

Indiana Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria



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Overview of Indiana CCBHC Certification Criteria

The State has defined requirements for becoming a Certified Community Behavioral Health Clinic (CCBHC) in Indiana during the Demonstration Program. The following Certification Criteria are the State's initial requirements for CCBHCs and will be continuously, iteratively refined in collaboration with stakeholders including all prospective CCBHCs.

The State's Certification Criteria are meant to serve as a floor, not a ceiling. During the certification/designation process, prospective CCBHCs will demonstrate how they meet the Criteria as a minimum, and how they will or plan to go beyond the Criteria to meet needs in their community.

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Program Requirement 1: General Staffing Requirements

This program requirement describes:

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

Criteria 1.A: General Staffing Requirements

1.a.1 As part of the process leading to certification/designation, recertification/redesignation, and before certification/designation or attestation, a community needs assessment and a staffing plan that is responsive to the community needs assessment are completed and documented. The needs assessment and staffing plan will be updated regularly, but no less frequently than every 3 years. The community needs assessment should be submitted to the Division of Mental Health and Addiction (DMHA) to receive certification/designation.

Additional community needs assessment requirements include:

- Community needs assessment updated every 3 years and submitted with re-certification/re-designation documentation
- Describe population that will be served
- Describe how access (including hours and service locations) will be responsive to community need
- Identify community partners that the CCBHC engages with or has a Memorandum of Understanding (MOU) or other Contractual Agreement with
- Collect information on disabilities
- List ways the CCBHC is currently able to address specific populations or community needs specific to their area
- List areas the CCBHC cannot meet due to limited staff, hours, location, or other factors, as well as plans to outsource or contract with a DCO to address these areas
- Address what staff positions currently exist and what positions will need to be created and/or filled to meet CCBHC requirements
- Survey undocumented population and underserved and historically marginalized individuals within the mental health and substance use space

1.a.2 The CCBHC submits a list of staffing (position and number of staff) in its application for certification/designation. 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. The CCBHC must share the CEO and Medical Director information with DMHA as part of the certification/designation process.

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.

Note: If a CCBHC is unable, after reasonable efforts, to employ or contract with a psychiatrist as Medical Director, a medically trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law, 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.a.4 The CCBHC maintains liability/malpractice insurance adequate for the staffing and scope of services provided.

Criteria 1.B: Licensure and Credentialing of Providers

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

Pursuant to the requirements of the statute (PAMA § 223 (a)(2)(A)), CCBHC providers must have and maintain all necessary state-required licenses, certifications, or other credentialing. When CCBHC providers are working toward licensure, appropriate supervision must be provided in accordance with applicable state laws.

All DCOs that the CCBHC contracts with must be currently certified or designated when applicable in their field of service, such as Addictions Service Provider. The CCBHC must document the relationship with a DCO with an MOU or other contractual arrangement and will inform DMHA as part of the certification/designation process.

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. The CCBHC must inform DMHA of all staffing information and licensure as part of the certification/designation process.

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, but are not limited to, a combination of the following: (1) psychiatrists (including general adult psychiatrists and subspecialists), (2) nurses (including LPNs and RNs), (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, (13) community health workers, (14) licensed addiction counselors, and (15) staff who have the time and ability to assist individuals navigating financial needs, housing needs, and service transition needs (ex: navigators,

peers). Staff should reflect the communities identified in the CCBHC's needs assessment in lived experiences, cultures, and identities.

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.

Additional staff requirements include:

- Navigator position: Staff member with the time and ability to help individuals receiving services navigate the CCBHC process, barriers, and service offerings. The position must align with the services referenced above in Item 15.

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

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 annually thereafter, the CCBHC must provide training on:

- Evidence-based practices as defined by the State during demonstration
- Cultural competency and awareness (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

- Risk assessment (ex: suicide risk, homicidal risk, etc.)
- Suicide and overdose prevention and response, suicide prevention EBPs, policies and procedures for responding after a suicide death, suicide risk assessment training
- Safety planning training
- The roles of family and other informal supports
- The roles of Certified Peer Support Professionals
- Confidentiality and privacy requirements

Trainings may be provided on-line. Training logs must be kept and made available for QI auditing purposes.

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, the HHS Office of Minority Health, or through the website of the Health Resources and Services Administration.

