MI Certified Community Behavioral Health Clinic (CCBHC) Handbook

Version 1.4

Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging Services Administration

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The purpose of this Handbook is to provide Medicaid program policy, clinical and financial operations, and systems/IT guidance to the providers participating in Michigan's CMS CCBHC Demonstration.

Note: The information included in this Handbook is subject to change.

Contents

Preface

The Michigan Department of Health & Human Services (MDHHS) created the CCBHC Handbook to provide Medicaid policy and billing guidance to providers participating in Michigan's CMS CCBHC Demonstration. Most broadly, this handbook will provide detailed instructions that will help providers complete and submit documentation necessary for policy adherence and billing completion. The handbook will also provide links to additional information where necessary.

MDHHS requires that all providers participating in CCBHC Demonstration be familiarized with all Medicaid policies and procedures prior to rendering services to beneficiaries. This includes policies and procedure currently in effect in addition to those issued in the future.

While it is the intent of MDHHS to keep this handbook as updated as possible, the information provided throughout is subject to change. All current and future policies and procedures will be maintained on the MDHHS CCBHC website listed below. Finally, this handbook should not be construed as policy for the CCBHC Demonstration.

The handbook will be maintained on the CCBHC website here: www.michigan.gov/ccbhc

1. Introduction to the Certified Community Behavioral Health Clinic (CCBHC) Demonstration

1.A. Background of CCBHCs in Michigan

In 2016, MDHHS applied to the Centers for Medicare & Medicaid Services (CMS) to become a CCBHC Demonstration state under Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA). That request was approved on August 5, 2020, when the federal CARES Act of 2020 authorized two additional states—Michigan and Kentucky—to join the demonstration. As a result, MDHHS was approved for a two-year demonstration with an anticipated implementation start date of October 1, 2021. The two-year period begins upon implementation. CMS requires a state to implement the demonstration in at least two sites – one rural and one urban. Moreover, per CMS, only the 14 prospective CCBHC Demonstration Sites named in Michigan's 2016 application are eligible to participate in the state's demonstration. These sites include 11 Community Mental Health Services Programs (CMHSPs) and 3 non-profit behavioral health entities, together serving 18 Michigan counties. CCBHC Demonstration Sites are selected in accordance with federal requirements, including the attainment of state based CCBHC certification, and available funding.

The CMS CCBHC Demonstration requires states and their certified sites to provide a robust set of coordinated, integrated, and comprehensive services to all persons with any mental illness or substance use disorder diagnosis. Moreover, the demonstration requires and emphasizes 24/7/365 crisis response services (e.g., mobile crisis services). Other critical elements include but are not limited to strong accountability in terms of financial and quality metric reporting; formal coordination with primary and other care settings to provide intensive care management and transitions; linkage to social services, criminal justice/law enforcement, and educational systems; and an emphasis on providing services to veterans and active-duty service members. To account for these requirements, the state must create a PPS reimbursement structure that finances CCBHC services at an enhanced payment rate to properly cover costs and offer greater financial predictability and viability. The PPS is integral to sustaining expanded services, investments in the technological and social determinants of care, and serving all eligible Michiganders regardless of insurance or ability to pay.

MDHHS will effectuate the demonstration with prospective CCBHC sites, the relevant Prepaid Inpatient Health Plans (PIHPs), and a multi-disciplinary team-based structure reflective of a collaborative care model. At the end of the demonstration, MDHHS will evaluate the program's impact and assess the potential to continue or expand the initiative under the CMS State Plan option.

1.B. CMS Demonstration and SAMHSA CCBHC Expansion Grants

Two federal programs contain the "CCBHC" name – the CMS CCBHC Demonstration and the Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHC Expansion Grants. These are two disparate opportunities with different funding sources and state oversight responsibilities.

1.B.1. SAMHSA Expansion Grants

SAMHSA CCBHC Expansion Grants are available to community treatment providers in every state, and applications for the $2 million, 2-year grants are accepted annually. Qualified applicants must meet the requirements of a CCBHC within four months of receiving the grant. Clinics self-attest that they meet the baseline CCBHC criteria, and the state authority has no direct involvement in the oversight or implementation of these grants.

1.B.2. The CMS CCBHC Demonstration

The CMS CCBHC Demonstration is operationalized by the State and uses a Prospective Payment

System (PPS) rate for qualifying encounters provided to Medicaid beneficiaries. Prospective CMS CCBHC Demonstration Sites are limited to the 14 entities included in Michigan's 2016 application to CMS. Moreover, the State is responsible for overseeing the demonstration program, including clinic certification, payment, and compliance with federal reporting requirements.

Existing SAMHSA CCBHC Expansion grantees can participate in the CMS CCBHC Demonstration and continue to use SAMHSA CCBHC Expansion grant funds provided they meet the requirements of both federal programs. Appendix C lists Michigan's current SAMHSA CCBHC Expansion Grantees.

1.C. The CCBHC Model

CCBHCs are considered a new Medicaid provider type and are designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals. In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations. CCBHCs are non-profit organizations or units of a local government behavioral health authority. Unlike traditional service organizations that operate differently in each state or community, CCBHCs are required to meet established criteria related to care coordination, crisis response and service delivery, and be evaluated by a common set of quality measures. Furthermore, CCBHCs establish a sustainable payment model that differs from the traditional system funded by time-limited grants that only support pockets of innovation for specific populations. Early experiences demonstrate that CCBHCs have shown tremendous progress in building a comprehensive, robust behavioral health system that can meet the treatment demand.

1.C.1. Expanded Service Array

In accordance with PAMA, CMS requires CCBHCs, directly or through designated collaborating organizations, to provide a set of nine comprehensive services to address the complex and myriad needs of persons with mental health or SUD diagnoses services. This full array of services must be made available to all consumers and represent a service array necessary to facilitate access, stabilize crises, address complex mental illness and addiction, and emphasize physical/behavioral health integration. These services include the following:

1. Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
2. Screening, assessment, and diagnosis, including risk assessment.
3. Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
4. Outpatient mental health and substance use services.
5. Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
6. Targeted case management.
7. Psychiatric rehabilitation services.
8. Peer support and counselor services and family supports.
9. Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas.

1.C.2. Expanded Access to Services

CCBHC program requirements stipulate that CCBHCs cannot refuse service to any person based

on either ability to pay or residence, expanding the population eligible for the robust service array. Any fees or payments required by the clinic for such services will be reduced or waived to ensure appropriate accessibility and availability. Additionally, CCBHCs must follow standards intended to make services more available and accessible, including expanding service hours, utilizing telehealth, engaging in prompt intake and assessment processes, offering 24/7 crisis interventions, and following person and family-centered treatment planning and service provision.

1.C.3. Improved Care Coordination and Integrated Care
Care coordination is central to the CCBHC model. CCBHCs are required to build a comprehensive partnership network of health and social service providers, formalized through care coordination agreements.

1.C.4. Expanded Person-Centered Treatment
Expansion of person-centered, family-centered, trauma-informed, and recovery-oriented care that integrates physical and behavioral health care to serve the "whole person".

1.C.5. Expanded Data Collection and Quality Reporting
CCBHCs are required to collect, report, and track a robust set of encounter, outcome, and quality data that includes consumer characteristics, staffing, access to services, use of services, screening, prevention, and treatment, care coordination, other processes of care, costs, and consumer outcomes. Data will also be captured to measure the effectiveness of the demonstration and inform planning for potential future expansion of the CCBHC model statewide.

1.D. Eligibility

1.D.1. CCBHC Site Eligibility
In its 2016 CCBHC Demonstration application, MDHHS named 14 prospective CCBHC demonstration sites (11 Community Mental Health Services Programs and 3 non-profit behavioral health entities). Collectively, the sites currently serve 18 counties, although services are not limited by county of residency. Per CMS directive, the following 14 sites cited in the 2016 application are eligible to become CCBHCs under the demonstration:

- Centra Wellness Network (Benzie and Manistee Counties)
- Community Mental Health and Substance Abuse Services of St. Joseph County
- Community Mental Health Authority of Clinton, Eaton, and Ingham Counties
- Community Network Services (Oakland County)
- Easter Seals (Oakland County)
- HealthWest (Muskegon County)
- Integrated Services of Kalamazoo
- Macomb County Community Mental Health
- Saginaw County Community Mental Health Authority
- St. Clair County Community Mental Health Authority
- The Guidance Center (Wayne County)
- The Right Door (Ionia County)
- Washtenaw County Community Mental Health

- West Michigan Community Mental Health (Lake, Mason, and Oceana Counties)

Prospective CCBHC Demonstration sites must be certified by MDHHS to be designated as CCBHCs.

1.D.2. CCBHC Recipient Eligibility

Any person with a mental health or substance use disorder (SUD) ICD-10 diagnosis code as cited in Appendix B is eligible for CCBHC services. The mental health or SUD diagnosis does not need to be the primary diagnosis. Individuals with a dual diagnosis of intellectual disability/developmental disability are eligible for CCBHC services. Eligibility review should align with assessment and diagnosis (see 13.D.4.1 for more on requirements) and take place as frequently as clinically appropriate. If an individual continues to have a behavioral health diagnosis, they are eligible for all CCBHC services.

For those with Medicaid, eligible Medicaid beneficiaries include those enrolled in Medicaid (MA), Health Michigan Plan (MA-HMP), Freedom to Work (MA-FTW), MIChild Program (MA-MICHILD), Full Fee-for-Service Health Kids-Expansion (HK-EXP), and Integrated Care – MI Health Link (ICO-MC).

Medicaid beneficiaries eligible for CCBHC are eligible for all Medicaid covered services. However, payment for duplicative services on the same day is prohibited. The CCBHC must choose which available Medicaid covered service best meets the person's needs.

1.D.3. Residency

CCBHCs must serve all individuals regardless of residency or ability to pay. CCBHCS may define service catchment areas for targeted outreach that correspond directly to the required annual needs assessment (See Program Requirements, criteria 1A.) For individuals residing out of state, CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services and should have protocols developed for coordinating care across state lines.

2. PIHP and CCBHC Requirements

2.A. CCBHC General Requirements

PIHPs must adhere to the CCBHC contractual and policy requirements with MDHHS. CCBHCs must meet the requirements indicated in CCBHC certification. PIHPs and CCBHCs must adhere to the requirements of all Medicaid statutes, policies, procedures, rules, and regulations, and the CCBHC Handbook.

2.B. PIHP Requirements

PIHPs share responsibility with MDHHS for ensuring continued access to CCBHC services. PIHPs are responsible for meeting minimum requirements, distributing payment, facilitating CCBHC outreach and assignment, monitoring and reporting on CCBHC measures, and coordinating care for eligible CCBHC recipients as described below.

2.B.1. Minimum Requirements

- PIHPs must be a regional entity as defined in Michigan's Mental Health Code (330.1204b) or organized as the three standalone CMHSPs (i.e., Macomb, Oakland, and Wayne Counties).
- PIHPs must contract or develop a Memorandum of Understanding with all CCBHCs in their region and ensure access to CCBHC services for their enrollees.

- PIHP contracts with CCBHCs must permit subcontracting agreements with DCOs and credentialing of DCO entities and/or practitioners.
- PIHP contracts with CCBHCs must reflect the CCBHC scope of services and ensure compensation for CCBHC services equates to clinic-specific PPS-1 rates.
- PIHPs must understand the CCBHC certification process and certification requirements.
- PIHPs must have the capacity to evaluate, select, and support providers who meet the certification standards for CCBHC, including:
    - Identifying providers and DCOs who meet the CCBHC standards,
    - Establishing an infrastructure to support CCBHCs in care coordination and providing required services, including but not limited to crisis services, SUD services, and primary care services
    - Collecting and sharing member-level information regarding health care utilization and medications with CCBHCs
    - Providing implementation and outcome protocols to assess CCBHC effectiveness
    - Developing training and technical assistance activities that will support CCBHC in effective delivery of CCBHC services.
- MDHHS recommends that PIHPs provide training and technical assistance on certification requirements, including helping other potential CCBHC sites in preparing to meet CCBHC requirements.
- PIHPs must utilize Michigan claims and encounter data for the CCBHC population.
- PIHPs must use CareConnect360 to analyze health data spanning different settings of care for care coordination purposes among CCBHC Medicaid beneficiaries.
- PIHPs must provide support to CCBHCs related to Health Information Technology, including WSA, CareConnect360, EHR, and HIEs.
- PIHPs provide access and utilization management of Medicaid-covered services, including Medicaid-covered services for individuals enrolled in CCBHC. If a PIHP delegates managed care functions to the CCBHC, the PIHP remains the responsible party for adhering to its contractual obligations.

2.B.2. CCBHC Enrollment and Assignment

- PIHP will use the WSA for CCBHC assignment activities. This includes maintaining an updated list of eligible individuals and sharing with CCBHCs for outreach, assignment management, and report generation.
- Utilize the WSA to upload information on CCBHC recipients for the non-Medicaid population by CCBHC.
- Verify diagnostic criteria for CCBHC recipients who are not automatically identified and enrolled (such as walk-ins) and non-Medicaid recipients.
- Review consent document when uploaded by a CCBHC before assigning an individual to a CCBHC.
- Require and monitor that the CCBHC has policies and procedures in place that ensure that attempts to collect the MDHHS-5515 consent form have taken place before requesting assignment of a CCBHC recipient to a CCBHC in the WSA. Services can be provided before the consent is obtained or if a CCBHC recipient denies signing the 5515 consent. Other consent forms can be used if held to more stringent requirements under federal law.
- No additional orientation or consent to CCBHC enrollment is required.

2.B.3. CCBHC Coordination and Outreach

- Maintain a network of providers that support the CCBHC to service all Michiganders with a

mental illness or substance use disorder.

- Develop and maintain working relationships with primary and specialty care providers such as Federally Qualified Health Centers, Rural Health Clinics, inpatient hospitals, crisis services providers, and SUD providers
- Assist CCBHC with outreach of eligible CCBHC recipients, if requested by CCBHC.
- Coordinate crisis and other referral services with the Michigan Crisis and Access Line (MiCAL), when available in PHIP region.
- Coordinate services when eligible individuals utilize the PIHP's centralized access system, including assigning them to a CCBHC of their choice.

2.B.4. CCBHC Payments

- PIHPs are responsible for reimbursing CCBHCs at the site-specific PPS-1 rate for each valid CCBHC service encounter (note: the PPS-1 payment may only be paid once per day regardless of the number of CCBHC service encounters reported for a given day) in accordance with the CCBHC Payment section of the policy and this Handbook (Section 5).
    - The full PPS-1 payment amount (less any applicable cost offsets) must be received by the CCBHC within 60 days following the month in which the service was rendered.
- PIHPs will develop a process to collect CCBHC "encounters" for the non-Medicaid population for cost reporting and monitoring purposes.
- PIHPs will submit encounters to MDHHS in accordance with 5.C.1.3 of this Handbook.

2.B.5. Reporting

2.B.5.1. Cost and Quality Metric Reporting

- Review, audit, and submit CCBHC quality metric reports to MDHHS for MDHHS review and submission to CMS.
- Collect and report access data quarterly to include, by CCBHC, the number of individuals requesting services and the number of individuals receiving their first service.

2.B.5.2. Grievance Monitoring and Reporting

- PIHPs must monitor, collect, and report grievance, appeal, and fair hearing information, with details, by CCBHC, to MDHHS (MDHHS will specifically monitor this activity as it relates to CCBHC services related to certification criteria requiring CCBHCs to serve all populations regardless of severity, ability to pay, or county of origin). PIHPs are not responsible for recipient rights reporting.

2.B.5.3. Other Reporting

- PIHPs must submit other MDHHS-required reports such as Financial Status Reports (FSRs) pursuant to MDHHS-defined instructions and timelines.

MDHHS is seeking to leverage the MDHHS Customer Relationship Management (CRM) for CCBHC reporting. Guidance will be provided to PIHPs relative to reporting submissions. Until further guidance is issued, PIHPs will email required reports (except for those with submissions processes already defined [e.g., FSR]) to MDHHS-CCBHC@michigan.gov.

2.B.6. Oversight

- Monitor CCBHC performance and lead quality improvement efforts. PIHPs are not

responsible for overseeing and monitoring any certification corrective action plan, however MDHHS will share the plans with the PIHP and the PIHP may be asked to assist the CCBHC in meeting goals where appropriate.

- Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
- Designs and develops prevention and wellness initiatives, and referral tracking.
- Network monitoring and performance.
- Cost and quality report audit and compliance review.
- Compliance with other State and/or Federal reporting requirements.

2.C. CCBHC Requirements

The State's minimum requirements and expectations for CCBHCs are listed below. CCBHCs are also required to meet all CCBHC program requirements outlined in Section V: Certification Criteria.

2.C.1. Minimum Requirements

- Must be enrolled in the Michigan Medicaid program and in compliance with all applicable program policies.
- Must be certified by the State of Michigan.
- Must adhere to all federal and state laws regarding Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA), including the capacity to perform all CCBHC required services specified by CMS.
- Participate in state sponsored activities designed to support CCBHC's in transforming service delivery. This includes a mandatory MDHHS-hosted CCBHC orientation for providers and clinical support staff before the program is implemented.
- Recommend CCBHC beneficiary assignment to PIHPs.
- Participate in ongoing technical assistance (including but not limited to trainings and webinars).
- Participate in ongoing individual assistance (including but not limited to audits, site visits, trainings, etc., provided by State and/or State contractual staff).
- Support CCBHC team participation in all related activities and trainings, including coverage of travel costs associated with attending CCBHC activities.
- Adhere to all applicable privacy, consent, and data security statutes.
- Enhance beneficiary access to behavioral and physical health care.
- Possess the capacity to electronically report to the State and/or its contracted affiliates information regarding service provision and outcome measures.
- Practice in accordance with accepted standards and guidelines and comply with all applicable policies published in the Michigan Medicaid Provider Manual.
- If working with a DCO, the CCBHC must meet the standards outlined in the CCBHC handbook.
- Must have access to the WSA and CareConnect360
- Utilize the WSA to develop a participant roster, review relevant reports, recommend individual assignment to CCBHC, and view data for assigned beneficiaries.
- Attest to diagnostic criteria for walk-ins and non-Medicaid.
- Utilize CC360 to analyze health data spanning different settings of care for care coordination purposes among Medicaid beneficiaries.

2.C.2. MI CCBHC Certification Requirements

2.C.2.1. Certification Overview

Potential CCBHCs must complete the MDHHS certification process to become a CCBHC under the CMS CCBHC Demonstration. Certification is required to bill the T1040 code and to receive the PPS-1 payment. MDHHS will document and monitor CCBHC certification through the MDHHS CRM database. Potential CCBHCs must provide justification of meeting CCBHC criteria and upload supporting documentation verifying that standards have been met. Certifications are valid for two years. MDHHS can issue a provisional certification for a CCBHC site that does not fully meet all the program requirements. Provisional certifications are term-limited and the CCBHC must provide MDHHS with a plan for meeting the full certification requirements to maintain certification. CCBHCs can receive the PPS payment while provisionally certified.

MDHHS will conduct at least one site visit to each certified CCBHC during the demonstration period to verify that program requirements are being met and implemented in practice. MDHHS staff will review documentation and client records and offer feedback on CCBHC practices.

2.C.2.2. Certification Application

2.C.2.2.1. Accounts

To complete the CCBHC certification process, the CCBHC must have an organizational account in the MDHHS CRM. Each organizational account may have several staff who are assigned the profile of CCBHC Certification Coordinator. These staff will receive alerts and communication about the CCBHC certification, have necessary permissions for completing the application and submitting documentations, and submit the completed application for MDHHS approval.

Requests for MDHHS CRM accounts should be sent to mdhhs-ccbhc@michigan.gov. CCBHCs are responsible for requesting CRM access for appropriate staff as well as alerting MDHHS of any staff changes that may require changing or revoking system access. Prior to recertification, MDHHS will also attempt to verify that user accounts and access privileges are accurate.

2.C.2.2.2. Application Process

MDHHS CRM users assigned the role of CCBHC Certification Coordinator will receive notification that the CCBHC certification is open and ready to complete. Each user will have access to the open application and may enter data and upload documents in any format (Word, PDF, Excel, etc.). For each program requirement, a short description should be provided explaining how the CCBHC meets the given criteria. Documents providing further evidence should be uploaded to correspond with each program requirement. Text must be entered into each Description field at the time of final application submission, or else the user will receive a system error.

