Michigan Certified Community Behavioral Health Clinic (CCBHC) Handbook

Version 2.1

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.

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Preface

The Michigan Department of Health & Human Services (MDHHS) Behavioral and Physical Health and Aging Services Administration (BPHASA) created the Certified Community Behavioral Health (CCBHC) Demonstration Handbook to provide Medicaid policy and billing guidance for providers and PIHPs participating in Michigan's CCBHC Demonstration. Most broadly, this handbook provides detailed instructions to assist providers in meeting certification, policy, and billing requirements while participating in the CCBHC Demonstration. The handbook also provides 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 persons served. 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 must 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 a start date of October 1, 2021. The Bipartisan Safer Communities Act of 2022 extended eligibility to participate in the demonstration for an additional four years. CMS requires a state to implement the demonstration in at least two sites – one rural and one urban. In February 2023, states participating in the Section 223 PAMA Act of 2014, were permitted to expand the opportunity for eligible providers to join the demonstration. CCBHC Demonstration Sites are selected by the state 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 (SUD) 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 Prospective Payment System (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 operationalizes the demonstration through CCBHC sites and the relevant Prepaid Inpatient Health Plans (PIHPs), by utilizing a collaborative and interdisciplinary team-based model of care to ensure the totality of one's needs – physical, behavioral, and/or social, are met. At the end of the demonstration, MDHHS will evaluate the program's impact and assess the potential to continue or expand the initiative under federal authority.

1.B. CMS Demonstration and SAMHSA CCBHC Grants

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

1.B.1. SAMHSA Grants

SAMHSA CCBHC Grants are available to community treatment providers in every state. 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 (MDHHS) 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 persons served. Moreover, the State is responsible for overseeing the demonstration program, including clinic certification, payment, and compliance with federal reporting requirements.

Existing SAMHSA CCBHC grantees can participate in the CMS CCBHC Demonstration and continue to use SAMHSA CCBHC grant funds provided they meet the requirements of both federal programs.

1.C. The CCBHC Model

CCBHCs are designed to provide a comprehensive range of mental health and SUD services and serve as a safety net behavioral health service provider. 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 and standardized criteria related to care coordination, crisis response and service delivery, and to 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 (9) comprehensive core 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 persons served 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 partnerships.

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 persons served characteristics, staffing, access to services, use of services, screening, prevention, and treatment, care coordination, other processes of care, costs, and individual 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
Per CMS directive, states have the flexibility to determine which behavioral health providers can participate in the CCBHC Demonstration. Sites must meet all requirements as outlined in the below sections of the handbook and be certified by MDHHS to be designated as a CCBHC demonstration site. Certified CCBHC Demonstration sites are located on the MDHHS CCBHC webpage.

Eligible sites must fall into one of the categories outlined in Section 2.C.13., Organizational Governance. Eligible sites must be enrolled in the Michigan Medicaid program, in compliance with all applicable program policies, and evidence historical participation and familiarity with Michigan's Medicaid program. Additionally, eligible sites must evidence historical and current delivery of behavioral health/substance use disorder services and programming.

1.D.2. CCBHC Recipient Eligibility
Any person with a mental health or SUD ICD-10 diagnosis code as cited in Appendix B of this handbook 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 Must align with assessment and diagnosis requirements (see 8.D.4.1 for more on requirements) and take place as frequently as specified or as clinically appropriate following the person-centered planning process and must be medically necessary.

For those with Medicaid, eligible Medicaid persons served include those enrolled in Medicaid (MA), Healthy Michigan Plan (MA-HMP), Freedom to Work (MA-FTW), MIChild Program (MA- MICHILD), Full Fee-for-Service Healthy Kids-Expansion (HK-EXP), and Integrated Care – MI Health Link (ICO-MC). Medicaid persons served cannot be enrolled in the PACE or Brain Injury Services Benefit Plans concurrently with CCBHC.

Medicaid persons served 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 medically necessary 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 8. A.1.) For individuals residing out of state or out of the United States, CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services. If an individual residing outside the state or country intends on remaining in the service area temporarily and could benefit from ongoing care, the CCBHC Must provide those services and consider the individual to be non-Medicaid for purposes of the demonstration. CCBHCs must have protocols developed for coordinating care across state lines.

2. PIHP and CCBHC Requirements

2.A. PIHP 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.

MDHHS acknowledges PIHPs may have both the responsibility to oversee components of the CCBHC program and (1) have affiliated Community Mental Health Service Providers (CMHSPs) certified as CCBHCs or (2) be a standalone PIHP/CMHSP certified as a CCBHC. To preserve program integrity and mitigate conflict of interest risk across PIHPs and CCBHCs (CMHSPs and independent providers operating as CCBHCs), MDHHS has developed requirements described in Section 2.B.7 PIHP and CCBHC Conflicts of Interest Safeguards.

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, reporting on CCBHC measures, and coordinating care for all populations served by the CCBHC sites in their region (regardless of payor).

MDHHS reserves the right to implement alternative payment models, as permitted by federal guidance, including but not limited to making PPS payments outside of the managed care delivery system, for CCBHCs participating in the CMS Demonstration. If

such alternative models are implemented, PIHP oversight and responsibilities may be altered to reflect those changes.

2.B.1. Minimum Requirements

- PIHPs must be a regional entity as defined in Michigan's Mental Health Code (330.1204b) or organized as one of the three standalone PIHPs/CMHSPs (i.e., Macomb, Oakland, and Wayne Counties).PIHPs must contract with all CCBHCs in their region to meet requirements as outlined in the PIHP contract, CCBHC policy, and CCBHC demonstration handbook. In the event that a Prepaid Inpatient Health PIHP terminates its contract with the CCBHC, the State shall assume full responsibility for administrative, oversight, and payment functions related to the CCBHC, provided that the CCBHC continues to meet all applicable certification requirements and remains certified by MDHHS. In such a situation, the PIHP must collaborate with MDHHS and CCBHC to ensure that a seamless transition of care is facilitated for all individuals served by the CCBHC. 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. Contracts must not limit the CCBHC's ability to serve all populations with behavioral health needs per CCBHC eligibility requirements.
- PIHPs must understand the CCBHC certification process and certification requirements. PIHPs do not have the authority to certify or change the certification status of a CCBHC.
- PIHPs must support providers who meet certification criteria and standards and cannot create access barriers to eligible persons seeking CCBHC covered services.
- PIHPs must distribute data requests from MDHHS to CCBHCs for data collection.
- PIHPs must validate data by reviewing for completion and evaluating for reasonability and accuracy of completed data requests. PIHPs must evaluate data and information reported by CCBHCs within known context and communicate any discrepancies identified with the CCBHCs prior to submission to MDHHS. This includes but is not limited to quality metrics, cost reports, level of care (LOC) data, reconciliation templates, and ad-hoc requests by MDHHS.
- PIHPs must utilize Michigan claims and encounter data for the CCBHC population.
- PIHPs must work with CCBHCs to establish a timeline to meet MDHHS reporting deadlines.
- PIHPs must maintain compliance with State and/or Federal reporting requirements.
- PIHPs must maintain a continuous quality improvement program that incorporates data collection and reporting to ensure 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 is demonstrated. The PIHPs Quality Assessment and Performance Improvement Program (QAPIP) must include utilization management procedures to comply with CCBHC requirements.
- PIHPs must provide access to CCBHC services through providers certified as a CCBHC.
- PIHPs must panel CCBHCs to provide substance use disorder (SUD) services or assist the CCBHC to develop a DCO agreement with a SUD provider already on the PIHP panel.

- PIHPs must honor intake, access, screening, and authorization for CCBHC services completed by a CCBHC demonstration provider when an individual seeks services at a CCBHC (i.e., calling the CCBHC directly or walk-ins).
    - Individuals who present at a CCBHC for services must, at the time of first contact, receive preliminary screening from the CCBHC and risk assessment to determine acuity of needs, as described in the Section called Timeliness for New CCBHC Recipients of the CCBHC Demonstration Handbook. PIHP must pay the CCBHC the full PPS rate for this first encounter.
    - Established CCBHC recipients must obtain timely access to services as specified in Section – 8.B.9.3 Timely Access to Outpatient Services of the CCBHC Demonstration Handbook.
    - PIHPs must work with CCBHCs to ensure access to services and warm handoffs for persons served including but not limited to the instances listed below:
        - Individuals who require a service that is at a higher level of care than the nine core CCBHC services offered at the CCBHC or their contracted DCO, including substance use disorder (SUD) services.
        - Individuals seeking access to services a CCBHC does not provide.
        - Individuals seeking access to services offered through the 1915(c) waivers (Habilitation Supports Waiver, Children's Waiver Program, Waiver for Children with Serious Emotional Disturbances) or 1915(i) services.
        - PIHPs cannot require any prior authorizations or additional screening requirements beyond those noted above before an individual can access CCBHC services.
- PIHP utilization management of CCBHC services is limited to retrospective review of approved/rendered services to confirm that the care was medically necessary.
    - PIHPs cannot delegate retrospective reviews for CCBHC services to a CCBHC or CMHSP.
- MDHHS recommends that PIHPs provide training and technical assistance on certification requirements, including helping other potential CCBHC sites in preparing to meet CCBHC requirements.
- MDHHS recommends that PIHPs provide support to CCBHCs related to Health Information Technology (HIT), including the Waiver Support Application (WSA), CareConnect360(CC360), the PIHP Electronic Health Record (EHR), and Health Information Exchanges (HIEs).

2.B.2. <u>CCBHC Enrollment and Assignment</u>

- Use of 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 is entered into WSA. PIHPs must work with the CCBHCs to confirm diagnostic eligibility, particularly for non-Medicaid individuals, and may establish other review processes to verify diagnosis for all populations.
- 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 to ensure 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 consents and must be updated annually. Entities are required to use and accept the MDHHS-5515 consent form unless the entity is held to more stringent requirements under federal law. The only entities who are held to more stringent requirements under federal law are entities receiving funding resulting from the Victims of Crime Act, Violence Against Women Act, or Family Violence Prevention and Services Act.

- When consent is obtained via the MDHHS-5515 form, no additional orientation, consent or authorization is required to receive CCBHC services. PIHP shall not require additional signatures from the person served outside of those necessary to be enrolled outside of the 5515.

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 SUD.
- Develop and maintain working relationships with primary and specialty care providers such as Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), inpatient hospitals, crisis services providers, and SUD providers.
- Assist CCBHC with outreach to eligible CCBHC recipients, if requested by CCBHC.
- Coordinate crisis and other referral services with the Michigan Crisis and Access Line (MiCAL), when available in the PIHP region.
- Coordinate services when eligible individuals utilize the PIHP's centralized access system, including assigning them to a CCBHC of their choice.
- PIHPs are encouraged to engage in regional care coordination agreement between themselves, the CCBHCs in their region, and residential/withdrawal management health facilities. Agreements must outline the responsibilities of each party, including timelines and expectations for coordination, and will be reviewed and updated as appropriate throughout the year.

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 per Medicaid individual 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). PIHPs must reimburse CCBHCs in a timely manner according to the Federal Clean Claims Act and the Michigan Medicaid Provider Manual. PIHPs will submit encounters to MDHHS in accordance with Section 5.C.1 of this Handbook.
- PIHPs will distribute general fund (GF) and quality bonus payments (QBPs) to CCBHCs as described in Section 5.C and 5.D of this Handbook.

2.B.5. CCBHC Reporting

For a detailed list of reporting requirements, please navigate to Appendix H of this handbook. CCBHCs must coordinate with PIHPs to meet PIHP review deadlines prior to the deadline for submission to MDHHS.

2.B.5.1. CCBHC Metric Reporting

2.B.5.1.1. Clinic-Reported Quality Metric Reporting (See Section 7.A.4.1 for details)

- PIHPs must work closely with CCBHCs to ensure the CCBHC can

successfully collect required clinic-reported quality measures.

- On a quarterly basis, the PIHP will review clinic-reported metric templates for completeness and reasonability.
- PIHPs will work with CCBHCs to remedy data collection issues to ensure accuracy of metric reporting.
- Annually, the PIHP will submit the final demonstration year clinic-reported measures to MDHHS.

2.B.5.1.2. State-Reported Quality Metric Reporting

- PIHPs will share quarterly state-reported quality metric data with CCBHCs for ongoing performance monitoring. Data is updated in CC360 on a quarterly basis and updated on the timeline listed in Appendix E: State Reported Measures, Specifications and Measurement Years.
- PIHPs will review updated measure information for accuracy/ consistency with PIHP data.
- PIHPs will share final data from the end of year update of metrics in CC360 upload for clinics to complete the state-reported metrics sheets of the reporting template (MI-CCBHC-Data-Demonstration-Templates (FY25).xlsx). PIHPs will submit end of year templates to MDHHS.

2.B.5.1.3. Access Data Reporting

- PIHPs will 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.
- Submission of the I-SERV and I-SERV(Supplemental) tab of the 'CCBHC Data Demonstration Template' meets this requirement. The (Supplemental) tab an optional quarterly reporting requirement in CY25.

2.B.5.2. <u>CCBHC Cost Reporting</u>

- PIHPs must review, validate, and submit CCBHC Office of Management and Budget (OMB) Cost Reports annually.
  - PIHPs must provide support to CCBHCs completing their cost reports, including providing encounter information for daily visit calculation.
  - PIHPs must review cost reports for accuracy and sustainability. PIHPs must provide feedback to the site related to the cost report and technical assistance, as needed.
- CCBHCs and PIHPs must complete and submit reconciliation templates quarterly. The templates are due to the MDHHS actuarial mailbox (<u>qmpmeasures@michigan.gov</u>) by the due date identified in the reconciliation template instructions. To better align reconciled numbers with what is stored in the MDHHS data warehouse, each CCBHC/PIHP must report the encounter submission cut-off date they used in the comments section of the template.
  - **Note**: Receipt of quarterly reporting is to assist with monitoring

reconciliation throughout the year. Submission does not impact reconciliation throughout the year; the final reconciliation takes place at the end of the year utilizing the FSR.

Quarter 1	Quarter 2	Quarter 3	Quarter 4 (year-end)
Oct. 1 - Dec. 31	Oct. 1 - March 31	Oct. 1 - June 30	Oct. 1- Sept. 30

2.B.5.3. CCBHC Grievance Monitoring and Reporting

- PIHPs must monitor, collect, and report Medicaid grievance, appeal, and service authorization denials, with details, by CCBHC, to MDHHS through the DCH File Transfer (MDHHS will specifically monitor this activity as it relates to CCBHC services related to certification criteria requiring CCBHCs to provide CCBHC services to all eligible populations regardless of severity, ability to pay, or county of origin). PIHPs are not responsible for recipient rights reporting.