Cultural Awareness is the recognition of one's own cultural influences and understanding how clients' culture, beliefs, and values affect their perceptions, understanding of mental health, and their relationship with their service provider. To provide culturally responsive treatment services, counselors, other clinical staff, and organizations need to become aware of their own attitudes, beliefs, biases, and assumptions about others. Providers need to invest in gaining cultural knowledge of the populations that they serve and obtaining specific cultural knowledge as it relates to help-seeking, treatment, and recovery. This dimension also involves competence in clinical skills that ensure delivery of culturally appropriate treatment interventions. This language was inspired by *TIP 59: Improving Cultural Competency Quick Guide for Clinicians* (<https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4931.pdf>).

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 records that the training and demonstration of competency are successfully completed. CCBHCs are required to provide ongoing coaching and supervision to ensure initial and ongoing compliance with, or fidelity to, evidence-based, evidence-informed, and promising practices, as defined by the State during demonstration. Training logs, supervision and ongoing coaching schedules should be documented and described, as stated in the CCBHC continuous quality improvement (CQI) plan. Staff personnel records will be kept and made available for QI auditing purposes.

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. The CCBHC is required to provide meaningful access to language services if a need for such services is addressed in the Needs Assessment. The State recommends utilizing the Office of Healthy Opportunity's manual for language access for LEP.

1.d.2 The CCBHC is required to have access to interpretation/translation service(s) that 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.

The CCBHC is required to have written translations of vital documents for each eligible LEP language group as identified by and in alignment with a State-approved accreditation body.

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/designation, 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. The CCBHC is required to upload all policies at certification/designation to DMHA's identified location.

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, inclusive, and welcoming environment for staff and people receiving services, conducive to the provision of services identified in program requirement 4. CCBHCs are encouraged to operate tobacco-free campuses and as required by State contracts. CCBHCs must align with standards provided by a State-approved accreditation body.

2.a.2 Informed by the community needs assessment, the CCBHC ensures that all services are provided during times that facilitate accessibility and meet the needs of the population served by the CCBHC, including outside of standard business

hours, such as some evening and weekend hours. In addition, crisis response services will be available through the CCBHC 24 hours per day, 7 days a week.

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 preferred by the person receiving services and family, in the homes of people receiving services. The preferred location of the person receiving services will be honored when safe. Other additional allowable sites for CCBHC services include but are not limited to group homes and nursing facilities. Services are restricted to those activities not billable or included into a payment structure or per diem by Medicaid.

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. The CCBHC will assist the person receiving services in navigating transportation access, including but not limited to sharing relevant phone numbers and websites to schedule transportation. The CCBHC will document in the treatment plan and address transportation barriers for the person receiving services, if applicable.

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 best practices and the preferences of the person receiving services to support access to all required services. The CCBHC shall adhere to State telehealth guidelines.
All listed and related technologies must adhere to the same in-person confidentiality guidelines that are outlined in Criteria 3.a.2.

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 develops and maintains 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.

The CCBHC is required to respond to disasters or public calamities as defined by IC 10-14-3-1. The CCBHC will designate a primary and secondary point of contact who can be contacted to coordinate their organization's available staff when planning for or responding to a disaster or mass violence event. The contact information for the primary and secondary point of contact must be shared with DMHA.

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 (routine, urgent, or emergent). 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.

- The preliminary triage must be completed during the first contact.
- Based on preliminary triage, the initial evaluation request is offered within 24 hours for emergent needs, one business day for urgent needs, and within 10 business days for routine needs unless the person receiving services chooses otherwise.
- A comprehensive evaluation must occur within 60 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.

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.

Please note that the State does not anticipate same or next day access will be achieved by the CCBHC immediately. Required staffing changes (including new and unfilled positions) to ensure same or next day access must be included in the Community Needs Assessment and PPS rate calculations.

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, changes in individual status, changes in level of care, and/or at the request of the person receiving services or their legal guardian. The treatment plan must be reviewed and updated no less frequently than every 90 days, 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 with an appointment within 10 business days of the request, unless the person receiving services chooses otherwise. 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 or hospital discharge, 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. Open access scheduling is encouraged.

Discharge planning from outpatient or emergent care settings (e.g., hospitals, jail-based, residential facilities) is encouraged to occur while the individual is at the respective facility.

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

2.c.1 In accordance with program requirement 4.c and 2.a.2, the CCBHC provides crisis management services that are available and accessible 24 hours a day, seven days a week. Crisis management services include but are not limited to mobile crisis teams and Crisis Receiving Stabilization services.

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. The CCBHC is required to align methods with SAMHSA best practices and state code.

