Guidance to Planning Grant States to Apply to Participate in the Section 223 CCBHC Demonstration Program

Introduction

Planning Grants for CCBHCs are designed to support states to prepare to participate in a demonstration program as described in Section 223 of the Protecting Access to Medicare Act of 2014 (known as PAMA or "the statute"). As a recipient of a Planning Grant for CCBHCs, you are expected to submit an application to formally apply to participate in the two-year demonstration. Up to eight states may participate, and will be selected based on the quality of the applications and geographic distribution, per the statute.

Applications will be reviewed by a panel of federal subject matter experts. Based on that review, recommendations for selection will be made to federal officials of ASPE, CMS, and SAMHSA for final selection no later than December 31, 2016. This document outlines the key application materials that must be submitted, as well as clarifying the evaluation criteria that will be used to select states to participate in the demonstration.

The statute at subsection 223 (d)(4)(A) under which the program is authorized is explicit that preference must be given to selecting demonstration programs where participating CCBHCs will achieve at least one of the following:

- Provide the most complete scope of services as described in the Criteria to individuals eligible for medical assistance under the state Medicaid program; OR
- Improve availability of, access to, and participation in, services described in subsection Criteria to individuals eligible for medical assistance under the state Medicaid program; OR
- Improve availability of, access to, and participation in assisted outpatient mental health treatment in the state; OR
- Demonstrate the potential to expand available mental health services in a demonstration area and increase the quality of such services without increasing net federal spending.

This guidance is provided to clarify the criteria that federal subject matter experts will use to assess which states are most likely to achieve at least one of the above goal(s) during the demonstration program. Other criteria will be considered such as each state's readiness to participate in the program in terms of meeting the expectations of the planning grant, the state's compliance with the CCBHC Criteria (see Appendix II of the SM16-001, *Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics*) and conformance of the state's PPS to the PPS Guidance (see Appendix III of SM16-001, *Section 223*

Demonstration Programs to Improve Community Mental Health Services Prospective Payment System Guidance).

Planning Grant States must submit applications to participate in the demonstration no later than October 31, 2016, 11:59 EST. States selected to participate in the demonstration program will be announced in January 2017.

Components of the Application to Participate in the Section 223 Demonstration Program

Applications to participate in the demonstration program will be assessed on the completeness of the application and the score applied by an objective review of applications. There are three parts to this application: Required Attachments, Program Narrative, and Prospective Payment System Methodology Description. The components are described in greater detail below along with the points assigned for each section in parentheses. The total possible score is 100 for the complete application.

Part 1: Required Attachments

You must include all of the following attachments. Attachment 1 will be scored as described under Part 2, item B.

Attachment 1. Complete the attached *State's Compliance with CCBHC Criteria Checklist*. This single checklist will verify that all of the CCBHCs in your state will be certified as compliant with the CCBHC Criteria by the time of the Demonstration. Include the completed checklist as Attachment 1.

Attachment 2. Include a statement that describes the target Medicaid population(s) to be served under the demonstration program.

Attachment 3. Include a list of participating certified community behavioral health clinics including designated collaborating organizations (DCOs).

Attachment 4. Include a signed statement that verifies that the state has agreed to pay for CCBHC services at the rate established under the prospective payment system.

Attachment 5. Include a description of the scope of services required by the state in compliance with CCBHC Criteria, Scope of Services, provided by/through CCBHCs in your state, available under the state Medicaid program, and that will be paid for under one of the selected PPS methodologies either CC PPS-1 or CC PPS-2 tested in the demonstration program.

Attachment 6. Include the SAMHSA Budget Justification form from your state's original application for a Planning Grant for CCBHCs and modify it to project the amount of unexpended funds and how they will be used after January 1, 2017.

Part 2: Program Narrative

In the Program Narrative, you will describe your state's readiness to participate in the demonstration program and project the impact of participation. The Program Narrative will be scored up to a total of 80 points and may not exceed 30 pages. Each of the sections will be scored as listed below. More detailed guidance is provided in the next section.

A. Solicitation of input by stakeholders in developing CCBHCs (10 points)
B. Certification of clinics as CCBHC (20 points)
C. Development of enhanced data collection and reporting capacity (10 points)
D. Participation in the national evaluation (15 points)
E. Projection of the impact of the state's participation in the Demonstration program (25 points)

Part 3: Prospective Payment System Methodology Description

Please complete Part 3 Prospective Payment System Methodology Description, the form that is attached later in this guidance. Part 3 will be scored up to a total of 20 points. Using this form, you will describe the following:

1. CCBHC PPS Rate-Setting Methodology Options
2. Payment to CCBHCs that are FQHCs, Clinics, or Tribal Facilities
3. Cost Reporting and Documentation Requirements
4. Managed Care Considerations
5. Funding Question

Part 2: Program Narrative

In the Program Narrative, you will describe your state's readiness to participate in the demonstration program and project the impact of participation. This part will be scored up to a total of 80 points and may not exceed 30 pages.

A. (10 points) Solicitation of input by stakeholders with respect to the development of such a demonstration program from consumers, family members, providers, tribes, and other key stakeholders. Please provide the following:

- A description of the steering committee or use of an existing committee, council, or process composed of relevant state agencies, providers, service recipients, and other key stakeholders to guide and provide input throughout the grant period.

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

- A description of the coordination with other local, state, and federal agencies and tribes to ensure that services are accessible and available.

B. (20 points) Certification of CCBHCs for purposes of participating in a demonstration program, using the criteria in Appendix II of SM16-001. Reviewers will examine the state's submission of *State's Compliance with CCBHC Criteria Checklist* of this application and will rate the CCBHCs in the state as "ready to implement," "mostly ready to implement," "ready to implement with remediation" and "unready to implement."

   In addition, please provide the following:

- A description of the application processes and review procedures that you used to certify clinics as CCBHCs that demonstrates attention to quality of care, access and availability of services.

- A description of the diversity of CCBHCs including geographic area, population density, underserved areas or other data. Cite documentation including medically underserved area (MUA) designations that at least one CCBHC is located in a rural and/or underserved area.

- A description of how the state facilitated cultural, procedural, and organizational changes to CCBHCs that will result in the delivery of high quality, comprehensive,

person-centered, and evidence-based services that are accessible to the target population.

- A description of how the CCBHC needs assessment process reflects behavioral health needs and resources in the service area and addresses transportation, income, culture, and other barriers.

- A description and justification of the evidence based practices that the state has required.

- A description of the guidance to CCBHCs regarding the CCBHCs organization governance that ensures meaningful input by consumers, persons in recovery, and family members.

C. (10 points) Development of enhanced data collection and reporting capacity. Please provide the following:

- A description of the developed or enhanced data collection and reporting capacity in support of meeting PPS requirements, quality reporting requirements, and demonstration evaluation reporting requirements listed under Criteria Program Requirement 5: Quality and Other Reporting in the Criteria.