2.B.5.4. Placeholder for CCBHC Compliance Exam and Audit Review

PIHPs will incorporate CCBHC into current compliance examinations and audit review processes.

2.B.5.5. Other Reporting

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

PIHPs must send required reports to MDHHS-CCBHC@michigan.gov or through the File Transfer Service (FTS) (except for those with submissions processes already defined [e.g., FSR]).

2.B.6. CCBHC Encounter Reporting and Oversight

PIHPs must establish procedures to monitor compliance with CCBHC encounter reporting requirements.

- T1040 identification: PIHPs will review CCBHC-eligible service encounters, as listed in Appendix A of the CCBHC Handbook, with CCBHCs to troubleshoot T1040 submissions.
- TF Modifier: PIHPs will ensure that all CCBHC services to individuals who meet the CCBHC reporting definition of Mild-to-Moderate are submitted with the TF modifier on the T1040. PIHPs must be able to translate this information into daily visits for reporting on the quarterly reconciliation template.
- DCOs: PIHPs will develop a system for monitoring service encounters submitted by CCBHCs for services provided by a Designated Collaborating Organization (DCO).
- Service Locations: PIHPs will monitor the service location on encounters submitted with a T1040 to ensure they were provided at a certified location. The actual place of service will be indicated on the service line of the claim/encounter in accordance with the current Behavioral Health Code and Provider Qualifications document. The T1040 will be coded with place of service 11.
- HSW Overlap: PIHPs will ensure that individuals are enrolled in the Habilitation

Supports Waiver (HSW) when appropriate. PIHPs will verify that CCBHCs do not bill overlapping HSW/CCBHC codes with a T1040 for individuals enrolled in the HSW benefit plan (see section 4.B.5. for CCBHC and HSW enrollment and Appendix A for overlapping services)

- Duplication: PIHPs will ensure that two encounters aren't submitted for the same service on the same day (i.e., DCO directly to PIHP and by the CCBHC to the PIHP).

2.B.7. PIHP and CCBHC Conflicts of Interest Safeguards

The requirements in this section are intended to mitigate conflicts of interest between PIHPs and CCBHCs and ensure individuals experience no barriers in obtaining access to CCBHC services.

MDHHS will develop an audit process to conduct oversight of the requirements described in this section.

2.B.7.1. Staffing

- PIHPs must conduct oversight of CCBHCs in the areas of CCBHC enrollment and assignment, CCBHC coordination and outreach, CCBHC payments, and CCBHC reporting (as described in Section 2.B. PIHP Requirements of the CCBHC Demonstration Handbook and the CCBHC Demonstration Section of the PIHP Contract) and may not delegate these oversight functions to a CMHSP or CCBHC.
- For PIHPs with one or more affiliated CMHSPs that are CCBHCs, CCBHC oversight as noted above, and utilization management functions must be conducted by PIHP staff and supervisors who are separate from staff and supervisors delivering services to individuals.
- PIHPs and CCBHCs must have separate and distinct staff leads for communication purposes with MDHHS.

2.B.7.2. Guardrails for PIHP Referrals and Assignments to CCBHCs

- PIHPs cannot require individuals to be referred to a PIHP "access center" before obtaining CCBHC services.
- In the event that an individual presents at the PIHP access center and the PIHP is referring the individual to a CCBHC, PIHPs must seek to identify that the CCBHC is best positioned to serve an individual according to the factors described below.
- PIHPs must take into account the following factors when referring/assigning an individual to a CCBHC:
    - **Choice:** If the individual served has expressed choice/preference for a specific CCBHC then the PIHP must honor that choice to the maximum extent possible.
    - **Existing Provider Relationship:** PIHPs must take into account whether the individual has an existing relationship with a CCBHC and give preference to that provider when making a referral unless there is a specific cause not to do so.
    - **Geographic Location:** PIHPs must take into account the individual's geographic location to ensure reasonable accessibility to the CCBHC.
    - **Acuity:** PIHPs must ensure that there are no preferential referrals to CCBHCs based on an individuals' acuity; individuals of all acuity levels should be distributed across CCBHCs qualified to serve

them.
- **Capacity:** PIHPs must ensure they refer/assign individuals to CCBHCs that have capacity to serve new individuals in a timely manner.

2.B.7.3. Implementation Plan

- PIHPs who have one or more certified CCBHCs in their region must submit an initial implementation plan that details how PIHPs will meet the requirements outlined in the following sections:
  - Access, Authorization, and Utilization Management (2.B.1)
  - Staffing (2.B.7.1)
  - Guardrails for PIHP Referrals and Assignments to CCBHCs (2.B.7.2)
- PIHPs must develop this plan with input from all CCBHCs in their region.
- PIHPs must submit the initial implementation plan within 60 days after the CCBHC Demonstration site start date.
- PIHPs must use the template developed by MDHHS.
- The implementation plan must be submitted to MDHHS at MDHHS-CCBHC@michgan.gov and approved in order for the PIHP to be in compliance with PIHP contract requirements. MDHHS will review and provide a decision on the plan within 30 days of receipt of the plan.
- PIHPs must submit a revised plan for MDHHS review and approval when changes occur that impact the plan, including the addition of new sites, within 30 days of the change.

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, in compliance with all applicable program policies, and evidence historical participation and familiarity with Michigan's Medicaid program.
- Must evidence historical and current delivery of behavioral health/substance use disorder services and programming.
- 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.
- CCBHCs must contract with the PIHP in their region and ensure access to CCBHC services for their service area.
- If a CCBHC is also a CMHSP, it must maintain full CMHSP Certification as required by the Michigan Mental Health Code MCL 330.1232a and Administrative Rule R 330.2701, which states in part that, as a condition of state funding, a single overall certification is required for each community mental health services program.
- Must successfully participate in and complete a financial risk assessment prior to joining the CCBHC Demonstration during initial certification.
- 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 person served assignment to PIHPs.
- Participate in ongoing technical assistance (including but not limited to trainings and webinars).
- Participate in ongoing staff and/or entity specific 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 person served 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 ensure the DCO meets the standards and requirements outlined in the CCBHC handbook.
- Utilize the WSA to develop a participant roster, review relevant reports, recommend individual assignment to CCBHC, and view data for assigned persons served.
- Attest to diagnostic criteria for walk-ins and non-Medicaid persons served.
- Utilize HIT/HIE systems to analyze health data spanning different settings of care for care coordination purposes among Medicaid persons served. Coordinate with PIHP for collecting and sharing member-level information regarding health care utilization and medications with CCBHCs.
- CCBHCs must accept any individual who seeks services.
    - Individuals who present at a CCBHC for services must at the time of first contact, whether that contact is in person, by telephone, or using other remote communication, receive preliminary screening from the CCBHC and risk assessment to determine acuity of needs.
    - Established CCBHC recipients must obtain timely access to services as specified in Section 8.B.9.3. Timely Access to Outpatient Services of this handbook.
- Based on the results of CCBHC screening and risk assessment to determine acuity of needs, CCBHCs must refer individuals with the following needs to the PIHP access center:
    - Individuals who require a service that is at a higher level of care than the nine core CCBHC services offered at the CCBHC or their contracted DCO described in Section 1.C.1. Expanded Service Array.
    - Individuals seeking access to services a CCBHC does not provide.
    - Individuals seeking access to services offered through the 1915(c) waivers (Habilitation Supports Waiver, Children's Waiver Program, Waiver for Children with Serious Emotional Disturbances) or 1915(i) services.
- For individuals who must be referred to a PIHP access center, CCBHCs must work with the PIHPs to ensure access to services and warm handoffs for persons served including but not limited to:
    - Assisting the person served with contacting the PIHP access center (e.g., CCBHC to call PIHP Access Center on behalf of or with the person served), and
    - Sharing results of completed screening and/or risk assessments with the PIHPs, with the individual’s consent.

2.C.2. MI CCBHC Certification Requirements

2.C.2.1. Certification Overview

Pursuant to Section 223 of the Protecting Access to Medicare Act, decisions surrounding certification for CCBHC Demonstration sites are the sole responsibility of MDHHS. PIHPs do not have the authority to certify or change the certification status of a CCBHC. 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 BH Customer Relationship Management (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 three years; however, recertification may be necessary when SAMHSA CCBHC criteria updates require revisions to CCBHC certification requirements.

Prior to the demonstration start date, it is the expectation that the site will be able to attest and successfully evidence all components of the CCBHC Model, successfully complete a financial risk assessment, and evidence historical participation and familiarity with Michigan's Medicaid program, as well as delivery of behavioral health/substance use disorder services and programming. The CCBHC must be in full compliance with the full array of CCBHC services by the first day of the CCBHC Demonstration start date. See Section 2.C.2.1.1 for Rural and Frontier Certification Considerations.

During the demonstration, a Corrective Action Plan (CAP) may be provided to support a CCBHC site that does not fully meet all program requirements. CAPs are term-limited and the CCBHC must provide MDHHS with a plan for meeting the full certification requirements to maintain certification. If the site is unable to meet all criteria, they are subject to decertification. The CCBHC, along with the PIHP, will receive a notification of decertification 90 days in advance and will have the opportunity to appeal the decision. CCBHCs can receive the PPS payment during the implementation and monitoring of the CAP.

The MDHHS CCBHC Team will conduct site visits 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. Specified levels related to certification during the recertification process can be found in 2.C.3.3. Specific components of a CCBHC site visit are identified in section 2.C.3.3.8.

2.C.2.1.1. Rural and Frontier Certification Considerations

Rural and Frontier CCBHCs (as identified within the CCBHC community needs assessment) are provided the opportunity to meet staffing and DCOs requirements as outlined below. These considerations are unique to Rural and Frontier CCBHCs and are provided to assist with barriers associated with service delivery related to time/distance and federal ratio standards.

- Rural/Frontier sites will have until the end of the first demonstration year to comply with all staffing requirements. CCBHCs can request an extension year by evidencing efforts to recruit appropriate staff on a case-by-case basis.
- Rural/Frontier sites may develop a DCO agreement with another CCBHC demonstration site to meet CCBHC certification criteria.
- Rural/Frontier sites are encouraged to utilize telehealth/telemedicine services where clinically appropriate and applicable. CCBHCs can establish telehealth-based DCO agreements.
- Rural/Frontier sites may define their Community Needs Assessment to focus on one physical service delivery location and a limited, defined service area. CCBHCs may ramp up services at additional sites to allow for a slower ramp up period at outlying service sites.
- Rural/Frontier sites joining the demonstration will meet full crisis requirements by the end of the 3-year certification period. CCBHCs can propose alternate models to meet the 24/7 mobile crisis requirements, including co-response models and virtual options. As CCBHCs work towards meeting the CCBHC crisis requirements, they are held to the “state-sanctioned” crisis services requirements as outlined in the MI Mental Health Code.
    - Crisis Phone Line: A telephone that is answered 24 hours a day for dealing with mental health emergencies. The number for this telephone must be advertised through the telephone book, public information efforts, and by notifying the appropriate agencies of the telephone number and the services provided.
    - Operate inpatient screening units following crisis screening standards: Offer emergency intervention services with sufficient capacity to provide clinical evaluation of the problem; to provide appropriate intervention; and to make timely disposition to admit to inpatient care or refer to outpatient services. The organization may use: telephonic crisis intervention counseling, face-to-face crisis assessment, mobile crisis team, and dispatching staff to the emergency room, as appropriate.
    - Walk in provision of face-to-face services to persons in the areas of crisis evaluation, intervention, and disposition. (CCBHCs can define walk in service hours based on needs identified in the community needs assessment.)
- Rural/Frontier sites are required to implement certain evidence-based practices (EBPs) but may request alternate accommodations for some EBPs, including:
    - Waivers for certain practices provided that the waiver is granted by the MDHHS program area that oversees the EBP.

- CCBHCs can establish DCO agreements with other CCBHCs to deliver required EBPs
- Sites can choose from MDHHS recommended alternate EBPs or elect EBPs that respond to the needs of specific populations. Needs assessment must correspond to the identified EBP most appropriate to implement for the community.
- Waiver eligible EBPs include: Assertive Community Treatment (ACT), Infant Mental Health (IMH), Parent Management Training – Oregon (PMTO) and/or Parenting through Change (PTC), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).
- Required EBPs include: Air Traffic Control, Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy (CBT), Medication Assisted Treatment (MAT), Motivational Interviewing, Screening, Brief Intervention and Referral to treatment (SBIRT), and Zero Suicide.
- Waiver requests must be submitted to MDHHS for approval prior to implementation. Requests must be submitted through the EBP Waiver Consideration template.

2.C.2.1.2. Dual CCBHC and FQHC Requirements

Federally Qualified Health Centers (FQHCs) that become CCBHC demonstration sites must determine which program each service must be billed to using the guidance in Appendix G of this handbook to ensure duplicative billing does not occur. Ultimately, the CCBHC is responsible to bill the correct program and understand which costs and daily visits are attributable to each program. Regardless of the CCBHC's choice, the CCBHC cost report must still be reconciled to an audited financial statement.

FQHCs must develop a CCBHC specific NPI for CCBHC service encounter submission. The NPI must be submitted to the MDHHS CCBHC mailbox.

2.C.2.2. Certification Application

2.C.2.2.1. The Behavioral Health (BH) Customer Relationship Management System (CRM) Account Access

To complete the CCBHC initial application or recertification process, the potential or current CCBHC must have an organizational account in the MDHHS BH CRM. Each organizational account is permitted to have several staff who are assigned to the account and each staff is considered a CCBHC Certification Coordinator in the CRM. These staff will receive alerts and communication about the CCBHC certification, have necessary permissions for completing the application and submitting documentation, and have the ability to submit the completed application for MDHHS approval.

Requests for MDHHS BH CRM accounts must be sent to mdhhs-ccbhc@michigan.gov and include the staff name(s), email, phone number, and site name and address. Potential and current CCBHCs are responsible for requesting and ensuring CRM access for appropriate staff, as well as alerting MDHHS of any staff changes that may require changing or revoking system access. Prior to initial certification and recertification, MDHHS will attempt to verify that user accounts and access privileges are accurate; however, it is the responsibility of the CCBHC to maintain access for initial application and recertification purposes.