Sample postvention services include but are not limited to: local community Local Outreach to Suicide Survivors (LOSS), suicide loss support groups, and Alternatives to Suicide Peer Support Groups.

2.c.3 Individuals who are served by the CCBHC are educated about crisis prevention planning and safety planning, psychiatric advanced directives, and how to access crisis services, including the 988 Suicide & Crisis Lifeline (by call, chat, or text) and other area hotlines and warmlines, and overdose prevention, at the time of the initial evaluation meeting following the preliminary triage. Please see 3.a.4. for further information on crisis prevention planning. This includes but is not limited to individuals with LEP (limited English proficiency), individuals with disabilities, older adults, and others with dually diagnosed psychiatric and developmental 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), including Acute Psych 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 and the court system (drug courts, veteran courts, problem solving courts, etc.), 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. The CCBHC is recommended to have protocols that include the Justice Reinvestment Advisory Council (JRAC) or other local justice advisory groups as a collaboration partner.

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 prevention plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises.

The crisis prevention plan should include but is not limited to: 988 crisis response system information, evidence of participation of person receiving services, and information and resources about supports (please see criterion 3.a.4 for more details on crisis prevention planning requirements). Once finalized, a copy of the crisis prevention plan should be shared with the person receiving services and their relevant caregiver/support person when possible and with permission.

Crisis prevention plans should be completed at initial evaluation to gather information around triggers leading to mental health crisis or substance use crisis, signs of mental health or substance use crisis, coping skills, informal supports, formal supports, and other related topics.

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). People seeking services should be able to receive behavioral health care and crisis response services regardless of their ability to pay, what service provider they work with, and other personal information including diagnoses, age, and history.

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/format 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. In compliance with federal and state policies, the CCBHC must share necessary medical records with the new provider if a person receiving services changes providers and consents to sharing information.

All listed and related technologies must adhere to the same in-person confidentiality guidelines that are outlined in Criteria 3.a.2.

Program Requirement 3: Care Coordination

This program requirement describes:

- 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

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.

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 at time of treatment plan review and/or as needed.

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.

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. The CCBHC must follow up with the person receiving services or their parent/guardian to ensure they were able to access services they were referred to, including external referral sources. The CCBHC must document follow-up services in the patient's record.

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 prevention plan with each person receiving

services. At minimum, people receiving services should be counseled about the use of the National Suicide & Crisis Lifeline (988), local hotlines, warmlines, mobile crisis, stabilization services, and Recovery Hubs peer recovery supports (211) should a crisis arise when providers are not in their office. Crisis prevention plan specifics are detailed in Criteria 2.c.6.

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. If the person receiving services is on methadone treatment, the CCBHC must connect with the Opioid Treatment Program (OTP) to adequately provide services.

3.a.6 Nothing about a CCBHC's agreements for care coordination should limit the freedom of a person receiving services and/or their parent/guardian to choose their provider within the CCBHC, with its DCOs, or with any other provider. The CCBHC must include language around freedom of choice, as part of the patient's rights documents. This language shall include that a person receiving services has the freedom to choose their provider and to change their provider, without having to specify a reason.

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. The CCBHC must agree to interact with 988 state-owned software for mobile crisis dispatch and Crisis Receiving and Stabilization Services providers and outpatient follow-up referral.

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. 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.

The CCBHC is expected to share data with the State in accordance with the requirements set forth in its contractual agreement to provide CCBHC services.

3.b.3 The CCBHC uses technology that has been certified to current criteria¹³ 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/designation criteria and standards) that align with key clinical practice and care delivery requirements for CCBHCs:

- Capture health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status (as feasible).
- At a minimum, support care coordination by sending and receiving summary of care records.
- 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.
- Provide evidence-based clinical decision support.
- Conduct electronic prescribing.

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

3.b.4 The CCBHC will work with DCOs to ensure all steps are taken, including obtaining consent from people receiving services, to comply with privacy and confidentiality requirements. These include, but are not limited to, those of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.

3.b.5 The CCBHC develops and implements a plan within two-years from CCBHC certification/designation 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.

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 utilize evidence-based practices to provide inpatient psychiatric treatment, OTP services, medical withdrawal management facilities and ambulatory medical withdrawal management providers for substance use disorders, residential substance use disorder treatment programs, school-based mental and behavioral health services, and/or social work services (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 (including a plan if the person receiving services is not being referred or receiving additional care), 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; the CCBHC may utilize guidance documents from the State for such partnerships if they exist. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.