- A description of the designed or modified and implemented data collection systems—including but not limited to registries or electronic health record functionality that report on access, quality, scope of services, and costs and reimbursement for behavioral health services. A description of how the state assisted CCBHCs with preparing to use data to inform and support continuous quality improvement processes within CCBHCs, including fidelity to evidence-based practices, and person-centered, and recovery-oriented care during the demonstration.

- A description of the format of the data and when and how evaluators will be able to access this data.

D. (15 points) Participation in the national evaluation of the Demonstration Program. Please provide the following:

- A description of the capacity and willingness to assist HHS to assess the cost, quality, and scope of services provided by CCBHCs and the impact of the demonstration programs on the federal and state costs for a full range of mental health and

substance abuse services (including inpatient, emergency, and ambulatory services paid for through sources other than the demonstration program funding).

- A summary of discussions with the federal evaluation planning team regarding the selection of an appropriate comparison group for an assessment of access, quality, and scope of services available to Medicaid enrollees served by CCBHCs.

- The status of requests or planned requests for an Institutional Review Board's approval to collect and report on process and outcome data (as applicable and necessary).

E. (25 points) Project the impact of the state's participation in the Demonstration program. Please project the impact of CCBHCs in your state to achieve at least one of the goals listed below during the two year demonstration program. Use the following guidance to develop your narrative.

- Select one or more goals from the four listed below to project the impact of CCBHCs in your state. Explain the process by which you selected the goal(s) and why it is important to your state and CCBHC communities.

- List specific measures that will show the impact on the target population served by CCBHCs over the two year demonstration program period. Explain how these measures are related to the goal(s) selected.

- Provide baseline data on selected measures from the planning grant period.

- Describe your plan for data collection, documentation, tracking of outcomes, and analysis to measure progress in achieving the outcome.

- Using the selected measures, project the impact on the target population from baseline to the completion of the demonstration program and justify your projections.

  Goal 1. Provide the most complete scope of services required in the CCBHC Criteria to individuals who are eligible for medical assistance under the state Medicaid program;

  Goal 2. Improve availability of, access to, and participation in, services described in subsection (a) (2) (D) to individuals eligible for medical assistance under the State Medicaid program;

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

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

Part 3: Prospective Payment System Methodology Description

Using the following format, describe the state's prospective payment system (PPS) methodology. This part of the Guidance will be scored up to a total of 20 points and your response may not exceed 30 pages. Each section of this part of the application corresponds to the same section of the CCBHC PPS Guidance. Sections 1-4 of this form pertain to fee for service prospective payment; managed care payment is addressed in section 5.

Section 1: Introduction

Section 223 of the Protecting Access to Medicare Act of 2014 (known as PAMA or "the statute"), requires payment using a prospective payment system (PPS) for Certified Community Behavioral Health Clinic (CCBHC) services provided by qualifying clinics and related satellite sites established prior to April 1, 2014. The Centers for Medicare & Medicaid Services (CMS) offers a state the option of using either the Certified Clinic (CC) PPS (CC PPS-1) or the CC PPS alternative (CC PPS-2) demonstration-wide for payments that are either fee for service (FFS) or made through managed care payment systems. The PPS guidance (Appendix III from the Planning Grant for CCBHCs) provides information about each of the allowed PPS payment methodologies.

Section 2: CCBHC PPS Rate-Setting Methodology Options

CMS offers a state the option of either the CC PPS-1 or CC PPS-2 for use demonstration-wide. The state chooses the following methodology (select one):

☐ Certified Clinic PPS (CC PPS-1) (Continue to Section 2.1)

☐ Certified Clinic PPS (CC PPS-2) (Continue to Section 2.2)

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

The CC PPS-1 methodology is implemented as a fixed daily rate that reflects the expected cost of all CCBHC services provided on any given day to a Medicaid beneficiary. This is a cost based, per clinic rate that applies uniformly to all services rendered by a CCBHC and qualified satellite facilities established prior to April 1, 2014. The state has the option of offering Quality Bonus Payments (QBPs) that are to be paid in addition to the PPS rate to any certified clinic that achieves at least the six required measures as shown in Table 3 of the PPS guidance.

Section 2.1.a Components of the CC PPS-1 Rate Methodology

Demonstration Year One (DY1) Rate Data

In the box below explain the source(s) of cost and visit data used to determine the DY1 rate. Detail any estimates that the state used to determine allowable cost and the appropriate number of daily visits to include in the rate calculation. If more space is needed, please attach and identify the page that pertains to this section.

PPS-1 Rate Updates from DY1 to DY2

☐ The DY1 CC PPS-1 rates will be updated for DY2 by (select one):

☐ ☐ The Medicare Economic Index (MEI)

☐ Rebasing CC PPS-1 rate

If rebasing the DY2 rate to reflect DY1 cost experience, provide in the box below an explanation of the interim payment methodology[1]. Specify how the interim rate plus the DY2 rebased rate will cover the expected cost of care in DY2 and how long the interim payment will be in effect during DY2. If more space is needed, please attach and identify the page that pertains to this section.

[1] An interim rate is requested as it is likely that DY1 data will not be available to the state in time to analyze and rebase the rate for the DY2 payment.

Section 2.1.b CC PPS-1 Quality Bonus Payments (QBPs)

When using the CC PPS-1 method, a state may elect to offer a QBP to any CCBHC that has achieved all of the six required quality measures as shown in Table 3 of the PPS guidance in section 2.1. The state can make a QBP on the basis of additional measures provided in the PPS Guidance and may propose its own quality measures. Any additional state-defined measure must be approved by CMS. The state chooses to (select one):

☐ Not offer QBP(s) (Continue to Section 3)

☐ Offer QBP(s)

In the box below provide a list of the quality measures that will be used (in addition to the six required measures shown in Table 3 of the PPS guidance) for QBPs. Note any measure that is state-defined and provide a full description of the measure. If additional space is needed, please attach and identify the page that pertains to this section.

Description of Quality Bonus Payment Methodology

In the box below describe the CC PPS-1 QBP methodology, specifying (1) factors that trigger payment, (2) the methodology for making the payment, (3) the amount of the payment, and (4) how often the payment is made to CCBHCs. Also provide an annual estimate of the amount of QBP payment by demonstration year (DY) for all CCBHCs, including an estimate of the percentage of QBP payment to payment made through the PPS rate. If additional space is needed, please attach and identify the page that pertains to this section.

If Section 2.1 is completed, skip Section 2.2 and continue to Section 3.

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

The CC PPS-2 methodology is implemented as a fixed monthly rate that reflects the expected cost of all CCBHC visits provided within any given month to a Medicaid beneficiary. This is a cost-based, per clinic rate that applies uniformly regardless of the number of services rendered within the month by a CCBHC and qualified satellite facilities established prior to April 1, 2014. Under this method, separate rates are developed for both the base population and clinic users with certain conditions. As part of the rate setting CC PPS-2 methodology, outlier payments paid for costs exceeding state-defined thresholds are considered. Finally, this methodology requires the state to select quality measure(s) and make bonus payments to incentivize improvements in quality of care.