Once the application is submitted, MDHHS will begin the review process, which will involve verifying the submitted explanations, reviewing the evidence

documentation, and giving each criteria a standardize score based on the CCBHC's response. The CCBHC can check in on the MDHHS review process at any time by visiting the open application. Upon reviewing the documents, MDHHS can submit additional requests to the CCBHC to fill out any missing information or submit additional documentation via the CRM. All representatives with CCBHC Certification Coordinator permissions at a given CCBHC will receive an email notification with the additional documentation request.

2.C.2.2.3. Assigning Certification Levels

Once MDHHS has received and reviewed all materials, MDHHS will assign a certification level. If the CCHBC meets all requirements, they will be considered fully certified. Certifications are active for two years.

If the CCBHC does not yet meet all requirements, MDHHS will assign the Provisional Certification status. A CCBHC with provisional certification status can still receive the PPS payment. MDHHS will also select the length of the Provisional Certification, which will depend on the time expected to meet CCHBC requirements. Due to ongoing communication throughout the certification application, it is likely that the CCBHC and MDHHS will have shared expectations for the steps necessary to meet all CCBHC requirements and an appropriate timeframe will have been discussed. The MDHHS CRM will send automatic reminder emails once every two (2) weeks to remind the CCBHC to submit the required information or other evidence supporting requirements have been met to MDHHS. At any time during this process, the CCBHC has access to make changes to the Certification Application and can upload additional documentation. Once submitted, MDHHS will review the documentation and may either change the certification from Provisionally Certified to Certified or revise the length of time of the Provisional Certification.

2.C.2.2.4. Certification Expiration

The CCBHC Certification will expire two years after receiving Certified status. After the first certification cycle, the CRM system will automatically send out notification one hundred twenty (120) days before the CCBHC certification application is due. As the recertification date approaches, monthly reminders will be sent for the first two months and biweekly reminders for the last two months. If the application has not been submitted during this time, the CCBHC certification will be considered discontinued and the CCBHC will no longer participate in the demonstration. CCBHCs with expired certifications (notwithstanding provisional certification) will not be able to receive PPS-1 payment for CCBHC services. CCBHCs should plan accordingly and work with MDHHS and their PIHP to obtain any needed technical assistance to ensure continuation of certification. CCBHCs with expired certifications may reapply for certification when the next application period reopens.

2.C.2.2.5. CCBHC Termination

Failure to abide by the terms of the CCBHC policy and requirements may result in disciplinary action, including placing the provider in a probationary period and, to the fullest degree, termination as an CCBHC provider. If a CCBHCs status

is terminated by MDHHS or if its certification lapses with no provisional status issued by MDHHS, the provider must continue providing CCBHC services for six months without receiving the PPS-1 payment.

2.C.2.2.6. On-Site Reviews

MDHHS will conduct at least one site visit to each certified CCBHC during the demonstration period to verify that program requirements are being met and implemented in practice. The site review may be in person or virtual and will be scheduled after the CCBHC has been operational and certified for 6 months. MDHHS staff will review documentation and client records and offer feedback on CCBHC practices. PIHPs will be permitted to accompany MDHHS and will receive the full final report.

2.C.3. Medicaid Requirements

Unless otherwise specified or detailed in the CCBHC Program Requirements section of this handbook, CCBHCs must comply with all Medicaid laws, regulations, and policies when providing services to CCBHC recipients. Additionally, CCBHCs must follow the Mental Health Code when applicable. CCBHC Medicaid beneficiaries should be included in all required Medicaid reporting, including MMBPIS, Critical Incidents, and performance incentive measures for all programs that apply to each beneficiary. CCBHC services do not need to be tracked and/or reported for Service Authorizations. If an individual is receiving both CCBHC and non-CCBHC services, all service authorization requirements for non-CCBHC services apply.

2.C.4. Behavioral Health Treatment Episode Data Set (BH-TEDS)

BH-TEDS data must be collected for all CCBHC recipients per current BH-TEDS reporting requirements. Every CCBHC recipient is required to have an active BHTEDS episode during the time they are receiving any CCBHC services.

The type of BHTEDS records required for treatment episodes is determined by the funding source utilized for services. SUD-funded services require A and D BHTEDS records. Beginning 10/01/2022, annual S records for SUD episodes open longer than 1 year are required. These episodes can be SUD only or Integrated MH-SUD funded with SUD dollars. Their services are reported on encounters with the PIHP's SUD CHAMPS ID. MH-funded services require M and E BHTEDS records, with annual U records for episodes open longer than 1 year. These episodes can be MH only or Integrated MH-SUD funded with MH dollars. Their services are reported on encounters with the mental health PIHP CHAMPS ID.

Service Type	Required BHTEDS Records	Encounter Reporting Type
Mental Health/ Co-Occurring	• M and E • Annual U for episodes open longer than 1 year	Encounters submitted with mental health Member ID Type (Type 89)
Substance Use Disorder	• A and D • Beginning 10/01/2022, Annual S for	Encounters submitted with SUD Member ID Type (Type 88)

	episodes open longer than 1 year	

2.C.5. Community Outreach and Education

PIHPs and CCBHCs will provide information about the CCBHC benefits to all potential enrollees through community referrals, peer support specialist/recovery coach networks, other providers, courts, health departments, law enforcement, schools, and other community-based settings. MDHHS will work with PIHPs and CCBHCs to strategically provide these settings with informational brochures, posters, and other outreach materials to facilitate awareness and engagement of the CCBHC Demonstration. CCBHCs and PIHPs will work together to delineate responsibilities regarding community outreach and partnership development. PIHPs will also identify eligible CCBHC recipients utilizing the Waiver Support Application and assigning individuals to a CCBHC. See Section 4: CCBHC Recipient Enrollment, Assignment, and Disenrollment for more information on the Waiver Support Application and CCBHC recipient assignment.

2.C.6. Staffing

CCBHCs are responsible for maintaining an appropriate staff (both clinical and non-clinical) that meets standards of the state governing body and accreditation authorities. Staff are hired to meet the needs of the community as identified in a comprehensive needs assessment. CCBHC staff will follow a training plan which must address, among other requirements, cultural competence (including implicit bias training); person-centered and family-centered, recovery-oriented, evidence-based, and trauma-informed care; and primary care/behavioral health integration. The training plan must also address training for DCO staff providing services to CCBHC beneficiaries. CCBHCs are also able to provide translation and interpretation services to those consumers with limited English proficiency.

To effectuate the staffing requirements, MDHHS will require CCBHCs to utilize a collaborative and interdisciplinary team-based model of care to ensure the totality of one's needs – physical, behavioral, and/or social – are met through the provision of CCBHC services.

Notwithstanding staffing requirements needed to provide all services, CCBHC staffing plans must include administrative oversight, behavioral health specialists, nurse care managers, peers and community health workers, medical consultants (e.g., primary care providers), and psychiatric consultants. Formal agreements with outside providers, including FQHCs, can be established to meet these requirements.

2.C.7. Availability and Accessibility

The CCBHC must provide a functional, safe, clean, and welcoming environment for consumers and staff and are subject to all state standards for provision. Services are delivered at times and in locations that meet the needs of the population to be served, offering transportation, mobile in-home services, and telehealth/telemedicine when appropriate to guarantee access (See Appendix F, 13.B.1-13.B.4). Consumers are to be served regardless of ability to pay, insurance, or place of residence. Although there is technically no limit on the amount or duration of services offered, the amount, scope, and duration of services are determined through a person-centered planning process based on service eligibility and medical necessity criteria.

The CCBHC must also meet the standards for timeliness for screening, assessment, referral, service initiation, and crisis interventions as listed in Program Requirement 2 (Appendix F, 13B).

2.C.8. Care Coordination

The CCBHC must provide care coordination across a spectrum of health services, including access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. These activities are carried out in accordance with HIPAA and other confidentiality standards, as well as the consumer's needs and preferences. Care coordination agreements should be in place with the facilities and community service providers listed in Program Requirement 3.

CCBHCs must have health IT system capable of being used for population health management and quality improvement. The use of Health Information Technology (HIT) to facilitate optimal care coordination and care management is essential. As such, MDHHS expects HIT to bolster each of the CCBHC services. Utilization of MDHHS systems such as CareConnect360 and the Waiver Support Application are encouraged to coordinate care for CCBHC recipients.

CCBHCs will also be required to coordinate crisis and other referral services with the Michigan Crisis and Access Line (MiCAL), when available. See section criteria 3.C.6 in Section IV for more information.

2.C.9. Scope of Service and Evidence Based Practices

CCBHCs must provide the 9 core services. Crisis services may be provided by the state-sanctioned crisis system. All services, including those provided directly or via DCOs, must be person and family-centered, recovery-oriented, and respectful of the individual consumer's needs, preferences, and values, with both consumer involvement and self-direction of services. Services to children and youth must be family-centered, youth guided, and developmentally appropriate. CCBHCs must also be equipped to meet the additional needs of transition age youth. Additionally, veteran navigators should be utilized to connect military service members and their families to appropriate behavioral health services. The Veteran Navigator program, administered through the PIHPs, was created to connect veterans and their families to federal, state, and local resources to ease issues regarding mental health, substance abuse, ho0using, and other common issues that impact veterans to support healthier lifestyles and provide support. CCBHCs may also utilize their own veteran supports, including veteran peer support specialists.

To promote efficiencies and better outcomes reflective of behavioral health needs, MDHHS will require the provision of select evidence-based practices (EBPs) listed below. MDHHS also recommends that CCBHCs implement other EBPs that will best serve CCBHC recipients and may be asked by MDHHS to participate in pilot programs to expand EBPs throughout the demonstration. CCBHCs must implement all required EBPs by the end of the first demonstration year and can be offered either directly by the CCBHC or through a DCO. CCBHCs will be responsible for ensuring that EBPs are provided by individuals with appropriate training and credentials and have an established process for monitoring model fidelity, either locally or with Michigan Fidelity Assistance Support Team (MIFAST) reviews. CCBHCs will follow current EBP practice requirements and approval processes as outlined in the Medicaid Provider Manual. For questions about EBP approval applications, please email MDHHS-CPI-Section@michigan.gov.

2.C.9.1. *Required EBPs:*

- "Air Traffic Control" Crisis Model with MiCAL
- Assertive Community Treatment (ACT)
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Infant Mental Health
- Integrated Dual Disorder Treatment (IDDT)
- Motivational Interviewing (MI) for adults, children, and youth
- Medication Assisted Treatment (MAT)
- Parent Management Training – Oregon (PMTO) and/or Parenting through Change (PTC)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Zero Suicide

2.C.9.2. *Recommended EBPs:*

- An EBP of the CCBHC's choice addressing trauma in adult populations
- An EBP of the CCBHC's choice addressing needs of transition age youth (such as the Transition to Independence Process [TIP] model)
- An EBP of the CCBHC's choice addressing chronic disease management
- Dialectical Behavior Therapy for Adolescents (DBT-A)
- Permanent Supportive Housing
- Supported Employment (IPS model)

2.C.10. Quality and Reporting

Both CCBHCs and MDHHS are required to report on cost and quality measures. Please see Section VII: CCBHC Evaluation and Monitoring for more information. Performance on quality measures will be made available in CC360 for both PIHPs and CCBHCs during DY2.

2.C.10.1. *Reporting DCO Information*

Collection of some of the data and quality measures that are the responsibility of the CCBHC may require access to data from DCOs and it is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship with DCOs and to ensure adequate consent as appropriate and that releases of information are obtained for each affected consumer.

2.C.10.2. *Data Collection*

CCBHCs must collect, report, and track encounter, outcome, and quality data, including but not limited to data capturing:

- CCBHC recipient characteristics
- Staffing
- Access to services
- Use of services
- Screening, prevention, and treatment

- Care coordination
- Other processes of care
- Costs
- CCBHC recipient outcome

CCBHCs will report this data to MDHHS in response to ad hoc requests needed to support the success of the demonstration. A minimum of 30 days' notice will be given to respond to these requests. (See 7.B Additional Monitoring Requirements.)

2.C.10.3. *Continuous Quality Improvement (CQI) Plan*
CCBHCs must use the data outlined in 2.C.10.3 to develop, implement, and maintain a continuous quality improvement (CQI) plan for clinical services and clinical management. This plan must address suicide, hospital readmissions, and other events as specified by the state. (See certification criteria 13.E.2. Continuous Quality Improvement (CQI) Plan.)

2.C.10.4. *Metric Reporting*
CCBHCs must collect and report on CCBHC-reported performance metrics identified in Section 7.A.1- CCBHC Reported Measures. Data are required to be reported for all CCBHC enrollees annually unless data constraints exist (e.g., the metric is specific to only the Medicaid-enrolled population).

2.C.11. Organizational Governance
The CCBHC must meet one of the following criteria: a non-profit organization, exempt from tax under Section501(c)(3) of the United States Internal Revenue Code; a part of a local government behavioral health authority (which includes all forms of CMHSPs); an organization 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.); an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian HealthCare Improvement Act (25 U.S.C. 1601 et seq.). Board members are to be representative of those served by the CCBHC and must incorporate meaningful participation from adult consumers, individuals in recovery, and families. CCBHCs must also adhere to all applicable state policy, accreditation, certification, and/or licensing requirements.

2.C.12. Training and Technical Assistance
CCBHC's are expected to participate in state sponsored activities designed to support CCBHC's in transforming service delivery. This includes a mandatory CCBHC orientation for providers and clinical support staff before the program is implemented. Additionally, CCBHCs must participate in ongoing individual assistance (including but not limited to audits, site visits, trainings, etc., provided by State and/or State contractual staff). CCBHC leadership staff must support CCBHC team participation in all related activities and trainings, including coverage of travel costs associated with attending CCBHC activities.

3. Designated Collaborating Organization (DCO) Requirements

3.A. DCO Overview

A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal

relationship with the CCBHC and delivers services under the same requirements as the CCBHC. Persons receiving CCBHC services from DCO personnel under the contract are CCBHC recipients. DCOs must meet CCBHC requirements for scope of services and must be appropriately credentialed. DCO-provided services must be provided in a manner aligned with the requirements of Section 2402(a) of the Affordable Care Act, titled "Removal of Barriers to Providing Home and Community-Based Services." Under this section, services must reflect person- and family-centered, recovery-oriented care; be respectful of the individual consumer's needs, preferences, and values; and ensure consumer involvement and self-direction of services. Services for children and youth should be family-centered, youth-guided, and developmentally appropriate. DCOs may be private, for-profit organizations.

3.B. CCBHC Agreements with DCOs

CCBHCs must establish formal agreements if they choose to utilize a DCO. A formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized. This includes payment for DCO services. Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. Payment will be provided directly to the DCO from the CCBHC based on agreed upon contractual service rates. These rates must be reflective of fair market value. The CCBHC must also be involved in care coordination activities with DCOs, including improving health information technology (HIT) to facilitate coordination and care transfers across organizations, and arranging access to data necessary for metric reporting. CCBHCs must also ensure beneficiaries receiving services at the DCO have access to the CCBHC grievance process. The PIHPs may help effectuate these activities to the extent it is proper and efficient. CCBHCs are required to submit all DCO agreements to MDHHS.

Formal agreements between the CCBHC and DCO must be submitted to MDHHS during the certification process or as soon as an agreement is executed. Agreements must include the minimum following provisions:

- The CCBHC maintains financial and clinical responsibility for services provided by the DCO,
- The CCBHC retains responsibility for care coordination,
- The DCO must have the necessary certifications, licenses and/or enrollments to provide the services,
- The staff providing CCBHC services within the DCO must have the proper licensure for the service provided,
- The DCO meets CCBHC cultural competency and training requirements,
- The DCO must follow all federal, state and CCBHC requirements for confidentiality and data privacy,
- The DCO must follow the grievance procedures of the CCBHC,
- The DCO must follow the CCBHC requirements for person and family-centered, recovery-oriented care, being respectful of the individual person's needs, preferences, and values, and ensuring involvement by the person being served and self-direction of services received. Services for children and youth are family-centered, youth-guided, and developmentally appropriate,
- People seeking services must have freedom of choice of providers,
- The DCO must be part of the CCBHCs health IT system,
- The CCBHC must arrange for the PIHP to access data about the DCO where access to data outside the CCBHC is required (such as claims data), and
- The CCBHC and the DCO must have safeguards in place to ensure that the DCO does not

receive a duplicate payment for services that are included in the CCBHC's PPS rate.

3.C. CCBHC Clinical and Financial Responsibilities of DCOs

CCBHCs must maintain clinical and financial oversight of CCBHC services provided by DCOs. This includes the responsibility for billing CCBHC services rendered under contract by a DCO. This also includes ensuring a DCO meets all clinical parameters required of CCBHCs. Financial and payment processes must follow the Payment Section of the CCBHC policy and this Handbook.

3.D. Expectations for State-sanctioned Crisis Providers as DCOs

CCBHCs may contract with state-sanctioned providers of crisis services if they are not providing the crisis services internally. State-sanctioned providers deliver crisis services to all populations using public funds. DCO contracts with state-sanctioned crisis providers should be for Medicaid beneficiaries only, and procedures should be outlined for identifying individuals eligible for CCBHC services. It is the responsibility of the CCBHCs and the PIHP in shared service regions to coordinate which service site is appropriate for CCBHC assignment.

3.E. Adding New DCO Relationships

Adding new DCO relationships after initial certification requires updates to the CCBHC Certification and approval by MDHHS. CCBHCs should provide MDHHS with notice of the expected addition of a DCO as soon as possible by emailing mdhhs-ccbhc@michigan.gov. The CCBHC is responsible for updating DCO information and uploading the DCO agreement to the CCBHC Certification in the MDHHS CRM at a minimum of 30 days prior the initiation of the CCBHC/DCO MOU/contract. MDHHS will review and approve or offer recommendations for DCO MOU/contract changes.

4. CCBHC Recipient Enrollment, Assignment, and Disenrollment

4.A. Beneficiary Identification, Enrollment, and Assignment

PIHPs and CCBHCs will provide information about the CCBHC benefits to all CCBHC eligible recipients through community referrals, peer support specialist/recovery coach networks, other providers, courts, health departments, law enforcement, schools, and other community-based settings. MDHHS will work with PIHPs and CCBHCs to strategically provide these settings with informational brochures, posters, and other outreach materials to facilitate awareness and engagement of the CCBHC Demonstration. CCBHCs and PIHPs will work together to delineate responsibilities regarding community outreach and partnership development.

Eligible CCBHC recipients are identified using a multifaceted approach for both Medicaid beneficiaries and non-Medicaid persons. MDHHS reserves the right to review and verify all enrollments and assignments.

CCBHC Recipient Status Defined:

CCBHC Status	Definition
Eligible	Medicaid or non-Medicaid person who is eligible for CCBHC services. These individuals are not yet assigned to a CCBHC in WSA.
Assigned	Medicaid or non-Medicaid CCBHC recipient assigned to a CCBHC in WSA.
Enrolled	Medicaid beneficiary who is enrolled in the CCBHC benefit plan in CHAMPS.
CCBHC Recommended	Medicaid or non-Medicaid eligible recipient recommended by a CCBHC for assignment by the PIHP.
Disenrolled	Medicaid or non-Medicaid recipient disenrolled from CCBHC.

The processes below delineate the approach for Medicaid beneficiaries and non-Medicaid persons, respectively:

4.B. MDHHS Identification and PIHP Assignment of CCBHC-Eligible Medicaid Beneficiaries

4.B.1. MDHHS Identification/Enrollment of CCBHC-Eligible Beneficiaries

MDHHS uses administrative claims data from the MDHHS Data Warehouse to identify CCBHC-eligible Medicaid beneficiaries in counties with a CCBHC Demonstration Site based on having a primary or secondary mental health and/or SUD diagnosis within the last 18 months. All Medicaid beneficiaries eligible for CCBHC are automatically enrolled in the CCBHC benefit plan in Michigan's Medicaid Management Information System (MMIS), known as the Community Health Automated Medicaid Processing System (CHAMPS). The initial list will be sent on or near October 1, 2021, and continuously updated to reflect the most recent 18 months of administrative data and to account for any changes in eligibility requirements. Beneficiaries will remain enrolled in the CCBHC benefit plan in perpetuity if they continue to meet eligibility requirements.