3.c.3

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

- Schools and Local Education Agencies (LEAs)
- 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, where applicable
- State licensed and nationally accredited child placing agencies for therapeutic foster care service
- Other social and human services
- Local Outreach to Suicide Survivors Teams (LOSS)

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

- Suicide and crisis hotlines and warmlines
- Indian Health Service or other tribal programs
- Homeless shelters or other housing supports
- Housing agencies
- Employment services systems
- Peer-operated programs
- 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
- 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, LGBTQ+ centers or organizations)

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

The State may require CCBHCs to establish additional partnerships based on the Community Needs Assessment.

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. The CCBHC is required to have partnerships with a training provider who utilizes evidence-based and cultural fluency practices for those who are active or have served in the military.

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. The interdisciplinary team should meet at a cadence that aligns with the person receiving service's treatment planning updates, in accordance with the treatment plan cadence, or at the request of the person receiving services. It is expected that care provided is person-centered, strengths based, wellness focused, and trauma-informed.

The CCBHC may determine how to best staff their interdisciplinary team and which functions staff carry out. The interdisciplinary team must include staff that address short-term and long-term support/care coordination, medication management, medical needs, access to peer services, and/or coordination with other services and supports.

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

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

Program Requirement 4: Scope of Services

This program requirement describes the nine services delivered by the CCBHC directly or through its DCOs, in a manner reflecting person-centered and family-centered care:

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
9. Community Care for Uniformed Service Members and Veterans

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 the Protecting Access to Medicare Act (PAMA). The CCBHC organization will directly deliver the majority (51% or more) of encounters across the required service (excluding Crisis Services) rather than through DCOs. 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. All DCOs that the CCBHC contracts with must be currently certified or designated when applicable in their field of service. The CCBHC must document the relationship with a DCO with an MOU or other contractual arrangement, and will inform DMHA as part of the certification/designation process.

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. The CCBHC must include language around freedom of choice, as part of the patient's rights documents.

The CCBHC is required to document services they directly provide and then services they link with a DCO to provide. This information must be available online, in paper, and highly accessible.

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.

The CCBHC must develop a grievance procedures client guide that explains processes, procedures, and client rights (including, but not limited to switching providers and filing a grievance). The client guide must be written in an accessible and easy to understand manner, and available in multiple languages and modalities. The CCBHC is required to post the CCBHC grievance policies in highly visible and accessible places.

The CCBHC must display information about the DMHA consumer service line, disability rights hotline, and other relevant resources, as part of patient's rights documents. This information must be available online, in paper, and posted in highly visible and accessible places.

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.

The CCBHC must receive consent from the person receiving services and/or their legal guardian. Criteria 4.b.1 must be included as part of patient's rights documents and be posted in high visibility areas.

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.

The CCBHC must include language around person-centered and family-centered care, as part of the patient's rights documents. Person-centered and family-centered care is responsive to the person receiving services and includes care which recognizes and respects the individual's cultural and other needs.

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.

The State must request approval from HHS to certify CCBHCs 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.

PAMA requires provision of these three crisis behavioral health services, whether provided directly by the CCBHC or by a DCO. The CCBHC must develop and document procedures on how they provide the three crisis behavioral services below:

- **Emergency crisis intervention services:** The CCBHC 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 (90 minutes 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 90-minute 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.

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.

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. All relationships with a DCO or other consultation organization must be documented by the CCBHC.

When necessary and appropriate screening, assessment and diagnosis can be provided through telehealth/telemedicine services. All screening tools must be evidence-based. Multiple tools may be used such as screening suicide risk and violence risk. Other screening tools and assessments may be used to measure progress and outcomes, as well as level of care (*i.e.*, LOCUS).

4.d.2 Screening, assessment, and preliminary diagnosis are conducted in a time frame responsive to the needs and preferences of the person receiving services and meeting other CCBHC criteria for emergent, urgent, and routine appointments. They 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 schools, child welfare, and/or juvenile justice)

The initial evaluation is conducted by a licensed Master's degree level clinician, licensed clinician, or clinical trainee.