DY1 Rate Data

In the box below explain the source(s) of cost and visit data used to determine the DY1 rate. Detail any estimates that the state used to determine allowable cost and the appropriate number of daily visits to include in the rate calculation. If more space is needed, please attach and identify the page that pertains to this section.

PPS-2 Rate Updates from DY1 to DY2

The DY1 CC PPS-2 rates will be updated in DY2 by (select one):

☐ The Medicare Economic Index (MEI)

☐ Rebasing CC PPS-2 rate

If rebasing the DY2 rate to reflect DY1 cost experience, provide in the box below an explanation of the interim payment methodology[2]. Specify how the interim rate plus the DY2 rebased rate will cover the expected cost of care in DY2 and how long the interim payment will be in effect during

[2] An interim rate is requested as it is likely that DY1 data will not be available to the state in time to analyze and rebase the rate for the DY2 payment.

DY2. If more space is needed, please attach and identify the page that pertains to this section.

PPS-2 Identification of Populations with Certain Conditions

In the box below, identify populations with certain conditions for which separate PPS rates will be determined by the state and explain the criteria used to identify them. If more space is needed, please attach and identify the page that pertains to this section. Note: the populations listed below should match those shown on the sample cost report submitted by the state.

PPS-2 Outlier Payments

Outlier payments are reimbursements to clinics in addition to PPS rates for participant costs that exceed a state-defined threshold to ensure that clinics are able to meet the costs of serving their users.

In the box below provide a description of the outlier payment methodology including an explanation of the threshold for making payment and how much of total allowable cost is set aside for outlier payment; how often outlier payment is calculated; and, how often certified clinics receive outlier payment. If more space is needed, please attach and identify the page that pertains to this section.

Section 2.2.b CC PPS-2 Quality Bonus Payments

Under the CC PPS-2 method, a state *must* offer a QBP to any CCBHC that demonstrates it has achieved all of the six required quality measures as shown in Table 3 of the PPS guidance. The state can make a QBP on the basis of additional measures provided in Table 3 of the PPS guidance and may propose its own quality measures for CMS approval.

In the box below provide a list of the quality measures that will be used (in addition to the six required measures shown on Table 3 of the PPS guidance) and provide a full description of any state-defined measure. If more space is needed, please attach and identify the page that pertains to this section.

In the box below describe the CC PPS-2 QBP methodology, specifying (1) factors that trigger payment, (2) the methodology for making the payment, (3) the amount of the payment, and (4) how often the payment is made. Also provide an annual estimate of the amount of QBP payment by DY for all clinics expected to be certified, including an estimate of the percentage of QBP payment to payment made through the PPS rate. If more space is needed, please attach and identify the page that pertains to this section.

Section 3: Payment to CCBHCs that are FQHCs, Clinics, or Tribal Facilities

In some instances, a CCBHC already may participate in the Medicaid program as a Federally Qualified Health Center (FQHC), clinic services provider or Indian Health Service (IHS) facility that receives payment authorized through the Medicaid state plan. In these instances, the state should

refer to the guidance for how these Medicaid providers would be paid when a clinic user receives a service authorized under both the state plan and this demonstration.

☐ The state will require each certified clinic on its CCBHC cost report to report whether it is dually certified as a FQHC, clinic services provider or IHS facility.

Section 4: Cost Reporting and Documentation Requirements

In order to determine CCBHC PPS rates, states must identify allowable costs necessary to support the provision of services.

Section 4.1: Treatment of Select Costs

CMS provides additional guidance for the state regarding how to treat select costs, including uncompensated care, telehealth, and interpretation or translation service costs.

☐ The state excludes the cost of uncompensated care from its calculation of the CCBHC PPS.

Section 4.2: Cost Report Elements and Data Essentials

Cost Reporting

☐ The state will use the CMS CCBHC cost report and has attached a sample completed form plus an explanatory narrative that demonstrates the rate for DY1.

☐ The state will use its own cost report and has attached a sample completed form plus an explanatory narrative that demonstrates the rate for DY1.

The attached state-developed cost report template includes following key elements as specified in section 4.2 of the PPS guidance:

☐ Provider Information

☐ Direct and Indirect Cost-Identification

☐ Direct and Overhead Cost-Allocations

☐ Number of Visits

☐ Rate Calculations

Section 5: Managed Care Considerations

The statute requires payment of PPS and allows payment to be made FFS and through managed care systems for demonstration services. If the state chooses to include CCBHC service coverage in

their managed care agreements, CCBHCs must still receive the actual PPS rates, or their actuarial equivalent. The state has two options for incorporating the CCBHC rate into the managed care payment methodology: (1) fully incorporate the PPS payment into the managed care capitation rate and therefore require the managed care plan to pay the full PPS, or (2) have the managed care plans pay a rate that another provider would receive for a similar service and use a supplemental payment (wraparound) to ensure that total payment is equivalent to CCBHC PPS.

Section 5.0.a Managed Care Capitation CCBHC PPS Rate Method

☐ The PPS methodology selected in Section 2 will apply to services delivered in both managed care payment and FFS.

Section 5.0.b Building CCBHC PPS Rates into Managed Care Capitation

Explain how the state will ensure access to CCBHC services from Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), or Prepaid Ambulatory Health Plans (PAHP) through network adequacy requirements. If additional space is needed, please attach and identify the page that pertains to this section.

CMS offers states the option of using either of the following methodologies for incorporating the CCBHC rate into the managed care payment methodology (select one):

☐ Fully incorporate the PPS payment into the managed care capitation rate and require the managed care plans to pay the full PPS or its actuarial equivalent.

Explain how the state will provide adequate oversight for CCBHCs that receive the actual PPS rates or their actuarial equivalent, including provisions for special populations and outlier payments. If

additional space is needed, please attach and identify the page that pertains to this section.

OR

☐ Require the managed care plans to pay a rate to the CCBHCs that other providers would receive for similar services, then use a supplemental payment (wraparound) to ensure payment to CCBHCs is equal to the PPS.

Explain how the state will provide adequate oversight related to reconciling managed care payments with full PPS rates, including provisions for special populations and outlier payments. If additional space is needed, please attach and identify the page that pertains to this section.

Explain the frequency and timing of the wraparound payment used by the state:

Section 5.0.c PIHP and PAHP Coverage Areas in Managed Care States

☐ The state contracts with a PIHP or PAHP and intends to use these delivery systems as part of CCHBC service delivery.

Describe which managed care plans will be responsible for providing CCBHC services and what services provided in other managed care plans may duplicate the CCBHC services.

Explain the methodology for removing services that duplicate CCBHC demonstration services from the managed care plans not responsible for the CCBHC services, how managed care capitation rates will be changed, the timing/process for determining that the new managed care rates will be actuarially sound, and how the state will ensure no duplication of expenses. If additional space is needed, please attach and identify the page that pertains to this section.

