornerstone is active participation between families and professionals. Family-centered care recognizes families are the ultimate decision-makers for their children, with children gradually taking on more and more of this decision-making themselves as developmentally appropriate. When care is family-centered, services not only meet the physical, emotional, developmental, and social needs of children, but also support the family's relationship with the child's health care providers and recognize the family's customs and values". [15] More recently, this concept was broadened to explicitly recognize that family-centered services should be both developmentally appropriate and youth guided. [16] Family-centered care is family-driven and youth-driven.

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

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

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

Health Information Exchange (HIE) –A Health Information Exchange (HIE) is the electronic movement of health-related information among organizations according to nationally recognized standards. The Mississippi Hospital Association (MHA) implements the statewide Mississippi HIE, IntelliTrue.

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

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

Measurement-Based Care: For purposes of these criteria, measurement-based care (MBC) is the systematic use of patient-reported information to inform clinical care and shared decision-making among clinicians and patients and to individualize ongoing treatment plans.

Peer Support Provider- a self-identified person (or family member of a person) is a person who uses their lived experience of recovery from mental or substance use disorders or as a family member/caregiver of such a person, plus skills learned in formal training, to deliver services to promote recovery and resiliency. Peer providers may have titles that may differ from state to state, e.g., certified peer specialist, peer support specialist, recovery coach, family partner, parent partner specialist. In states where Peer Support Services are covered through the state Medicaid Plans, the title of "certified peer specialist" often is used. SAMHSA recognizes states use different terminology for these providers.

Peer Support Service - Peer Support Services are non-clinical activities with a rehabilitation and resiliency/recovery focus that allow people receiving mental health services and substance use services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms, substance use issues and challenges associated with various disabilities while directing their own recovery. Peer support may be provided in behavioral health, health, and community settings, e.g., mobile crisis outreach, psychiatric rehabilitation, outpatient mental health/substance use treatment, emergency rooms, wellness programs, peer-operated programs. Peer Support is a helping relationship between peers and/or family member(s) that is directed toward the achievement of specific goals defined by the person. Peer Support Services are provided by a Certified Peer Support Specialist Professional.

Person or People Receiving Services: Within this document, person or people receiving services refers to people of all ages (i.e., children, adolescents, transition age youth, adults, and older adults) who are receiving one of the nine required services from the CCBHC (including through any DCO arrangements). Use of the term "patient" is restricted to areas where the statutory or other language is being quoted. In many places in the Certification Criteria, the person receiving services has a role in directing, expressing preferences, planning, and coordinating services. In these situations, when there is a legal guardian for the person receiving services, these roles shall also be filled by the legal guardian

Person-Centered Care is aligned with the requirements of Section 2402(a) of the Patient Protection and Affordable Care Act, as implemented by the Department of Health & Human Services Guidance to HHS Agencies for Implementing Principles of Section 2403(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs. [17]That guidance defines "person-centered planning" as a process directed by the person with service needs which identifies recovery goals, objectives and strategies. If the person receiving services wishes, this process may include a representative whom the person has freely chosen, or who is otherwise authorized to make personal or health decisions for the person. Person-centered planning also includes family members, legal guardians, friends, caregivers, and others whom the person wishes to include. Person-centered planning involves the person receiving services to the maximum extent possible. Person-centered planning also involves self-direction, which means the person receiving services has control over selecting and using services and supports, including control over the amount, duration, and scope of services and supports, as well as choice of providers. [18]

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

Recovery - a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential. The 10 guiding principles of recovery are: hope; person-driven; many pathways; holistic; peer support; relational; culture; addresses trauma; strengths/responsibility; and respect. Recovery includes: Health ("making informed healthy choices that support physical and emotional wellbeing"); Home (safe, stable housing); Purpose ("meaningful daily activities … and the independence, income and resources to participate in society"); and Community ("relationships and social networks that provide support, friendship, love, and hope"). [19]

Recovery-oriented care - Recovery-oriented care is oriented toward promoting and sustaining a person's recovery from a behavioral health condition. Care providers identify and build upon each individual's assets, strengths, and areas of health and competence to support the person in managing their condition while regaining a meaningful, constructive sense of membership in the broader community.

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[17] Department of Health & Human Services. *Guidance to HHS Agencies for Implementing Principles of Section 2403(a) of the Affordable Care Act: Standards for Person Centered Planning and Self-Direction in Home and Community-Based Services Programs* (June 6, 2014). Available at: Implementing Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs | Guidance Portal (hhs.gov).

[18] Ibid

[19] Substance Abuse and Mental Health Services Administration. *SAMHSA's Working Definition of Recovery*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012. Available at: SAMHSA's Working Definition of Recovery | SAMHSA Publications and Digital Products.