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 gather information for a treatment plan and crisis prevention plan. The comprehensive evaluation must be completed within 60 days of initial evaluation. Providers that oversee the treatment plan are required to see the person receiving services and family/legal guardian again, if applicable, or review the documentation to certify the treatment and specific treatment methods at intervals not to exceed 90 days, unless the state, federal, or applicable accreditation standards are more stringent. These reviews must be documented in writing. 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 health- related social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status.
3. A description of cultural and environmental factors that may affect the treatment plan of the person receiving services, including the need for linguistic services or supports for people with LEP.
4. Pregnancy and/or caregiver 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), substance use disorders (including tobacco, alcohol, and other drugs), and gambling.
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, 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.

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 the State defined required and recommended Quality Metrics, Evidence Based Practices, Assessments and Screeners. The CCBHC should not take non-inclusion of a specific metric in the pre-approved defined list 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. The CCBHC must use State-approved screening and assessment tools.

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. The CCBHC should utilize interpreters when possible, pursuant to their community's needs. Interpreters must be fluent in English and the relevant non-English language, and meet the remaining qualifications outlined in Criteria 1.d.2.

4.d.8 If the preliminary triage 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 prevention 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 treatment plan will document how identified transportation barriers will be addressed, if applicable. The treatment plan must clearly demonstrate evidence for diagnoses and address which EBPs will be employed for said diagnoses. 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. An initial treatment plan is required within 60 days of first contact. The initial evaluation must be completed at first visit, with background information submitted during screening.

Providers that oversee the treatment plan are required to see the person receiving services and family/legal guardian again, if applicable, or review the documentation to certify the treatment and specific treatment methods at intervals not to

exceed 90 days, unless the state, federal, or applicable accreditation standards are more stringent. These reviews must be documented in writing.

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 for relevant topics including but not limited to: eating disorders, traumatic brain injury, intellectual and developmental disabilities (I/DD), interpersonal violence, human trafficking, school-based wellbeing, and school-based social emotional supports.

The CCBHC must document any external consultation relationships.

4.e.7 The person's health record documents any advance directives related to treatment and crisis prevention 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 prevention plan with each person receiving services.

Consistent with the criteria in 4.e.1 through 4.e.7, the State may specify other aspects of person-centered and family-centered treatment planning that will be required based upon the needs of the population served. Treatment planning components that should be included as appropriate are: prevention; community inclusion and support (housing, employment, social supports); involvement of family/caregiver and other supports; recovery planning; and the need for specific services required by the statute (i.e., care coordination, physical health services, peer and family support services, targeted case management, psychiatric rehabilitation services, tailored treatment to ensure culturally and linguistically appropriate services).

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

4.f.1 The CCBHC directly, or through a DCO, provides outpatient behavioral health care, including psychopharmacological treatment. The CCBHC or the DCO must provide evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for adults, children, and families. SUD treatment and services shall be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 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.

The State expects that CCBHC utilizes evidence-based and promising practices when possible across its services. The State has established a minimum set of evidence-based practices required of the CCBHCs and optional, recommended evidence-based practices as part of the Demonstration Program.

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

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) 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. Examples of supports include, but are not limited to: crisis services, screening diagnosis & risk assessments, psychiatric rehabilitation services, outpatient primary care screening and monitoring, outpatient mental health and substance use services, person- and family-centered care planning, peer family support and counselor services, and/or targeted case management.

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. The CCBHC ensures that the person receiving services receives an initial outpatient primary care screening and is accurately monitored for physical health conditions including, at a minimum, diabetes, heart disease, obesity, tobacco and vaping usage, and chronic obstructive pulmonary disease (COPD). The CCBHC will make every attempt to connect the person receiving services with a primary care physician (PCP), either directly through the CCBHC, through consult or contract with local PCP or pediatrician, or their established PCP or pediatrician. All connection attempts must be documented.

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
- 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.

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:

1. Ensuring individuals have access to primary care services;
2. Ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions;
3. Coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and
4. Promoting a healthy behavior lifestyle.

may elect to require specific other screening and monitoring to be provided by the CCBHCs in addition to the those described in 4.g.

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 Services¹

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

¹ CCBHC targeted case management services are separate from and do not follow state targeted case management rules under the Medicaid state plan or waivers.

goes beyond the care coordination that is a basic expectation for all people served by the CCBHC. CCBHC targeted case management services should include but are not limited to the following services:

1. 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.
2. During other critical periods, such as episodes of homelessness or transitions to the community from jails or prisons.
3. For individuals 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.

Based upon the needs of the population served, states should specify the scope of other CCBHC targeted case management services that will be required, and the specific populations for which they are intended.

The state will develop and specify required targeted case management scope and populations during the demonstration program. Additional details of service and delivery definitions for targeted case management will be further defined in the CCBHC demonstration handbook.