If a state chooses not to include all demonstration services under one contractor, define the delineation of services between contractors. If this delineation will require a change to managed care capitation rates, explain how rates will be affected, the timing and process for determining that the new managed care rates will be actuarially sound, and how the state will ensure non-duplication of payments. If additional space is needed, please attach and identify the page that pertains to this section.

Section 5.0.d Data Reporting and Managed Care Contract Requirements

Describe the data reporting policies and processes, including specific data deliverables to be reported by each entity, collection of data, timing of reporting, and contract language for data reporting. If additional space is needed, please attach and identify the page that pertains to this section.

Section 5.0.e Identification of Expenditures Eligible for Enhanced Federal Matching Percentage (FMAP)

Describe the process whereby the state will ensure proper claiming of enhanced FMAP for CCBHC services by identifying the portion of the capitation payment(s) applicable to the new adult group rate cells and the existing managed care population associated with CCBHC services. If additional space is needed, please attach and identify the page that pertains to this section.

Funding Questions: Section 223 Behavioral Health Demonstration

The questions below should be answered relative to all payments made to CCBHCs reimbursed pursuant to Section 223 of P.L. 113-93 Protecting Access to Medicare Act of 2014[3] and the methodology described in the state's application to participate in the demonstration program.

CMS requests the following information about the source(s) of the non-federal share of payment made for demonstration services.

[3] H.R. 4302, 113th Congress. Protecting Access to Medicare Act of 2014. PL No 113092; April 2, 2014. https://www.congress.gov/bill/113th-congress/house-bill/4302

1. Section 1902(a)(2) stipulates that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

- Describe how the non-federal share of each type of Medicaid payment (e.g., basic PPS rate, outlier payment and quality bonus payments) is funded.

- Describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share.

Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or a CPE. In this case, please identify the agency to which the funds are appropriated.

- If any of the non-federal share of payment is being provided using IGTs or CPEs, fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

- If certified public expenditures (CPEs) are used, describe the methodology used by the state to verify that the total expenditures being certified are eligible for federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or intergovernmental transfers (IGTs), please provide the following:
  I. A complete list of the names of entities transferring or certifying funds
  II. The operational nature of the entity (state, county, city, other)
  III. The total amounts transferred or certified by each entity
  IV. Whether the certifying or transferring entity has general taxing authority
  V. Whether the certifying or transferring entity received appropriations (identify level of appropriations)
  VI. A cost report for CMS approval for any CPE-funded payment(s)

2. Do CCBHC providers receive and retain the total Medicaid expenditures claimed by the state for demonstration services (includes basic PPS and enhanced payments) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization?

If providers are required to return any portion of payments, provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned, and the disposition and use of the funds once they are returned to the state (e.g., general fund, medical services account, etc.).

Attachment 1. State's Compliance with CCBHC Criteria Checklist

STATE: _____

This compliance checklist includes the criteria required for the Certified Community Behavioral Health Clinics (CCBHCs) and their Designated Collaborating Organizations (DCOs) which together form the CCBHC. For each item below, write in one of the following ratings in the space provided that describes the CCBHCs readiness, as a whole in your state to implement each criteria:

1. **Ready to implement**
2. **Mostly ready to implement**
3. **Ready to implement with remediation**
4. **Unready to implement**

Program Requirement 1: Staffing

Criteria 1.A. General Staffing Requirements

1.a.1 Needs Assessment and Staffing Plan

_____CCBHCs have completed a state approved needs assessment.

_____CCBHC needs assessment addresses cultural, linguistic, treatment and staffing needs and resources of the area to be served by the CCBHCs and addresses transportation, income, culture, and other barriers.

_____CCBHC needs assessment addresses work-force shortages.

_____Consumers and family members and relevant communities (e.g., ethnic, tribal) were consulted in a meaningful way to complete the needs assessment.

_____There is recognition of the CCBHCs' obligation to update the assessment at least every 3 years.

_____The state approved a staffing plan for each CCBHC that reflects the findings of the needs assessment.

_____The state based its requirements for services at each CCBHC, including care coordination, on the needs assessment findings.

1.a.2 Staff

_____CCBHC staff (both clinical and non-clinical) is appropriate in size and composition for the population to be served by each of the CCBHCs.

_____If veterans are served by the CCBHC, staffing satisfies the requirements of criteria 4.K.

1.a.3 Management Staffing

_____CCBHC management staffing is adequate for the needs of CCBHCs as determined by the needs assessment and staffing plan.

_____CCBHCs have a management team structure with key personnel identified by name, including a CEO or Executive Director/Project Director and a Medical Director (may be the same person and Medical Director need not be full time).

_____CCBHCs that are unable to employ or contract with a psychiatrist are located in Health Resources and Services Administration (HRSA) behavioral health professional shortage areas and have documented reasonable and consistent efforts to obtain a psychiatrist as Medical Director.

CCBHC name(s):_____

_____For those CCBHCs without a psychiatrist as Medical Director, provisions are made for psychiatric consultation and a medically trained behavioral health provider with appropriate education and licensure to independently prescribe is the Medical Director.

1.a.4 Liability/Malpractice Insurance

_____CCBHCs maintain adequate liability/malpractice insurance.

Criteria 1.B. Licensure and Credentialing of Providers

1.b.1 Appropriate Licensure and Scope of Practice

_____CCBHC practitioners providing demonstration services will furnish these services within their scope of practice in accordance with all applicable federal, state, and local laws and regulations.

_____CCBHCs have policies or procedures in place to ensure continuation of licensure (non-lapse).

_____CCBHCs have formal agreements in place with their Designated Collaborating Organizations (DCOs), ensuring the DCO staff members serving CCBHC consumers also have appropriate licensure.

1.b.2 Required Staffing

_____CCBHC staffing plans meet requirements of the state behavioral health authority and any accreditation or other standards required by the state and identify specific staff disciplines that are required.

_____CCBHC staffing plans require 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, naltrexone and other medications used to treat opioid and alcohol use disorders.

_____CCBHC staffing plans require credentialed substance abuse specialists.

_____CCBHC staffing plans require individuals with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI).

_____CCBHC staffing plans require other disciplines that can address needs identified by the needs assessment.

_____CCBHCs have taken steps to alleviate workforce shortages where they exist.

Criteria 1.C. Cultural Competence and Other Training

1.c.1 Training Plans

_____CCBHC training plans realistically address the need for culturally competent services given the needs identified in the needs assessment.

_____CCBHC training plans require the following training at orientation and annually thereafter: (1) risk assessment, suicide prevention and suicide response; and (2) the roles of families and peers.

_____CCBHC training plans require the following training at orientation and thereafter as needed: (1) cultural competence; (2) person-centered and family-centered, recovery-oriented, evidence-based and trauma-informed care; (3) integration of primary care and behavioral health care; and (4) a continuity plan.