4.B.2. PIHP Assignment of CCBHC-Enrolled Beneficiaries

Utilizing the Waiver Support Application (WSA), MDHHS will provide PIHPs the list of CCBHC-eligible Medicaid beneficiaries for their respective PIHP region. PIHPs must work with CCBHCs to assign beneficiaries to the pertinent CCBHC within the WSA. The assignment may include an attestation that the Consent to Share Behavioral Health Information for Care Coordination Purposes (MDHHS-5515) or other approved consent form (if held to more stringent requirements under federal law) has been signed by the CCBHC-eligible Medicaid beneficiary.

4.B.3. CCBHC Recommendation of CCBHC-Eligible Medicaid Beneficiaries

For Medicaid beneficiaries not identified or enrolled into the CCBHC Benefit Plan by MDHHS, CCBHCs are permitted to recommend eligible beneficiaries for enrollment into the CCBHC benefit plan to the PIHP via the WSA. CCBHC providers must provide documentation that indicates a potential CCBHC enrollee meets eligibility for the CCBHC benefit, including diagnostic verification. The completion of the Consent to Share Behavioral Health Information for Care Coordination Purposes (MDHHS-5515) or other approved consent form (if held to more stringent requirements under federal law) should be used when appropriate. The PIHP must review and process all recommended enrollments in the WSA. The PIHP is responsible for verifying eligibility criteria but cannot deny enrollment of an individual with a qualifying diagnosis. Once processed by the PIHP, the beneficiary is assigned to the recommending CCBHC in the WSA and the record is sent to CHAMPS, which enrolls the beneficiary in the CCBHC Benefit Plan. MDHHS reserves the right to review and verify all enrollments and assignments.

4.C. MDHHS Identification and PIHP Assignment of CCBHC-Eligible Non-Medicaid Recipients

4.C.1. MDHHS Identification of CCBHC-Eligible Non-Medicaid Recipients

MDHHS identifies non-Medicaid CCBHC-eligible recipients in counties with CCBHCs by utilizing BH-TEDS data from the MDHHS Data Warehouse. These recipients will be identified as CCBHC-eligible by having a current/open BH-TEDS record with a mental health and/or SUD diagnosis, or a service end date in the last 18 months, and not previously identified in the Medicaid process specified in 1.A. above. MDHHS will utilize the PIHP Consumer ID or the Medicaid beneficiary ID (if applicable) to identify these CCBHC-eligible recipients. Unlike the Medicaid beneficiaries, non-Medicaid recipients will not be assigned to the CCBHC benefit plan in

CHAMPS (since they do not have Medicaid). Rather, the WSA will be leveraged to track the non-Medicaid CCBHC recipients. The CCBHCs must still submit the pertinent encounter codes for these enrollees to the PIHPs and the PIHPs must submit these "look-alike encounters" to MDHHS via CHAMPS per the existing process for submitting claim/encounter information for non-Medicaid persons.

4.C.2. PIHP Assignment of CCBHC-Eligible Non-Medicaid Recipients

Utilizing the WSA, MDHHS will provide PIHPs the list of CCBHC-eligible non-Medicaid recipients for their respective PIHP region. PIHPs must work with CCBHCs in their region to assign these eligible recipients to the pertinent CCBHC within the WSA. The assignment must include diagnostic verification. The Consent to Share Behavioral Health Information for Care Coordination Purposes (MDHHS-5515) or other approved consent form (if held to more stringent requirements under federal law) by the CCBHC-eligible non-Medicaid recipient can also be collected.

4.C.3. CCBHC Requesting Assignment of CCBHC-Eligible Non-Medicaid Recipients

For Non-Medicaid recipients not identified by MDHHS, CCBHCs are permitted to request assignment of eligible recipients to the PIHP via the WSA. CCBHC providers must provide documentation that indicates a potential CCBHC recipient meets eligibility for the CCBHC benefit, including diagnostic verification and the completion and attestation of the Consent to Share Behavioral Health Information for Care Coordination Purposes (MDHHS-5515) or other approved consent form (if held to more stringent requirements under federal law).

PIHPs may develop procedures to review and verify eligibility criteria for recommended assignments as appropriate for their region. The WSA can be used to meet this requirement. The PIHP must review/verify eligibility criteria for non-Medicaid individuals and process all recommended assignments in the WSA. After verification, the PIHP must provide the recipient with a PIHP Consumer ID (if they do not already have one in the PIHP's region) within the WSA. Once processed by the PIHP, the beneficiary is assigned to the requesting CCBHC in the WSA. MDHHS reserves the right to review and verify all non-Medicaid CCBHC-eligible assignments.

Please note, CCBHC services should be provided to an eligible recipient before being assigned to a CCBHC in the WSA. However, as soon as appropriate, the CCBHC and PIHP shall assign the person into the CCBHC via the WSA.

4.D. Beneficiary Consent

CCBHC recipients should provide a signed Consent to Share Behavioral Health Information for Care Coordination Purposes form prior to assignment in the WSA. The MDHHS-5515 form should be used but other consent forms are permitted if held to more stringent requirements under federal law. The consent form must be collected and stored in the recipient's health record (with attestation in the WSA when there is information related to the diagnosis and treatment of substance use disorders). The MDHHS-5515 can be found on the MDHHS website at https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/behavioral/consent/michigan-behavioral-health-standard-consent-form . The form should also be available at the designated CCBHC office and on the PIHP's website. CCBHCs are responsible for verifying receipt of the signed consent form and cannot request assignment of an individual in the WSA by the PIHP before receipt of the MDHHS-5515 consent. All documents must be maintained in compliance with MDHHS record- keeping requirements.

PIHPs should develop regional policies for verifying and monitoring beneficiary consents, which may include uploading materials to the WSA for review. Policies should also outline processes for consent denials and regular attempts are made to obtain a MDHHS-5515. All CCBHC services can still be provided even if a MDHHS-5515 is not obtained.

4.E. CCBHC Recipient Disenrollment

PIHPs are permitted to disenroll recipients from the CCBHC utilizing the WSA. CCBHCs are permitted to recommend recipient disenrollment to the PIHP via the WSA. Since anyone with a mental health or SUD diagnosis is eligible for CCBHC services, CCBHC recipients can only be disenrolled for the following reasons:

- Administrative Dismissal
- Assigned in Error
- Beneficiary is Unresponsive
- Deceased*
- Hospice
- Moved
- Voluntary Disenrollment

(*PLEASE NOTE: In most cases non-Medicaid recipients will be disenrolled by PIHPs or recommended-disenrolled by CCBHCs. Medicaid and non-Medicaid recipients can be manually disenrolled by the PIHP or automatically disenrolled by MDHHS using death records found in CHAMPS or BH-TEDS records, respectively. Please see the WSA user manual for disenrollment/recommended-disenrollment instructions.)

CCBHC Disenrollment Reasons Defined:

CCBHC Disenrollment Reason	Definition
Administrative Dismissal	CCBHC recipient is unable to continue participating in services due to inability to follow agency rules, violence toward staff, etc.
Assigned in Error	CCBHC recipient was assigned to the wrong CCBHC.
Beneficiary is Unresponsive	CCBCH recipient stopped participating in services, CCBHC is unable to contact the recipient.
Deceased	CCBHC recipient is deceased.
Hospice	CCBHC recipient enrolled in hospice services.
Moved	CCBHC recipient moved out of state or moved into a non-CCBHC county and is no longer receiving services.
Voluntary Disenrollment	CCBHC recipient voluntarily disenrolled from services or no longer needs CCBHC services. Recipient's case is closed for Mental Health or SUD services with the CCBHC.

4.F. CCBHC Recipient Transfer

While the CCBHC recipient's individualized plan of care will be utilized to determine the appropriate setting and CCBHC provider of care, recipients will have the ability to change CCBHC providers to the extent feasible within the CCBHC network. To maximize continuity of care and the

patient-provider relationship, MDHHS expects recipients to establish a lasting relationship with their chosen CCBHC provider. However, if a recipient decides to transfer to a different CCBHC, they should notify their current CCBHC provider immediately if they intend to do so. The current and future CCBHC providers must discuss the timing of the transfer and communicate transition options to the recipient.

4.G. CCBHC Transfer Process

A beneficiary who is assigned to a CCBHC can be transferred to another CCBHC via the WSA within the same PIHP region or to a different PIHP region. CCBHCs are permitted to recommend a transfer to the PIHP via the WSA. The transfer recommendation will automatically be moved to the PIHP work queue as an "Enrolled (Transfer Recommended)" case status. The PIHP will review the CCBHC transfer recommendation and approve, send back for more information, or deny the transfer. PIHPs can also initiate a transfer without receiving a CCBHC recommendation.

The "new" PIHP region will receive the transfer request and either approve, send back the request for more information, or deny the transfer. If the transfer is denied, the beneficiary will remain in "Enrolled" status. The existing CCBHC site/PIHP will discuss next steps and possibly disenroll the individual from the CCBHC if they are no longer receiving services.

After the transfer is complete, the previous CCBHC will have access to the information obtained while the beneficiary was enrolled in their service. This includes information which can be stored within the WSA:

- Documents
  - Care Plan
  - Consent to Share Behavioral Health Information
- Enrollment History
- Transfer History

Detailed information on the transfer process can be found in the Waiver Support Application under the training tab.

5. CCBHC Payment

5.A. General Provisions for CCBHC Payment

MDHHS will utilize the Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment System 1 (PPS-1) methodology in which CCBHC Demonstration Sites receive a daily clinic-specific rate for providing approved CCBHC services to eligible individuals, including Medicaid beneficiaries and non-Medicaid individuals with a mental health and/or substance use disorder diagnosis. For Medicaid beneficiaries receiving CCBHC services, MDHHS will operationalize the PPS-1 payment through their contracted Prepaid Inpatient Health Plans (PIHPs), specifically those PIHPs that have CCBHC Demonstration Sites within their service areas. PIHPs will reimburse CCBHC Demonstration Sites at clinic-specific PPS-1 rate or their actuarial equivalent. For non-Medicaid individuals receiving CCBHC services, MDHHS will provide an annual reconciliation payment and/or prospective payments based on anticipated utilization to the PIHP for dispersal to the CCBHC. The processes for PPS-1 payment for Medicaid beneficiaries and non-Medicaid CCBHC recipients is further delineated in the sections below. Finally, MDHHS will provide Quality Based Payments (QBPs) that will reward CCBHC Demonstration Sites based on attainment of CMS-defined quality metrics in a given performance year specifically reflective of the Medicaid beneficiaries receiving CCBHC services.

5.B. CCBHC Prospective Payment System Methodology

MDHHS utilizes the prospective payment system 1 (PPS-1) methodology in which CCBHCs receive a daily clinic-specific rate based on the average expected daily cost to deliver core CCBHC services.

5.B.1. PPS-1 Rate Development

- *Demonstration Year 1*
  Pursuant to federal requirements, the PPS-1 rate for Demonstration Year 1 is based on the CCBHC Cost Reports submitted to CMS in 2016. These rates may be updated based on FY19 clinic data and/or the appropriate Medicare Economic Index (MEI) adjustment. Any updates to the rates must be approved by MDHHS and CMS.

- *Demonstration Year 2*
  Pursuant to federal requirements, the PPS-1 rate for Demonstration Year 2 may be rebased according to the actual costs of providing the nine core CCBHC services, including the costs of serving the uninsured and underinsured. As such, Demonstration Year 2 PPS-1 rates will be based on the CCBHC Cost Reports submitted for Demonstration Year 1, as applicable.

5.B.2. PPS-1 Rate Amounts

The PPS-1 Rates for Demonstration Year 1 can be found in Appendix D of this Handbook. PPS-1 Rates for Demonstration Year 2 will be included in this Handbook upon completion of the rebasing process following the end of Demonstration Year 1, if applicable. All PPS-1 Rates are subject to final approval from CMS.

5.C. CCBHC Payment Operations

5.C.1. General Provisions

5.C.1.1. Required CCBHC Service Encounter Codes

The T1040 code is the dedicated CCBHC demonstration encounter code and is used solely to identity CCBHC service encounters. CCBHCs must submit valid CCBHC encounter codes reflecting qualifying services (as cited in Appendix A) with a corresponding T1040 code to the PIHP. In turn, PIHPs will submit all encounters to MDHHS via CHAMPS.

Encounter reporting systems must have the capacity to report at least two service lines and at least two diagnoses. The combination of the T1040 code, the CCBHC Encounter Code, and a qualifying diagnosis must be submitted for the service s to be recognized as a CCBHC service. Omitting either the T1040 code or the CCBHC Encounter Code will preclude payment at the PPS-1 rate. Additionally, if a T1040 code is submitted without a valid CCBHC service, the encounter will be rejected with the CHAMPS Error Code of 20906. If a valid CCBHC Service Code is reported without a T1040 code, the encounter will be accepted but will not be able to be identified as a CCBHC encounter.

Multiple T1040 codes can be submitted on a given day, although the CCBHC is only eligible for reimbursement of one PPS-1 rate per individual per day. Since the CCBHC service array is a blend of Mental Health and Substance Use Disorder services, a PIHP may need to submit encounters using both MH and SUD provider identification

numbers.

5.C.1.1.A Encounter Code Set

Qualifying CCHBHC encounter codes can be found in Appendix A of this handbook. Unless otherwise specified, all potential modifiers can be used with CCBHC encounter codes. Although changes to the code list cannot be made during a given demonstration year, additional service codes may be considered for use in future demonstration years provided they fit within the required CCBHC service array. Requests for changes can be sent to mdhhs-ccbhc@michigan.gov.

The H0023 code for drop in services has been removed from the DY1 code set. Encounters should not be submitted with a corresponding T1040, and total costs of operating the centers should continue to be reported accordingly.

5.C.1.2. Reporting Detail of CCBHC Service Encounter Codes

For Medicaid beneficiaries, the CCBHC must submit the encounter with the beneficiary's Medicaid ID; for non-Medicaid recipients, the CCBHC must submit the encounter with the PIHP's Consumer ID assigned to the recipient. In turn, PIHPs must submit all CCBHC service encounters to MDHHS via CHAMPS consistent with the requirements of this section.

All CCBHC service encounters, whether provided directly or through a DCO, must be submitted to the PIHP with the CCBHC as the Billing NPI. For CCBHC services provided through a DCO, the DCO's NPI number must be reported in the Service Facility Location loop (See Appendix I). Note: If the DCO is not eligible for an NPI, please contact mdhhs-ccbhc@michigan.gov.

PIHPs may determine what amount should be reported for the T1040 Claim Charge Amount and the Payment Amount. Charge and Payment amounts reported on the individual CCBHC service lines should align with historical reporting, with the Charge amount representing estimated actual costs and Payment Amount representing historically paid amounts. Reporting encounters in this way allows for the identification of CCBHC services while retaining consistency with reporting methodology of previous years and of non-CCBHC services. There is no expectation that the sum of the charged or paid amounts will equal the PPS rate.

See Example of encounter reporting in Appendix I. In this example, the CCBHC is reporting $0.00 on the T1040 line.

5.C.1.3. Timely and Complete CCBHC Service Encounter Code Submission

CCBHCs and PIHPs must submit timely and complete CCBHC service encounters in accordance with federal managed care rules and state requirements. CCBHCs must submit encounters to the PIHP within 30 days following the month in which CCBHC services are rendered. The PIHPs must validate encounters to ensure the inclusion of appropriate details, including any third party or other applicable payments. The PIHPs must submit validated encounters to MDHHS within 90 days following the month in

which CCBHC services are rendered.

5.C.1.4. Documenting ICD-10-CM "Z-Codes"

Applicable ICD-10-CM Z diagnosis codes should be submitted, as applicable, with the CCBHC encounters to document social determinants of health. Please note that any Z-Codes should be secondary to the mental health and/or SUD diagnosis. The pertinent list is as follows:

- Z55 Problems related to education and literacy
- Z56 Problems related to employment and unemployment
- Z57 Occupational exposure to risk factors
- Z59 Problems related to housing and economic circumstances
- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Other problems related to primary support group, including family circumstances
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances

5.C.1.5. Encounter Submission

The PIHP will use the File Transfer Service (FTS) to submit and retrieve encounter related files electronically with MDHHS. Refer to Section 6: Health Information Technology, of this handbook for additional information relating to FTS.

The PIHP will submit 837 HIPAA Encounter Files through the FTS to MDHHS, and to recognize files that MDHHS returns to your billing agent "mailbox". When submitting CCBHC encounters, you will use Class ID/file number 5476 for encounter files. After submission, you will receive a response in the mailbox via a 999-acknowledgment file. The 999 file does not mean that all encounters submitted were accepted. Once the 5476 file is processed by MDHHS, you will receive a 4950 file, also known as the Encounter Transaction Results Report (ETRR), which will provide details on accepted and rejected encounters.

CCBHCs are encouraged to review the "Electronic Submissions Manual" (ESM) for additional information and instructions relating to submitting data electronically and the FTS. The ESM can be found at www.michigan.gov/tradingpartners >> HIPAA - Companion Guides >> Electronic Submissions Manual.

The MDHHS Encounter Team will handle all electronic questions related to Encounter file submission and FTS issues for CCBHC organizations. Questions or issues can be directed to the following email addresses: MDHHSEncounterData@michigan.gov.

5.C.2. CCBHC Payment Operations for Medicaid Beneficiaries

MDHHS will operationalize the CCBHC payment for Medicaid beneficiaries through the PIHPs by integrating the CCBHC PPS-1 payment into the PIHP capitation rates for qualifying CCBHC services (see Appendix A for a list of CCBHC-eligible services). In turn, MDHHS will require the PIHP to reimburse the CCBHC at the clinic-specific PPS-1 rate or its actuarial equivalent for

qualifying CCBHC services (daily visits).

5.C.2.1. PIHP CCBHC Capitation Payment

MDHHS will integrate the CCBHC PPS-1 payment into the PIHP capitation rates for CCBHC-eligible services (see Appendix A). Because CCBHC services reflect services traditionally provided through the PIHP delivery system, a portion of the CCBHC payment is comprised by the PIHP's "base" capitation. To make whole the PPS-1 rate, MDHHS will prospectively provide PIHPs a "supplemental" CCBHC capitation payment. The supplemental CCBHC capitation payment reflects the difference between the PPS-1 rate and the amount in the PIHP's base capitation based on anticipated utilization of CCBHC services for Medicaid beneficiaries enrolled in the CCBHC benefit plan. MDHHS will also provide an amount for PIHP CCBHC administration and the Quality Based Payment in the supplemental CCBHC capitation payment. The supplemental CCBHC payment is considered non-risk and will be reconciled annually as cited in 5.C.2.1.1. The base CCBHC payment, which reflects the payment that would normally be made to the PIHPs regardless of the CCBHC Demonstration, will be at risk per current policy.

5.C.2.1.1. Annual Reconciliation of Supplemental CCBHC Payments

On an annual basis, MDHHS will reconcile with the PIHPs the supplemental costs and payments based on actual PPS-1 eligible CCBHC service utilization (which equals CCBHC daily visits * PPS-1 rate). To assist in the reconciliation process, MDHHS is creating a new module in the Milliman DRIVE Tool for PIHPs to run reports on CCBHC enrollment, issued payments, and adjudicated encounters. MDHHS and the PIHPs will be able to query this data by CCBHC site, discrete service(s) rendered, demographics, Medicaid vs. non-Medicaid, and generate monitoring reports to view actual versus real utilization/costs of CCBHC services.

5.C.2.2. PIHPs to CCBHCs: CCBHC Payment to CCBHC Demonstration Sites

MDHHS requires the PIHP to reimburse a CCBHC at its clinic-specific PPS-1 rate for each qualifying CCBHC service (note: the PPS-1 payment may only be paid once per day per beneficiary/recipient regardless of the number of CCBHC services provided on a given day). PIHPs must reimburse a CCBHC the full PPS-1 payment amount within 60 days following the month in which the service was rendered. CCBHCs must submit to the PIHP valid CCBHC Encounter Codes cited in Appendix A of the CCBHC Handbook with a corresponding T1040 service encounter code.