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 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 co- workers.²⁷ 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 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.

The State may specify which evidence-based and other psychiatric rehabilitation services will be required based upon the needs of the population served above the minimum requirements described in 4.i.

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 specialist and recovery coaches, peer counseling, and family/caregiver supports. Peer services may include: peer-run wellness and recovery centers; youth/young adult peer support; recovery coaching; peer-run crisis respites; warmlines; peer-led crisis prevention 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.

Requirements for certified peer specialists include (please refer to criteria 3.d.2 for additional details on requirements for peer support professionals and the interdisciplinary team):

1. Scope of services peers provide must be reflective of Community Needs Assessment
2. Partake in interdisciplinary team, crisis prevention planning, treatment planning, and other related activities

3. Serve within service lines that require related engagement, outreach, and other activities
4. Scope of peer specialists must be distinguishable from life skills training providers and case management services

The number of certified peer specialists must be 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.

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. The CCBHC is

required to provide direct services and/or conduct a warm handoff to an eligible TRICARE-authorized provider, network, or non-network that can provide such services.

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. The Principal Behavioral Health Provider must have specific training around military and veteran culture and/or lived experience as a veteran or in the military. 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.
6. The principal therapist or Principal Behavioral Health Provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2).
7. The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the Principal Behavioral Health Provider suspects the veteran lacks the capacity to make a decision about the mental health treatment plan, the provider must ensure the veteran's decision-making capacity is formally assessed and documented. For veterans who are determined to lack capacity, the provider must identify the authorized surrogate and document the surrogate's verbal consent to the treatment plan.

4.k.5 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

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. Training must be completed annually.
2. All staff receive cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity. Training must be completed annually.

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.

Program Requirement 5: Quality and Data

This program requirement describes:

- a. Data collection, reporting, and tracking
- b. Continuous quality improvement planning

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. CCBHCs are responsible for collecting data from DCOs providing services on their behalf. All data collection and reporting is required to be shared with the State of Indiana to meet State or federal requirements.

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 for all people receiving CCBHC services. 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.

The State requires the CCBHC to collect the required Clinic-Collected Quality Metrics and support the State's collection of the State-Collected Metrics. The CCBHC is required to follow SAMHSA, State, and CMS technical guidelines that are updated and published for existing and any additional future measures added by SAMHSA or the State.

5.a.3 In addition to the State- and Clinic-Collected quality measures described above, Section 223 Demonstration program states may be requested to provide CCBHC- identifiable Medicaid claims or encounter data to the evaluators of the Section 223 Demonstration program annually for evaluation purposes. These data also must be submitted to CMS through T-MSIS in order to support the state's claim for enhanced federal matching funds made available through the Section 223 Demonstration program. At a minimum, Medicaid claims and encounter data provided by the state to the national evaluation team, and to CMS through T-MSIS, should include a unique identifier for each person receiving services, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. Clinic site identifiers are very strongly preferred. All data collection and reporting are required to be shared with the State of Indiana to meet State or federal requirements.

In addition to data specified in this program requirement that the Section 223 Demonstration state is to provide, the state will 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. CCBHC states are required to submit cost reports to CMS annually including years where the state's rates are trended only and not rebased. 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/designated by the State (if the State is selected to participate in the Section 223 Demonstration Program).

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. This information will be made available to DMHA for quality review purposes.

A center which has applied for certification/designation or which has been certified must provide information related to services as requested by the division and must participate in the division's quality assurance program. A center must respond to a request from the division as fully as it is capable. Failure to comply with a request from the division may result in termination of a center's certification/designation.

5.b.2 The CCBHC develops, implements, and puts into policy a CQI plan that 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 and Governance

This program requirement describes:

1. Organizational Authority and Financing
2. Governance

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

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

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

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

6.a.2 To the extent CCBHCs are not operated under the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, 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 for the duration that the clinic is designated as a CCBHC in accordance with federal audit requirements, and, where indicated, a corrective action plan is submitted addressing all findings, questioned costs, reportable conditions, and material weakness cited in the Audit Report.

Criteria 6.B: Governance

6.b.1 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.³² CCBHCs reflect substantial participation by one of two options:

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

Option 2: Other means are established to demonstrate meaningful participation in board governance involving people with lived experience (such as creating an advisory committee that reports to the board). The CCBHC provides staff support to the individuals involved in any alternate approach that are equivalent to the support given to the governing board. Under option 2, individuals with lived experience of mental and/or substance use disorders and family members of people receiving services must have representation in governance that assures input into:

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

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. Board meeting summaries and the annual summary of recommendations must be available for auditing purposes by DMHA.