2.C.2.2.2. Application Process

CCBHC CRM users assigned the role of CCBHC Certification Coordinator will receive notification that the CCBHC initial application or recertification process is open and ready to complete. Each assigned 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, an explanation must be written in the space provided which supports how the potential or current CCBHC meets the given criteria. If no explanation is given in the space provided, the CRM user will receive a system error during the final submission process.

Documents providing further evidence such as policies, procedures, etc., must be uploaded to correspond with each program requirement standard. If a potential or current CCBHC uploads a specific document that applies to multiple standards, the document must be uploaded in each standard area. For example, if an entity is using a staffing plan as evidence for Standard 1.a.2 Staffing Plan and 1.b.2 Staffing Requirements/Accreditation, then the staffing plan document must be uploaded in both standards. All documents uploaded must be titled with the name of the document and the standard number (i.e.: ABC Mental Health Staffing Plan 1.a.2). Additionally, when submitting policies, processes, or other written evidence, the areas of the document that demonstrate compliance must be highlighted to streamline the review process.

Once the initial or recertification application is submitted, the MDHHS CCBHC Team will begin the review process. This process includes multiple MDHHS CCBHC staff reviewing the written explanations, verifying and examining the documentation submitted as evidence, and scoring each criteria utilizing a standardized scoring metric. During this review period, MDHHS may reach out to applicants to complete any missing information, request clarification, or ask for additional documentation to be submitted via email or through the CRM. All representatives with CCBHC Certification Coordinator permission in the CRM will receive an email notification regarding MDHHS CCBHC Team communications.

The potential or current CCBHC can check in on the MDHHS CCBHC Team review process at any time by reviewing the application in the CRM.

2.C.3. Certification Levels

2.C.3.1. Initial Certification

During the initial certification process, a provider must submit their CCBHC certification application to MDHHS for review via the BH CRM by the specified deadline. Once the MDHHS CCBHC Team has completed its review of the application, the MDHHS CCBHC Team will have 45 days to determine whether the provider meets CCBHC certification criteria and can enter the demonstration. Providers must achieve full certification status to be considered certified under Michigan's CCBHC Demonstration.

2.C.3.2. Full Certification

To be awarded full certification status, a potential CCBHC must meet or exceed all standards during the initial certification application process as scored with a standardized rubric. Additionally, it is expected that the CCBHC will be in compliance with the full array of CCBHC services by the first day of the CCBHC Demonstration start date.

CCBHCs are expected to participate in state sponsored activities designed to support CCBHCs in transforming service delivery. This includes a **mandatory** CCBHC orientation for providers and clinical staff before the CCBHC Demonstration is implemented. CCBHCs must also participate in ongoing staff and entity specific assistance (including but not limited to audits, site visits, trainings, etc.) provided by the MDHHS CCBHC Team. CCBHC leadership staff must be committed to supporting their CCBHC's team's participation in all related assistance and trainings, including coverage of travel costs associated with occasionally attending CCBHC activities.

Prior to the demonstration start date, the site must be able to successfully evidence all components of the CCBHC certification criteria.

A potential CCBHC who does not meet or exceed all standards during the initial certification application process as scored with a standardized rubric is not eligible to join the CCBHC Demonstration.

2.C.3.3. Recertification

CCBHCs must submit a recertification application to MDHHS via the BH CRM. The MDHHS CCBHC Team will use a standardized scoring rubric to review each application and will assign a certification level. CCBHCs will receive one of the following certification levels:

- Full Certification
- Full Certification with a Corrective Action Plan
- Provisional Certification with a Corrective Action
- Decertification

2.C.3.3.1. Full Certification

If the CCHBC meets or exceeds all certification criteria standards during the recertification application process as well as demonstrates successful implementation of all service delivery criteria, they will be

awarded Full Certification.

CCBHC sites with identified application deficiencies will be categorized as follows:

2.C.3.3.2. Full Certification with a Corrective Action Plan (CAP)
If the CCHBC meets or exceeds all criteria standards during the recertification application process but all service delivery criteria have not been successfully implemented, the CCBHC will be awarded Full Certification with a Corrective Action Plan.

Following the recertification application review, the MDHHS CCBHC team will generate a report within 45 days identifying the findings and recommendations that require a response by the CCBHC site. The CCBHC site will have 15 calendar days to submit a Corrective Action Plan (CAP) for achieving compliance, which must include a timeline for implementation and/or completion. The CCBHC site may also present new information to MDHHS that potentially demonstrates prior compliance with the identified CCBHC criteria. The MDHHS CCBHC Team will review the CAP, seek clarifying or additional information from the CCBHC site as needed, and issue a response within 15 calendar days of receipt. The MDHHS CCBHC team will take steps to monitor the CCBHC site's implementation of the CAP as part of performance monitoring. Please note that new information and updates can be provided anytime during the CAP process.

Follow-up will be conducted by the MDHHS CCBHC Team to ensure that all compliance issues are remediated within 90 days after the CAP is approved by the MDHHS CCBHC team. Following the identified timeframe, if the CCBHC site still fails to meet compliance standards as outlined in the CCBHC Handbook and the CAP, then the site will be moved to provisional certification status.

However, if deficiencies are resolved, and criteria has been met by the CCBHC at the conclusion of the CAP process, the certification level will remain as Full Certification.

2.C.3.3.3. Provisional Certification with a Corrective Action Plan (CAP)
If the CCHBC does not meet or exceed all CCBHC criteria standards during the recertification application process as scored with a standardized rubric, the CCBHC will be moved to Provisional Certification with a Corrective Action Plan.

Following the recertification application review, the MDHHS CCBHC team will generate a report within 45 days identifying the findings and recommendations that require a response by the CCBHC site. The CCBHC site will have 15 calendar days to submit a CAP for achieving compliance which must include an implementation plan not to exceed six (6) months in duration. The CCBHC site may also present new information to MDHHS that potentially demonstrates prior compliance with the identified deficient CCBHC criteria.

The MDHHS CCBHC team will review the CAP, seek clarifying or

additional information from the CCBHC site as needed, and issue a response within 15 calendar days of receipt. The MDHHS CCBHC team will take steps to monitor the CCBHC site's implementation of the CAP as part of performance monitoring. Please note that new information and updates can be provided anytime during the CAP process.

Follow-up will be conducted by the MDHHS CCBHC Team to ensure that all compliance issues are remediated after the CAP is approved by the MDHHS CCBHC team, with the MDHHS CCBHC team conducting quarterly check-ins over 6 months. Following the identified timeframe, if the CCBHC site still fails to meet compliance standards as outlined in the CCBHC Handbook and the CAP, provisional certification will continue with an additional six (6) months of monitoring with quarterly check-ins required. After 12 months of support with the identified CAP(s), if the site is not able to achieve full certification, then formal notification of decertification will be sent to the CCBHC and the PIHP. If the CCBHC disagrees with the decertification determination, they may appeal. Requests for reconsideration must be sent to the CCBHC shared email address at MDHHS-CCBHC@michigan.gov within 14 business days from the date of MDHHS decertification notice. Requests should detail reasons why the CCBHC disagrees with the determination and include supporting documentation. The MDHHS CCBHC Team will review the request and provide written response affirming, reversing, or modifying the determination.

However, if deficiencies are resolved, and criteria has been met by the CCBHC at the conclusion of the CAP process, the certification level will be updated accordingly by the MDHHS CCBHC Team.

When access or care to persons served is a serious issue, the CCBHC site may be given a much shorter period to initiate corrective action, and this condition may be established, in writing, as part of the MDHHS CCBHC Team findings. If an MDHHS CCBHC team member identifies an issue that places a person served in imminent risk to health or welfare, the MDHHS CCBHC team has the right to require an immediate review and response by the CCBHC site, which must be completed within seven (7) calendar days.

2.C.3.3.4. Decertification (Certification Level)

If a CCHBC does not meet most criteria standards, and/or is unable to demonstrate successful implementation and maintenance of the full array of CCBHC services during the recertification application process, the MDHHS CCBHC Team will move to decertify a CCBHC for non-compliance with CCBHC requirements.

For additional information related to the Decertification process please see CCBHC Decertification section 2.C.3.3.10.

2.C.3.3.5. Certification Expiration

The CCBHC Certification will expire three (3) years after receiving certified status unless updates to the SAMHSA criteria requires a

revision to implement new certification criteria. After the first certification cycle, the CRM system will automatically send out notification at least 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/expired 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 must 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.3.3.6. Certification Changes

To keep CCBHC certification documentation accurate and to ensure ongoing compliance with requirements, CCBHCs must notify PIHPs and the MDHHS CCBHC Team within seven (7) days of any significant change in policy or practice that would impact a clinic's ability to meet certification and/or state budgeting. Examples include a change in ability (long or short term; permanent or temporary) to provide any of the 9 CCBHC core services, any annual changes, updates to DCO agreements, or significant changes in the ability to serve the defined populations in a timely manner. Failure to notify the MDHHS CCBHC Team of changes to the clinic that impacts CCBHC fidelity and full-service delivery may result in an immediate six-month Corrective Action Plan.

Specific situations requiring notification include, but are not limited to:

- Potential CCBHC recipients eligible for the nine (9) core required CCBHC services, regardless of payer, being turned away for any reason,
- Closing or opening a service delivery site, including starting or ending a DCO arrangement,
- Staff changes limiting the ability to provide services as required (for example – 24/7 mobile crisis response),
- Change in capacity to implement required evidence-based practices.

2.C.3.3.7. Corrective Action Plan (CAP)

At any time during the demonstration period (including the recertification process), if a site is found to be out of compliance with CCBHC required criteria, the MDHHS CCBHC Team will issue a Corrective Action Plan (CAP). The CAP allows the MDHHS CCBHC Team the ability to provide additional support in bringing the CCBHC site into compliance. Each site has commitment and support from MDHHS as they develop and implement their plan to meet certification requirements. PIHPs are not responsible for overseeing and monitoring any certification corrective action plan; however, MDHHS will share CCBHC corrective action plans with the PIHP and the PIHP may be asked to assist the CCBHC in meeting goals where appropriate.

Once informed of non-compliance, a CCBHC site will have 15 calendar days from the date of MDHHS notice to submit a CAP for achieving compliance, which must include a timeline for implementation/completion. The CCBHC site may also present new information to the MDHHS CCBHC Team that potentially demonstrates prior compliance with the identified CCBHC criteria.

The MDHHS CCBHC team will review the CAP, seek clarifying or additional information from the CCBHC site as needed, and issue a response within 15 calendar days of receipt. The MDHHS CCBHC team will take steps to monitor the CCBHS site's implementation of the CAP as part of performance monitoring. Please note that new information and updates can be provided by the site anytime during the CAP process.

Follow-up will be conducted by the MDHHS CCBHC Team to ensure that all compliance issues are remediated within 90 days after the CAP is approved by the MDHHS CCBHC team, with the MDHHS CCBHC team conducting a quarterly check-in. Following the identified timeframe, if the CCBHC site still fails to meet compliance standards as outlined in the CCBHC Handbook and the CAP, then the site will be moved to provisional certification status and required to provide a new and/or enhanced 90-day CAP, with successful implementation and completion of the CAP(s) not to exceed six (6) months.

After six (6) months, if the CCBHC site still fails to meet compliance standards as outlined in the CCBHC Handbook and CAP(s), then provisional certification will continue and an additional six (6) months of monitoring with quarterly check-ins will be required. After 12 months of support with the identified CAP(s), if the site is not able to achieve full certification, then formal notification of decertification will be sent to the CCBHC and the PIHP. If the CCBHC disagrees with the decertification determination, they may appeal. Requests for reconsideration must be sent to the CCBHC shared email address at MDHHS-CCBHC@michigan.gov within 14 business days from the date of MDHHS decertification notice. Requests should detail reasons why the CCBHC disagrees with the determination and include supporting documentation. The MDHHS CCBHC Team will review the request and provide written response affirming, reversing, or modifying the determination.

However, if deficiencies are resolved, and criteria has been met by the CCBHC at the conclusion of the CAP process, the certification level will be updated accordingly by the MDHHS CCBHC Team.

When access or care to persons served is a serious issue, the CCBHC site may be given a much shorter period to initiate corrective action, and this condition may be established, in writing, as part of the MDHHS CCBHC Team findings. If an MDHHS CCBHC team member identifies an issue that places a person served in imminent risk to health or welfare, the MDHHS CCBHC team has the right to require an immediate review and response by the CCBHC site, which must be completed within seven (7) calendar days.

2.C.3.3.8. On-Site Reviews

With the extension of the demonstration, the MDHHS CCBHC Team will conduct site visits to each certified CCBHC minimally once every three (3) years during the demonstration period to verify that program requirements are being met and implemented in practice. Site reviews will be scheduled between recertification application periods. Site visits may also be initiated earlier at the discretion of MDHHS. The site review may be in person or virtual. MDHHS staff will review documentation and client records and offer feedback on CCBHC practices. PIHPs will be permitted to accompany MDHHS onsite and will receive the full final report.

Site visits may take place in a condensed format or via the CRM database as a part of the recertification process. A site visit may be scheduled in an effort to support the CCBHC site and provide guidance at any time during the demonstration period. Expectations for all site visits will be provided to the site in advance to aid in preparation for the visit.

Following the site visit, the MDHHS CCBHC team will generate a report within 45 days detailing the site review findings and identifying any corrective action needed. Information regarding CAPs can be found under Corrective Action Plan in 2.C.3. Certification Levels.

Deficiencies related to meeting CCBHC service delivery criteria found during a site visit resulting in corrective action can impact the CCBHC's certification level. More information on certification levels related to corrective action can be found in 2.C..3 Certification Levels.

When access or care to persons served is a serious issue, the CCBHC site may be given a much shorter period to initiate corrective action, and this condition may be established, in writing, as part of the MDHHS findings. If an MDHHS CCBHC team member identifies an issue that places a person served in imminent risk to health or welfare, the MDHHS CCBHC team has the right to require an immediate review and response by the CCBHC site, which must be completed within seven (7) calendar days.

2.C.3.3.9. Accreditation and Certification

MDHHS strongly encourages each site to pursue and achieve accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC) to enhance service delivery quality and streamline the certification process. The programs listed below under the corresponding accreditation body will be used in the certification review process. If a site has obtained accreditation in any of the programs below, MDHHS may waive certain CCBHC certification standards (outlined in the CRM).