5.C.2.3. PIHP Payment Schedule for Medicaid Beneficiaries

The enrollment file for enrollments processed each month in the Wavier Support Application (WSA) will be sent to CHAMPS on the 26th of the month for processing. CHAMPS will send the enrollment to the PIHP on the 5093 Waiver Enrollment File on the last day of each month. For illustrative purposes, the July 26th WSA enrollment file and 5093 would include:

- Enrollment for newly enrolled beneficiaries added to CCBHC effective August 1.
- Retroactive enrollment for beneficiaries enrolled effective February 1, March 1, April 1, May 1, June 1, or July 1 since June 26.

Payment for CCBHC enrolled Medicaid beneficiaries will be sent on the 5093 Wavier Enrollment File and will be made on the second pay cycle (the Thursday after the 2nd Wednesday of the month). The payment will be included with any other scheduled payments associated with the PIHP's tax identification number.

5.C.3. CCBHC Payment Operations for Non-Medicaid CCBHC Recipients

Contingent on available funding, MDHHS will provide payment via the PIHPs to offset the eligible portion of the cost of CCBHCs providing CCBHC services to the non-Medicaid CCBHC recipients. CCBHCs and the PIHPs must ensure all third-party and other applicable revenue sources are exhausted by a CCBHC for a CCBHC-eligible service for a non-Medicaid CCBHC recipient.

CCBHCs throughout the country have leveraged multiple funding mechanisms to cover the unreimbursed costs of serving the non-Medicaid population. To the extent possible, MDHHS will provide funding to the PIHPs to reimburse the CCBHCs for non-Medicaid CCBHC services, but PIHPs and CCBHCs should leverage existing grant funds, third party collections, and other available local funds.

5.C.3.1 DY1 and DY2 General Fund Distribution

$5 million General Fund is available in DY1 and DY2 to support non-Medicaid service expenses. In DY1, MDHHS will distribute these funds in a single payment to the PIHPs prior to October 1, 2022. Amounts will be determined based on the number of non-Medicaid CCBHC-eligible daily visits provided by each PIHP. PIHPs will be given 30 days' notice to ensure encounter submissions are up to date and accurate. After 30 days, the $5 million will be divided proportionally based on the number of non-Medicaid daily visits reported on the Milliman CCBHC DRIVE Dashboard from October 1, 2021 – March 31, 2022. PIHPs will distribute funds based on proportional utilization as specified by MDHHS. CCBHCs will not be expected to cost settle if they do not need the full amount to cover non-Medicaid expenses.

In DY2, the $5 million General Fund will be distributed proportionally based on the full year of DY1 non-Medicaid utilization, as reported on the Milliman CCBHC DRIVE Dashboard. DY1 utilization will be reviewed, and a determination of the funding amounts allotted to each PIHP will be made in January 2023.

5.C.4. Third-Party Reimbursement/Coordination of Benefits

For all CCBHC services (daily visits), whether provided directly or through a DCO, CCBHCs must first bill any applicable third-party payors, including Medicare, prior to submitting the encounter to the PIHP for CCBHC PPS-1 payment*. In addition, *for non-Medicaid CCBHC daily visits*, CCBHCs must first use all applicable federal or state grant funding (including but not limited to SAMHSA CCBHC Expansion grant funding) and maximize collection of all other applicable revenue sources such as sliding fee scale payments.

CCBHCs will report all applicable third-party payment/COB/other revenue used for CCBHC services (daily visits) to the PIHP. The PIHP will apply this funding against CCBHC service costs (eligible daily visits * PPS-1 rate) via CCBHC encounters submitted for both the Medicaid and non-Medicaid CCBHC recipients.

- For *Medicaid beneficiaries*, the PIHP will utilize Medicaid capitation to reimburse the

balance of CCBHC service costs less the third-party/COB payments.

- For *non-Medicaid recipients*, the PIHP will, to the extent available, utilize dedicated state funds to reimburse the balance of CCBHC service costs less the third-party/COB/other grant and/or revenue source funds.

(*Note: there are cases where certain third-party payors may not allow the CCBHC to bill on behalf of a DCO; in this case, the DCO must provide any payment received from the third-party payor to the CCBHC.)

5.D. Quality Bonus Payments (QBP)

MDHHS affords a QBP for CCBHCs meeting CMS-defined quality benchmarks.* To receive a QBP, a CCBHC must achieve or exceed the threshold for all QBP-eligible measures as specified by CMS. The QBP is based on 5% of the total CCBHC Medicaid Demonstration Year Costs. QBP for Demonstration Year 2 will also be calculated at 5% of total CCBHC Medicaid Demonstration Year Costs but will be based on DY2 Benchmarks (to be defined).

(*Please note: the QBP is only pertinent to Medicaid CCBHC costs and beneficiaries.)

5.D.1. QBP Measures, Measure Stewards, and DY1 Benchmarks

Performance Measure Number	Measure Name and NQF # (if applicable)	Measure Steward	Benchmark	Technical Specification Document (see 5.D.3. for link)	Technical Specification Document Page Number
1.	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)*	AMA-PCPI	23.9%	SAMHSA Metrics and Quality Measures (2016)	74
2.	Major Depressive Disorder: Suicide Risk Assessment (SRA-A)*	AMA-PCPI	12.5%	SAMHSA Metrics and Quality Measures (2016)	82
3.	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)^*	CMS	58.5%	CMS Adult Core Set (2021)	138
4.	Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)^*	NCQA	58%	CMS Adult Core Set (2021)	66
5.	Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)^*	NCQA	70%	CMS Child Core Set (2021)	71

6.	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)*	NCQA	IET-14 (Initiation) - 42.5% IET-34 (Engagement)-18.5%	SAMHSA Metrics and Quality Measures (2016)	193

^Denotes updated technical specification from the original 2016 measure
*Denotes the measure is both a quality measure AND a quality bonus payment measure

5.D.2. QBP Distribution Methodology

5.D.2.1. Distribution

CCBHC QBP performance will be evaluated and awarded at the CCBHC site level. Per federal guidance, all performance benchmarks must be met by a CCBHC site for QBP to be awarded. If performance benchmarks are met, MDHHS will provide the QBP payment to the PIHP for distribution to the awarded CCBHC(s).

5.D.2.2. Timelines

MDHHS will distribute QBP payments to the PIHP within one year of the end of a Demonstration Year (DY). The PIHP will distribute the QBP to the awarded CCBHC(s) within 60 days of receiving the payment from MDHHS.

5.D.3. QBP Technical Specifications

CMS is currently updating the CCBHC Quality Measure Technical Specifications. In the interim, states must report using existing technical specifications cited in the *2016 SAMHSA Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications Manual* or, for select measures, using more current technical specifications cited in the *2021 CMS Adult and Child Core Set Manuals*. Select measures for which technical specification updates have been made are denoted with the ^ symbol.

The two technical specification documents encompassing the CCBHC quality measures are as follows:

- SAMHSA Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual (2016)

- CMS Medicaid Core Set Technical Specifications and Resource Manual:
  - Adult Core Set (2021)
  - Child Core Set (2021)

6. CCBHC and Health Information Technology

6.A. MDHHS Customer Relationship Management (CRM) Database

The MDHHS CRM is the platform in which MiCAL, and other MDHHS business processes are housed. The CRM is a customized technological platform designed to automate and simplify procedures related to the regulatory relationship between MDHHS and its customers (PIHPs, CMHSPs, CCBHCs, SUD entities, Michiganders, etc.). The MDHHS CRM will house the CCBHC

certification process for the demonstration. Each CCBHC will have an account and will complete all certification processes using the MDHHS CRM including submitting the CCBHC application and pertinent documents and completing the on-site review process.

Please contact the MiCAL inbox if you need support at MDHHS-BHDDA-MiCAL@michigan.gov

6.B. Waiver Support Application (WSA)

The Waiver Support Application (WSA) is the assignment, maintenance, and management tool for the CCBHC demonstration. The WSA will be used by PIHPs to identify and assign eligible CCBHC recipients to a relevant CCBHC. The CCBHC will be permitted to recommend assignment of a recipient to a CCBHC. WSA will be used for the following:

- Identify eligible CCBHC Medicaid beneficiaries
- Assign eligible Medicaid and Non-Medicaid CCBHC recipients to a CCBHC
- Recommend eligible recipients for CCBHC assignment
- Verify clinical criteria and signed consent to share behavioral health information
- View beneficiary demographics and chronic condition counts
- Communicate between the PIHP and CCBHC using comments
- Upload and share documents
- Review reports and develop a CCBHC recipient roster

At the beginning of the demonstration (October 2021) an initial batch of eligible CCBHC recipients will be added to the WSA, both Medicaid and non-Medicaid. PIHPs will have access to all eligible recipients that reside in their region for CCBHC assignment. Every month thereafter, individuals with a qualifying diagnosis will be uploaded to WSA.

Users must request access to WSA through MILogin, please see the WSA User Manual for instructions. Training materials will be housed under the training tab in WSA.

Users will access the WSA through MILogin (https://milogintp.michigan.gov)

6.C. CareConnect 360

CareConnect360 will help HIT-supported care coordination activities for the CCBHC Demonstration. Broadly, it is a statewide care management web portal that provides a comprehensive view of individuals in multiple health care programs and settings based on paid Medicaid claims and encounters. This will allow the PIHP and CCBHCs with access to CareConnect360 the ability to analyze health data spanning different settings of care for people with Medicaid. In turn, this will afford CCBHCs a more robust snapshot of a beneficiary and allow smoother transitions of care. It will also allow the PIHP to make better and faster decisions for the betterment of the beneficiary. Providers will only have access to individuals that are established as patients of record within their practice. Finally, with appropriate consent, CareConnect360 facilitates the sharing of cross-system information, including behavioral health, physical health, and social support services.

Users will access the CareConnect360 through MILogin (https://milogintp.michigan.gov)

6.D. File Transfer Service (FTS)

Michigan's data-submission portal is the File Transfer Service (FTS); however, it has previously been referred to as the Data Exchange Gateway (DEG). Some documents may still reference the (DEG); be aware that a reference to the DEG portal is a reference to the FTS. Billing agents will use the FTS

to submit and retrieve files electronically with MDHHS. MDHHS has established an internet connection to the FTS, which is a Secure Sockets Layer connection. This connection is independent of the platform used to transmit data. Every billing agent receives a "mailbox", which is where their files are stored and maintained. Billing agents can access this mailbox to send and retrieve files.

CCBHCs are encouraged to review the "Electronic Submissions Manual" (ESM) for additional information and instructions relating to the FTS. The ESM can be found at www.michigan.gov/tradingpartners >> HIPAA - Companion Guides >> Electronic Submissions Manual

Users will access the FTS through MILogin (https://milogintp.michigan.gov)

7. CCBHC Monitoring and Evaluation

7.A. CCBHC Monitoring & Evaluation Requirements

CMS has defined reporting requirements and guidance for the CCBHC Demonstration. There are two broad sets of requirements – CCBHC Reported Measures and State Reported Measures. A state-lead measure is calculated by the state for each CCBHC, usually relying on administrative data. A CCBHC-lead measure is calculated by the CCBHC and sent to the state. The measures are not aggregated by the state. To the extent necessary to fulfill these requirements, providers must agree to share all CCBHC clinical and cost data with MDHHS. It is the goal of MDHHS to utilize administrative data as much as possible to avoid administrative burden on providers. The data will be reported annually by MDHHS to CMS within 12 months of the end of Demonstration Year 1. CCBHCs must report measures to MDHHS within 6 months of the end of Demonstration Year 1.

The specific Core Measures and other federal requirements are laid out below:

7.A.1. CCBHC Reported Measures

Measure Name	Measure Steward	Technical Specification Document	Technical Specification Page Number
Time to Initial Evaluation (I-EVAL)	SAMHSA	SAMHSA Metrics and Quality Measures (2016)	30
Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	CMS	SAMHSA Metrics and Quality Measures (2016)	44
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)^	NCQA	CMS Child Core Set (2021)	100
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	AMA-PCPI	SAMHSA Metrics and Quality Measures (2016)	66
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	AMA-PCPI	SAMHSA Metrics and Quality Measures (2016)	69

Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)*	AMA-PCPI	SAMHSA Metrics and Quality Measures (2016)	74
Major Depressive Disorder: Suicide Risk Assessment (SRA-A)*	AMA-PCPI	SAMHSA Metrics and Quality Measures (2016)	82
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)^	CMS	CMS Adult Core Set (2021)	47
Depression Remission at Twelve Months (DEP-REM-12)	MNCM	SAMHSA Metrics and Quality Measures (2016)	95

7.A.2. State Reported Measures

Measure Name	Measure Steward	Technical Specification Authority and Reference	Technical Specification Page Number
Housing Status (HOU)	SAMHSA	SAMHSA Metrics and Quality Measures (2016)	101
Patient Experience of Care Survey (PEC)	SAMHSA	SAMHSA Metrics and Quality Measures (2016)	109
Youth/Family Experience of Care Survey (Y/FEC)	SAMHSA	SAMHSA Metrics and Quality Measures (2016)	111
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA	SAMHSA Metrics and Quality Measures (2016)	113
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	NCQA	SAMHSA Metrics and Quality Measures (2016)	118
Plan All-Cause Readmission Rate (PCR-AD)^	NCQA	CMS Adult Core Set (2021)	116
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD-AD)^	NCQA	CMS Adult Core Set (2021)	145
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)^*	CMS	CMS Adult Core Set (2021)	138
Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)^*	NCQA	CMS Adult Core Set (2021)	66
Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)^*	NCQA	CMS Child Core Set (2021)	71
Follow-up care for children prescribed ADHD medication (ADD-CH)^	NCQA	CMS Child Core Set (2021)	15
Antidepressant Medication Management (AMM-AD) ^	NCQA	CMS Adult Core Set (2021)	14
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)*	NCQA	SAMHSA Metrics and Quality Measures (2016)	193

^Denotes updated technical specification from the original 2016 measure
*Denotes the measure is both a quality measure AND a quality bonus payment measure

7.A.3. CCBHC Metric Specifications

CMS is currently updating the CCBHC Quality Measure Technical Specifications. In the interim, states must report using existing technical specifications cited in the *2016 SAMHSA Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications Manual* or, for select measures, using more current technical specifications cited in the *2021 CMS Adult and Child Core Set Manuals*. Select measures for which technical specification updates have been made are denoted with the ^ symbol.

The two technical specification documents encompassing the CCBHC quality measures are as follows:

- SAMHSA Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual (2016)

- CMS Medicaid Core Set Technical Specifications and Resource Manual:
  - Adult Core Set (2021)
  - Child Core Set (2021)

7.A.3.1. Deviation from Technical Specifications

CMS has permitted deviation from the identified Technical Specifications for the following measures:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH): In the context of the CCBHC demonstration, the BMI screening may be conducted by medical personnel at either the CCBHC or a DCO without regard to whether they are a PCP or OB/GYN for the consumer, as long as they are operating within the scope of practice for their licensure. "Medical personnel" may include nurses, medical assistants, and others operating within the licensure or certification requirements of the state. Because this is a deviation from the measure Technical Specification, however, it should be so indicated in the section of the data reporting template where adherence or non-adherence to the Technical Specification is reported.

7.A.3.2. Reporting Requirements

CCBHC-reported measures will be compiled by the CCBHC using the SAMHSA 2016 Data Reporting Template (XLSX file). CCBHCs are responsible for completing the "Case Load Characteristics" sheet and the reporting sheets for the clinic-reported measures (green colored tabs).

During DY1, CCBHCs are required to participate in a mid-year trial exercise to ensure clinics can acquire the appropriate data and complete the template reporting. Metrics will be calculated based on a measurement period of October 1, 2021 – March 31, 2022.

During DY2, CCBHCs should complete their reporting template quarterly. PIHPs should assist with validation and review of measures. Templates should be sent to PIHPs by the

end of the month following the measurement period (specified in the table below). PIHPs will also make the quarterly templates available to MDHHS or external evaluators throughout DY2 for purposes of monitoring and evaluation planning.

Reporting Timelines – Templates Due to PIHPs	
Measurement Period	Due Date
October 1, 2022 – December 31, 2022	January 30, 2023
January 1, 2023 – March 31, 2023	April 30, 2023
April 1, 2023 – June 30, 2023	July 31, 2023
July 1, 2023 – September 30, 2023	October 31, 2023
October 1, 2022 – September 30, 2023	April 30, 2024 (to MDHHS)

PIHPs should collect, validate, and submit the final templates to MDHHS within 6 months of the end of the Demonstration Year. Final templates should be sent via email to mdhhs-ccbhc@michigan.gov by April 30 of each year.

Reporting Timelines – Templates Due to MDHHS	
Measurement Period	Due Date
October 1, 2022 – September 30, 2023	April 30, 2024

7.A.3.3. *Defining Eligible CCBHC Population*

Per CMS guidance and the technical specifications listed above, the eligible population for these measures includes all CCBHC recipients (Medicaid and non-Medicaid) served by a CCBHC provider (including those served at DCOs). The denominator-eligible population for each measure includes CCBHC recipients who satisfy the measure-specific eligibility criteria that may include requirements such as age and continuous enrollment. Specification details will indicate the population that should be included in each measure and the reporting unit for the measure (e.g. consumers or visits).

State reported measures are calculated using administrative claims data and will use the presence of a T1040 service code to identify the CCBHC population. CCBHC assignment will be attributed to the CCBHC an individual is assigned to in the WSA. Individuals receiving services at multiple CCBHCs should have only one clinic assignment in the WSA and should have been identified by both clinics as the primary care provider and care coordinator (see section 13.C.1.5). PIHP assignment will correspond to CCBHC assignment.

CCBHC-reported measures will be calculated using data collected in the local Electronic Health Record (EHR) and generated using the EHR-developed reporting module. CCBHCs should assign CCBHC service recipients according to EHR requirements for inclusion in the reporting modules (e.g. assignment to CCBHC program or insurance type). It is the responsibility of the CCBHC to ensure that all eligible CCBHC service recipients are assigned and included in the calculation. CCBHCs should cross-reference WSA clinic assignment to CCBHC service assignment in their EHR. To the extent possible, attribution to clinics for individuals served at multiple CCBHCs should be

based on assignment in the WSA.

7.B. Additional Monitoring Requirements

7.B.1. CCBHC Ad Hoc Reporting

As described in section 2.C.10, CCBHCs must collect, report, and track encounter, outcome, and quality data, including but not limited to data capturing CCBHC recipient characteristics, Staffing, Access to Services, Use of Services, Screening, prevention, and treatment, Care Coordination, other processes of care, CCBHC recipient outcomes, and costs. Data collection is required for both direct CCBHC services and those provided by DCOs. A minimum of 30 days' notice will be given to respond to these requests.

7.B.1.1. Level of Care Information Reporting

CCBHCs must collect and report on the experience of CCBHC service recipients with mild to moderate levels of care. CCBHCs should use the data fields identified in the state-supplied collection template of each given demonstration year. Data are required to be reported for all CCBHC enrollees annually unless data constraints exist. Reports are due to MDHHS by the first Friday in July of each demonstration year.

Data collected may include:

- Working definitions of mild to moderate levels of care at a given CCBHC
- Time span in which a beneficiary was defined as mild to moderate
- Movement through different levels of care during a treatment episode
- Historical service information, if available

7.C. Evaluation Requirements

CCBHCs and PIHPs must work with MDHHS and contracted evaluation partners to develop and implement a rigorous evaluation of the CCBHC demonstration. CCBHCs and PIHPs will participate in stakeholder groups and respond to requests for information as needed.

8. Appendix A: CCBHC Demonstration Service Encounter Codes

CMS has issued dedicated 223 demonstration encounter billing codes and a billing code modifier. MDHHS will utilize the T1040 code in conjunction with one of the CCBHC service encounter codes cited in the tables below. CCBHC encounters must be submitted with the T1040 code in addition to one of the proceeding service encounter codes to be counted as a CCBHC Demonstration service.

CCBHC services provided via telemedicine should follow the BPHASA coding requirements and BPHASA Telemedicine Database. These materials can be found hyperlinked at the top of the BPHASA Reporting Requirements website at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html.