_____CCBHCs have policies or procedures in place to implement this training, ensure the competence of trainers and trainees, and keep track of training by employee.

_____If active duty military and/or veterans are served, CCBHC cultural competency training includes information related to military culture.

1.c.2 – 1.c.4 Skills and Competence

_____CCBHCs have written policies and procedures that describe the methods used for assessing skills and competencies of providers.

_____CCBHC in-service training and education programs are provided.

_____CCBHCs maintain a list of in-service training and educational programs provided during the previous 12 months.

_____CCBHCs maintain documentation of completion of training and demonstration of competencies within staff personnel records.

_____Individuals providing training to CCBHC staff have the qualifications to do so as evidenced by their education, training, and experience.

Criteria 1. D. Linguistic Competence

1.d.1 – 1.d.4 Meaningful Access

_____If the CCBHCs serve consumers with Limited English Proficiency (LEP) or with language based disabilities, the CCBHCs take reasonable steps to provide meaningful access to their services for such consumers.

_____CCBHCs interpretation and translation service(s) (e.g., bilingual providers, onsite interpreter, and language telephone line) are appropriate and timely for the size and needs of the LEP CCBHC consumer population identified in the needs assessment.

_____CCBHC interpreters are trained to function in a medical setting.

_____CCBHC auxiliary aids and services are readily available and responsive to the needs of consumers with disabilities (e.g., sign language interpreters, teletype [TTY] lines).

_____On the basis of the findings of the CCBHCs needs assessment, documents or messages vital to a consumer's ability to access CCBHC services (e.g., registration forms, sliding-scale fee discount schedule, after-hours coverage, and signage) are available for consumers in languages common in the community served. The documents take into account the literacy levels of the community as well as the need for alternative formats (e.g., for consumers with disabilities), and they are provided in a timely manner.

_____CCBHC consumers are made aware of resources designed to provide meaningful access.

1.d.5 Meaningful Access and Privacy

_____CCBHC policies have explicit provisions for ensuring that all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider, including but not limited to the requirements of the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records), patient privacy requirements specific to care for minors, and other state and federal laws.

_____CCBHC consumer consent documentation is regularly offered, explained, and updated.

_____CCBHCs satisfy the requirements of privacy and confidentiality while encouraging communication between providers and family of the consumer.

Provide the pertinent criteria number and explain any response with a rating higher than 1.

Program Requirement 2: Availability and Accessibility of Services

Criteria 2.A. General Requirements of Access and Availability

2.a.1-2.a.8 Access and Availability Generally

_____CCBHCs take measures to ensure provision of a safe, functional, clean, and welcoming environment for consumers and staff.

_____CCBHCs comply with all relevant federal, state, and local laws and regulations regarding client and staff safety, cleanliness, and accessibility.

_____CCBHC outpatient clinic hours include some night and weekend hours and meet the needs of the population served.

_____CCBHC locations are accessible to the consumer population being served.

_____CCBHCs provide transportation or transportation vouchers for consumers as resources allow.

_____CCBHCs plan to use mobile in-home, telehealth/telemedicine, and/or online treatment services, where appropriate, and have either sufficient experience or preparation to do so effectively.

_____CCBHCs engage in outreach and engagement activities to assist consumers and families to access benefits and services.

_____CCBHC services are aligned with state or county/municipal court standards for the provision of court-ordered services.

_____CCBHCs have adequate continuity of operations/disaster plans in place.

_____ CCBHCs provide available and accessible services that will accommodate the needs of the population to be served as identified in the needs assessment.

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

2.b.1 Timing of Screening, Evaluation and Provision of Services to New CCBHC Consumers[4]

_____For new CCBHC consumers with an initial screening identifying an urgent need, the CCBHC complies with either: (1) the criteria requirement that clinical services and initial evaluation are to be provided/completed within 1 business day of the time the request is made, or (2) a more stringent state standard of _____.

_____For new CCBHC consumers with an initial screening identifying routine needs, the CCBHC complies with either: (1) the criteria requirement that clinical services and initial evaluation are to be provided/completed within 10 business days, or (2) a more stringent state standard of _____.

_____For new consumers, the state either: (1) uses the criteria requirement that a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation be completed within 60 calendar days of the first request for services, or (2) has a more stringent time standard of _____.

_____CCBHCs have in place policies and/or procedures for new consumers that include administration of a preliminary screening and risk assessment to determine acuity of needs in accordance with state standards.

[4] Also see Criteria 4.D, related to the content of these evaluations.

_____CCBHCs have in place policies and/or procedures for conducting: (1) an initial evaluation, and (2) a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation in accordance with state standards.

_____CCBHCs have in place policies and/or procedures to ensure immediate, appropriate action, including any necessary subsequent outpatient follow-up if the screening or other evaluation identifies an emergency or crisis need.

_____CCBHCs have in place policies and/or procedures for initial evaluations that are conducted telephonically that require the initial evaluation to be reviewed and the consumer to be seen in person at the next encounter, once the emergency is resolved.

2.b.2 Updating Comprehensive Person-Centered and Family-Centered Diagnostic and Treatment Planning Evaluation[5]

_____CCBHC treatment teams update the comprehensive person-centered and family-centered diagnostic and treatment planning evaluation, in agreement with and endorsed by the consumer and in consultation with the primary care provider (if any), when changes in the consumer's status, responses to treatment, or goal achievement have occurred

_____Assessment (1) must be updated no less frequently than every 90 calendar days; (2) has a more stringent time standard of ____ days; or (3) has an existing less stringent time standard that is acceptable. If the third option is chosen, the time standard and the justification for using it are described below.

_____.

2.b.3 Timing of Services for Established Consumers

_____CCBHCs comply with the state standard for established CCBHC consumers seeking an appointment for routine needs. The state standard may be either: (1) uses the criteria requirement that outpatient clinical services for established CCBHC consumers seeking an appointment for routine needs are provided within 10 business days of the requested date for service and, for those presenting with an urgent need, within 1 business day of the request, (2) has a more stringent time standard of ____ days, or (3) has an existing less stringent time standard that is acceptable. If the third option is chosen, the time standard and the justification for using it are:

_____.

[5] See criteria 3.D and 4.E for other requirements related to the treatment planning process.

_____CCBHCs have in place policies and/or procedures for established CCBHC consumers who present with an emergency/crisis need, that include options for appropriate and immediate action.

Criteria 2.C. Access to Crisis Management Services[6]

_____CCBHCs provide crisis management services that are available and accessible 24 hours a day and required to be delivered within 3 hours.

_____CCBHCs have policies or procedures in place requiring communication to the public of the availability of these services, as well as to consumers at intake, and that the latter is provided in a way that ensures meaningful access.

_____CCBHCs have policies or procedures in place addressing: (1) coordination of services when consumers present to local emergency departments (EDs); (2) involvement of law enforcement when consumers are in psychiatric crisis; and (3) reducing delays in initiating services during and after a consumer has experienced a psychiatric crisis.