Accreditation from CARF must include any combination of the following standards from the most recent CARF behavioral health accreditation manual(s):

- Substance Use Disorders/Addictions

- Mental Health
- Family Services
- Integrated SUD/Mental Health
- Integrated IDD/Mental Health
- Comprehensive Care
- CCBHC

Accreditation from TJC must include any combination of the following standards from the most recent TJC behavioral health accreditation manual(s):

- Comprehensive Behavioral Health Services to Children, Youth, and Adults
- CCBHC

Sites who achieve a 3-year CARF or TJC award in one or more of the programs listed above, might be allowed to use accreditation to meet specific CCBHC certification requirements. Accreditation award time frames will be monitored by MDHHS. A crosswalk to outline CCBHC criteria that may be waived during the certification/recertification process based on accreditation, will be provided.

All sites choosing to use accreditation to aid in meeting CCBHC certification standards will be required to upload CARF or TJC survey results in the CRM within each pertinent CCBHC certification standard. Follow up items listed within the survey results will be subject to review during MDHHS site visits. Additionally, accreditation expiration dates will be monitored by MDHHS. Should a site decide to not continue with an accreditation award, the site must notify MDHHS 30 days prior to the award expiration date. If accreditation expires without renewal, the CCBHC site will be required to provide evidence to meet each standard waived during the certification process.

2.C.3.3.10. CCBHC Decertification

Failure to abide by all terms of the CCBHC policy and requirements may result in disciplinary action, including moving a CCBHC provider to decertification and terminating privileges as a CCBHC provider.

Reasons for decertification include:

- Failure to provide MDHHS with requested documentation demonstrating CCBHC requirements are met,
- Failure to correct identified deficiencies in meeting CCBHC certification requirements,
- Persons served complaints related to non-compliance with CCBHC policies or not meeting CCBHC certification criteria,
- Failure to maintain required licensures and certifications as applicable,
- Non-compliance with rate setting, including rebasing,
- Misrepresentation of data.

The MDHHS CCBHC team will give CCBHCs and PIHPs 90 days written notice of the intent to decertify. CCBHCs may either accept

the decertification or respond with a detailed corrective action plan (CAP) to address the identified reasons for decertification within 15 calendar days from the date of MDHHS decertification notice, which must include an implementation plan not to exceed six (6) months in duration. If MDHHS approves the corrective action plan, the CCBHC will be moved to provisional status.

The MDHHS CCBHC team will take steps to monitor the CCBHC site's implementation of the CAP as part of performance monitoring. Please note that new information and updates can be provided anytime during the CAP process.

Follow-up will be conducted by the MDHHS CCBHC Team to ensure that all compliance issues are remediated within six (6) months after the CAP is approved by the MDHHS CCBHC team. Following the identified timeframe, if the CCBHC site has not met compliance standards as outlined in the CCBHC Handbook and the CAP, the decertification process will continue with a formal final notification being sent to the CCBHC and PIHP.

When access or care to persons served is a serious issue, the CCBHC site may be given a much shorter period to initiate corrective action, and this condition may be established, in writing, as part of the MDHHS CCBHC Team findings. If an MDHHS CCBHC team member identifies an issue that places a person served in imminent risk to health or welfare, the MDHHS CCBHC team has the right to require an immediate review and response by the CCBHC site, which must be completed within seven (7) calendar days.

The MDHHS CCBHC Team can also deny the CCBHC's proposed corrective action plan, with formal final notice of decertification subsequently being provided to the CCBHC and PIHP.

If a CCBHC disagrees with the decertification determination, they may appeal. Requests for reconsideration must be sent to the CCBHC shared email address at MDHHS-CCBHC@michigan.gov within 14 business days from the MDHHS decertification notice. Requests should detail reasons why the CCBHC disagrees with the determination and include supporting documentation. The MDHHS CCBHC Team will review the request and provide written response affirming, reversing, or modifying the determination.

If a CCBHC's status is terminated by MDHHS or if the certification lapses with no provisional status issued by MDHHS, the provider must submit a plan to MDHHS outlining how the clinic will transition persons served to appropriate care. CCBHCs who are decertified will no longer receive the PPS rate. MDHHS will recoup any PPS payments made after the decertification date.

2.C.3.4. Transition Expectations When a DCO becomes a CCBHC

Under certain circumstances, a clinic who has been operating as a DCO for another CCBHC may be certified and approved to join the demonstration. At that time, the

two CCBHCs must update the WSA CCBHC assignment to reflect the new primary CCBHC for shared persons served.

The person's choice of provider must be offered and documented whenever there is a change in provider. If two CCBHCs are unable to determine the primary CCBHC for individuals served jointly, MDHHS will assist in the transition by providing both CCBHCs with a recent list of service recipients. This list will use a tiered methodology based on encounter data to assign each individual to a single CCBHC. If the individual received targeted case management (TCM) from at least one entity during each month, they will be assigned to the entity with the highest TCM utilization. If TCM was not provided, daily visits across all CCBHC services will be considered for assignment. In cases of a tie, the individual will be assigned to the CCBHC that joined the demonstration first. This list is intended as a guide and should not override the individual's choice of provider. Metrics attribution will follow the methodology outlined in Appendix E.

Transitions of care must be seamless for persons served and be completed within the first 30 days of the CCBHC entering the demonstration. Both CCBHCs should work together closely to determine appropriate clinic assignment, share treatment details, and shift care coordination responsibilities. WSA assignment should follow the determined care provider but does not prohibit payment for CCBHC services provided by a CCBHC.

The newly certified CCBHC may only continue to operate as a DCO for another CCBHC if it meets eligibility requirements described in Section 3.B.1 of this Handbook. In the absence of a DCO agreement, both clinics are eligible to receive their PPS rates beginning on the day of entry into the demonstration for providing any CCBHC service, regardless of where the person served had historically received services.

2.C.4. 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. Services must be provided in accordance with the Michigan Medicaid Provider Manual. Additionally, CCBHCs must follow the Mental Health Code when applicable. CCBHC Medicaid persons served must be included in all required Medicaid reporting, including MMBPIS, Critical Incidents, and performance incentive measures for all programs that apply to each person served.

A CCBHC who receives Medicaid and/or other public funding is subject to the provisions of the Freedom of Information Act (FOIA) under State Law (Public Act 442 of 1976 – MCL 15.231 – 15.246) and Federal Regulations. FOIA provides all persons (except persons incarcerated in correctional facilities) with access to public records of public bodies. Some records are exempt from disclosure under the FOIA or another statute and cannot be provided.

CCBHCs who receive Medicaid and/or other public funding are required to adhere to Program Integrity policies, procedures and processes that are designed to detect, report, and prevent fraud, waste, and abuse activities as detailed in 42 CFR 438.608 Program Integrity Requirements.

2.C.5. Behavioral Health Treatment Episode Data Set (BH-TEDS)

BH-TEDS records must be created, and data must be collected for all state-funded CCBHC persons served receiving services at a CCBHC Demonstration site, in accordance with current BH-TEDS reporting requirements. Every CCBHC recipient is required to have an active BH-TEDS episode during the time they are receiving any CCBHC services.

The type of BH-TEDS records needed for treatment episodes depends on the provider reported in the record. Follow the instructions below to report integrated treatment episodes. Integrated treatment occurs when an individual receives mental health (MH) and substance use (SU) treatment managed by a single entity under an integrated treatment plan.

- For providers that have a LARA ID, but not CMHSP ID, use the LARA ID as the State Provider ID and A-S-D records.
- For providers that have a CMHSP ID, but no LARA ID, use the CMHSP ID as the State Provider ID and M-U-E records.
- For providers that have both a LARA ID and a CMHSP ID, the provider decides which ID to use.
    - If the admission is based on ASAM criteria, admit under the LARA ID and use A-S-D records.
    - If the primary treatment admission criteria is MH, admit under the CMHSP ID and report M-U-E records.

BH-TEDS records must be submitted by the CCBHC even if the individual's county of origin is out of the service area following the most recent BH-TEDS Coding Instructions posted here: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting.

State Provider ID	Service Type	Required BH-TEDS Records	Encounter Reporting Type
CMHSP ID	Mental Health/Integrated Mental Health and SUD	• M and E • Annual U for episodes open longer than 1 year	Encounters submitted with mental health Member ID Type (Type 89)
LARA ID	SUD/Substance Use Integrated with Mental Health	• A and D • Annual S for episodes open longer than 1 year	Encounters submitted with SUD Member ID Type (Type 88)

2.C.6. 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.

CCBHCs must ensure that all individuals receiving CCBHC crisis services, either directly or through a state-sanctioned crisis provider acting as a DCO, are provided with information about CCBHC services and offered a follow up appointment at a CCBHC following the resolution of the crisis event.

2.C.7. 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 care, 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 persons served. CCBHCs must provide translation and interpretation services to those recipients 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.

2.C.8. Availability and Accessibility

The CCBHC must provide a functional, safe, clean, and welcoming environment for persons served 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 Chapter 8: Program Requirements, 8.B.1-8 B.4). Recipients 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.9. County of Financial Responsibility (COFR)

County of Financial Responsibility (COFR) agreements between clinics, who are both CCBHCs, should not occur for CCBHC eligible services regardless of the individual's county of residence. A COFR agreement is only applicable if they are receiving other services not covered under CCBHCs eligible service codes listed in the CCBHC Handbook's . If an individual is receiving other services not listed in Appendix A, a COFR agreement as outlined in Michigan Mental Health Code (Section 330.1302) should be in place for non-CCBHC services. It is recommended that CCBHCs assist during the person-centered planning process with connecting individuals to providers near their residing county who can meet their needs. COFR agreements should still be honored for non-CCBHC services rendered.

2.C.10. 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 recipient's needs and preferences. Care coordination partnerships must be in place with the facilities and community service providers as 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 CC360 and the WSA are encouraged to coordinate care for CCBHC persons served.

CCBHCs will also be required to coordinate crisis and other referral services with the Michigan Crisis and Access Line (MiCAL).

2.C.11. Scope of Service and Evidence Based Practices

CCBHCs must directly provide the 9 core services, unless otherwise utilizing DCOs for reasons outlined in Chapter 3 of this handbook. 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 recipient's needs, preferences, and values, with both persons served 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, CCBHCs must be equipped to serve military service members and their families and/or connect them to appropriate behavioral health services. The Walking with Warriors Veteran Navigator program, administered through the PIHPs and several CMHSPs was created to connect Veterans and their families to federal, state, and local resources to ease issues regarding mental health, substance use, housing, and other common issues that impact Veterans to support healthier lifestyles, lower stigma and reduce suicidal ideation. CCBHCs should work with their PIHP to coordinate Veteran's services with the PIHP Veteran Navigator. Together, regions should determine a staffing strategy that maximizes resources to best fit the needs of Veterans and military family members in the community. In some instances, this will likely mean the CCBHC will need to utilize their own resources and directly hire a Veteran Navigator to provide needed services. To capture the statewide impact of Veteran Navigators, CCBHC-funded Veteran Navigators must submit a report twice a year that collects data on Veteran Navigator activities. See Appendix H for submission details.

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 support persons served by CCBHCs and may be asked by MDHHS to participate in pilot programs to expand EBPs throughout the demonstration.

CCBHCs must implement all required EBPs either directly or through a DCO. CCBHCs must follow the EBP approval process as outlined in the Medicaid Provider Manual. CCBHCs will be responsible for ensuring that EBP practice requirements are met, including Network Adequacy, and services are delivered by professional staff with appropriate training and credentials. CCBHCs are responsible for establishing a process to monitor model fidelity with the Michigan Fidelity Assistance Support Team (MIFAST) reviews. A request for EBP fidelity exception(s) must be approved by the Community Practices and Innovation Section (CPI) and communicated to the CCBHC team. Exceptions will be subject to additional oversight and direction from CPI. For questions about EBP approval applications or fidelity exception(s), please email MDHHS-CPI-Section@michigan.gov.

2.C.11.1. 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.11.2. 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 to addressing older adult population (such as Wellness Initiative for Senior Education or Wellness Recovery Action Plan)
- 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) Please contact MDHHS-CPI-Section@michigan.gov for criteria and steps to be recognized as providing fidelity- measured Individual Placement and Support model services.

2.C.12. Quality and Reporting

For a detailed list of reporting requirements, please navigate to Appendix H of this handbook. Both CCBHCs and MDHHS are required to report on cost and quality measures. Please see Section 7: CCBHC Evaluation and Monitoring for more information on quality measure reporting. For reporting requirements that require review from the PIHP, CCBHCs must coordinate with PIHPs to meet PIHP review deadlines prior to the deadline for submission to MDHHS.

2.C.12.1. 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 recipient.

2.C.12.2. 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 Pservices
- 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.12.3. Continuous Quality Improvement (CQI) Plan

CCBHCs must use the data outlined in 2.C.11 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 8.E.2. Continuous Quality Improvement (CQI) Plan.)

2.C.12.4. Metric Reporting

CCBHCs must collect and report on CCBHC-reported performance metrics identified in Section 7.A.1 CCBHC Reported Measures annually. Access measures are to be reported quarterly. 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.12.5. Staffing and Expense Survey

CCBHCs must participate in the Behavioral Health (BH) Provider Staffing and Expense Survey to collect staffing, wages, and other compensation, and provider expense information from contracted behavioral health providers. Survey instructions and resources can be found following this link: Reporting Requirements (michigan.gov) under Policy 21-39 Reporting Requirements.

2.C.12.6. Supplemental Cost Reporting for CCBHCs

CCBHCs must submit a Supplemental Cost Report and non-CMHSPs must include an audited financial statement each year with their annual CCBHC

Cost Report submission. The Supplemental Cost Report collects additional information about organizational funding sources and expenses for CCBHCs.

2.C.12.7. Placeholder for Compliance Examination and Audit Reviews

2.C.12.7.1. Providers will incorporate CCBHC into current compliance examinations and audit review processes.

2.C.12.7.2. CCBHCs must successfully participate in and complete a financial risk assessment prior to the Demonstration start date.

2.C.13. Organizational Governance

The CCBHC must meet one of the following criteria:

1. A non-profit organization, exempt from tax under Section501(c)(3) of the United States Internal Revenue Code,
2. A part of a local government behavioral health authority (which includes all forms of CMHSPs). If a CCBHC is also a CMHSP, it must maintain full CMHSP Certification as required by the Michigan Mental Health Code MCL 330.1232a and Administrative Rule R 330.2701, which states in part that, as a condition of state funding, a single overall certification is required for each community mental health services provider.
3. 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.).
4. 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 a representative of those served by the CCBHC and must incorporate meaningful participation from adult persons served, individuals in recovery, and families. CCBHCs must also adhere to all applicable state policy, accreditation, certification, and/or licensing requirements.