CCBHC services utilizing modifiers should follow code sets and guidance cited on the BPHASA Mental Health & Substance Abuse Reporting Requirements website at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html. Once on the site, the applicable materials can be found by clicking the "Encounter Data Integrity Team (EDIT)" ribbon. Unless otherwise specified, all potential modifiers can be used with CCBHC encounter codes.

T1040	Medicaid certified community behavioral health clinic services, per diem

Service Category: Crisis Services

Code	Description
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service)
H2011	Crisis intervention service, per 15 minutes
S9484	Crisis intervention mental health services, per hour
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter

Service Category: Screening, Assessment, and Diagnosis, including Risk Assessment

Code	Description
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, (e.g., by Boston diagnostic aphasia examination) with interpretation and report, per hour
96110	Developmental screening
96112	Developmental test administration by qualified health care professional with interpretation and report, first 60 minutes
96113	Developmental test administration by qualified health care professional with interpretation and report, additional 30 minutes
96116	Neurobehavioral status examination by qualified health care professional with interpretation and report, first 60 minutes
96120	Neuropsych test admin w/comp
96121	Neurobehavioral status examination by qualified health care professional with interpretation and report, additional 60 minutes
96127	Brief emotional or behavioral assessment
96130	Psychological testing evaluation by qualified health care professional, first 60 minutes

96131	Psychological testing evaluation by qualified health care professional, additional 60 minutes
96132	Neuropsychological testing evaluation by qualified health care professional, first 60 minutes
96133	Neuropsychological testing evaluation by qualified health care professional, additional 60 minutes
96136	Psychological or neuropsychological test administration and scoring by qualified health care professional, first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by qualified health care professional, additional 30 minutes
96138	Psychological or neuropsychological test administration and scoring by technician, first 30 minutes
96139	Psychological or neuropsychological test administration and scoring by technician, additional 30 minutes
96146	Psychological or neuropsychological test administration and scoring by single standardized instrument via electronic platform with automated result
H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility for admission to treatment program
H0031	Mental health assessment, by non-physician
H2000*	Comprehensive multidisciplinary evaluation
90887*	Explanation of psychiatric, medical examinations, procedures, and data to other than patient
90785	Interactive complexity (list separately in addition to the code for primary procedure)

Service Category: Treatment Planning

Code	Description
H0032	Mental health service plan development by non-physician
90887*	Explanation of psychiatric, medical examinations, procedures, and data to other than patient
H2000*	Comprehensive multidisciplinary evaluation

Service Category: Outpatient Mental Health and Substance Use Services

Code	Description
90832	Psychotherapy, 30 minutes
90833	Psychotherapy, 30 minutes
90834	Psychotherapy, 45 minutes
90836	Psychotherapy, 45 minutes
90837	Psychotherapy, 60 minutes
90838	Psychotherapy, 60 minutes
90846	Family psychotherapy, 50 minutes
90847	Family psychotherapy including patient, 50 minutes
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
99201	New patient office or other outpatient visit, typically 10 minutes
99202	New patient office or other outpatient visit, typically 20 minutes
99203	New patient office or other outpatient visit, typically 30 minutes

99204	New patient office or other outpatient visit, typically 45 minutes
99205	New patient office or other outpatient visit, typically 60 minutes
99211	Established patient office or other outpatient visit, typically 5 minutes
99212	Established patient office or other outpatient visit, typically 10 minutes
99213	Established patient office or other outpatient visit, typically 15 minutes
99214	Established patient office or other outpatient, visit typically 25 minutes
99215	Established patient office or other outpatient, visit typically 40 minutes
99341	New patient home visit, typically 20 minutes
99342	New patient home visit, typically 30 minutes
99343	New patient home visit, typically 45 minutes
99344	New patient home visit, typically 60 minutes
99345	New patient home visit, typically 75 minutes
99347	Established patient home visit, typically 15 minutes
99348	Established patient home visit, typically 25 minutes
99349	Established patient home visit, typically 40 minutes
99350	Established patient home visit, typically 60 minutes
H0004	Behavioral health counseling and therapy, per 15 minutes (SUD)
H0005	Alcohol and/or drug services; group counseling by a clinician
H0012	Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient) ASAM WM-3.2
H0014	Alcohol and/or drug services; ambulatory detoxification ASAM WM-1
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)
H0022	Alcohol and/or drug intervention service (planned facilitation)
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0033	Oral Medication Administration, direct observation.
H0034	Medication training and support, per 15 minutes
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0050	Alcohol and/or drug services, brief intervention, per 15 minutes
H2010	Comprehensive medication services, per 15 minutes
H2019	Therapeutic behavioral services, per 15 minutes (DBT)
H2021	Community-based wrap-around services, per 15 minutes
T1027	Family training and counseling for child development, per 15 minutes
H0039*	Assertive community treatment, face-to-face, per 15 minutes

Service Category: Outpatient Clinic Primary Care Screening and Monitoring

Code	Description

99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382	Initial new patient preventive medicine evaluation, age 1 through 4 years
99383	Initial new patient preventive medicine evaluation, age 5 through 11 years
99384	Initial new patient preventive medicine evaluation, age 12 through 17 years
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99387	Initial new patient preventive medicine evaluation, age 65 years and older
99391	Established patient periodic preventive medicine examination infant younger than 1 year
99392	Established patient periodic preventive medicine examination, age 1 through 4 years
99393	Established patient periodic preventive medicine examination, age 5 through 11 years
99394	Established patient periodic preventive medicine examination, age 12 through 17 years
99395	Established patient periodic preventive medicine examination age 18-39 years
99396	Established patient periodic preventive medicine examination age 40-64 years
99397	Established patient periodic preventive medicine examination, age 65 years and older

Service Category: Targeted Case Management

Code	Description
T1017	Targeted case management, each 15 minutes

Service Category: Psychiatric Rehabilitation

Code	Description
G0176*	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)
G0177*	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
H2023	Supported employment, per 15 minutes
H2030	Mental health clubhouse services, per 15 minutes
H0039*	Assertive community treatment, face-to-face, per 15 minutes

Service Category: Peer/Family Support

Code	Description

H0038	Self-help/peer services, per 15 minutes
H0045	Respite care services, not in the home, per diem
H2014	Skills training and development, per 15 minutes
H2027	Psychoeducational service, per 15 minutes
S5110	Home care training, family; per 15 minutes
S5111	Home care training, family; per session
T1005	Respite care services, up to 15 minutes
T1012	Alcohol and/or substance abuse services, skills development

*Code included in multiple service categories.

9. Appendix B: List of CCBHC-eligible ICD-10 Diagnosis Codes

- Any individual with a mental health and/or substance use disorder diagnosis, including:

    - Any mental health disorder, including all codes in the following ranges:
        - F01-F09: Mental disorders due to known physiological conditions
        - F20-F29: Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
        - F30-F39: Mood [affective] disorders
        - F40-F48: Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
        - F50-F59: Behavioral syndromes associated with physiological disturbances and physical factors
        - F60-F69: Disorders of adult personality and behavior
        - F90-F98: Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
        - F99-F99: Unspecified mental disorder

    - Any substance use disorder, including all codes in the following ranges:
        - F10-F19: Mental and behavioral disorders due to psychoactive substance use

10. Appendix C: Michigan's SAMHSA Expansion Grantees

SAMHSA Expansion Grant Recipients, August 2021 **Also, a CMS CCBHC Demonstration Site*
Allegan County Community Mental Health Services
Alternative Community Living, Inc. dba Hope Network New Passages
Barry County Community Mental Health Authority
Berrien Mental Health Authority dba Riverwood Center
Branch County Community Mental Health Authority dba Pines Behavioral Health
Community Care Services (Wayne Co)
Clinton-Eaton-Ingham (CEI) Community Mental Health Authority*
Community Network Services, Inc. (Oakland Co)*
Detroit Recovery Project, Inc (Wayne Co)
Detroit Rescue Mission Ministries (Wayne Co)
Development Centers Inc. (Wayne Co)
Easter Seals Michigan, Inc. (Oakland Co)*
Elmhurst Homes, Inc. (Wayne Co)
Faith Hope and Love Outreach Center (Wayne)
Genesee Health System
HealthWest (Muskegon Co)*
Hegira Programs, Inc. (Wayne Co)
Integrated Services of Kalamazoo*
Judson Center, Inc. (Macomb Co)
LifeWays Community Mental Health (Jackson, Hillsdale Co)
Macomb County Community Mental Health*
Neighborhood Service Organization (Wayne)
Network180 (Kent Co)
Northeast Guidance Center (Wayne)
Ottawa County Community Mental Health
Saginaw County Community Mental Health Authority*
Southwest Counseling Solutions (Wayne)
St. Clair County Community Mental Health Authority*
Summit Pointe (Calhoun Co)
Team Mental Health Services (Wayne Co)
The Guidance Center (Wayne Co)*
Washtenaw County Community Mental Health Center*
West Michigan Community Mental Health System (Lake, Mason, Oceana Co)*

11. Appendix D: Demonstration Year 1 PPS-1 Rates by CCBHC

CCBHC Demonstration Site	PIHP	FY22 PPS-1 Rate
CEI	Region 5	$ 373.07
CNS	Region 8	$ 342.23
Easter Seals	Region 8	$ 327.63
HealthWest	Region 3	$ 383.02
Kalamazoo	Region 4	$ 445.73
Macomb	Region 9	$ 388.01
Right Door	Region 5	$ 384.14
SCCMHA	Region 5	$ 432.16
St Clair	Region 10	$ 332.37
St Joseph	Region 4	$ 292.62
TGC	Region 7	$ 478.53
Washtenaw	Region 6	$ 281.33
West MI	Region 3	$ 357.85

12. Appendix E: Demonstration Year 1 PPS-1 Rates by PIHP Region (Weighted Average less PIHP Admin and QBP)

PIHP	Weighted FY22 PPS-1 Rate (less PIHP Admin and QBP)
Region 3	$ 372.94
Region 4	$ 389.77
Region 5	$ 384.88
Region 6	$ 281.33
Region 7	$ 478.53
Region 8	$ 333.47
Region 9	$ 388.01
Region 10	$ 321.89

13. Appendix F: MI CCBHC Certification Criteria—Program Requirements

13.A. Program Requirement #1: Staffing

13.A.1. General Staffing Requirements

13.A.1.1. Needs Assessment

As part of the process leading to certification, the CCBHC will prepare an assessment of the needs of the target consumer population and a staffing plan for prospective CCBHCs. The needs assessment will include cultural, linguistic and treatment needs. The needs assessment is performed prior to certification of the CCBHCs to inform staffing and services. After certification, the CCBHC will update the needs assessment and the staffing plan, including both consumer and family/caregiver input, at least every three years.

The statewide needs assessment, performed prior to the demonstration period, will inform the overall direction and goals of all participating CCBHCs, but will not replace site-specific needs assessments.

A written staffing plan should correspond to the needs identified in the needs assessment. If a CCBHC plans on utilizing DCOs, the staffing plan should include DCO capacity and describe how DCO staff will assist in meeting CCBHC service requirements.

CMHSPs automatically meet needs assessment requirement per compliance with the Michigan Mental Health Code 330.1226(a), R 330.2035, and corresponding CMHSP Certification, which requires a CMHSP board to annually prepare a written assessment of community needs.

CCBHCs that are not CMHSPs should incorporate the following into their annual needs assessment for consistency:

- A description of the population served, including demographic information, geographic descriptions, economic data, and estimates of the types and extent of significant health and social problems. CCBHCs should consider the expanded population eligible for CCBHC services.
- A description of the human service systems serving the population.
- Estimates of the types and extent of mental health-related problems, including social indicator data, characteristics of caseloads of mental health-related agencies, and observations by service agencies.
- An assessment of existing services dealing with the estimated mental health-related programs, including an evaluation of the degree to which the services match the estimated problems.
- A projection of the type and amount of mental health services required to adequately serve the comprehensive mental health needs of the client population, including a description of the methods and data used to project need.

13.A.1.2. Staffing Plan

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

- The staffing plan should correspond to the population needs identified in the annual needs assessment.
- Staffing plans can consider both CCBHC and DCO capacity.
- CCBHCs providing intensive outpatient services for veterans must also meet the requirements described in Handbook Section 13.D.11 (SAMHSA Criteria 4.K).

13.A.2. Management

The Chief Executive Officer (CEO) of the CCBHC maintains a fully staffed management team as appropriate for the size and needs of the clinic as determined by the current needs assessment and staffing plan. The management team will include, at a minimum, CEO or Executive Director/Project Director and a Medical Director.

CMHSPs automatically meet management requirements per compliance with the Michigan Mental Health Code 330.1230 and 330.1231.

13.A.2.1. Provisions relative to the Medical Director include:

- The Medical Director must be a psychiatrist and will ensure the medical component of care and the integration of behavioral health (including addictions) and primary care are facilitated. The Medical Director does not have to be a full-time employee of the CCBHC. Depending on the size of the CCBHC, the CEO/Executive Director/Project Director and the Medical Director positions can be held by the same person.
- If a CCBHC is unable, after reasonable and consistent efforts to employ or contract with a psychiatrist as Medical Director because of a HRSA-defined and documented behavioral health professional shortage, the CCBHC may request a waiver from MDHHS to utilize alternative providers. The waiver will be time-limited and the CCBHC should continue to pursue hiring or contracting with a psychiatrist for the Medical Director position.
    - In this situation, SAMHSA recommends that psychiatric consultation will be obtained on the medical component of care and the integration of behavioral health and primary care, and a medically trained behavioral health care provider with appropriate education and licensure with prescriptive authority in psychopharmacology who can prescribe and manage medications independently pursuant to state law will serve as the Medical Director.

13.A.3. **Liability/Malpractice Insurance**

The CCBHC must maintain liability/malpractice insurance adequate for the staffing and scope of services provided. CCBHCs are responsible for verifying DCOs also maintain appropriate liability/malpractice insurance. Please note that CMHSPs automatically meet liability/malpractice insurance requirement per compliance with CMHSP Certification R330.2808 Fiscal Management.

13.A.4. Licensure and Credentialing of Providers

13.A.4.1. Licensure and Credentialing

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

- PIHPs are ultimately responsible for maintaining credentialing files and ensuring that each provider, directly or contractually employed, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual (MPM) requirements. MDHHS' provider credentialing requirements may be found at the following website: https://www.michigan.gov/documents/mdhhs/Provider_Credentialing_702781_7.pdf
- Consistent with existing CMHSP contractual requirements, CCBHCs should have written credentialing policies and procedures for ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform their services. Credentialing shall take place every two years.
- CCBHCs who are working with DCOs that are not current network providers for which credentialing is currently not overseen by the PIHPs must demonstrate that appropriate credentialing and licensure is maintained at all DCOs. CCBHCs should verify and monitor supervision requirements for providers working toward licensure. Credentialing information should be sent to the PIHP.
- CCHBCs must ensure that DCOs residing and providing services in bordering states meet all applicable licensing and certification requirements within their state.
- Provider credentialing documentation will be collected in the maintained in the Uniform Credentialing Section of the MDHHS CRM, currently under development.

13.A.5. Staffing Requirements/Accreditation

The CCBHC staffing plan must meet the requirements of the state behavioral health authority and any accreditation standards required by the state and must include clinical and peer staff. In accordance with the staffing plan, the CCBHC must maintain a core staff comprised of employed and as needed, contracted staff, as appropriate to the needs of CCBHC consumers as stated in consumers' individual treatment plans and as required by Handbook Sections 13.C and 13.D (3 and 4 of the SAMHSA Criteria). Unless otherwise specified, staff must meet the MDHHS PIHP/CMHSP Provider Qualifications as described for CCBHC services.
https://www.michigan.gov/documents/mdhhs/PIHP-MHSP_Provider_Qualifications_530980_7.pdf

Required staffing disciplines include:

- Medically trained providers, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other medications used to treat opioid and alcohol use disorders.

- Child Mental Health Professional (CMHP)
    - CCBHCs must have CMHPs with expertise in addressing trauma.

- Mental Health Professional (MHP)
    - CCBHCs must have MHPs with expertise in addressing trauma.
    - The approved licensures for disciplines identified as a Mental Health Professional include the full, limited, and temporary limited categories.

- Qualified Mental Health Professional (QMHP)
    - CCBHCs must have QMHPs with expertise in addressing trauma.

- Health Care Professional
    - CCBHCs should have health care professionals available, either directly or through contractual arrangements, that have been trained to work with individuals across the lifespan.

- Substance Abuse Treatment Practitioner (SATP)

- Substance Abuse Treatment Specialist (SATS)
    - CCBHCs must ensure that SATS are supervised by an individual who is a certified clinical supervisor (a CCS) or who has a registered development plan (Development Plan – Supervisor [DP-S]) to obtain the supervisory credential when providing substance abuse treatment services.

- Peers
    - Peer Support Specialist
    - Peer Recovery Coach
    - Parents Support Partner
    - Youth Peer Support Partner

It is preferred that the CCHBC directly staffs the required positions; however, MDHHS recognizes that some staffing types (including credentialed substance use disorder specialists) may be part of the DCO network. The CCBHC should include DCO staffing in their staffing plan and show evidence that they can meet credentialing and training requirements. Recognizing professional shortages exist for many behavioral health providers, MDHHS will allow the following:

- Some services can be provided by contract, part-time, or as needed.
- In CCBHC organizations comprised of multiple clinics, providers may be shared among clinics.
- CCBHCs may utilize telehealth/telemedicine and online services to alleviate shortages. (Handbook Section 13.B.5 or SAMHSA Criteria 2.a.5)
- CCBHCs may utilize providers working toward licensure, provided they are working under the requisite supervision.

13.A.6. Cultural Competence and Other Training

13.A.6.1. Training Plan

The CCBHC must have a training plan, for all employed and contract staff, and for providers at DCOs who have contact with CCBHC consumers or their families, which satisfies and includes requirements of the state behavioral health authority and any accreditation standards on training which may be required by the state. The training must address:

- Cultural competence.
- Person-centered and family-centered care.
- Recovery-oriented, evidence-based, and trauma-informed care.
- Primary care/behavioral health integration.
- Risk assessment, suicide prevention and suicide response.
- Collaborating with families and peers.
- Military culture

Cultural competency training should reflect the diversity within the population being served, as defined by the annual needs assessment. Per Section 3.3.3I of the CMHSP Contract, CMHSPs must also use the community needs assessment to demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area.

13.A.6.2. Training Timelines, Settings, and Reciprocity

Training, as well as training on the clinic's continuity plan, must occur at orientation and annually thereafter. If necessary, trainings may be provided on-line. CCBHCs should accept staff training provided by other entities to meet their training requirements when that staff training is substantially like their own training and staff member completion of such training can be verified.

13.A.6.3. Skills/Competence

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

13.A.6.4. Training Documentation

The CCBHC documents in the staff personnel records that the training and demonstration of competency are successfully completed. Verification of training documentation will take place at CCBHC certification site visits and should be demonstrated via the initial certification application.

13.A.6.5. Trainer Qualifications

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

13.A.7. Linguistic Competence and Confidentiality of Patient Documentation

13.A.7.1. Access for individuals with Limited English Proficiency (LEP)

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

Please note that CMHSPs meet this requirement, due to contractual requirements requiring CMHSP compliance with the Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency.

13.A.7.2. Interpretation/Translation Services are Appropriate and Timely
Interpretation/translation service(s) are provided that are appropriate and timely for the size/needs of the LEP CCBHC consumer population (e.g., bilingual providers, onsite interpreters, language telephone line). To the extent interpreters are used, such translation service providers are trained to function in a medical and, preferably, a behavioral health setting.

13.A.7.3. Auxiliary Aids
Auxiliary aids and services are readily available, Americans with Disabilities Act (ADA) compliant, and responsive to the needs of consumers with disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines).

13.A.7.4. Document Availability
Documents or messages vital to a consumer's ability to access CCBHC services (for example, registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available for consumers in languages common in the community served, taking account of literacy levels and the need for alternative formats (for consumers with disabilities). Such materials are provided in a timely manner at intake. The requisite languages will be informed by the needs assessment prepared prior to certification, and as updated. All materials shall be made available in the languages appropriate to the individuals served within the CCBHC catchment area, and written materials should consider literacy limitations and appropriate reading levels.