_____CCBHCs are required to work with consumers at intake and after a psychiatric emergency or crisis to create, maintain and follow a crisis plan.

Criteria 2.D. No Refusal of Services Due to Inability to Pay

_____CCBHCs have a policy that services cannot be refused because of inability to pay.

_____CCBHCs have policies or procedures that ensure (1) provision of services regardless of ability to pay; (2) waiver or reduction of fees for those unable to pay; (3) equitable use of a sliding fee discount schedule that conforms to the requirements in the criteria; and (4) provision of information to consumers related to the sliding fee discount schedule, available on the website, posted in the waiting room, and provided in a format that ensures meaningful access to the information.

Criteria 2.E. Provision of Services Regardless of Residence

_____CCBHCs have a policy that services cannot be refused due to residence.

_____CCBHCs have in place policies or protocols addressing services for those living out of state.

_____CCBHCs have policies or procedures ensuring: (1) services will not be denied to those who do not live in the catchment area (if there is one), including provision of crisis services,

[6] See criteria 4.C regarding content of crisis services and 3.a.4 regarding crisis planning in the context of care coordination.

provision of other services, and coordination and follow-up with providers in the individual's catchment area; and (2) services will be available for consumers living in the CCBHC catchment area but who are distant from the CCBHC.

Provide the pertinent criteria number and explain any response with a rating higher than 1.

Program Requirement 3: Care Coordination[7]

Criteria 3.A. General Requirements of Care Coordination

_____CCBHCs coordinate care across the spectrum of health services, including access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person.

_____CCBHCs have procedures in place that comply with HIPAA, 42 CFR Part 2, requirements specific to minors, and other privacy and confidentiality requirements of state or federal law addressing care coordination and in interactions with the DCOs,

_____CCBHCs have policies and/or procedures in place to encourage participation by family members and others important to the consumer in care coordination, subject to privacy and confidentiality requirements and subject to consumer consent.

_____CCBHCs have policies and procedures in place to assist consumers and families of children and adolescents in obtaining appointments and keeping the appointment when there is a referral to an outside provider, subject to privacy and confidentiality requirements and consistent with consumer preference and need.

_____CCBHCs have procedures for medication reconciliation with other providers.

[7] If the answer to any question is "No," please provide justification at the end of the program requirement checklist.

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

_____CCBHCs have health information technology (HIT) systems in place that (1) include EHRs; (2) can capture demographic information, diagnoses, and medication lists; (3) provide clinical decision support; and (4) can electronically transmit prescriptions to the pharmacy.

_____CCBHC HIT systems allow reporting on data and quality measures required by the criteria.

_____CCBHCs have plans in place to use the HIT system to conduct activities such as population health management, quality improvement, disparity reduction, outreach and research.

_____If a CCBHC HIT system is being newly established, it is certified to accomplish the activities above; to send and receive the full common data set for all summary of care records; to support capabilities including transitions of care, privacy, and security; and to meet the *Patient List Creation* criterion (45 CFR §170.314(a)(14)) established by the Office of the National Coordinator (ONC) for ONC's Health IT Certification Program.

_____CCBHCs recognize the requirement to have a plan in place by the end of the 2-year demonstration program, focusing on ways to improve care coordination between the CCBHCs and DCOs using HIT. The plan should include how the CCBHC can support electronic health information exchange to improve care transitions to and from the CCBHC using the HIT system they have or are developing related to transitions of care.

Criteria 3.C. Care Coordination Agreements

CCBHCs are expected to work towards formal agreements (contract, Memorandum of Agreement (MOA), or Memorandum of Understanding (MOU)) during the time of the demonstration project but should at least have some informal agreement (letter of support, letter of agreement, or letter of commitment) with each entity at certification. The agreement must describe the parties' mutual expectations and responsibilities related to care coordination.

_____CCBHCs have an agreement in place with ***Federally Qualified Health Centers (FQHCs) and, where relevant, Rural Health Clinics (RHCs)***, unless health care services are provided by the CCBHC.

_____CCBHCs have protocols for care coordination with other primary care providers when they are the provider of health care for consumers.

_____CCBHCs have an agreement in place with ***Inpatient psychiatric treatment***, with ambulatory and medical ***detoxification, post-detoxification step-down services, and residential programs***.

_____CCBHCs have provisions for tracking consumers admitted to and discharged from these facilities (unless there is a formal transfer of care).

_____CCBHCs have protocols for transitioning consumers from EDs and these other settings to a safe community setting, including transfer of medical records, prescriptions, active follow-up, and, where appropriate, a plan for suicide prevention and safety, and for provision of peer services.

_____CCBHCs have an agreement in place with ***Community or regional services, supports, and providers***. These include the following specified in the statute: schools; child welfare agencies; juvenile and criminal justice agencies and facilities including drug, mental health, veterans and other specialty courts; Indian Health Service (IHS) youth regional treatment centers; state licensed and nationally accredited child placing agencies for therapeutic foster care service; and other social and human services. Also noted in the criteria as potentially relevant are the following: specialty providers of medications for treatment of opioid and alcohol dependence; suicide/crisis hotlines and warm lines; other IHS or tribal programs; homeless shelters; housing agencies; employment services systems; services for older adults, such as Aging and Disability Resource Centers; and other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs).

_____CCBHCs have an agreement in place with the nearest ***Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department***

- _____CCBHCs explored agreements with each of the facilities of different types that are nearby.

_____CCBHCs have an agreement in place with ***inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers***.

- _____CCBHCs have provisions for tracking consumers admitted to and discharged from these facilities (unless there is a formal transfer of care from a CCBHC).

- _____CCBHCs have procedures and services for transitioning consumers from EDs and these other settings to CCBHC care, for shortened lag time between assessment and treatment, and for transfer of medical records, prescriptions, active follow-up.

- _____CCBHCs have care coordination agreements that require coordination of consent and follow-up within 24 hours, continuing until the consumer is linked to

services or is assessed as being no longer at risk, for consumers presenting to the facility at risk for suicide.

- _____CCBHCs make and document reasonable attempts to contact all consumers discharged from these settings within 24 hours of discharge.

Criteria 3.D. Treatment Team, Treatment Planning and Care Coordination Activities[8]

_____CCBHC treatment planning includes the consumer, the family of child consumers, and, if the consumer chooses, the adult consumer's family or others designated by the consumer.

_____CCBHC treatment planning and care coordination are person-centered and family-centered.

_____CCBHC treatment planning and care coordination comply with HIPAA and other privacy and confidentiality requirements.

_____CCBHCs coordinate care provided by DCOs.

_____CCBHCs designate interdisciplinary treatment teams composed of individuals who work together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of CCBHC consumers that may include traditional approaches to care for consumers who may be American Indian or Alaska Native as appropriate for the individual's needs.