2.C.14. 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 staff and/or entity specific 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.

2.C.15. Information Sharing and Retention

Some of the data and quality measures that are the responsibility of the CCBHC may require access to data from PIHP/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 PIHPs/DCOs and to ensure adequate consent as appropriate.

Additionally, in accordance with 42 CFR 438.3 and 42 CFR 438.230, the State, CMS, Office of Inspector General (OIG), the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the

CCBHC, and/or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of the completion of any audit, whichever is later.

2.C.16. New Service Delivery Locations

Additions of new clinic locations and/or service delivery sites, including DCOs, require approval from MDHHS. Per PAMA Section 223, no payment will be made under the demonstration program to satellite facilities of CCBHCs if such facilities were established after April 1, 2014.

Requests must be sent to mdhhs-ccbhc@michigan.gov. MDHHS will respond to the request within 60 days once all supporting documentation is received for new service delivery sites, including DCOs. CCBHC services delivered by a DCO prior to MDHHS approval must not be submitted with a T1040 and are not eligible for reimbursement at the PPS rate. The CCBHC is responsible for providing MDHHS with the fully executed DCO agreement and receiving approval from MDHHS prior to the initiation of services. MDHHS will notify the CCBHC and the PIHP once a DCO agreement or new service delivery location is approved.

2.C.17. Identification of Persons served with Mild-to-Moderate Behavioral Health Needs

CCBHC services provided to recipients with Mild-to-Moderate (M/M) mental health needs must be identified on the service encounter by adding the TF modifier to the T1040. This identification is necessary for budget monitoring and rate setting purposes related to funding these services with supplemental funds.

Identification is only required for persons served with Mild-to-Moderate mental health needs. Due to Michigan's funding structure, service recipients with a primary diagnosis of substance use disorder (SUD) or an Intellectual/Developmental Disability (I/DD) will not be identified as Mild-to-Moderate for this purpose and services would not be identified with the TF modifier.

For budget monitoring and rate setting purposes, persons served with mental health conditions must be identified based on assessment to be either a Mild-to-Moderate severity (which can apply to either adults or children), severe mental illness (SMI) for adults or a serious emotional disturbance (SED) for children. For a determination of SED, please refer to the Technical Requirement for Infants, Toddlers, Children, Youth, and Young Adults with Serious Emotional Disturbance (SED) and Intellectual and/or Developmental Disabilities (I/DD), which can be found on the MDHHS website at Policies & Practice Guidelines (michigan.gov). CCBHCs will use the Michigan Child and Adolescent Needs and Strengths Tool (MichiCANS) ratings and the American Association for Community Psychiatry's Level of Care Utilization System (LOCUS 20) scores to determine which category of mental health severity an individual may be assigned to: Mild-to-Moderate or SED/SMI.

The use of LOCUS described in this document for assigning to Mild-Moderate vs SMI for budget monitoring purposes is unique to Michigan CCBHCs and has been approved by the American Association for Community Psychiatry within its licensing of LOCUS to MDHHS specifically for use within the CCBHC system in Michigan, within the constraints described in this document. LOCUS assessments – whether

required or optional – for determining service intensity or "level of care" require using the LOCUS algorithm and not just simply "scoring" by adding up the scores on the different dimensions. Persons served are not permanently assigned to one category or another. The clinical severity of recipients changes over time along with their LOCUS scores and MichiCANS ratings, when improvements and decompensation occur, therefore causing a change in category assignment. Additional LOCUS scoring is not required for budget reconciliation purposes other than what is clinically indicated for service intensity or level of care determinations. A clinical re-evaluation using the MichiCANS and LOCUS must be conducted to demonstrate a change in category of the SMI/SED or M/M designation, level of clinical need, medically necessary services, and/or the person-centered plan. These changes must be documented in the EHR.

The definition of Mild-to-Moderate (M/M) does not dictate/and or limit which clinical services may be provided and should not be used for clinical decision making. Services are to be determined based on person centered planning, medical necessity, and clinically appropriateness.

2.C.17.1. Thresholds

Children with Mental Illness

- Recommendation Non-Emergency: Mild/Moderate Needs using the MichiCANS Screener Decision Support Model for the appropriate age range.

Adults with Mental Illness:

- LOCUS level of care identified; 10-16 score would be identified as Mild-to-Moderate severity.
    - *Note: Making this determination with total LOCUS scores uses an arbitrary cut-off score agreed to by MDHHS and its stakeholders and should be used solely for the purpose of CCBHC budget reconciliation as described in this section. The LOCUS instrument is not designed or validated to identify clinically who is "mild-moderate" vs. who is "SMI".*

2.C.17.2. Encounter Reporting and Validation

The modifier TF must be added to the T1040 when submitting encounters for persons serviced with an M/M designation. MDHHS will use LOCUS data collected with BH-TEDS records available to us in the data warehouse and MichiCANS data available in CC360 to review encounters using the TF modifier for reasonability. If a significant discrepancy is identified, MDHHS will work with the PIHPs and CCBHCs to validate reported TF modifiers using EMR documentation.

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 considered 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 recipient's needs, preferences, and values; and ensure person served involvement and self-direction of services. Services for children and youth must be family-centered, youth-guided, and developmentally appropriate. DCOs may be private, for-profit organizations.

In Michigan, CCBHCs may utilize DCOs to increase capacity to provide core services and respond to fluctuating service demands. The CCBHC's community needs assessment must clearly articulate the need for a DCO relationship, and the CCBHC will adapt their staffing plan to illustrate how DCOs will be used to meet service demands.

3.B. General DCO Requirements

3.B.1. Eligibility to Utilize DCOs

CCBHCs are permitted to enter into a formal relationship and utilize a DCO to meet the nine (9) core services based on capacity needs and as identified within the CCBHC's community needs assessment. Upon request to add a DCO, a CCBHC must be prepared to translate service gaps identified in the needs assessment to justify a new DCO arrangement. DCO agreements must be reevaluated minimally at recertification and when there are changes to the CCBHC's submitted certification application.

CCBHCs can enter into DCO agreements with other CCBHCs participating in the demonstration for the purpose of meeting requirements associated with Evidence Based Practices or use of the state-sanctioned crisis provider (See Section 3.D).

Formal agreements between the CCBHC and DCO must be submitted to MDHHS during the certification process or prior to the agreement being executed. MDHHS must review DCO agreements to ensure they meet the requirements as outlined in Section 3.B.3, monitor for duplicate payment and collect encounter and quality data.

3.B.2. DCO Agreement Requirements

A formal relationship between a CCBHC and a DCO is evidenced by a written and fully executed or such other formal written 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. The CCBHC maintains financial and clinical responsibility and oversight for services provided by the DCO (see section 3.C. below). CCBHCs are required to submit all DCO agreements to MDHHS for approval (see Section 3.E of this handbook) **prior** to the DCO executing service delivery. CCBHC services delivered by a DCO prior to MDHHS approval must not be submitted with a T1040 and are not eligible for reimbursement at the PPS rate. Payments to a CCBHC for services provided by a DCO not authorized by MDHHS or operating in violation of the handbook are subject to recoupment.

To request a new DCO agreement, the CCBHC must complete the "New CCBHC Location or New DCO Agreement Request Form," found on the MDHHS CCBHC website.

Requests must be sent to MDHHS at mdhhs-ccbhc@michigan.gov and include the Request Form, and updated 51% Attestation Form, the proposed DCO agreement, and any other relevant information that will assist in MDHHS making a final decision.

MDHHS will respond to the request within 60 days once all supporting documentation is received. MDHHS will notify the PIHP once a DCO agreement is approved.

MDHHS requires that DCO agreements are developed as a written attachment or an addendum to a comprehensive Medicaid services contract. Agreements must include the following components:

- References to specific DCO requirements,
- Rate of purchased service and corresponding Appendix A service codes,
- Data sharing expectations and methodology for collecting required metric information (HIE),
- Assurance and evidence that DCO personnel have completed a basic CCBHC training and understand the goals of the model, responsibilities of a DCO, and service and billing requirements. Evidence of training(s) must be available to MDHHS upon request.
- Assurance and evidence that CCBHC Informational Training is provided to DCO organizations at least once every three (3) years. Evidence of training(s) must be made available to MDHHS upon request.
- Expectations around EBP delivery and monitoring, if DCO is providing CCBHC-required EBP, including evidence that the DCO meets EBP fidelity at the time the agreement is executed,
- Payment terms, including enhanced payments for added DCO requirements and expectations and defined share of quality bonus payments (QBPs) (if applicable),
- Method and frequency for sharing CCBHC policy and handbook updates.

3.B.3. 51% Requirement

Per the 2023 SAMHSA CCBHC Certification Criteria, the CCBHC itself must provide the majority (51% or more) of service encounters rather than through DCOs. Service encounters are identified using the T1040 code. Crisis services, as identified in Appendix A of this Handbook, are excluded from the calculation. Service encounter totals must include all non-crisis CCBHC services for all payers, including private payers and non-Medicaid.

CCBHCs will attest to meeting this requirement at certification, and the proportion of services will be verified using encounter reporting at year end. Verification will occur 90 days following year-end to allow for encounter submission run-off. CCBHCs must also provide evidence of the current CCBHC vs. DCO service distribution when requesting the addition of a new DCO agreement. PIHPs will assist with monitoring throughout the year to support compliance with this requirement.

CCBHCs who fail to meet the 51% majority of services requirement for the full demonstration year will be issued a CAP to bring the CCBHC into compliance in a reasonable timeframe (usually six (6) months). More information on CAPs can be found under Corrective Action Plan in 2.C.3 Certification Levels.

3.B.4. Designated DCO Lead Role

The CCBHC must have a designated DCO Lead to ensure all DCO requirements are being met as outlined in Chapter 3 of the CCBHC handbook. The DCO Lead can be a new or existing CCBHC team member and have other responsibilities or roles within the organization. The following oversight must be provided by the CCBHC through a DCO

Lead:

- DCO follow through with service delivery as it relates to an individual's referral needs, person-centered planning, care coordination in adherence of the current treatment plan,
- Ensure documentation is available to the clinical team, when a shared EHR is not available,
- Contract monitoring,
- CCBHC training adherence,
- Maintain active and open lines of communication between the CCBHC and the DCO as provider.

The DCO Lead will act as the contact liaison between the CCBHC and the DCO provider and will be able to respond to questions about existing DCO relationships.

3.B.5. Care Coordination and HIE

The CCBHC must also be involved in care coordination activities with DCOs, including improving health information exchange (HIE) to facilitate coordination and care transfers across organizations, and arranging access to data necessary for metric reporting. The CCBHC must clearly identify processes in place in the contract for exchanging CCBHC persons served health information and how DCO data collection is reflected in CCBHC required reporting, if not utilizing a shared health IT system.

CCBHCs and DCOs may choose to share health records and IT systems, but it is not required. If not utilizing a shared IT system, the CCBHC must clearly identify processes in place for exchanging health information and maximizing care coordination. CCBHCs must also outline plans to collect data for Clinic-Reported Quality measures and incorporate into quarterly and annual metric reporting. As outlined in Section 8.D.7.3, CCBHCs and DCOs must develop a two-year plan to further effectuate HIE and improve care coordination between parties. The HIE should support data sharing related to billing and payment, quality measures, service activity and methods to support care coordination and clinical/quality monitoring. In addition, it should build upon current exchange technology which supports ADTs to support transitions and timely follow up care.

3.B.6. DCO Adherence to CCBHC Criteria

As the direct contracting agency, CCBHCs are responsible for informing DCOs of any program changes and must share the current version of the CCBHC handbook, as updated. Prior to requesting a DCO, CCBHCs must develop a plan for ensuring DCOs receive up to date information regarding their responsibilities and role within the CCBHC demonstration. CCBHCs must be able to demonstrate that appropriate DCO staff have received training on DCO requirements and the role of a DCO within the CCBHC demonstration (See Sections 8.A.6.and 8.A.7). The PIHPs should help effectuate these activities to the extent it is proper and efficient but the CCBHCs are ultimately responsible for DCO compliance with CCBHC criteria.

CCBHCs are responsible for ensuring the DCO complies with the following requirements:

- The DCO, as an organization, must hold and maintain the necessary certifications, licenses and/or enrollments to provide the services,

- The staff providing CCBHC services within the DCO must hold and maintain the proper licensure for the service provided. DCO staff must meet the clinical and licensure requirements as documented in Section 8.A of the MDHHS CCBHC Handbook, as well as the MDHHS Behavioral Health Code Charts and Provider Qualifications as described for CCBHC services located on the MDHHS website at: Reporting Requirements (michigan.gov).
- The DCO meets CCBHC cultural competency and training requirements. DCO providers are required to have a training plan for all staff who have contact with CCBHC persons served or their families. Training requirements can be found in Section 8.A.7 of the MDHHS CCBHC Handbook
- 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 (see Section 8.D.1.3. Member Appeals and Grievance Procedures),
- The DCO must ensure all service recipients have access to a statutorily mandated Recipient Rights Office and a Recipient Rights Complaint Process (See Section 8.D.1.4),
- The DCO must follow the sliding fee scale 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 engage in efforts to enhance health information exchange (HIE) to facilitate coordination between the DCO and the CCBHC (see Section 3.B.5).
- 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.B.7. CCBHC Service Delivery Oversight

CCBHCs must oversee clinical service delivery at the DCO to ensure services are provided at the same standard as the CCBHC. To this end, CCBHCs must:

- Ensure DCO meets quality standards and evidence-based practice guidelines to fidelity,
- Coordinate care for individuals served by a DCO, including obtaining the MDHHS 5515 consent form and following HIPAA requirements.
- Ensure DCO licensure and credentialing are accurate and monitored for Fraud, Waste, and Abuse (FWA),
- Immediately notify MDHHS if DCO service delivery is non-compliant, disrupted, or terminated.

3.B.8. Financial Responsibilities

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. Costs associated with DCO contracts included in the CCBHC Cost Report must correspond correctly to DCO contracts. 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 and must take into account the costs of meeting the additional requirements of being a DCO. Since DCOs are required to capture data for metric reporting, CCBHCs may share a portion of the Quality Bonus Payment (QBP) to DCOs.