13.A.7.5. Confidentiality/Privacy
The CCBHC's policies have explicit provisions for ensuring all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider, including but not limited to the requirements of Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors. The HIPAA Privacy Rule allows routine – and often critical – communications between health care providers and a consumer's family and friends, so long as the consumer consents or does not object. If a consumer is amenable and has the capacity to make health care decisions, health care providers may communicate with a consumer's family and friends.

13.B. Program Requirement #2: Availability and Accessibility of Services

13.B.1. CCBHC Environment

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

- The CCBHC must comply with all relevant federal, state, and local laws and

regulations regarding client and staff safety, facility cleanliness, and accessibilities. The CCBHC is responsible for overseeing the environmental conditions of contracted DCOs and guaranteeing these regulations are met.

- The CCBHC environment should align with the standards of trauma informed care (see https://www.michigan.gov/documents/mdhhs/Trauma-Policy_704460_7.pdf associated PIHP requirements).

13.B.2. CCBHC Hours

The CCBHC provides outpatient clinical services during times that ensure accessibility and meet the needs of the consumer population to be served, including some nights and weekend hours. The annual needs assessment, along with direct consumer feedback in the form of satisfaction surveys, focus groups, or advisory councils, should directly inform CCBHC service hours. The needs assessment should consider availability and accessibility for all eligible individuals, not just those currently being served.

13.B.3. CCBHC Location

The CCBHC provides services at locations that ensure accessibility and meet the needs of the consumer population to be served. The annual needs assessment, along with direct consumer feedback in the form of satisfaction surveys, focus groups, or advisory councils, should be reviewed to determine appropriateness of service site locations. The needs assessment should consider availability and accessibility for all eligible individuals, not just those currently being served. For office or site-based mental health services, the individual's primary service providers (e.g., case manager, psychiatrist, primary therapist, etc.) should be within 30 miles or 30 minutes of the individual's residence in urban areas, and within 60 miles or 60 minutes in rural areas. ("Primary provider" excludes community inpatient, state inpatient, partial hospitalization, extended observation beds and any still existing day programs.) This requirement aligns with existing CMHSP Access Standards. However, services should never be limited due to an individual's residency.

13.B.4. Transportation

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

13.B.5. In-Home/Telehealth Services

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

- CCBHCs are responsible for following existing state standards and requirements for reporting telehealth encounters.
- Telemedicine Database can be found at this link.
- Services to individuals within incarceration facilities are not eligible for CCBHC reimbursement.

13.B.6. Outreach and Engagement

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

- Additional attention should be paid to outreach and engagement activities targeting individuals with new service access under the CCBHC, including those

without Medicaid and with mild/moderate levels of behavioral health needs.

- CCBHCs should monitor outreach and engagement activities closely to ensure that efforts are effectively expanding access to CCBHC services.
- MDHHS will promote CCHBC activities statewide and will provide marketing materials to CCBHC sites.

13.B.7. Court Ordered Requirements

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

13.B.8. Continuity of Operations

CCBHCs have in place a continuity of operations/disaster plan. The continuity of operations/disaster plan should align with any requirements to be established for CMHSP certification as well as CMS emergency preparedness standards. Staff should be made aware of the disaster plan and be trained on their relative roles and responsibilities in executing the disaster plan.

13.B.9. Requirements for Timely Access to Services and Initial and Comprehensive Evaluation for New Consumers

13.B.9.1. Timeliness for New CCBHC Recipients

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

- If the screening identifies an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent outpatient follow-up.
    - If screening includes pre-admission screening for psychiatric inpatient care, the disposition should be completed in there hours.

- If the screening identifies an urgent need, clinical services are provided, and the initial evaluation completed within one business day of the time the request is made.
    - Face-to-face meetings with professionals are preferred, however telehealth visits can occur if standards and reporting requirements are met as specified in requirement Handbook Section 13.B.5 (SAMHSA Criteria 2.a.5)

- If the screening identifies routine needs, services will be initiated within 14 calendar days
    - The initial assessment/evaluation will also be completed within 14 days.
    - Face-to-face meetings with professionals are preferred, however telehealth visits can occur if standards and reporting requirements are met as specified in Handbook Section 13.B.5 (SAMHSA Criteria

2.a.5).

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

13.B.9.2. Person/Family-Centered Planning

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

- The Michigan Mental Health Code establishes the right for all recipients to have an Individual Plan of Service (IPS) developed through a person-centered planning process (Section 712, added 1996). CCBHCs shall implement person-centered planning in accordance with the MDHHS Person-Centered Planning Practice Guideline, Behavioral Health and Developmental Disabilities Administration, Person-Centered Planning Practice Guideline (michigan.gov)
- The comprehensive treatment plan should be updated by the treatment team, in agreement with and endorsed by the CCBHC recipient and aligned with MDHHS Person-Centered Planning guidance, no less frequently than every 90 calendar days for more severe needs and no less than 180 days for mild/moderate needs yet updated earlier if appropriate.
    - CCBHCs must develop clear protocols for transitioning a CCBHC recipient with mild/moderate needs to a higher level of care without a major disruption in the individual's treatment experience. Without such protocols, treatment plans for all CCBHC recipients should be updated every 90 days.

13.B.9.3. Timely Access to Outpatient Services

Outpatient clinical services for established CCBHC recipients seeking an appointment for routine needs must be provided within 14 calendar days of the requested date for service.

- A CCBHC recipient is considered "established" if they have been receiving ongoing CCBHC services and have a case start date in the WSA on or after October 1, 2021.

- If a CCBHC recipient requests an appointment for routine needs for a date beyond 14 calendar days from the request, the individual's preferences should be followed, and a note should be made in the record.

- If an established CCBHC recipient identifies an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent outpatient follow-up.
    - If screening includes pre-admission screening for psychiatric inpatient care, the disposition should be completed in there hours.

- If an established CCBHC recipient identifies an urgent need, clinical services are provided, and the initial evaluation completed within one business day of the time the request is made.
    - Face-to-face meetings with professionals are preferred, however telehealth visits can occur if standards and reporting requirements are met as specified in Handbook Section 13.B.5 (SAMHSA Criteria 2.a.5).

13.B.10. Access to Crisis Management Services

13.B.10.1. Crisis Service Availability
The CCBHC provides crisis management services that are available and accessible 24-hours a day and delivered within three hours. Crisis management services are outlined in section 4.C (13.D.3), and must include 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

13.B.10.2. Crisis Continuum
The methods for providing a continuum of crisis prevention, response, and postvention services are clearly described in the policies and procedures of the CCBHC and are available to the public. Policies and procedures must clearly describe that crisis services are available to everyone, regardless of ability to pay, insurance, and county of residency.

13.B.10.3. Education on Crisis Services/Advanced Directives
Individuals who are served by the CCBHC are educated about crisis management services and Psychiatric Advanced Directives and how to access crisis services, including suicide or crisis hotlines and warmlines, at the time of the initial evaluation. This includes individuals with LEP or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels in accordance with program requirement 1).

13.B.10.4. Crisis Coordination with Emergency Departments (EDs)
In accordance with the care coordination requirements of program requirement 3, CCBHCs maintain a working relationship with local Emergency Departments (EDs). Protocols are established for CCBHC staff to address the needs of CCBHC consumers in psychiatric crisis who come to those EDs.

13.B.10.5. Protocols Following Crisis
Protocols, including protocols for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a psychiatric crisis. Protocols/policies should clearly outline procedures for initiating services during and following a psychiatric crisis, including exactly when and how to include law enforcement.

13.B.10.6. Crisis Planning
Following a psychiatric emergency or crisis involving a CCBHC consumer, in conjunction with the consumer, the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises for the consumer and their family. Handbook Section 13.C.4 (SAMHSA Criteria 3.a.4) addresses

precautionary crisis planning.

13.B.11. No Refusal of Services Due to Inability to Pay

13.B.11.1. Inability to Pay

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).

The CCBHC should have in place policies or procedures for verifying ability to pay including specifications for when and how to reduce or waive fees (see Handbook Section 13.B.11.2 regarding Sliding Fee requirements.) CCBHCs may cap the amount recipients are expected to pay at different income levels as long as they comply with the Statutory requirement as outlined under PAMA, 223 (a)(2)(B) "no rejection for services or limiting of services on the basis of a patient's ability to pay or a place of residence."

The CCBHC is responsible for ensuring that the DCO policies and procedures also guarantee that no individual is denied services because of inability to pay.

13.B.11.1.1. *Definition of Income*

CCBHCs will follow the U.S. Census Bureau definition of income when determining recipient eligibility for discounted services. The Census Bureau establishes income thresholds that vary by family size and other factors to determine the poverty status of a family. If a family's total income is less than the family's threshold, then that family and every individual in it is considered in poverty.

Income is computed using the factors related to an individual's:

- Earnings
- Unemployment compensation
- Workers' compensation,
- Social Security
- Supplemental security Income
- Public assistance
- Veterans' payments
- Survivor benefits
- Pension or retirement income
- Interest
- Dividends
- Rents
- Royalties
- Income from estates
- Trusts
- Educational assistance
- Alimony
- Child support

- Assistance from outside the household
- Other miscellaneous sources.

Money income does not include:

- Capital gains or losses
- Noncash benefits (e.g. food stamps and housing subsidies)
- Tax credits

These calculations are done prior to tax deductions. Additional detail related to the U.S. Census Bureau definition of income can be found here: U.S. Census Bureau

*NOTE: Income levels are determined by the most recent Federal Poverty Guidelines and will align with the National Health Service Corps guidelines. Individuals at or below 100% FPG will receive a full discount on services. Individuals above 100% but at or below 200% FPG will be charged a nominal fee consistent with the sliding fee schedule established by the CCBHC.
The implementation of a Sliding Fee Discount Program is intended to minimize financial barriers to care for patients at or below 200 percent of the current FPG. Therefore, the required fees and the process of assessing patient eligibility and collecting payment must not create barriers to care.

13.B.11.2. Sliding Fee Discount Schedule

13.B.11.2.1. Policy

CCBHC must have policies and procedures describing eligibility for and implementation of the sliding fee discount schedule. The CCBHC must extend this policy, including the requirements and posting parameters cited below, to any DCOs in their formal written agreement.

13.B.11.2.2. Requirements

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.

Public Act 91 of 2022 (HB5165) was signed in June of 2022 with immediate effect, amending the Michigan Mental Health Code (330.1818) to align existing ability to pay schedules with federal sliding fee requirements.

13.B.11.2.3. Posting

The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC proposes to offer pursuant to these criteria. Such fee schedule will be included on the CCBHC website, posted in the CCBHC waiting

room and readily accessible to consumers and families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP or disabilities.

13.B.12. Provision of Services Regardless of Residence

13.B.12.1. Place of Residence

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

13.B.12.2. Protocols for Individuals out of Area

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

13.C. Program Requirement #3: Care Coordination

13.C.1. General Requirements of Care Coordination

13.C.1.1. Care Coordination

CCBHC must coordinate care across the spectrum of health services, including access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. The benefits of a care coordination are achieved primarily through referrals and through the exchange of health information and information about the consumer's needs and preferences (where information exchange is contemplated in the agreement and consented to by the consumer).

Care coordination activities include, but are not limited to:

- Organization of all aspects of a beneficiary's care.
- Management of all integrated primary and specialty medical services, behavioral health services, physical health services, and social, educational, vocational, housing, and community services.
- Information sharing between providers, patient, authorized representative(s), and family.
- Resource management and advocacy.
- Maintaining beneficiary contact, with an emphasis on in-person contact (although telephonic contact may be used for lower-risk beneficiaries who

require less frequent face-to-face contact).
- Appointment making assistance, including coordinating transportation.
- Development and implementation of care plan.
- Medication adherence and monitoring.
- Referral tracking.
- Use of facility liaisons.
- Use of patient care team huddles (short, daily meetings where the care team can discuss schedules, address care coordination needs, and problem solve).
- Use of case conferences.
- Tracking of test results.
- Requiring discharge summaries.
- Providing patient and family activation and education.
- Providing patient-centered training (e.g., diabetes education, nutrition education, etc.).
- Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.)

13.C.1.2. Coordination with Medicaid Health Plans and Integrated Care Organizations

The PIHP and CCBHC must work with Medicaid Health Plans and Integrated Care Organizations to coordinate services for eligible beneficiaries who wish to receive CCBHC Demonstration services. MDHHS will require the PIHP and health plans to confer to optimize community-based referrals and informational materials regarding the CCBHC demonstration to eligible recipients. Health Plans are contractually obligated to provide a certain level of care coordination and care management services to their beneficiaries. To minimize confusion and maximize patient outcomes, bi-directional communication between the CCBHC and health plan is essential. MDHHS expects the CCBHC to take the lead in the provision of care management, spanning health and social supports. At the same time, health plan coordination in terms of supporting outreach/assignment, facilitating access to recipient resources, and maintaining updated information in CareConnect360 and other Health Information Exchange technology will be critical to the success of the CCBHC and the individual's health status.

13.C.1.3. Care Coordination as a CCBHC Activity (not a service)

Care coordination is regarded as an activity in the CCBHC model, not a service. An encounter consisting solely of care coordination activities would not be eligible for payment under the CCBHC prospective payment system (PPS). However, administrative costs associated with care coordination should be tracked and included as CCBHC costs on the annual CCBHC cost reports.

13.C.1.4. Care Coordination and Duplicative Services

At times, care coordination activities may overlap with components of service delivery that are eligible for reimbursement. CCBHCs should incorporate care coordination activities into such services as appropriate and submit claims accordingly. For example, if an individual's person-centered treatment plan includes Targeted Case Management (TCM) services, care coordination activities can be billed as part of TCM.

CCBHC service recipients may have complex needs and be eligible for different service

programs other than CCBHC, which may include reimbursement options for care coordination. To avoid duplication, these codes should not be billed on the same day as CCBHC services. Care management is distinct from care coordination. Service codes denoting care management programs such as the collaborative care model (99402) or complex chronic care management services (99487) can be billed independently for CCBHC individuals.

13.C.1.5. CCBHC Recipient Receiving Services at Multiple CCBHC Locations

CCBHC recipients are permitted to receive CCBHC eligible services at multiple CCBHC locations. In this scenario, one CCBHC must become the lead for CCBHC care coordination activities and are responsible for assigning the person in the Waiver Support Application. Additionally, the lead CCBHC must coordinate CCBHC services among all CCBHCs to avoid service duplication and to monitor the individual's treatment plan. If the CCBHC lead changes, the current CCBHC lead should transfer the individual to the new CCBHC using the transfer process outlined in section 4.G. The prospective payment will be provided to the lead CCBHC's PIHP (where the recipient is assigned), but all CCBHCs providing services to the individual should continue to submit encounters to the PIHP in which they are contracted with. Reconciliation between the CCBH and the PIHP will ensure that each CCBHC receives the full PPS rate for each daily visit, regardless of where the individual is assigned. Reconciliation between MDHHS and the PIHP will ensure that the PIHP can sufficiently reconcile with the CCBHCs to the PPS rate.

13.C.1.6. Coordination with Medicaid Health Homes

CCBHC Medicaid beneficiaries are permitted to be enrolled in the CCBHC and one of Michigan's Health Home benefit plans. Health home benefit plans include, Behavioral Health Home (HHBH), MI Care Team (HHMICare), and Opioid Health Home (HHO). To receive payment for both services and to avoid duplication, the health home care team must be responsible for and provide care coordination services to the beneficiary. The health home care team is responsible for providing the 6 required health home services and coordinating care with the CCBHC. The beneficiary will be assigned to both benefit plans in the WSA and CHAMPS.

13.C.2. Confidentiality/Privacy

The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state privacy laws, including patient privacy requirements specific to the care of minors. The HIPAA Privacy Rule allows routine – and often critical – communications between health care providers and a consumer's family and friends. Health care providers may always listen to a consumer's family and friends. If a consumer consents and has the capacity to make health care decisions, health care providers may communicate protected health care information to a consumer's family and friends. Given this, the CCBHC ensures consumers' preferences, and those of families of children and youth and families of adults, for shared information are adequately documented in clinical records, consistent with the philosophy of person and family-centered care.

Necessary consent for release of information should be obtained from CCBHC service recipients for all care coordination relationships. The MDHHS-5515 Consent to Share Behavioral Health and Substance use Disorder Information should be utilized if possible. Alternate consents can

be used if held to more stringent requirements under federal law. Consents must be collected and stored in the recipient's health record with attestation in the WSA.

If CCBHCs are unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program requirement 3, such attempts must be documented and revisited periodically. If a consent for the exchange of information cannot be obtained by a potential CCBHC recipient accessing CCBHC services at a DCO, they are still entitled to CCHBC services and be enrolled as a CCBHC recipient. However, the CCBHC is responsible for ensuring that information exchanged is restricted to the appropriate regulations.

13.C.3. Referral and Follow-Up

Consistent with requirements of privacy, confidentiality, and consumer preference and need, the CCBHC assists consumers and families of children and youth, referred to external providers or resources, in obtaining an appointment and confirms the appointment was kept. CCBHCs are expected to remain involved throughout the referral process to ensure the recipient was successfully connected to external supports or resources. They are expected to work collaboratively with the external providers to relay needs and preferences. CCBHCs should have the ability to track successful referral and follow-up rates for performance monitoring and quality improvement activities.

13.C.4. Consumer Preferences

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

13.C.5. Medication Management

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

13.C.6. Freedom of Choice

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

13.C.7. Care Coordination and Other Health IT Systems

13.C.7.1. Health IT System

The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records. The health IT system has the capability to capture structured information in consumer records (including demographic information, diagnoses, and medication lists), provide clinical decision support, and electronically transmit prescriptions to the pharmacy. To the extent possible, the CCBHC will use the health IT system to report on data and quality measures as required by Handbook Section 13.E (SAMHSA Criteria 5). Utilization of

MDHHS systems such as CareConnect360 and the Waiver Support Application are encouraged to coordinate care for CCBHC recipients.

13.C.7.2. Population Health

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

13.C.7.3. New Health IT Systems

If the CCBHC is establishing a health IT system, the system will have the capability to capture structured information in the health IT system (including demographic information, problem lists, and medication lists). CCBHCs establishing a health IT system will adopt a product certified to meet requirements in 13.C.7.1, to send and receive the full common data set for all summary of care records and be certified to support capabilities including transitions of care and privacy and security. CCBHCs establishing health IT systems will adopt a health IT system that is certified to meet the "Patient List Creation" criterion (45 CFR §170.314(a)(14)) established by the Office of the National Coordinator (ONC)4 for ONC's Health IT Certification Program.

13.C.7.4. DCOs Privacy/Confidentiality

The CCBHC will work with DCOs to ensure all steps are taken, including obtaining consumer consent, to comply with privacy and confidentiality requirements, including but not limited to those of HIPAA (Pub. L. No. 104- 191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors. DCOs should also use the MDHHS-5515 Consent form or other consent form if held to more stringent requirements under federal law.

13.C.7.5. Health Info Exchange Plan

Whether a CCBHC has an existing health IT system or is establishing a new health IT system, the CCBHC will develop a plan to be produced within the two-year demonstration program time frame to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan shall include information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care. The plan should include timelines and expected milestones for systems integration with each DCO partner. Plans should detail how the integrated systems will be used to enhance care coordination and improve CCBHC recipient outcomes above and beyond allowing DCO access to the CCBHC's health records. Improvements in Health IT are an allowable CCBHC cost and should be included on the CCBHC cost report.

13.C.8. Care Coordination Agreements

13.C.8.1. Health Care Services Coordination

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

Centers, the CCBHC has established protocols to ensure adequate care coordination.

If an agreement cannot be established with a FQHC or RHC within the time frame of the demonstration project, the CCBHC should provide justification and establish contingency plans with other providers offering similar services (e.g., primary care, preventive services, other medical care services). CCBHCs are expected to work toward formal contracts with entities with which they coordinate care if they are not established at the beginning of the demonstration project.

13.C.8.2. Inpatient Service Coordination

The CCBHC has an agreement establishing care coordination expectations with programs that can provide inpatient psychiatric treatment, with ambulatory and medical detoxification, post-detoxification step-down services, and residential programs to provide those services for CCBHC consumers. The CCHBC can track when consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity. The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric, detoxification, and residential settings to a safe community setting. This includes transfer of medical records of services received (e.g., prescriptions), active follow-up after discharge and, as appropriate, a plan for Heal prevention and safety, and provision for peer services.