_____CCBHCs provide recovery support needs of CCBHC consumers, including, as appropriate, traditional approaches to care for consumers who may be American Indian or Alaska Native.

Provide the pertinent criteria number and explain any response with rating higher than 1.

[8] See criteria 2.b.2 and 4.E related to other aspects of treatment planning.

Program Requirement 4: Scope of Services[9]

Criteria 4.A. General Service Provisions

_____CCBHCs directly provide, at a minimum, the four required services.

_____CCBHC formal agreements with DCOs in the state make clear that the CCBHC retains ultimate clinical responsibility for CCBHC services provided by DCOs.

_____All required CCBHC services, if not available directly through the CCBHC, are provided through a DCO.

_____CCBHC consumers have freedom to choose providers within the CCBHC and its DCOs.

_____CCBHC consumers have access to CCBHC grievance procedures, including for CCBHC services provided by a DCO.

_____With regard to CCBHC or DCO services, the grievance process satisfies the minimum requirements of Medicaid and other grievance requirements such as those that may be mandated by relevant accrediting entities.

_____CCBHC services provided by DCOs meet the same quality standards as those required of the CCBHC.

Criteria 4.B. Person-Centered and Family-Centered Care

_____CCBHCs and its DCOs are person-centered, family-centered, and recovery oriented, being respectful of the individual consumer's needs, preferences, and values, and ensuring both consumer involvement and self-direction of services received.

_____The services that CCBHCs and its DCOs provide for children and adolescents are family-centered, youth-guided, and developmentally appropriate.

_____CCBHC services are culturally appropriate, as indicated in the needs assessment.

Criteria 4.C. Crisis Behavioral Health Services[10]

_____The following services are explicitly included among CCBHC services that are provided directly or through an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services: (1) 24 hour mobile crisis teams, (2) emergency crisis intervention services, (3) crisis stabilization services, (4) suicide crisis

[9] If the answer to any question is "No," please provide justification at the end of the program requirement checklist.

[10] See criteria 2.C regarding access to crisis services.

response, and (5) services for substance abuse crisis and intoxication, including ambulatory and medical detoxification services.

_____Crisis services are provided by CCBHCs or by an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services. Please indicate how crisis services are provided.

- _____The CCBHCs directly
- _____An existing system or network with which the CCBHCs have a formal agreement. Describe the existing system.

_____

Criteria 4.D. Behavioral Health Screening, Assessment, and Diagnosis[11]

_____CCBHCs directly provide behavioral health screening, assessment, and diagnosis, including risk assessment, in the state.

_____The state requires that all of the following (derived from the Appendix A quality measures) occurs: (1) tobacco use: screening and cessation intervention; (2) unhealthy alcohol use: screening and brief counseling; (3) child and adolescent major depressive disorder suicide risk assessment; (4) adult major depressive disorder suicide risk assessment; and (5) screening for clinical depression and follow-up plan.

_____CCBHCs' initial evaluation of consumers includes the following: (1) preliminary diagnoses; (2) source of referral; (3) reason for seeking care, as stated by the consumer or other individuals who are significantly involved; (4) identification of the consumer's immediate clinical care needs related to the diagnoses for mental and substance use disorders; (5) a list of current prescriptions and over-the-counter medications, as well as other substances the consumer may be taking; (6) an assessment of whether the consumer is a risk to self or to others, including suicide risk factors; (7) an assessment of whether the consumer has other concerns for their safety; (8) assessment of need for medical care (with referral and follow-up as required); (9) a determination of whether the person presently is or ever has been a member of the U.S. Armed Services; and (10) such other assessment as the state may require as part of the initial evaluation.

- _____Describe additional requirements (if any) established by the state, based on the population served, for the initial evaluation.

[11] See criteria 2.B regarding timing of evaluations and assessments.

_____

_____CCBHCs regularly obtain release of information consent forms as feasible as part of the initial evaluation.

_____Licensed behavioral health professionals, performing within the state's scope of practice and working in conjunction with the consumer as members of the treatment team, complete a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation within 60 days of the first request for services by new CCBHC consumers.

_____CCBHCs meet applicable state, federal or applicable accreditation standards for comprehensive diagnostic and treatment planning evaluations

_____CCBHCs conduct screening, assessment and diagnostic services in a timely manner as defined by the state and in a time period responsive to consumers' needs.

_____CCBHC screening, assessment and diagnostic services are sufficient to assess the need for all services provided by the CCBHCs and their DCOs.

_____CCBHCs use standardized and validated screening and assessment tools, and, where appropriate motivational interviewing techniques.

_____CCBHCs use culturally and linguistically appropriate screening tools.

_____CCBHCs use tools/approaches that accommodate disabilities (e.g., hearing disability, cognitive limitations), when appropriate.

_____CCBHCs conduct a brief intervention and provide or refer the consumer for full assessment and treatment if screening identifies unsafe substance use including problematic alcohol or other substance use.

Criteria 4.E. Person-Centered and Family-Centered Treatment Planning[12]

_____CCBHCs directly provide person-centered and family-centered treatment planning in the state.

- _____Describe additional state requirements, if any, based on the population served, as to what must be included in person-centered and family-centered treatment planning within the CCBHC care system.

  _____

[12] See criteria 2.b.2 and 3.D regarding other aspects of treatment planning.

_____CCBHCs provide for collaboration with and endorsement by (1) consumers, (2) family members or caregivers of child and adolescent consumers, and (3) to the extent adult consumers wish, adult consumers' families.

_____CCBHCs use individualized treatment planning that includes shared decision-making; addresses all required services; is coordinated with the staff or programs needed to carry out the plan; includes provision for monitoring progress toward goals; is informed by consumer assessments; and considers consumers' needs, strengths, abilities, preferences, and goals, expressed in a manner capturing consumers' words or ideas and, when appropriate, those of consumers' families/caregivers.

_____CCBHCs seek consultation for special emphasis problems and the results of such consultation are included in the treatment plan.

_____CCBHCs document consumers' advance wishes related to treatment and crisis management or consumers' decisions not to discuss those preferences.

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

_____CCBHCs directly provide outpatient mental health and substance use services.

_____CCBHCs provide state identified evidence-based or best practices outpatient mental health and substance use services.

_____CCBHCs make available specialized services for purposes of outpatient mental and substance use disorder treatment, through referral or formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine services.

_____CCBHCs provide evidenced-based services that are developmentally appropriate, youth guided, and family or caregiver driven to children and adolescents.

_____CCBHCs consider the individual consumer's phase of life, desires and functioning and appropriate evidenced-based treatments.

_____CCBHCs consider the level of functioning and appropriate evidenced-based treatments when treating individuals with developmental or other cognitive disabilities.

_____CCBHCs deliver treatment by staff with specific training in treating the segment of the population being served.

_____CCBHCs use approaches when addressing the needs of children that comprehensively address family/caregiver, school, medical, mental health, substance abuse, psychosocial, and environmental issues.