CCBHCs are responsible for billing all CCBHC services rendered under contract by a DCO, including third party collections. Financial and payment processes must follow the Payment Section of the CCBHC Demonstration policy and this Handbook. CCBHCs must collect and submit DCO encounters to MDHHS as well as ensure persons served at a DCO are included in quality data reporting.

Financial arrangements are required for all DCO partnerships, with the exception of DCO agreements between a CCBHC and a state-sanctioned crisis provider. Requirements for agreements with state-sanctioned crisis providers are outlined in Section 3.C - Expectations for State-Sanctioned Crisis Providers as DCOs.

3.B.9. Encounter Reporting

Encounters for services delivered by DCOs must be submitted to MDHHS with identifying DCO information, using loop 2310C or 2420C. Loop 2420C contains information about the rendering, referring, or attending provider on the service line level. This field is required when the location of the service is different than that carried in loop 2010AA Billing Provider or loop 2310C Service Facility Location (claim level). See Appendix D for an example.

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

CCBHCs who are not Community Mental Health Services Providers (CMHSPs) must utilize existing state-sanctioned crisis providers to ensure appropriate coverage across a CCBHC's service area and to avoid duplication of crisis services. In Michigan, State-Sanctioned Crisis providers are CMHSPs or contracted crisis providers acting on their behalf, who are statutorily required to provide crisis services (MHC 330.1206, R 330.2005, R 330.2006, R 330.2012, R.330.2810, R.330.8214).

Although CMHSP crisis providers can provide a broader array of crisis services, the following requirements are statutorily defined:

A. A crisis telephone line that is answered 24 hours a day, 365 days a year, for dealing with mental health emergencies. The number for this crisis line must be advertised through the telephone book, public information efforts, electronic means, and by notifying the appropriate agencies of the telephone number and the services provided.

B. Operate inpatient screening units following crisis screening standards: Offer emergency intervention services with sufficient capacity to provide clinical evaluation of the problem; to provide appropriate intervention; and to make timely disposition to admit to inpatient care or refer to outpatient services. The organization may use telephonic crisis intervention counseling, face-to-face crisis assessment, mobile crisis team, and dispatching staff to the emergency room as appropriate.

C. Walk in provision of face-to-face services to persons in the areas of crisis evaluation, intervention, and disposition.

In an effort to avoid duplication, CCBHCs must establish a DCO agreement for Crisis Service Coordination (which can be non-financial) with the CMHSP in their service area for the provision of state sanctioned crisis services. The agreement must clearly describe coordination expectations, including processes for data sharing and metric reporting, and include confirmation that the CMHSP will provide crisis services to

anyone referred by the CCBHC regardless of insurance or ability to pay. The agreement must also include a plan to collaboratively manage the demand for crisis services in the event a CMHSP cannot meet their mandated crisis service requirements. CCBHCs should work closely with the CMHSP to understand the capacity of their crisis continuum of care and may develop complementary crisis service teams to support the CMHSP in meeting the needs of the community. If the CMHSP contracts with external providers rather than providing crisis services directly, the agreement must clearly specify expectations for coordination between all parties.

CCBHC crisis services that are not provided by a state sanctioned CMHSP must be provided by the CCBHC directly, or through a written financial DCO agreement. CCBHCs must have the internal capacity to provide immediate crisis stabilization services in walk-in situations as well as provide crisis services to active service recipients if needed as a component of the treatment package. CCBHCs may engage in financial DCO agreements to provide extended access to Behavioral Health Urgent Care services.

CCBHCs who are also the CMHSP state-sanctioned crisis provider in their area must meet all CCBHC criteria for crisis services as outlined in Section 8.D.3 of this Handbook. As the state-sanctioned crisis provider, CCBHCs who are CMHSPs must offer the full array of crisis services to all individuals in their services area, and detail coordination expectations with other CCBHCs in the service area regarding crisis care via DCO agreements. CCBHCs who are the CMHSP state-sanctioned crisis provider are eligible to receive their clinic-specific PPS rate for CCBHC-eligible crisis services regardless of if they have received a CCBHC eligible service at another CCBHC.

3.D. Expectations for DCO Relationships between CCBHCs

CCBHCs can enter into DCO agreements with other CCBHCs participating in the demonstration for the purpose of meeting requirements associated with Evidence Based Practices or for Crisis Services, provided the CCBHC is the state-sanctioned crisis provider. Purchased services must be delivered directly by the CCBHC acting as a DCO. CCBHCs cannot enter into DCO agreements with other CCBHCs who have not implemented Evidence Based Practices to fidelity or who have active CCBHC Corrective Action Plans related to the proposed DCO services.

CCBHCs engaging in DCO relationships with other CCBHCs must follow all requirements as outlined in 3.B.

3.E. Adding New DCO Relationships

Adding new DCO relationships after initial certification requires updates to the CCBHC Certification and approval by MDHHS. Currently, only MDHHS is authorized to make changes to certification documents in the CRM after certification is closed. CCBHCs must submit a request and all supporting documentation to MDHHS as soon as possible as outlined in Section 2.C.16 (New Service Delivery Locations) and 3.B.2 (DCO Agreement Requirements). The addition of a new DCO must be directly related to capacity or identified as a need in the CCBHC community needs assessment submitted at certification. The CCBHC will complete a new attestation ensuring that they are continuing to provide the majority of CCBHC encounters at 51% or more. MDHHS will provide receipt of confirmation when certification documentation updates have been made in the CRM or provided via email for review.

3.F. Termination of DCO Relationships

CCBHCs must provide written notice and submit the DCO Termination form to MDHHS at least 30 calendar days prior to a DCO relationship termination. Additionally, CCBHCs must inform MDHHS of a transition plan to include service continuity for all individuals served by the DCO and how capacity of services provided by the DCO will continue at the CCBHC.

4. CCBHC Recipient Enrollment, Assignment, and Disenrollment

4.A. Person served Identification, Enrollment, and Assignment

Any individual with a qualifying behavioral health diagnosis is eligible to receive CCBHC services. Eligible CCBHC recipients are identified using a multifaceted approach for both Medicaid persons served and non-Medicaid persons. Eligibility and assignment are tracked using the WSA. MDHHS reserves the right to review and verify all enrollments and assignments. MDHHS also reserves the right to assign persons served to a CCBHC in the WSA.

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 person served 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 persons served and non-Medicaid persons, respectively:

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

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

MDHHS uses administrative claims data from the MDHHS Data Warehouse to identify CCBHC- eligible Medicaid persons served 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 persons served 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 loaded into the WSA near the demonstration start date and continuously updated to reflect the most recent 18 months of administrative data and to account for any changes in eligibility requirements.

Persons served 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 Persons Served

Utilizing the WSA, MDHHS's Data Warehouse will provide PIHPs a list of CCBHC- eligible Medicaid persons served for their respective PIHP region, via the WSA. PIHPs must work with CCBHCs to assign persons served to the pertinent CCBHC within the WSA as they initiate services. The assignment may include an attestation that the Consent to Share Behavioral Health Information for Care Coordination Purposes (MDHHS-5515 Form) has been signed by the CCBHC-eligible Medicaid person served. Entities are required to use and accept the MDHHS-5515 form unless the entity is held to more stringent requirements under federal law. The only entities who are held to more stringent requirements under federal law are entities receiving funding resulting from the Victims of Crime Act, Violence Against Women Act, or Family Violence Prevention and Services Act.

4.B.3. CCBHC Recommendation of CCBHC-Eligible Medicaid Persons Served

For Medicaid persons served not identified as eligible or enrolled into the CCBHC Benefit Plan by MDHHS's Data Warehouse, CCBHCs are permitted to recommend eligible persons served for enrollment into the CCBHC benefit plan via the WSA. CCBHC providers must provide documentation that indicates a potential CCBHC enrollee meets eligibility for the CCBHC benefit, including diagnostic verification and consent of the person served. The Consent to Share Behavioral Health Information for Care Coordination Purposes (MDHHS-5515 Form) must be used unless the entity is held to more stringent requirements under federal law. The only entities who are held to more stringent requirements under federal law are entities receiving funding resulting from the Victims of Crime Act, Violence Against Women Act, or Family Violence Prevention and Services Act. 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 person served is assigned to the recommending CCBHC in the WSA and the record is sent to CHAMPS, which enrolls the person served in the CCBHC Benefit Plan. MDHHS reserves the right to review and verify all enrollments and assignments. MDHHS also reserves the right to assign persons served to a CCBHC in the WSA.

4.B.4 CCBHC Assignment and Enrollment for 1915(i) Services

Medicaid persons served who are receiving ***only*** CCBHC services do not have to complete the eligibility determination and enrollment process in the WSA for 1915(i) services. If the person served is receiving CCBHC services ***and*** 1915(i) services (not offered under CCBHC) then they should be enrolled in both programs in the WSA. For example, an individual receiving CCBHC prevention services (service code H0025) and 1915(i) community living support services they (service code H2016) should be enrolled in both programs in the WSA. Functionality has been built into the WSA to alert users who input cases where individuals are enrolled in another waiver. The warning does not prevent the user from adding the case but rather helps the user consider the appropriate funding sources prior to enrollment.

4.B.5 CCBHC Assignment and Enrollment for HSW Services

Individuals whose level of care meets enrollment requirements for the Habilitation Supports Waiver (HSW), must be assessed for enrollment into the HSW and medical necessity criteria must be used in determining the amount, scope, and duration of services and supports offered on the waiver. Since CCBHCs must serve anyone with a behavioral health diagnosis, even if the individual has a primary I/DD

diagnosis it is likely that persons served may be enrolled into the CCBHC benefit plan and the HSW benefit plan simultaneously. CCBHCs cannot receive PPS-1 payment for overlapping services offered on both programs. See Appendix A for more information and a list of overlapping service encounter codes. Functionality has been built into the WSA to alert users who input cases where individuals are enrolled in another waiver to determine eligibility and the appropriate funding source. CCBHC and HSW share an overlapping service set, and persons served should be assigned to a CCBHC only if they are receiving CCBHC services outside the scope of the overlapping service set.

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

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

Unlike "eligible" Medicaid persons served, non-Medicaid recipients will not be enrolled in 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 primarily with a unique PIHP Consumer ID (CONID). A list of eligible non-Medicaid recipients ***will not*** be loaded in the WSA (like the eligible Medicaid population) and will require the CCBHCs and PIHPs to identify and enroll eligible non-Medicaid recipients, when applicable. 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. CCBHC Requesting Assignment of CCBHC-Eligible Non-Medicaid Recipients

For non-Medicaid recipients, CCBHCs are permitted to add and recommend eligible recipients to the PIHP for assignment 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 Form).

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 CONID (if they do not already have one in the PIHP's region) within the WSA. Once processed by the PIHP, the person served 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 must assign the person into the CCBHC via the WSA.

4.D. Persons Served Consent

CCBHC recipients should provide a signed Consent to Share Behavioral Health Information for Care Coordination Purposes (MDHHS-5515 form) prior to assignment in the WSA. Entities are required to use and accept this the MDHHS-5515 form unless the entity is held to more stringent requirements under federal law. The only entities who are held to

more stringent requirements under federal law are entities receiving funding resulting from the Victims of Crime Act, Violence Against Women Act, or Family Violence Prevention and Services Act. 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 SUD disorders). The MDHHS-5515 can be found on the MDHHS website at Michigan Behavioral Health Standard Consent Form. The form must also be available at the designated CCBHC office and on each 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, unless the CCBHC recipient denies signing consent. CCBHC policy should outline the process for consent denials included but not limited to regular attempts to obtain a MDHHS-5515 signed consent. All CCBHC services must be provided even if a MDHHS-5515 consent is not obtained. All documents must be maintained in compliance with MDHHS record- keeping requirements.

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
- Person served 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. If Medicaid individuals are enrolled in the CCBHC benefit plan in CHAMPS and are disenrolled in the WSA, they will subsequently be disenrolled from the CCBHC benefit plan in CHAMPS. 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. If recipients are disenrolled but later re-engage in services, a new case will need to be recommended for assignment as the previously disenrolled case status cannot be modified. 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.

CCBHC Disenrollment Reason	Definition
Person served is Unresponsive	CCBHC recipient stopped participating in services for a minimum of 90 days, 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 person served 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 person served 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 person served was enrolled in their service. This includes information stored within the WSA:

- Documents
  - Care Plan
  - MDHHS 5515 Consent to Share Behavioral Health Information
- Enrollment History
- Transfer History

Non-Medicaid transfers in the WSA should not follow the outlined transfer process above due to inconsistent PIHP CONIDs and tracking. The transferring PIHP should disenroll the case and notify the new PIHP.

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 persons served and non-Medicaid individuals with a mental health and/or SUD diagnosis. For Medicaid persons served receiving CCBHC services, MDHHS will operationalize the PPS-1 payment through their contracted 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. The processes for PPS-1 payment for Medicaid persons served and non-Medicaid CCBHC recipients is further delineated in the sections below. 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 persons served receiving CCBHC services. Finally, Wavier Support Application assignment cannot be used to authorize or prohibit CCBHC payments.

As noted in section 2.B., MDHHS reserves the right to implement alternative payment models, as permitted by federal guidance, including but not limited to making PPS payments outside of the managed care delivery system, for CCBHCs participating in the CMS Demonstration.

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. MDHHS will utilize 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.

The PPS rate methodology and rebasing will follow applicable federal requirements. Given the different timelines of sites joining the demonstration, rate rebasing methodology may differ amongst CCBHC sites. Rate development details will be documented in relevant draft and finalized rate materials shared with demonstration participants.

The PPS-1 rates for current demonstration year can be found on the CCBHC Demonstration website or in the rate letter. Future PPS rates will be based on review of cost reports and updated on both the CCBHC Demonstration website and in the dispersed rate letters. All PPS-1 rates are subject to final approval from CMS.

5.C. CCBHC Payment Operations

5.C.1. General Provisions for Encounter Reporting

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 services 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 SUD services, a PIHP may need to submit encounters using both MH and SUD provider identification numbers.

5.C.1.1.1 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.

5.C.1.1.2 Outpatient Service Requirement

Per the Protecting Access to Medicaid Act of 2014, Section 223.b.2.A, no payment will be made for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, as determined by the Secretary [Secretary of Health and Human Services through the Centers for Medicare & Medicaid Services].