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

For CCBHC recipients with private insurance, CCBHCs are expected to coordinate to the extent possible with the private insurer to coordinate care upon discharge.

13.C.8.2.1. Inpatient Follow-Up

The CCBHC has an agreement establishing care coordination expectations with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers, in the area served by the CCBHC, to address the needs of CCBHC consumers. This includes procedures and services, such as peers or community health workers, to help transition individuals from the ED or hospital to CCBHC care and shortened time lag between assessment and treatment. The agreement is such that the CCBHC can track when their consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to another entity. The agreement also provides for transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge.

13.C.8.3. Community Services Coordination

The CCBHC must have an agreement establishing care coordination expectations with a variety of community or regional services, supports, and providers. Agreements should be in place with:

- Schools
- Child Welfare Agencies
- Indian Health Service or other tribal programs
- Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans, and other specialty courts)
- Homeless shelters/housing services
- Employment services
- Services for older adults, including aging and disability resource centers)
- Specialty providers of medications for treatment of opioid or alcohol dependence
- End of life/palliative care
- Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food, and transportation programs), depending on the needs of the population identified in the annual needs assessment

If multiple community service agencies are present in the CCBHC catchment area, formal agreements should be prioritized in the most critical areas, and the CCBHC should work on increasing the number of agreements with other organizations throughout the demonstration period.

13.C.8.4. VA Coordination

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

If a care coordination agreement cannot be developed at the start of the demonstration, CCBHCs should continue to make, and document attempts to formalize an agreement with veteran's facilities throughout the demonstration period.

13.C.8.5. MiCAL Coordination

In accordance with Michigan Public Act 12 of 2020 (MCL 330.1165) and with consideration of best practice standards outlined in SAMHSA's National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit, MDHHS will require care coordination protocols between MiCAL and the CCBHCs for Michiganders needing CCBHC services, including the activation of real-time face-to-face crisis services (e.g., crisis stabilization, mobile crisis, etc.) when MiCAL goes live in the CCBHC's region. Care Coordination protocols will be streamlined to ensure the person in need receives the quickest and most direct support, as appropriate. MDHHS requires the protocols to include, at a minimum, the following:

- Receive crisis alerts from CCBHCs for individuals who are within the service area County of the CCBHC and likely to go into crisis. MiCAL staff will use the crisis alert guidance to prospectively plan for providing support to the individual. MiCAL staff will also provide follow up reports to the CCBHC for any support provided to the individual including a safety plan if one was developed. (Please note that each 42 CFR Part 2 covered entity is responsible for ensuring

that any information they share with MiCAL meets 42 CFR Part 2 requirements.)

- Provide daily activity reports to PIHPs/CCBHCs for callers who:
    - Call in on the CCBHC crisis/access line while it is forwarded to MiCAL and share relevant information, including but not limited to, protected health information for purposes of care coordination.
    - Call, chat, or text MiCAL or the National Suicide Prevention Lifeline (NSPL), report they receive services from a CCBHC, and would like information on the support provided by MiCAL to be shared with a CCBHC.
    - Call, chat, or text MiCAL or the NSPL, receive services from a CCBHC as determined by Active Care Relationship and/or Admission-Discharge-Transfer data and do not specifically prohibit information being shared with a CCBHC.
    - Share an individual's information with relevant parties as necessary to trigger face to face crisis interventions in crisis situations.
    - Provide afterhours or emergency crisis coverage for PIHPs/CMHSPs through the forwarding of CCBHC phone lines or other mediums of crisis inquiry.
    - Receive in real time all necessary crisis service information from the PIHPs/CMHSPs to directly trigger the provision of face-to-face crisis services, including not limited to the afterhours on call process, preadmission screening process, mobile crisis, and other crisis stabilization services.
    - Receive in real time all necessary service information from the PIHPs/CMHSPs to make warm handoffs and referrals from MiCAL to the PIHPs/CMHSPs in the most efficient and effective manner for the person in need.

13.C.9. Treatment Team, Treatment Planning, and Care Coordination

13.C.9.1. Person/Family-Centered Treatment Planning and Care Coordination

The CCBHC treatment team must include the consumer, the family/caregiver of child consumers, the adult consumer's family to the extent the consumer does not object, and any other person the consumer chooses. All treatment planning and care coordination activities must be person-centered, and family centered.

13.C.9.2. Interdisciplinary Team

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

CCBHCs should utilize a collaborative care model to provide an interdisciplinary team-based set of services to ensure the totality of one's needs – physical, behavioral, and/or

social – are met through the provision of CCBHC services. CCBHCs can adopt or define their own collaborative care model.

13.C.9.3. Care Coordination by DCOs

The CCBHC must coordinate care and services provided by DCOs in accordance with the current treatment plan.

13.D. Program Requirement #4: Scope of Services

13.D.1. General Service Provisions

13.D.1.1. Required Services

CCBHCs are responsible for the provision of all care specified in PAMA, including, as more explicitly provided, and more clearly defined below in Handbook Sections 13.D.2-13.D.11 (SAMHSA Criteria 4.B through 4.K):

1. Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
2. Screening, assessment, and diagnosis, including risk assessment.
3. Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
4. Outpatient mental health and substance use services.
5. Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
6. Targeted case management.
7. Psychiatric rehabilitation services.
8. Peer support and counselor services and family supports.
9. Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas.

Each of these services may be provided either directly by the CCBHC or through formal relationships with other providers that are DCOs. MDHHS recommends that the initial Screening, Assessment, and Diagnosis and Person-Centered Treatment Planning should be provided directly by the CCBHC rather than DCOs. The CCBHC should be equipped to provide 5 of the 9 core services directly. Whether directly supplied by the CCBHC or DCO, the CCBHC is ultimately clinically and financially responsible for all care provided.

13.D.1.1.1. Services to Incarcerated Individuals

CCBHCs should work closely with local justice systems, specifically courts and local jails. CCBHC services provided to incarcerated individuals should be considered non-Medicaid encounters and alternate funding should be used accordingly. Care coordination specifics should be outlined in care coordination agreements, as required in 13.C.8. and should facilitate the transition to outpatient care in CCBHCs upon release.

13.D.1.2. Freedom to Choose

The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are

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

13.D.1.3. Member Appeals and Grievance Procedures

CCBHC enrollees have rights that are protected by Michigan's Mental Health Code (Chapters 7 and 7A) and many other Federal and State Laws. All enrollees have the right to a fair and efficient process for resolving disputes and complaints regarding their services and supports. With either CCBHC or DCO services, consumers will have access to existing standardized appeals and grievance procedures, which satisfy at minimum, the requirements of Medicaid and others that may be mandated by appropriate accrediting entities.

- All CCBHC recipients will have access to the same services and supports, regardless of their level of need, residence, insurance, or eligibility for Medicaid. The same, reporting requirements and timelines will apply for both non-Medicaid and Medicaid beneficiaries. All CCBHC recipients will have access to the same services and supports, regardless of their level of need, residence, insurance, or eligibility for Medicaid.
- All CCBHC recipients will receive written notice of their rights and a written explanation of the local grievance and appeals processes.
- All CCBHCs will have clear written descriptions and mechanisms to address DCO grievances and complaints, and an appeal system to resolve disputes.
- All CCBHCs will maintain documented records of each grievance and/or appeal. At a minimum, the record shall contain:
  1. A general description of the reason for the grievance and/or appeal;
  2. The date received;
  3. The date of each review and/or review meeting;
  4. The resolution at each level of the grievance and/or appeal, as applicable;
  5. The date of resolution at each level, if applicable;
  6. The name of the enrollee for whom the grievance and/or appeal was filed.
- In some situations, an individual may be receiving services at a CCBHC in one PIHP region and non-CCBHC services from a provider in a different PIHP region. Grievances and appeals must follow the individual, with the grievance and appeal responsibilities remaining with the provider in which the grievance/appeal occurred. The CCBHC will assist with ensuring the individual has access to the appropriate grievance/appeal process.
- Responsibilities may change with the evolution of the demonstration.

Non-Medicaid Enrollees

The MDHHS/CMHSP Managed Mental Health Supports and Services Contract: *Attachment C.6.3.2.1 CMHSP Local Dispute Resolution Process* focuses on providing operational guidance regarding grievance and local appeal systems for Non-Medicaid enrollees and should be consulted for the most current and detailed information. The document can be found on the MDHHS website at Community Mental Health Services (michigan.gov), under CMHSP/PIHP Contracts. Select the most recent year's GF/CMHSP Contract, then search for the C.6.3.2.1 Attachment within the contract.

Briefly, the dispute resolution process for Non-Medicaid enrollees must:

1. Provide for a timeframe in which an enrollee has to initiate a local dispute – thirty (30) days from the time written Notice is received for reduction, suspension, or termination of services.
2. Provide for prompt resolution – forty-five (45) calendar days for appeals and sixty (60) calendar days for grievances.
3. Assure the participation of individuals with the authority to require corrective action. Someone with the authority to act upon the recommendation(s) of the dispute resolution process must be involved. This would include the executive director or designee.
4. Assure that the person reviewing the appeal or grievance will not be the same person(s) who made the initial decision that is subject to the dispute.
5. Provide the enrollee with written notification of the local dispute resolution process decision and subsequent avenues available to the enrollee if the enrollee is not satisfied with the result, including the right of enrollees without Medicaid coverage to access the MDHHS Alternative Dispute Resolution process after exhausting the local dispute resolution procedures.

Medicaid Enrollees
The MDHHS Policy & Practice Guideline entitled *Appeal and Grievance Resolution Processes Technical Requirement* provides guidance regarding grievances and appeals for Medicaid enrollees and should be consulted for the most current and detailed information. The document can be found on the MDHHS website at Policies & Practice Guidelines (michigan.gov).

As a brief overview, the grievance and appeal system for Medicaid enrollees must provide:

1. A written appeal process (one level only) which enables enrollees to challenge an Adverse Benefit Determination.
2. A written grievance process.
3. The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other service complaints.
4. Access to the State Fair Hearing process to further appeal an Adverse Benefit Determination, after receiving notice that the Adverse Benefit Determination has been upheld by the CCBHC level appeal.
5. Information that if the CCBHC fails to adhere to notice and timing requirements as outlined in the appeal process, the enrollee is deemed to have exhausted the CCBHC's Appeal Process and the enrollee may then initiate a State Fair Hearing.
6. The right to request and have Medicaid covered benefits continued while the CCBHC Appeal and/or the State Fair Hearing is pending.

It is important that the grievance and appeal system for Medicaid enrollees ensures "Due Process." Medicaid enrollees are entitled to Due Process whenever their Medicaid benefits are denied, reduced, suspended, or terminated. The Due Process helps protect the Medicaid enrollee's rights. Medicaid enrollees also have rights and dispute resolution protections under authority of 42 CFR 438, Subpart F, the Michigan Mental Health Code, Chapters 4, 4A, 7, and 7A. Due Process requires that enrollees receive:

1. Prior written notice of an adverse action;
2. A fair hearing before an impartial decision maker;
3. Continued benefits pending a final decision; and

4. A timely decision measured from the date that complaint is first made.

13.D.1.3.1. *Reporting*

PIHPs are responsible for compiling and submitting all appeals and grievances to MDHHS on a quarterly basis. CCBHCs will use existing appeals and grievance tracking management systems for both Medicaid and non-Medicaid beneficiaries. Reports should be submitted to MDHHS as specified in Schedule E of the PIHP contract or by the 15th of the second month following the end of each quarter via the MDHHS FTP site.

In the likely event that a statewide grievance tracking management system is developed in the BPHASA CRM during the demonstration period, CCBHCs and PIHPs will be onboarded and required to utilize this system.

13.D.1.3.2. *Grievances and Appeals for MI Health Link Members*

Beneficiaries enrolled with a MI Health Link (MHL) health plan are entitled to all grievance and appeal opportunities available to persons enrolled in both Medicare and Medicaid. Behavioral health grievance and appeals are managed by the PIHP. Please direct members to the PIHP handbooks for more information about how to file grievance and appeals.

The MI Health Link Ombudsman is available to help members understand which processes to follow to handle a problem. They are not connected with MDHHS or any insurance company. Services are free and available Monday through Friday, 8am -5pm by calling 1-888-746-6456.

If more than one appeal or grievance is pursued by a MHL member at the same time, the outcome that is most favorable to the member shall be adopted and honored by the CCBHC.

13.D.1.4. DCO Quality Standards

DCO-provided services for CCBHC consumers must meet the same quality standards as those provided by the CCBHC. CCBHCs are responsible for verifying and monitoring compliance of DCOs regarding quality standards. CCBHCs will include recipients served by DCOs in all quality reporting measures, as applicable.

13.D.1.5. DCO Mandatory Criteria

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

13.D.2. Requirements for Person Centered and Family Centered Care

13.D.2.1. Person/Family Centered Care

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

appropriate.

13.D.2.2. Cultural Needs

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

13.D.3. Crisis Behavioral Health Services

13.D.3.1. Crisis Behavioral Health Services

The CCBHC will provide robust and timely crisis behavioral health services.

- Whether provided directly by the CCBHC or by a state-sanctioned alternative acting as a DCO, available services must include the following:
  - 24-hour mobile crisis teams,
  - Emergency crisis intervention services, and
  - Crisis stabilization.
- Police departments do not represent an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services. Reliance on police does not constitute a robust crisis behavioral health service.
- Services provided must include suicide crisis response and services capable of addressing crises related to substance abuse and intoxication, including ambulatory and medical detoxification.
- A crisis situation is defined by the individual or the individual's family.

13.D.3.1.1. 24-hour Mobile Crisis

Mobile crisis services represent community-based support where people in crises are, either at home or a location in the community. Mobile crisis services must be available 24/7 with a minimum three-hour response time unless population or model requirements require a shorter response time. CCBHCs are responsible for tracking response time for each mobile crisis response activity.

At a minimum, mobile crisis teams must incorporate:

- A clinician capable of assessing the needs of the individual, regardless of population.
- Community response, not restricted to select locations within the region or days/times; and
- Warm hand-offs and coordination with other service locations, including ongoing treatment at CCBHCs.

Mobile crisis response should include the following components:

- Assessment
- Crisis de-escalation
- Planning
- Crisis and safety plan development
- Brief therapy

- Referral

CCBHCs Mobile crisis response for children should follow the standards for Intensive Crisis Stabilization Services (ICSS) for children as outlined in Section 9: Intensive Crisis Stabilization Services of the Behavioral Health and Intellectual and Developmental Disability Chapter of the Michigan Medicaid Provider Manual, with the added requirement of 24/7 availability. Mobile crisis providers do not have to be enrolled with MDHHS, but should meet the requirements for team, response timeliness, etc.

CCBHCs can propose alternate models of mobile crisis response that meet the needs of their community. CCBHCs should participate in statewide initiatives to develop and evaluate mobile crisis models as appropriate.

13.D.3.1.2. Emergency Crisis Intervention Services

Crisis intervention services are unscheduled activities that are provided in response to a crisis situation. Crisis intervention services include crisis response, availability of a crisis line, assessment, referral, and direct therapy.

Service components include:

- A telephone that is answered 24 hours a day for dealing with crisis situations. This phone number should be made widely available by the CCBHC. When regionally available, MiCAL can provide telephone crisis response coverage.
- Face-to-face services to individuals in the areas of crisis evaluation, intervention, and disposition.

13.D.3.1.3. Crisis Stabilization Services

Crisis stabilization services should prevent or reduce symptoms in a behavioral health crisis. Stabilization services may also follow psychiatric hospitalization events to prevent readmission. CCBHCs should coordinate treatment to higher levels of care when appropriate.

13.D.3.2. Medical Detoxification Requirements

The revised American Society of Addiction Medicine (ASAM) criteria list five levels of Withdrawal Management for Adults. As part of Handbook Section 13.D.3.1 (SAMHSA Criteria 4.c.1), it is required that CCHBCs have services for the first four levels readily available and accessible to people experiencing a crisis at the time of the crisis. The four levels include:

- 1-WM: Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery. The CCBHC or a DCO must directly provide 1-WM.
- 2-WM: Moderate withdrawal with all-day withdrawal management support and supervision; at night, has supportive family or living situation, likely to complete withdrawal management. The CCBHC is encouraged to directly provide 2-WM. While the CCBHC must have the 2-WM level of ambulatory withdrawal management available and accessible to eligible consumers, it is

not a requirement that this service be provided directly, although it is encouraged.

- 3.2-WM: Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery. May be provided directly either by the CCBHC or through a DCO relationship or by referral.
- 3.7-WM: Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, or nursing monitoring. May be provided directly either by the CCBHC or through a DCO relationship or by referral.

13.D.4. Screening, Assessment, and Diagnosis

13.D.4.1. Screening, Assessment, and Diagnosis Services

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

13.D.4.1.1. Evaluation Timeframe

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

13.D.4.1.2. Evaluation Components

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

Required evaluation components may be updated throughout the

demonstration depending on age, specific behavioral health needs, and intensity of needs.

13.D.4.1.3. Specific Substance Use Disorder Assessment Requirements

To align with the requirements outlined in the Medicaid 1115 Demonstration Waiver for Substance Use Disorder (SUD) Services, CCBHCs and DCOs who provide substance use disorder services must utilize the specified assessment tools – the ASAM Continuum Assessment for adults and the GAIN for adolescents. CCBHCs and DCOs are not required to have staff fully trained on the assessments prior to October 1, 2021. However, CCBHCs should coordinate with PIHPs to have CCBHC staff enrolled in upcoming training cohorts as available.

13.D.4.2. Diagnostic and Treatment Planning Evaluations

13.D.4.2.1. General Overview

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

13.D.4.2.2. Components of Diagnostic and Treatment Planning Evaluation

Although a comprehensive diagnostic and treatment planning evaluation is required for all CCBHC consumers, the extent of the evaluation will depend on the individual consumer and standards required by both MDHHS and applicable accreditation bodies. As part of certification, CCBHCs should demonstrate the following components are included: (1) reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the consumer's presentation to the CCBHC; (2) a psychosocial evaluation including housing, vocational and educational status, family/caregiver and social support, legal issues, and insurance status; (3) behavioral health history (including trauma history and previous therapeutic interventions and hospitalizations); (3) a diagnostic assessment, including current mental status, mental health (including depression screening) and substance use disorders (including tobacco, alcohol, and other drugs); (4) assessment of imminent risk (including suicide risk, danger to self or others, urgent or critical medical conditions, other immediate risks including threats from another person); (5) basic competency/cognitive impairment screening (including the consumer's ability to understand and participate in their own care); (6) a drug profile including the consumer's prescriptions, over-the-counter medications, herbal remedies, and other treatments or substances that could affect drug therapy, as well as information

on drug allergies; (7) a description of attitudes and behaviors, including cultural and environmental factors, that may affect the consumer's treatment plan; (8) the consumer's strengths, goals, and other factors to be considered in recovery planning; (9) pregnancy and parenting status; (10) assessment of need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services, LEP or linguistic services); (11) assessment of the social service needs of the consumer, with necessary referrals made to social services and, for pediatric consumers, to child welfare agencies as appropriate; and (12) depending on whether the CCBHC directly provides primary care screening and monitoring of key health indicators and health risk pursuant to Handbook Section 13.D.7 (SAMHSA criteria 4.G), either: (a) an assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the consumer's primary care provider (with appropriate referral and follow-up), or (b) a basic physical assessment as required by Handbook Section 13.D.7 (SAMHSA criteria 4.G). All remaining necessary releases of information are obtained by this point.

13.D.4.3. Screening and Assessment

13.D.4.3.1. Overview and CCBHC Indicators

Screening and assessment by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to required CMS reporting metric criteria. The CCBHC should not take non-inclusion of a specific metric as a reason not to provide clinically indicated behavioral health screening or assessment and the state may elect to require specific other screening and monitoring to be provided by the CCBHCs beyond those listed in Section 7: Monitoring and Evaluation, of this handbook.