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

_____CCBHCs are responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk and that care is coordinated. If primary care screening and monitoring are offered by a DCO(s), the CCBHCs have a formal agreement with the DCO(s).

_____CCBHCs are collecting and reporting the following (derived from the Appendix A quality measures) : (1) adult body mass index (BMI) screening and follow-up; (2) weight assessment and counseling for nutrition and physical activity for children and adolescents; (3) care for controlling high blood pressure; (4) diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications; (5) diabetes care for people with serious mental illness: Hemoglobin A1c (HbA1c); (6) metabolic monitoring for children and adolescents on antipsychotics; (7) cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications; and (8) cardiovascular health monitoring for people with cardiovascular disease and schizophrenia.

_____CCBHCs ensure that children receive age appropriate screening and preventive interventions including, where appropriate, assessment of learning disabilities, and older adults receive age appropriate screening and preventive interventions.

Criteria 4.H. Targeted Case Management Services

_____CCBHCs are responsible for high quality targeted case management services that will assist individuals in sustaining recovery, and gaining access to needed medical, social, legal, educational, and other services and supports. If targeted case management services are offered by a DCO(s), the CCBHCs have a formal agreement with the DCO(s).

_____The state established requirements, based on the population served, as to what targeted case management services must be offered as part of the CCBHC care system, including identifying target populations. The population(s) targeted is (are)

_____

Criteria 4.I. Psychiatric Rehabilitation Services

_____CCBHCs are responsible for evidence-based and other psychiatric rehabilitation services. If psychiatric rehabilitation services are offered by a DCO(s), the CCBHCs have a formal agreement with the DCO(s).

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

_____CCBHCs are responsible for peer specialist and recovery coaches, peer counseling, and family/caregiver supports. If peer support, peer counseling and family/caregiver support services are offered by a DCO(s), the CCBHCs have a formal agreement with the DCO(s).

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

_____CCBHCs are responsible for intensive, community-based behavioral health care for certain members of the U.S. Armed Forces and veterans, particularly those Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility (MTF) and veterans living 40 miles or more (driving distance) from a VA medical facility, or as otherwise required by federal law. The state has demonstrated efforts to facilitate the provision of intensive community-based behavioral health services to veterans and active duty military personnel.

_____CCBHC care provided to veterans is 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.

_____CCBHCs ask and document asking all individuals inquiring about services, whether they have ever served in the U.S. military. For those affirming current or former service in the U.S. military CCBHCs either direct them to care or provide care through the CCBHC as required by criterion 4.k.2.

_____CCBHCs offer assistance with enrollment in the VHA for the delivery of health and behavioral health services to persons affirming former military service.

_____CCBHCs provide coordination between the care of substance use disorders and other mental health conditions for veterans and active duty military personnel who experience both, to the extent those services are appropriately provided by the CCBHC in accordance with criteria 4.k.1 and 4.k.2.

_____CCBHCs provide for integration and coordination of care for behavioral health conditions and other components of health care for all veterans and active duty military personnel who experience both, to the extent those services are appropriately provided by the CCBHC in accordance with criteria 4.k.1 and 4.k.2.

_____CCBHCs assign a Principal Behavioral Health Provider to every veteran seen, unless the VHA has already assigned a Principal Behavioral Health Provider.

_____CCBHCs provide care and services for veterans that are recovery-oriented, adhere to the guiding principles of recovery, VHA recovery, and other VHA guidelines.

_____CCBHC staff who work with military or veteran consumers are trained in cultural competence, and specifically military and veterans' culture.

_____CCBHCs develop a behavioral health treatment plan for all veterans receiving behavioral health services compliant with provisions of Criteria 4.K.

Provide the pertinent criteria number and explain any response with a rating higher than 1.

Program Requirement 5: Quality and Other Reporting[13]

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

_____The state has the capacity to annually report any data or quality metrics required of it, including but not limited to CCBHC-level Medicaid claims and encounter data. The data include a unique consumer identifier, unique clinic identifier, date of service, CCBHC service, units of service, diagnosis, Uniform Reporting System (URS) information, pharmacy claims, inpatient and outpatient claims, and any other information needed to provide data and quality metrics required in Appendix A of the criteria. Data are reported through the Medicaid Management Information System (MMIS/T-MSIS).

_____The state has capacity to provide Treatment Episode Data Set (TEDS) data and other data that may be required by HHS and the evaluator.

_____CCBHCs evidence the ability (for, at a minimum, all Medicaid enrollees) to collect, track, and report data and quality metrics as required by the statute, criteria, and PPS guidance, and as required for the evaluation and annually submit a cost report with supporting data within six months after the end of each demonstration year to the state.

[13] If the answer to any question is "No," please provide justification at the end of the program requirement checklist.

_____CCBHCs have policies and procedures in place requiring and enabling annual submission of the cost report within 6 months after the end of the demonstration year.

_____CCBHCs have formal arrangements with the DCOs to obtain access to data needed to fulfill their reporting obligations and to obtain appropriate consents necessary to satisfy HIPAA, 42 CFR Part 2, and other requirements.

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

_____CCBHCs have written CQI plans that satisfy the requirements of the criteria and have been reviewed and approved by the state as part of certification.

_____CCBHC's CQI plans specifically address (1) consumer suicide attempts and deaths, (2) 30-day hospital readmissions, and (3) whether the state has required that the plans address any other state-specific subjects; if so, these subjects include the following: _____.

Provide the pertinent criteria number and explain any response with a rating higher than 1.

Program Requirement 6: Organizational Authority, Governance, and Accreditation[14]

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

_____CCBHCs organizational authority is among those listed in the statute and criteria.

_____CCBHCs not operated under or in collaboration with the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, reached out to these entities within their geographic service area and entered into arrangements with them to assist in the provision of services to and to inform the provision of services to AI/AN consumers.

[14] If the answer to any question is "No," please provide justification at the end of the program requirement checklist.

_____The CCHBCs have a procedure for an annual financial audit and correction plan, when the latter is necessary.

Criteria 6.B. Governance

_____CCBHCs board members are representative of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, and sexual orientation, and in terms of types of disorders. The CCBHCs incorporate meaningful participation by adult consumers with mental illness, adults recovering from substance use disorders, and family members of CCBHC consumers through the options listed below. Identify which method was used to certify the CCBHCs. If more than one option was used in the state, please identify the CCBHC to which the option applies.

- _____51 percent of the board are families, consumers or people in recovery from behavioral health conditions. The CCBHC has described how it meets this requirement or developed a transition plan with timelines appropriate to its governing board size and target population to meet this requirement that is satisfactory to the state.

- _____A substantial portion of the governing board members meet this criteria and other specifically described methods for consumers, people in recovery and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services. The state has reviewed and approved and documented its approval of the proportion of the governing board members and methods to obtain meaningful input to the board.

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

Provide the pertinent criteria number and explain any response with a rating higher than 1.