5.C.1.2. Required CCBHC Modifier for Mild-to-Moderate Populations

The use of modifier “TF” must be submitted in conjunction with the T1040 code to solely identify CCBHC services provided to the Mild-to-Moderate population. CCBHCs are required to utilize the Michigan Child and Adolescent Needs and Strengths Tool (MichiCANS) and Level of Care Utilization System (LOCUS) assessments to identify individuals ages 7 And up receiving CCBHC services with Mild-to-Moderate behavioral health needs for reporting and rate setting purposes (refer to section 8.D.4.1.4 for mental health level of care (LOC) determination requirements).

5.C.1.3. Reporting Detail of CCBHC Service Encounter Codes

For Medicaid persons served, the CCBHC must submit the encounter with the persons served Medicaid ID; for non-Medicaid recipients, the CCBHC must submit the encounter with the PIHP's CONID 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 National Provider Identifier Number (NPI). For CCBHC services provided through a DCO, the DCO's NPI number must be reported in the Service Facility Location loop (See Appendix D). Note: If the DCO is not eligible for an NPI, please contact mdhhs- ccbhc@michigan.gov.

With the exception of encounters submitted for the SUD Block Grant, PIHPs may determine what amount should be reported for the T1040 Claim Charge Amount and the Payment Amount. SUD Block Grant encounters must be reported as $0. 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 D. In this example, the CCBHC is reporting $0.00 on the T1040 line.

5.C.1.4. 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 adjudicated. 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 adjudicated.

5.C.1.5. 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.1.6. 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 Persons Served

MDHHS may operationalize the CCBHC payment for Medicaid persons served 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). CCBHCs must receive the clinic-specific PPS-1 rate or its actuarial equivalent for qualifying CCBHC services (daily visits). Each clinic may only receive one PPS-1 payment per day per person served, regardless of the number of CCBHC services provided on a given day.

5.C.2.1. PIHP CCBHC Capitation Payment

MDHHS may 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 persons served 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 has created a module in the Milliman DRIVE Tool for PIHPs to run reports on CCBHC enrollment, issued payments, and adjudicated encounters. MDHHS and the PIHPs can query this data by CCBHC site, distinct 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 person served/recipient regardless of the number of CCBHC services provided on a given day). 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 Persons Served
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 persons served added to CCBHC effective August 1.
- Retroactive enrollment for persons served enrolled effective February 1, March 1, April 1, May 1, June 1, or July 1 since June 26.

Payment for CCBHC enrolled Medicaid persons served 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.

PIHP and CCBHC payment contracts and processes must be developed within the first 30 days of a new fiscal year and/or upon notification of a new CCBHC demonstration site. PIHPs may choose to pay the full PPS rate when eligible CCBHC encounters are submitted or utilize an alternate payment methodology that involves quarterly reconciliation to ensure the full PPS rate is paid to the CCBHC for each eligible daily visit.

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 are expected to leverage existing grant funds, third party collections, and other available local funds.

5.C.3.1. CCBHC General Fund Distribution

General fund dollars, if available, will be distributed to support non-Medicaid service expenses. Funds will be dispersed prior to the end of the demonstration year.

Available funds will be divided proportionally based on the number of non-Medicaid daily visits provided by each CCBHC during the first 6 months of the demonstration year (October 1 – March 31). Encounter data reported on the Milliman CCBHC DRIVE Dashboard corresponding to the July 3 data export will be used to determine the distribution amounts.

PIHPs will distribute funds as specified by MDHHS by the end of the demonstration year. CCBHCs will not be expected to cost settle if they do not need the full amount to cover non-Medicaid expenses.

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*. As outlined in the CCBHC cost reporting instructions, clinic-specific PPS rates are composed of all costs and visits for CCBHC services covered under a state's CCBHC scope of services. Costs for providing CCBHC services are calculated regardless of payer, but the PPS rate is only paid for Medicaid-eligible beneficiaries. 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. For commercial persons served, CCBHCs must bill their negotiated rates with insurance companies, and Medicare rates for their Medicare persons served, however, payment for dually eligible patients must follow section 4.1a of the CCBHC PPS Technical Guidance. For these populations, CCBHCs may not bill Medicaid nor include in the calculation of the CCBHC PPS rate and must follow CCBHC SAMHSA Criteria section 2.D: No Refusal of Services due to Inability to Pay.

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 persons served*, 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.C.5. Reporting Expectations If Services Supported by Another Medicaid Program
CCBHCs are encouraged to maintain and expand current service arrangements with other Medicaid providers (e.g. Medicaid Health Plan). If CCBHC services are billed to another non-PIHP Medicaid MCO, the CCBHC is required to report any received reimbursement as an offset to the PPS payment received by the PIHP.

5.D. Quality Bonus Payments (QBP)
MDHHS affords a QBP for CCBHCs meeting benchmarks for the quality metrics defined by SAMHSA. To receive a QBP, a CCBHC must achieve or exceed the threshold for each QBP-eligible measure as specified below. Award methodology is subject to change annually to align with program priorities. The QBP is only pertinent to Medicaid CCBHC costs and persons served, it is based on 5% of the total CCBHC Medicaid Demonstration Year Costs.

5.D.1. QBP Measures, Measure Stewards, and Benchmarks
Please reference Appendix F – Quality Bonus Payment Measures, Measure Stewards, and Benchmarks.

5.D.2. QBP Distribution Methodology

5.D.2.1. Assessment and Distribution
CCBHC QBP performance will be evaluated and awarded at the CCBHC site level. QBP funding awarded to CCBHCs will be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system.

CCBHCs must meet the minimum numerator and denominator requirements (N=5, D=30) for the calculation of a QBP measure for it to be included in the determination and eligible for the award. If performance benchmarks are met, MDHHS will provide the QBP payment to the PIHP for distribution to the awarded CCBHC(s). CCBHCs are eligible to receive 5% of the clinic's annual Medicaid costs (defined as the reported Medicaid daily visits x demonstration year PPS rate). Each measure is weighted, and the portion of the QBP awarded for each measure is listed in Appendix F. For measures with sub-measures, CCBHCs must meet the benchmark for each sub-measure in order to receive payment related to the overall measure.

If a CCBHC does not meet benchmarks for QBP measures, the potential distribution amount will be added to a redistribution pool.

5.D.2.2. Timelines

MDHHS will distribute QBP payments to the PIHPs within one year of the end of the calendar measurement year (CY). CCBHCs are afforded an opportunity, prior to the final award distribution, to dispute results and engage in a consultation period to validate. During the measurement year (MY), MDHHS will identify baseline values for the performance metrics to be measured against during the subsequent payment years. Final clinic reported measures are to be submitted to MDHHS by June 30th of each year, or 6 months after the end of the calendar year.

5.D.3. QBP Technical Specifications

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

- Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual (samhsa.gov)

- CMS Medicaid Core Set Technical Specifications and Resource Manual: Adult and Child Health Care Quality Measures

6. CCBHC and Health Information Technology

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

The MDHHS Behavioral Health (BH) CRM is the platform in which MiCAL and other MDHHS business processes are housed. The BH 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 BH CRM will house the CCBHC certification process for the demonstration. Each CCBHC will have an account and will complete all certification processes using the BH CRM including submitting the CCBHC application and pertinent documents and completing the on-site review process.

Please contact the MiCAL/CRM inbox if you need support at mdhhs-bh-crm@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 persons served,
- 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 person served 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.

An initial batch of eligible Medicaid CCBHC recipients will be added to the WSA, per region. PIHPs will have access to all eligible Medicaid recipients that reside in their region for

CCBHC assignment. Every night thereafter, individuals with a qualifying diagnosis will be uploaded to WSA from MDHHS's Data Warehouse.

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 (CC360)

CareConnect360 (CC360) 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 CC360 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 person served and allow smoother transitions of care. It will also allow the PIHP to make better and faster decisions for the betterment of the person served. Quarterly integrated measure performance results are provided in CC360 and are based on state and/or national specifications. CCBHCs who do not have access to CC360 should coordinate closely with their PIHP to share appropriate information, performance measure data, and facilitate transitions in and out of the CCBHC. Providers will only have access to individuals that are established as patients of record within their practice. Finally, with appropriate consent, CC360 facilitates the sharing of cross-system information, including behavioral health, physical health, and social support services.

Users will access the CC360 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 (SSL) 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 described below. There are two broad sets of requirements – CCBHC reported measures and state reported measures. A state reported measure is calculated by the state for each CCBHC, usually relying on administrative data. A CCBHC reported measures are 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 the Demonstration Year. CCBHCs must report measures to MDHHS within 6 months of the end of the Demonstration Year.

The CCBHC core measures and other federal requirements are laid out below:

7.A.1. CCBHC Reported Measures

Measure Name and Designated Abbreviation	Steward	Required Measure or State Added
Time to Services (I-SERV)*	SAMHSA	Required
Depression Remission at Six Months (DEP-REM-6) *	MN Community Measurement	Required
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	NCQA	Required
Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD)	CMS	Required
Screening for Social Drivers of Health (SDOH)	CMS	Required
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	NCQA	State Added
Adult Major Depressive Disorder: Suicide Risk Assessment (SRA-A) *	Mathematica	State Added
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-C) *	Mathematica	State Added
Patient Experience of Care Survey	SAMHSA	Required
Youth/Family Experience of Care Survey	SAMHSA	Required

*Denotes a measure that is also a quality bonus payment measure

7.A.2. State Reported Measures

Measure Name and Designated Abbreviation	Steward	Required Measure or State Added
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	CMS	Required
Follow-Up After Hospitalization for Mental Illness, (FUH-CH) (FUH-AD)*	NCQA	Required
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)*	NCQA	Required
Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD)	NCQA	Required
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD)	NCQA	Required
Plan All-Cause Readmissions Rate (PCR-AD)*	NCQA	Required

Measure Name and Designated Abbreviation	Steward	Required Measure or State Added
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)	NCQA	Required
Antidepressant Medication Management (AMM-BH)	NCQA	Required
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	CMS	Required
Glycemic Status Assessment for Patients with Diabetes (GSD-AD)*	NCQA	Required
Child and Adolescent Well-Care Visits (WCV-CH)	NCQA	State Added

*Denotes a measure that is also a quality bonus payment measure

7.A.3. CCBHC Metric Specifications

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

- Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual (samhsa.gov)

- CMS Medicaid Core Set Technical Specifications and Resource Manual: Adult and Child Health Care Quality Measures

7.A.4. Reporting Requirements

CCBHC-reported measures will be compiled by the CCBHC using the MI- CCBHC Data Demonstration Templates (FY25).XLSX file. In addition to the federal template requirements, CCBHCs must complete the I-SERV (supplemental) tab and the patient experience survey tabs (PEC, YFEC, URS-Tables 9 URS-Table 11, URS-Table 11a). CCBHCs are responsible for completing the “Case Load Characteristics” sheet and the reporting sheets for the clinic-reported measures (blue colored tabs).

7.A.4.1. Quarterly Reporting

CCBHCs must complete the clinic-reported measures on the MI-CCBHC Data Demonstration Templates (FY25).xlsx template quarterly. Templates must be sent to PIHPs by the end of the month following the measurement period. For example, for the quarter ending June 30th, templates are due July 31st. PIHPs will work with CCBHCs to remedy data collection issues to ensure accuracy of metric reporting.

The PIHP’s review must include, but is not limited to, the following:

- Verify the template has been completed,
- Compare against previous quarter/year or to regional or state averages,
- Verify counts (i.e., the numerator is smaller than the denominator),
- Review calculations (i.e., no zeros or broken formulas).

PIHPs will also make the quarterly templates available to MDHHS or external

evaluators purposes of monitoring and evaluation planning. At minimum, the second quarter data of a clinic's initial demonstration year will be sent to MDHHS as a trial submission to ensure clinics can acquire the appropriate data and are prepared to complete the annual reporting.

7.A.4.2. *Annual Reporting*

Year-end clinic reported measures will be calculated based on a measurement period of January 1 through December 31. PIHPs will work with the CCBHCs in their region to collect, validate, and submit the final clinic-reported templates to MDHHS within 6 months of the end of the calendar year (June 30). Final templates for all measures must be submitted by the PIHP and sent via email to mdhhs-ccbhc@michigan.gov.

PIHPs will share final data from the end of year metric upload in CC360 to assist the CCBHC in completing the *state-reported metrics sheet* of the reporting template (MI-CCBHC-Data-Demonstration-Templates (FY25).xlsx).

7.A.4.2.1. *Measurement Periods*

Measure specifications may include measurement periods based on the CCBHC demonstration year or calendar year. Michigan's demonstration years follow the State Fiscal Year reporting structure, beginning October 1st, and ending September 30th. The CCBHC demonstration transition to calendar reporting will begin January 1, 2025.

Demonstration Year (DY)	Time Period
DY1	October 1, 2021 – September 30, 2022
DY2	October 1, 2022 – September 30, 2023
DY3	October 1, 2023 – September 30, 2024
DY4 (Transition to calendar year)	January 1, 2025 – December 31, 2025
DY5	January 1, 2026 – December 31, 2026
DY6	January 1, 2027 – December 31, 2027

7.A.5. Defining Eligible CCBHC Population

Per CMS guidance and the technical specifications listed above, the eligible population for the clinic-reported 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 must be included in each measure and the reporting unit for the measure (e.g. recipients or visits).

State reported measures are calculated using administrative claims data for persons served with full Medicaid coverage and will use the presence of a T1040 service code to identify the CCBHC population.

Rejected encounters are excluded, and continuous enrollment measure requirements are met based on Medicaid continuous enrollment rather than CCBHC continuous enrollment. Individuals are attributed to the CCBHC with the

highest share of service delivery (i.e. submitted the highest number of T1040s for an individual). In the event where multiple CCBHCs have submitted the same number of T1040s for a given individual, the individual's outcomes will be attributed to the clinic that submitted the most recent T1040.

CCBHC-reported measures will be calculated using data collected in the local Electronic Health Record (EHR) and may be generated using an EHR-developed reporting module.

CCBHCs will 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 accurately reflected in the WSA, as one CCBHC must be considered "lead" in WSA assignment, service coordination, and service delivery.

7.B. Additional Monitoring Requirements

7.B.1. CCBHC Ad Hoc Reporting

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.2. CCBHC Non-Medicaid Encounter Reporting

CCBHCs must complete an annual report which summarizes CCBHC services and associated revenue provided to individuals without Medicaid. This includes, but is not limited to, information for persons served with federal coverage, private/commercial insurance and who are uninsured/underinsured and are not eligible for reimbursement through the PPS-1 rate. See Appendix H for reporting requirements.