13.D.4.3.2. Standardized Screening and Assessment Tools

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

13.D.4.3.3. Culturally and Linguistically Appropriate Screening Tools

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

13.D.4.3.4. SUD Brief Intervention and Referral

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

13.D.5. Person-Centered and Family-Centered Treatment Planning

13.D.5.1. Treatment Planning Services

The CCBHC directly provides person-centered and family-centered treatment planning or similar processes, including but not limited to risk assessment and crisis planning. Person-centered and family-centered treatment planning satisfies the requirements of

13.D.5.2 below and is aligned with the requirements of Section 2402(a) of the Affordable Care Act, including consumer involvement and self-direction.

13.D.5.2. Person/Family Centered Planning

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

13.D.5.2.1. Assessments inform Plan

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

13.D.5.2.2. Treatment Plan Includes Needs, Strengths, Preferences

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

13.D.5.2.3. Comprehensive Treatment Plan

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

13.D.5.2.4. Consultation Sought During Treatment Planning

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

13.D.5.2.5. Advanced Wishes

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

13.D.5.2.6. State Standards for Treatment Planning

CCBHCs must meet all additional requirements for person-centered planning and the development and monitoring of an Individual Plan of Service, as described in the Michigan Mental Health Code, the Medicaid Provider Manual, and person-centered planning guidance.

13.D.6. Outpatient Mental Health and Substance Use Services

13.D.6.1. Outpatient Services

The CCBHC provides outpatient mental and substance use disorder services that are evidence-based or best practices, consistent with the needs of individual consumers as identified in their individual treatment plan, either directly or through a DCO arrangement. In the event specialized services outside the expertise of the CCBHC are required for purposes of outpatient mental and substance use disorder treatment (e.g., treatment of sexual trauma, eating disorders, specialized medications for substance use

disorders), the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine services. The CCBHC also provides or makes available through formal arrangement traditional practices/treatment as appropriate for the consumers served in the CCBHC area.

13.D.6.2. Evidence Based Practices

The CCBHC must offer, either directly or through a DCO, a minimum set of evidence-based practices as defined by the state.

CCBHCs will be responsible for ensuring that EBPs are provided by individuals with appropriate training and credentials and have an established process for monitoring model fidelity, either locally or with Michigan Fidelity Assistance Support Team (MIFAST) reviews.

MDHHS is committed to supporting the ongoing expansion of evidence-based practices via staff training and fidelity monitoring. The Community Practices and Innovation (CPI) Section is located in the Division of Quality Management & Planning and oversees many of the Medicaid specialty behavioral health services and supports for adults, as well as programmatic functions and oversight for adult mental health block grant projects. EBPs for children, youth, and families are overseen by the Division of Services to Children and Families, who offer ongoing training for TF-CBT, PMTO/PTC, and MI for children and adolescents.

MIFAST teams are currently available for the following required CCBHC EBPs for the adult population: Assertive Community Treatment (ACT), Integrated Dual Disorder Treatment (IDDT), Dialectical Behavior Therapy (DBT), and Motivational Interviewing (MI), as well as many recommended EBPs including Supported Employment (IPS Model), Family Psychoeducation (FPE), and trauma-informed care. Questions about MIFAST reviews can be directed to MDHHS-MIFAST@michigan.gov.

13.D.6.2.1. Required EBPs

- "Air Traffic Control" Crisis Model with MiCAL
- Assertive Community Treatment (ACT)
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Infant Mental Health
- Integrated Dual Disorder Treatment (IDDT)
- Motivational Interviewing (MI) for adults, children, and youth
- Medication Assisted Treatment (MAT)
- Parent Management Training – Oregon (PMTO) and/or Parenting through Change (PTC)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Zero Suicide

13.D.6.2.2. Recommended EBPs

- An EBP of the CCBHC's choice addressing trauma in adult populations
- An EBP of the CCBHC's choice addressing needs of transition age youth

(such as the Transition to Independence Process [TIP] model)
- An EBP of the CCBHC's choice addressing chronic disease management
- Dialectical Behavior Therapy for Adolescents (DBT-A)
- Permanent Supportive Housing
- Supported Employment (IPS model)

13.D.6.3. Treatment Appropriate for Phase of Life

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

13.D.6.4. Family Driven/Youth Guided

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

13.D.7. Outpatient Clinic Primary Care Screening and Monitoring

The CCBHC is responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk. Whether directly provided by the CCBHC or through a DCO, the CCBHC is responsible for ensuring these services are received in a timely fashion. Required primary care screening and monitoring of key health indicators and health risk provided by the CCBHC include those for which the CCBHC will be accountable pursuant to 13E- Program Requirement #5: Quality and Other Reporting and the metrics listed in Section 7 of this handbook. The CCBHC should not take non-inclusion of a specific metric Section 7 of this handbook as a reason not to provide clinically indicated primary care screening and monitoring and the state may elect to require specific other screening and monitoring to be provided by the CCBHCs. The CCBHC ensures children receive age-appropriate screening and preventive interventions including, where appropriate, assessment of learning disabilities, and older adults receive age-appropriate screening and preventive interventions. Prevention is a key component of primary care services provided by the CCBHC. Nothing in these criteria prevent a CCBHC from providing other primary care services.

13.D.8. Targeted Case Management Services

The CCBHC is responsible for high quality targeted case management services that will assist individuals in sustaining recovery, and gaining access to needed medical, social, legal, educational, and other services and supports. CCBHCs will follow all requirements for targeted case management as defined in the Medicaid Provider Manual and will follow any policy guidance intended to standardize and/or improve case management services. Targeted case management should include supports for persons deemed at high risk of suicide, particularly

during times of transitions such as from an ED or psychiatric hospitalization.

13.D.9. Psychiatric Rehabilitation Services

The CCBHC is responsible for evidence-based and other psychiatric rehabilitation services. Supported services such as housing, employment (specifically the Individual Placement and Support (IPS) model of supported employment, and education (in collaboration with local school systems) are encouraged. Other psychiatric rehabilitation services that might be considered include medication education; self-management; training in personal care skills; individual and family/caregiver psychoeducation; community integration services; recovery support services including Illness Management & Recovery; financial management; and dietary and wellness education.

13.D.10. Peer Supports, Peer Counseling, and Family/Caregiver Supports

The CCBHC is responsible for peer specialist and recovery coaches, peer counseling, and family/caregiver supports. CCBHCs are required to offer, either directly or through DCOs, peer services that serve all populations including peer support specialists, recovery coaches, parents support partners, and youth peer support partners. Peer services that also might be considered include peer-run drop-in centers, peer crisis support services, peer bridge services to assist individuals transitioning between residential or inpatient settings to the community, peer trauma support, peer support for older adults, and other peer recovery services. Potential family/caregiver support services that might be considered include family/caregiver psychoeducation and parent training.

13.D.11. Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans

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

13.D.11.1. Identification of Military/Veterans and Connection to Care

All individuals inquiring about CCBHC services must be asked whether they have ever served in the US military. BH-TEDS is required for all CCBHC recipients and meets the requirements for asking about military background and connections to veterans' resources.

13.D.11.1.1. Serving Current Military Personnel

Active-Duty military personnel must use their servicing Military Treatment Facility (MTF). CCBHCs should contact the individual's MTF Primary Care Manager for care coordination and referral for services.

Military personnel who are Active Duty and Active Reserve (Guard/Reserve) and reside more than 50 miles from a military hospital or clinic must use TRICARE PRIME Remote and use the network Primary Care Manager or

authorized TRICARE provider as the Primary Care Manager. CCBHCs should contact the Primary Care Manager for care coordination and referral for services.

Members of the Selected Reserves who are not on Active Duty are eligible for TRICARE Reserve Select and can see any TRICARE-authorized provider, network, or non-network. CCBHCs should help facilitate this transition to services.

13.D.11.1.2. Serving Veterans

If the individual is not enrolled in the VHA, the CCBHC should help enroll in VHA for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services are to be served by the CCBHC in a manner consistent with guidelines outlined in the VHA Uniform Mental Health Services Handbook.

13.D.11.2. Integrating Care for Veterans

CCBHCs must ensure there is integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both and for integration or coordination between care for behavioral health conditions and other components of health care for all veterans.

13.D.11.3. Principal Behavioral Health Provider for Veterans

Every veteran seen for behavioral health services is assigned a Principal Behavioral Health Provider (PBHP). The PBHP is noted in the medical record and known to the veteran and can be tracked for reporting purposes. The PBHP is responsible for:

- Maintaining regular contact with the veteran as clinically indicated.
- Ensuring a psychiatrist regularly reviews and reconciles the veteran's psychiatric medications.
- Working with the veteran and the veteran's family, when appropriate, to develop a person-centered, recovery-oriented treatment plan.
- Implementing the treatment plan, tracking, and documenting progress.
- Revising the treatment plan when necessary.
- Ensuring the veteran understands their treatment plan and addresses concerns about care. If veteran is at risk of losing decision making ability, the PBHP is responsible for discussing future treatment (see VHA Handbook 1004.2).
- Ensuring the treatment plan reflects the veteran's goals and preferences for care, and that consent is provided for treatment.

13.D.11.4. Recovery-Based Veterans' Services

Behavioral health services for veterans are recovery-oriented, and include additional recovery principles of privacy, security, and honor. Care for veterans must conform to that definition and to those principles to satisfy the statutory requirement that care for veterans adheres to guidelines promulgated by the VHA.

13.D.11.5. Cultural Competence- Veterans' Culture

All behavioral health care is provided with cultural competence, and staff will receive specific training on military and veteran's culture. Specifically, any staff who is not a veteran has training about military and veterans' culture to be able to understand the

unique experiences and contributions of those who have served their country. As described in staffing requirements, all staff should receive cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity.

13.D.11.6. Treatment Plan for Veterans

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

- The treatment plan includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis.
- 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.
- As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness.
- The plan is recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments.
- 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.

13.E. Program Requirement #5: Quality and Other Reporting

13.E.1. Data Collection, Reporting, and Tracking

13.E.1.1. Data Collection and Reporting Capacity

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

13.E.1.2. Annual Data Reporting

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

13.E.1.3. DCOs and Data Reporting

Although most data reporting requirements will be the responsibility of the PIHPs or MDHHS, some data may relate to services CCBHC recipients receive through DCOs. Collection of this data is the responsibility of the CCBHC. The CCBHC should arrange for access to data in DCO agreements and is responsible for ensuring adequate consent and releases of information are obtained for each affected CCBHC recipient.

13.E.1.4. State Encounter Reporting

MDHHS will provide federal demonstration evaluators with CCBHC-level Medicaid claims or encounter data annually.

13.E.1.5. Annual Cost Reporting

CCBHCs annually submit a cost report with supporting data within four months after the end of each demonstration year to the PIHP. The PIHP will review the submission for completeness and submit the report and any additional clarifying information within six months after the end of each demonstration year to MDHHS. The timelines should reflect other cost reporting timelines required by MDHHS. The CCBHC Cost Report template OMB #0398-1148/ CMS-10398 (#43) dated December 14, 2015 will be used for Demonstration Year 1 and 2.

13.E.2. Continuous Quality Improvement (CQI) Plan

13.E.2.1. Annual CQI Plan

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

13.E.2.2. CQI Plan Requirements

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

13.F. Program Requirement #6: Organizational Authority, Governance, and Accreditation

13.F.1. General Requirements of Organizational Authority and Finances

13.F.1.1. Organizational Authority

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.).

13.F.1.2. IHS Agreements

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

13.F.1.3. Independent Audit

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

13.F.2. Governance

13.F.2.1. Board Representation

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

13.F.2.2. Board Composition Plan

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

13.F.2.3. Alternative to Board Requirement

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

13.F.2.3.1. Advisory Group Requirements

As an alternative to the board membership requirement, any organization

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

13.F.2.4. Board Member Expertise and Interests

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

13.F.2.5. MDHHS Verification

MDHHS, directly or through the PIHPs, will determine what processes will be used to verify that these governance criteria are being met.

13.F.3. Accreditation

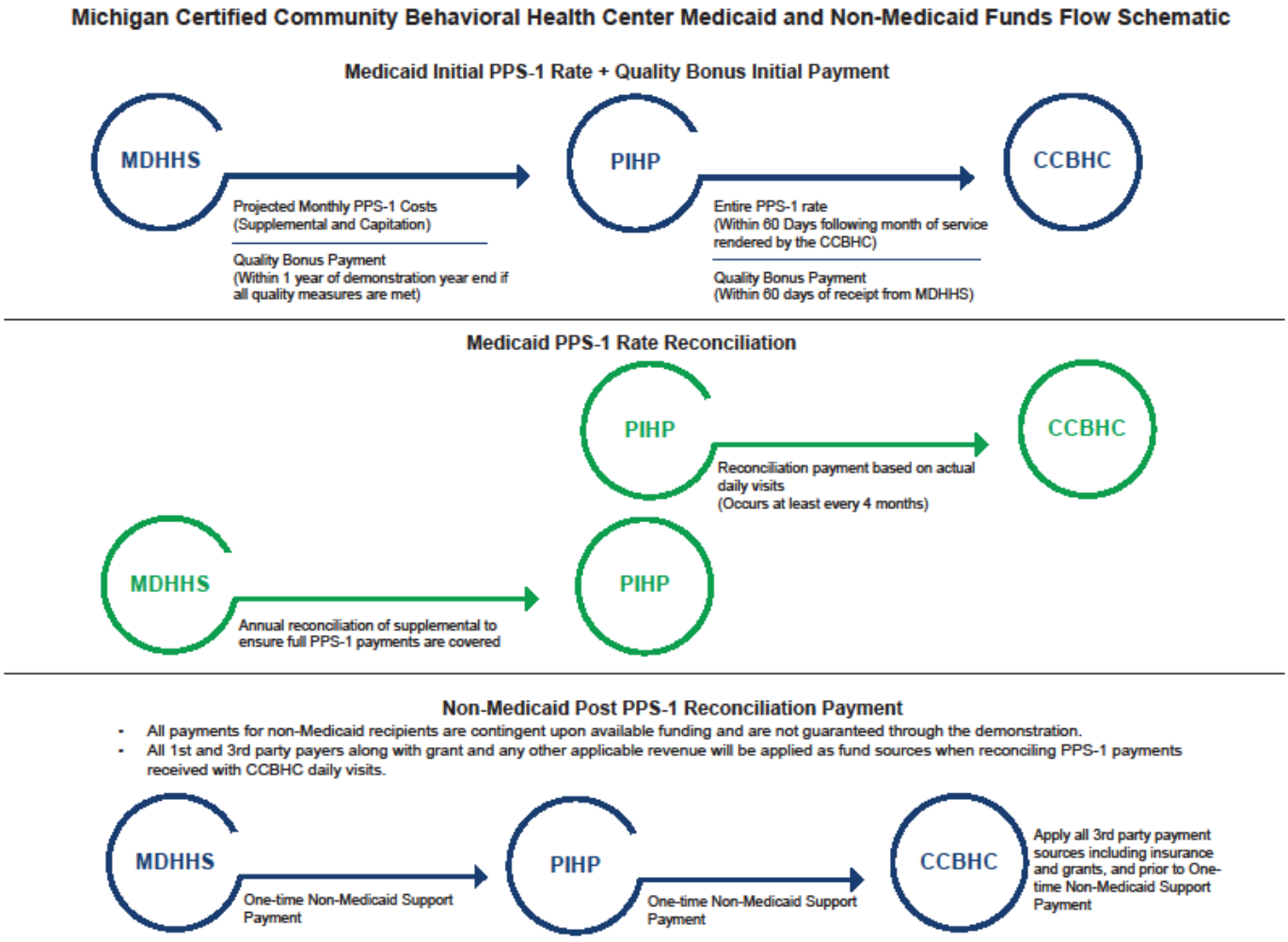
13.F.3.1. Accreditation and Licensing

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

13.F.3.2. State Accreditation Requirements

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

14. Appendix G: MI CCBHC Funds Flow Schematic



15. Appendix H: Requirements for use of ARPA Mental Health Block Grant (MHBG) Funds

MHBG funds may not be used to supplant existing mental health funding. They may not be used to fund Medicaid approved services for Medicaid recipients.

Federal authorizing legislation specifies that these funds may not be used to:

1. Provide inpatient services;
2. Make cash payments to intended recipients of mental health services (e.g., stipends, rent or lease payments, utility arrearages, insurance, furnishings, personal items, etc.)
3. Purchase or improve land; purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; or purchase major medical equipment;
4. Satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds; or
5. Provide financial assistance to any entity other than a public or nonprofit private entity.
6. Directly or indirectly purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders.

MDHHS contracts require that any service or activity funded in whole or in part with this funding be delivered in a smoke-free facility or environment.

In addition, this RFA calls attention to the MHBG emphasis upon service provision, and the following restrictions are also included:

1. No medication purchases;
2. No vehicle purchases, leases, or insurance; or
3. No administrative (e.g., office space, utilities, LAN line telephones, Internet, insurance, etc.) or indirect expenses.

For new projects, there are three ways in which MHBG funds may be used for project staffing so that no supplanting occurs:

- If the position is a new hire;
- If the position is assuming additional hours (e.g., part-time to full-time) and block grant funds are paying for the additional hours only; or
- If an existing staff member is assuming the duties of the new project and their old position will be back-filled with a comparable new hire.

Appendix I – 837 Encounter Examples

Example CCBHC Cost Scenario

16. Appendix I: Encounter Reporting Example

In this example, an individual received two eligible CCBHC services – H0031 and 99201 – on a given day. The Procedure Code T1040 is used as flag to indicate a CCBHC enrollees receiving CCBHC services. In this example, no payments are associated with the T1040. Payments to the CCBHC are shown on actual services H0031 and 99201 but reflect historical fee structures rather than the PPS-1 rate.

Loop	Claim	Notes
2300:	CLM✻A37YH556✻40✻✻✻11:B:1✻Y✻A✻Y✻I✻P~	Total Claim Charge Amount - CLM02
2320:	AMT✻D✻25~	Total Payment Amount - AMT02
2330B:	NM1✻PR✻2✻**Payer Name**✻✻✻✻✻PI✻11122333~	Payer ID – NM109 - Must match 2430 SVD01
2400:	**Line 1** SV1✻HC:T1040✻0✻UN✻1✻11✻✻1:2:3✻✻N~	Line Item Charge Amount - SV102
2430:	SVD✻11122333✻0✻HC:T1040✻✻3~	Service Line Paid Amount - SVD02; Payer ID – SVD01 Must match 2330B NM109
2430:	CAS✻OA✻93✻0~	Line Adjustment Amount - CAS03, Other Adjustment – CAS01
2430:	DTP✻573✻D8✻20130203~	Remittance Date
2400:	**Line 2** SV1✻HC:H0031✻20✻UN✻1✻11✻✻1:2:3✻✻N~	Line Item Charge Amount - SV102
2430:	SVD✻11122333✻15✻HC:H0031✻✻3~	Service Line Paid Amount - SVD02; Payer ID – SVD01 Must match 2330B NM109
2430:	CAS✻OA✻93✻5~	Line Adjustment Amount - CAS03, Other Adjustment – CAS01
2430:	DTP✻573✻D8✻20130203~	Remittance Date
2400:	**Line 3** SV1✻HC:99201✻20✻UN✻1✻11✻✻1:2:3✻✻N~	Line Item Charge Amount SV102
2430:	SVD✻11122333✻10✻HC:99201✻✻2~	Service Line Paid Amount SVD02; Payer ID – SVD01 Must match 2330B NM109
2430:	CAS✻OA✻93✻10~	Line Adjustment Amount - CAS03, Other Adjustment – CAS01
2430:	DTP✻573✻D8✻20130203~	Remittance Date

Reporting Instructions for the Designated Collaborating Organization (DCO)

For CCBHC encounters where the service is provided by a DCO, the name, address, and NPI of the DCO will be reported in the Facility Location (2310C loop).

2310C Loop – SERVICE FACILITY LOCATION NAME – Claim Level

NM1*77 segment – Service Location

NM1*77*2*ABC Provider*****XX*1234567890~

77 – Service Location
2 – Non-Person Entity
ABC Provider – Organization Name
XX – Centers for Medicare and Medicaid Services National Provider Identifier [is in next data element]
1234567890 – Identification Code - NPI