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

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.

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

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

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. The demographics of the needs assessment results should be reflected in the governing board. The governing board should be made of at least 51% of individuals with lived or living experience in outpatient mental health or substance use services as a person receiving services or a family member, considering different intersections with underserved and historically marginalized individuals within the mental health and substance use space.

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/designation, or accreditation to provide these services. The CCBHC will adhere to any applicable state accreditation, certification/designation, 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 their state 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/designation if they are in a state that certifies CCBHCs. The CCBHC must be recertified every three years.

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: Indiana CCBHC Evidence-Based Practices

Indiana has selected ten (10) mandatory and thirteen (13) recommended evidence-based practices (EBPs) for use by CCBHCs during the Demonstration Program. CCBHCs will implement, at a minimum, the required EBPs. This initial list of EBPs may be iteratively refined in collaboration with stakeholders based on information gathered throughout the Demonstration Program.

Table 1: Indiana CCBHC Required Evidence-Based Practices

Evidence-Based Practice	Population Indicated	Status
Assertive Community Treatment (ACT)	Adults	Required
Behavior Management Strategies*	All Populations	Required
Brief Strategic Family Therapy (BSFT)	Children and Adolescents	Required
Cognitive Behavioral Therapy (CBT)	All Populations	Required
Dialectical Behavior Therapy (DBT)	Adults and Adolescents	Required
Integrated Dual Diagnosis Treatment (IDDT)	Adults	Required
Integrated Community Based Treatment*	Children and Adolescents	Required
Motivational Interviewing (MI)	All Populations	Required
Parent Management Training (PMT)	Children	Required
Trauma-Focused CBT (TF-CBT)	All Populations	Required

* Indicates general categories of best practice interventions; CCBHCs may implement services that meet the needs of the populations served.

Table 2: Indiana CCBHC Recommended Evidence-Based Practices

Evidence-Based Practice	Population Indicated	Status
Cognitive Behavior Intervention for Therapy in Schools (CBITS)	Children and Adolescents	Recommended
Cognitive Behavioral Therapy for Obsessive Compulsive Disorder	All Populations	Recommended
Cognitive Behavioral Therapy for Psychosis (CBTp)	Adults and Adolescents	Recommended
Coordinated Specialty Care for First Episode Psychosis	Adults and Adolescents	Recommended
Eating Disorder Treatment*	All Populations	Recommended
Functional Family Therapy	Adolescents	Recommended
Illness Management and Recovery (IMR)	Adults	Recommended
Matrix Model	Adults	Recommended
Multisystemic Therapy (MST)	Adolescents	Recommended
Parent Child Interaction Therapy (PCIT)	Children	Recommended
Seeking Safety	Adults and Adolescents	Recommended
Solution-Focused Brief Therapy	All Populations	Recommended
START Model	All Populations	Recommended

* Indicates general categories of best practice interventions; CCBHCs may implement services that meet the needs of the populations served.

Appendix B: Indiana CCBHC Quality Metrics

Indiana is requiring seven (7) Clinic-Collected Metrics and fourteen (14) State-Collected Metrics during the Demonstration Program. These metrics are critical to help the State track the growth of the behavioral health system, delivery of services, and outcomes achieved through the CCBHC expansion.

Table 1: Clinic-Collected Metrics

This section includes the quality metrics that each CCBHC will be required to collect and report on.

Quality Metric	Description
Time To Services (I-SERV)	Replaces I-EVAL, includes average time to: Initial Evaluation, Initial Clinical Services, and Crisis Services
Depression Remission at Six Months (DEP-REM-6)	Percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission six months (+/- 60 days) after an index event date
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	Percentage of consumers aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user
Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD)	Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter
Screening for Social Drivers of Health (SDOH)	Percentage of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	Percentage of consumers aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user
Suicide Risk Assessment	Clinics must utilize at least one of the following suicidality risk assessments: 1) Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA): Percentage of consumer visits for those consumers aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk

Quality Metric	Description
	<p>2) Adult Major Depressive Disorder: Suicide Risk Assessment (SRA): Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified</p> <p>3) Ask Suicide-Screening Questions (ASQ): A brief (20-second) assessment that healthcare professionals can administer in a variety of settings (emergency department, inpatient medical unit, primary care clinics) to gauge suicide risk in patients. The toolkit website explains how to administer and respond to screening test results</p> <p>4) Suicide Assessment Five-Step Evaluation and Triage (SAFE-T): An assessment that can be used by mental health professionals during their first contact with an individual at risk of suicidal behavior and completed suicide. The five-step assessment includes identification of risk and protective factors; conducting an inquiry about suicidality; determining level of risk and selecting an appropriate intervention; and documenting the process, including a follow-up plan</p> <p>5) Columbia Suicide Severity Rating Scale (C-SSRS): Supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs</p>

Table 2: State-Collected Metrics

This section includes the quality metrics that the State will collect and report on during the Demonstration Program. CCBHCs will be expected to work with the State to accurately capture and report each metric in this section.

Quality Metric	Description
Patient Experience of Care Survey	Annual completion and submission of Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey, identifying results separately for BHCs and comparison clinics and oversampling those clinics
Youth/Family Experience of Care Survey	Annual completion and submission of Youth/Family Services Survey for Families (YSS-F) Experience of Care Survey, identifying results separately for BHCs and comparison clinics and oversampling those clinics
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	Percentage of consumers ages 19 to 64 during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period
Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)	Percentage of discharges for consumers age 21 and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported: <ul style="list-style-type: none"> Percentage of discharges for which the consumer received follow-up within 30 days of discharge Percentage of discharges for which the consumer received follow-up within 7 days of discharge
Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)	Percentage of discharges for children and adolescents ages 6-17 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported: <ul style="list-style-type: none"> Percentage of discharges for which children received follow-up within 30 days of discharge Percentage of discharges for which children received follow-up within 7 days of discharge
Initiation and Engagement of Alcohol and Other Drug	Percentage of consumers age 13 and older with a new episode of alcohol or other drug (AOD) dependence who received the following:

Quality Metric	Description
Dependence Treatment (IET-AD)	<ul style="list-style-type: none"> Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis Initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit
Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH & FUM-AD)	<p>Percentage of emergency department (“ED”) visits for consumers 6 years of age and older with a primary diagnosis of mental illness, who had an outpatient visit, an intensive outpatient encounter or a partial hospitalization for mental illness. Two rates are reported:</p> <ul style="list-style-type: none"> Percentage of ED visits for which the consumer received follow-up within 30 days of the ED visit Percentage of ED visits for which the consumer received follow-up within 7 days of the ED visit
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD)	<p>Percentage of ED visits for consumers 13 years of age and older with a primary diagnosis of alcohol or other drug (AOD) dependence, who had an outpatient visit, an intensive outpatient encounter or a partial hospitalization for AOD. Two rates are reported:</p> <ul style="list-style-type: none"> Percentage of ED visits for which the consumer received follow-up within 30 days of the ED visit Percentage of ED visits for which the consumer received follow-up within 7 days of the ED visit
Plan All-Cause Readmissions Rate (PCR-AD)	<p>For consumers age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. Data are reported in the following three categories:</p> <ul style="list-style-type: none"> Count of Index Hospital Stays (IHS) (denominator) Count of 30-Day Readmissions (numerator) Readmission Rate
Antidepressant Medication Management (AMM-AD)	<p>Percentage of consumers age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported:</p> <ul style="list-style-type: none"> Effective Acute Phase Treatment: Percentage of consumers who remained on an antidepressant medication for at least 84 days (12 weeks)

Quality Metric	Description
	<ul style="list-style-type: none"> Effective Continuation Phase Treatment: Percentage of consumers who remained on an antidepressant medication for at least 180 days (6 months)
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)	<p>Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:</p> <ul style="list-style-type: none"> Initiation Phase: Percentage of children ages 6 to 12 as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. Continuation and Maintenance (C&M) Phase: Percentage of children ages 6 to 12 as of the PSD with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	<p>Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year.</p> <p>This metric includes a Total rate as well as four separate rates representing the following four types of FDA-approved drug products:</p> <ul style="list-style-type: none"> Buprenorphine Oral naltrexone Long-acting, injectable naltrexone Methadone
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment

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Quality Metric	Description
Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)	<p>Percentage of members 18-75 years of age in the measurement year with a diagnosis of diabetes (Type 1 and Type 2) whose hemoglobin A1c was at the following levels during the measurement year:</p> <ul style="list-style-type: none">• HbA1c control (<8.0%)• HbA1c poor control (>9.0%) (inverted rate)