Required services: The nine service areas identified in PAMA, which CCBHCs must provide to people receiving services based on their needs (described in Program Requirement 4: Scope of Services), 1. Crisis Services; 2. Screening, Assessment, and Diagnosis; 3. Person-Centered and Family-Centered Treatment Planning; 4. Outpatient Mental Health and Substance Use Services; 5. Primary Care Screening and Monitoring; 6. Targeted Case Management Services; 7. Psychiatric Rehabilitation Services; 8. Peer Supports and Family/Caregiver Supports; and 9. Community Care for Uniformed Service Members and Veterans.

Satellite Facility: A satellite facility of a CCBHC is a facility that was established by the CCBHC, operated under the governance and financial control of that CCBHC, and provides the following services: crisis services; screening, diagnosis, and risk assessment; person and family centered treatment planning; and outpatient mental health and substance use services as specified in CCBHC certification criteria Program Requirement 4.
For CCBHCs participating in the Section 223 Demonstration only, the Protecting Access to Medicare Act of 2014 stipulates that "no payment shall be made to a satellite facility of a CCBHC established after April 1, 2014, under this Demonstration." This definition does not limit the provision of services in non-clinic settings such as shelters and schools or at other locations managed by the CCBHC that do not meet the definition of a satellite facility.

Shared Decision-Making (SDM): Shared decision-making is a best practice in behavioral and physical health that aims to help people in treatment and recovery have informed, meaningful, and collaborative discussions with providers about their health care services.
It involves tools and resources that offer objective information upon which people in treatment and recovery incorporate their personal preferences and values. Shared decision-making tools empower people who are seeking treatment or in recovery to work together with their service providers and be active in their own treatment.[20]

Sliding Fee Scale: Sliding scale fees are fees for services that are adjusted depending on an individual's income. They are set usually to allow for fairness and to address income inequality. The higher your income, the more you will pay, the lower your income, the less you will pay.

Trauma-informed: A trauma-informed approach to care realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in people receiving services, their families, staff, and others involved in the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. The six key principles of a trauma-informed approach include: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues.[21]

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

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

Appendix B

CCBHC's are required to report on these quality measures. Data specifications will be provided by DMH.

Updated 11/28/23

Clinic Level Required Measures	Measure Name and Designed Abbreviation
Clinic	Adult BMI Assessment (ABA)
Clinic	Adult Major Depressive Disorder: Suicide Risk Assessment (SRA) (SRA-C)
Clinic	CAHMI: Follow-up for children at risk for delays: proportion of children who were determined to be at significant risk for development, behavioral, or social delays who received some level of follow-up care.
Clinic	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA) (SRA-A)
Clinic	Controlling High Blood Pressure (CBP-AD)
Clinic	Depression Readmission at Six Months (DEP-REM-6)
Clinic	MEASURE DEV-CH: DEVELOPMENTAL SCREENING IN THE FIRST THREE YEARS OF LIFE. A. DESCRIPTION Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. Data Collection Method: Administrative or Hybrid.
Clinic	Mental Health Utilization (MPT). Number and percentage of Members receiving mental health services by service type (e.g., any service inpatient, intensive outpatient/partial hospitalization, outpatient or Emergency Department). For Members receiving Behavioral Health Services and enrolled in high-risk Care Management: Treatment plan: number and percentage of Members receiving Behavioral Health/Substance Use Disorder Services with a treatment plan (therapy, medications, etc.) Number of emergency department visits for Members receiving Behavioral Health/Substance Use Disorder Services.
Clinic	Prenatal and Postpartum Care: More details to be shared, but we are looking at: Postpartum Depression Screening and Follow-up (PDS). Depression Screening: The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period. Follow-Up on Positive Screen: The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.
Clinic	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (TSC)
Clinic	Screening for Clinical Depression and Follow-Up Plan (CF-CH and CDF-AD)
Clinic	Weight Assessment and Counseling for Nutrition and Physical Activity for children/Adolescents (WCC-CH)

Clinic	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)
Clinic	Screening for Social Drivers of Health (SDOH)
Clinic	Time to Services (I-SERV)

State-Collected	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
State-Collected	Antidepressant Medication Management (AMM-BH)
State-Collected	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-Ch and FUA-AD)
State-Collected	Follow-Up After Emergency Department Visit for Mental Illness (FUM-Ch and FUM-AD)
State-Collected	Follow-Up After Hospitalization for Mental Illness, ages 18+(adult) (FUH-AD)
State-Collected	Follow-Up After Hospitalization for Mental Illness, ages 6-17 (child/adolescent) (FUH-CH)
State-Collected	Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)
State-Collected	Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)
State-Collected	Initiative and Engagement of Alcohol and Other Durg Dependence Treatment (IET-AD)
State-Collected	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)
State-Collected	Patient Experience of Care Survey
State-Collected	Plan All-Cause Readmissions Rate (PCR-AD)
State-Collected	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
State-Collected	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)
State-Collected	Youth/Family Experience of Care Survey