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. MI CCBHC Certification Criteria—Program Requirements

8.A. Program Requirement #1: Staffing

8.A.1. General Staffing Requirements

8.A.1.1.1. CCBHC Community Needs Assessment

During initial CCBHC certification and again upon recertification, CCBHCs are required to conduct a CCBHC Community Needs Assessment utilizing the

MDHHS-specific template, *CCBHC Community Needs Assessment Template*. This needs assessment is specific to the CCBHC certification application, and the catchment area identified in the application. Regional and partnering assessments may be utilized to provide useful information for the assessment; however, those assessments may not be submitted in lieu of the CCBHC Community Needs Assessment Narrative Template. The CCBHC Community Needs Assessment Narrative Template is specific to CCBHC and requires information that is not found within other community needs assessments. This assessment will guide the CCBHC in meeting certification criteria, which includes staffing plans, quality and comprehensive service delivery, and the use of DCOs

Each site must complete the CCBHC Community Needs Assessment Narrative Template to evidence a thorough Assessment (requirements outlined below) that reflects the treatment and recovery needs of those who reside in the service area across the lifespan including children, youth and families. The CCBHC Community Needs Assessment Narrative Template must be completed prior to a new certification or recertification application submission in order to meet certification requirements

The CCBHC Community Needs Assessment is required to be completed every 3 years. It is expected that the CCBHCs will review their CCBHC Community Needs Assessment annually to identify gaps in service delivery. If applicable, the CCBHC must remedy identified gaps and ensure that underserved populations are effectively reached through updating and amending the CCBHC Community Needs Assessment Narrative Template. If completing an amendment to the CCBHC Community Needs Assessment, the site need only update the appliable section of the CCBHC Community Needs Assessment Narrative Template.

CCBHCs must incorporate the following components into their CCBHC community 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 physical boundaries and size of the service area, including identification of sites where services are delivered by the CCBHC, including through DCOs.
- Include cultural, linguistic and treatment needs of the service population.
- Include the behavioral health service landscape for all eligible CCBHC service recipients, regardless of insurance or ability to pay. Any individual with a qualifying behavioral health diagnosis is eligible to receive CCBHC services. Eligible CCBHC recipients are identified using a multifaceted approach for both Medicaid persons served and non-Medicaid persons.
- A thorough description of the crisis services available in the service area, which should inform how the CCBHC will sustain and operate a behavioral health urgent care, including how the site will meet staffing needs to operate.
- Identify the underserved population in their community and how the site will engage this population in service delivery.
- 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, including workforce shortages.
- Explanation to support additional care coordination partnerships and evidence-based practices being delivered outside of the required practices listed in this handbook.
- 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.

8.A.2. Staffing Plan

The CCBHC must ensure that staffing numbers (both clinical and non-clinical) are appropriate for serving the CCBHC recipient 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 8.D.11 (SAMHSA Criteria 4.K).

CCBHCs must complete the MDHHS provided Staffing Plan Template at initial application/certification and update the template at each recertification. The Staffing Plan Template can be found on the CCBHC website at www.michigan.gov/ccbhc.

A written staffing plan must correspond to the needs identified in the CCBHC community needs assessment. If a CCBHC plans to utilize DCOs, the staffing plan must include DCO capacity and describe how DCO staff will assist in meeting CCBHC service requirements. MDHHS has developed a required staffing plan template (see section 8.A.1.2.) to assist in identifying staff needs informed by the CCBHC community needs assessment and the CCBHC's ability to meet staffing program requirements.

8.A.3. 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.

8.A.3.1. 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 Health Resources and Services Administration (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 must 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.

8.A.4. 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.

8.A.5. Licensure and Credentialing of Organizational Providers and Individual Practitioners

8.A.5.1. Licensure and Credentialing

The MDHHS Credentialing and Re-Credentialing Processes can be found at the following website: Policies & Practice Guidelines (michigan.gov)

- Consistent with existing PIHP and CMHSP contractual requirements, all CCBHCs must have written credentialing policies and procedures for requiring and ensuring that all Organizational Providers and Individual Practitioners rendering services to persons served are appropriately credentialed within the state and are qualified to perform their services. Credentialing must take place every three (3) years and must follow the credentialing and re-credentialing processes established by MDHHS.
- PIHPs are ultimately responsible for maintaining credentialing files and ensuring that each Organizational Provider and Individual Practitioner (direct-hire and contracted) meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual (MPM) requirements.
- Pursuant to the requirements of the statute PAMA §223(a)(2)(A), all CCBHC Organizational Providers who furnish services must be legally authorized to do so in accordance with federal, state, and local laws, and act only within the scope of their respective state licenses, certifications, privileging and credentialing, registrations, and in accordance with all applicable laws and regulations, including any applicable state Medicaid billing regulations or policies. CCBHC Organizational Providers must

ensure and monitor that its clinical staff (direct-hire and contracted individual practitioners) are licensed and credentialed, including individual practitioners working toward licensure, and that appropriate supervision is in place and in accordance with applicable state law.

- Pursuant to the requirements of the statute PAMA §223(a)(2)(A), all CCBHCs who work with one or more DCOs to furnish services under a formal agreement must require and monitor that the DCO as an Organization is legally authorized in accordance with federal, state, and local laws, and act only within the scope of their respective state licenses, certifications, privileging and credentialing, registrations, and in accordance with all applicable laws and regulations, including any applicable state Medicaid billing regulations or policies.
- A DCO as an Organization must ensure and monitor that its clinical staff (direct-hire and contracted individual practitioners) are licensed and credentialed, including individual practitioners working toward licensure, and ensure that appropriate supervision is in place and in accordance with applicable state law, following the credentialing and re-credentialing processes established by MDHHS.
- CCBHCs must ensure that DCOs residing and providing services in bordering states meet all applicable licensing and certification requirements within that bordering state.
- CCBHCs must require and ensure that appropriate credentialing and licensure is maintained at DCOs when DCOs are not in-network Organizational Providers at the PIHP level. The PIHP will not oversee out-of-network Organizational Providers. The CCBHC must complete the following:
  - Upon successful completion of the DCO Organizational privileging and credentialing process, the DCO Organizational Application and supporting documentation must be sent to the PIHP by the CCBHC.
  - The CCBHC must monitor and provide oversight of the DCO, ensuring that the DCO is completing the privileging and credentialing process, licensure, and certification for all its clinical staff (direct-hire and contracted individual practitioners) and that the staff personnel files contain all required documentation.
  - The CCBHC must ensure that the DCO is in compliance with supervision requirements for all clinical staff (direct-hire and contracted individual practitioners), including staff working toward licensure.
- Provider credentialing documentation will be collected and maintained in the Uniform Credentialing Section of the MDHHS CRM.

8.A.6. Staffing Requirements and Qualifications

The CCBHC staffing plan template must meet the requirements of the state behavioral health authority and any accreditation standards required by the state and must include clinical professionals and certified peer staff. In accordance with the staffing plan, the CCBHC must complete the required staffing plan template provided by MDHHS and submit the template in the CRM during initial application/certification and/or recertification. The CCBHC must maintain a core staff comprised of employed and as needed, contracted staff, as appropriate to the needs of CCBHC persons served as stated in the recipient's treatment plan. CCBHCs must notify MDHHS by email (mdhhs-ccbhc@michigan.gov) within seven (7) days of staffing change(s) that negatively affects access to care. This includes, but is not limited to, an

inability of a CCBHC or DCO to serve individuals in a timely manner, staffing shortages, CCBHC or DCO gaps in service delivery, termination of a DCO, or a change in CCBHC or DCO circumstances affecting eligibility to participate in the program. Unless otherwise specified, staff must meet the MDHHS PIHP/CMHSP Provider Qualifications as described for CCBHC services Reporting Requirements (michigan.gov).

Required staffing disciplines include:

- Medically trained providers/practitioners, 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.
    - This would not include methadone, unless the CCBHC is also an Opioid Treatment Program (OTP). If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use, the CCBHC must develop a care coordination partnership or a referral process with an OTP to ensure access to methadone for all persons served.
    - MDHHS requires CCBHC service providers/practitioners that can prescribe medications used to treat Opioid Use Disorders (OUDs) register as a provider on the SAMHSA National Registry found at Facility Registration - FindTreatment.gov

- 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 must 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 Specialist (SATS)

- Substance Abuse Treatment Practitioner (SATP)
    - CCBHCs must ensure that SATP, when providing substance abuse treatment services, are supervised by a SATS, who is a certified clinical supervisor (CCS) or who has a registered development plan (Development Plan – Supervisor [DP-S]) to obtain the supervisory credential.
    - CCBHC sites that employ only SATS fully credentialed staff and no SATP are considered to have met the SATP requirement.

- Peers

- To ensure the CCBHC meets certification requirements, CCBHCs are required to offer, either directly or through DCOs, peer services.
- Peer staff must be fully trained and/or certified according to their role. Training and Certification requirements can be found beginning in Section 3.21 – Peer-Delivered or Operated Support Services beginning in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of the Medicaid Provider Manual, as well as the MDHHS websites noted below.
    - Certified Peer Support Specialist (CPSS)
        - Peer Recovery Information (michigan.gov)
    - Certified Peer Recovery Coach (CPRC)
        - Peer Recovery Information (michigan.gov)
    - Parent Support Partner (PSP)
        - Children, Youth and Families (michigan.gov)
    - Youth Peer Support Partner (YPSP)
        - Children, Youth and Families (michigan.gov)

- Recommended Staffing Disciplines:
    - Community Health Worker
    - Veteran Navigator
    - Care Coordinator
    - SOAR Navigator
    - Medical Billing Staff
    - Health Information Technology Specialist

It is preferred that the CCHBC directly staffs the required positions; however, MDHHS recognizes that some staffing types (including credentialed SUD specialists) may be part of the DCO network. The CCBHC must 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 8.B.5 and/or SAMHSA Criteria 2.a.5)
- CCBHCs may utilize providers working toward licensure, provided they are working under the requisite supervision.
- CCBHCs designated as Rural or Frontier, see section 2.C.2.1.1 for staffing certification considerations.

8.A.7. Cultural Competence and Other Training

8.A.7.1. Training Plan

The CCBHC must have a training plan, for all employed and contract staff, and for providers at DCOs who have direct contact with CCBHC persons served 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 CCBHC/DCO must provide training on:

- HIPAA/Privacy/Confidentiality
- Recipient Rights
- Person-centered and family-centered care
- Collaborating with/Roles of families and peers
- Corporate Compliance
- Due Process/Enrollee Rights/Grievance and Appeals
- Overdose prevention and response training with specific attention paid to Naloxone intervention
- Risk assessment, suicide prevention and suicide response
- Co-occurring Mental Health and SUD
- Military and veteran culture and care
- Older adult culture and care
- Primary care/behavioral health integration
- Recovery-oriented, evidence-based, and trauma-informed care
- CCBHC Continuity of Operations/Disaster Plan
- Cultural competence (including Implicit/Unconscious Bias)
- Limited English Proficiency
- CCBHC Informational Training for DCOs

Recommended Training

- LGTBQIA+
- Diversity Equity and Inclusion
- Social Determinants of Health
- Crisis Response Training

Training Name	Frequency
HIPAA / Privacy / Confidentiality	Within 30 days of hire and annually
Recipient Rights	Within 30 days of hire and annually
Person-centered and family-centered care	Within 60 days of hire and annually
Collaborating with / Roles of families and peers	Within 90 days of hire and annually
Corporate Compliance	Within 90 days of hire and annually
Due Process / Enrollee Rights / Grievance and Appeals	Within 90 days of hire and annually
Overdose prevention and response training with specific attention paid to Naloxone intervention	Within 90 days of hire and annually
Risk assessment, suicide prevention and suicide response	Within 90 days of hire and annually
Co-occurring Mental Health and SUD	Within 90 days of hire and every two years
Military and Veteran Culture and Care	Within 90 days of hire and every two years
Older adult culture and care	Within 90 days of hire and every two years

Training Name	Frequency
Primary care / behavioral health integration	Within 90 days of hire and every two years
Recovery-oriented, evidence-based, and trauma-informed care	Within 90 days of hire and every two years
CCBHC Continuity of Operations / Disaster Plan	Within 90 days of hire and every three years
Cultural competence (including Implicit / Unconscious Bias)	Within 90 days of hire and every three years
Limited English Proficiency	Within 90 days of hire and every three years
CCBHC Informational Training for DCOs	Within 90 days of DCO start date and every three years

Training must be aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality of services, and eliminate disparities. Cultural competency training must reflect the diversity within the population being served, as defined by the CCBHC and other community needs assessments. As required in the MDHHS/CMHSP Contract (Part II: Statement of Work, Section 3.3.3 (Cultural Competence)), CMHSPs must also use the CCBHC and other community needs assessments to demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area.

CCBHC sites that choose to utilize a DCO to meet certification criteria are **required** to provide a CCBHC informational session with each DCO provider to introduce them to the CCBHC model and requirements within 60 days of the DCO start date and every three years. This session is provided by the CCBHC and should include topics such as CCBHC Demonstration background and structure, review of most current CCBHC Handbook, six CCBHC principles, nine core CCBHC services, and CCBHC measures. This training is required for all staff including but not limited to the DCO financial leadership, clinical leadership, administration, and service delivery staff.

8.A.7.2. Training Timelines, Settings, and Reciprocity

Training, including training on the clinic's continuity plan, must occur at hire/orientation and at intervals specified in the Training Plan in Section 8.A.7.1 in this Handbook. If necessary, trainings may be provided on-line. To support reciprocity efforts, CCBHCs should accept staff training provided by other entities to meet their training requirements when the staff's previous training is substantially like their own training and staff member completion of such training can be verified.

8.A.7.3. Skills/Competence

The CCBHC will assess the skills and competence of each professional 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.

8.A.7.4. Training Documentation
The CCBHC documents in the staff personnel records indicate that the training and demonstration of competency are successfully completed. Verification of training documentation will take place at CCBHC certification site visits and must be demonstrated via the certification application.

8.A.7.5. Trainer Qualifications
Professionals who are providing staff training must be qualified as evidenced by their education, training, and experience.

8.A.8. Linguistic Competence and Confidentiality of Patient Documentation

8.A.8.1. 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. If the individual is unable to read or understand any of the CCBHC program written materials, every effort must be made to explain them to him or her in a language he or she understands.

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.

8.A.8.2. 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 person served 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. The cost of interpretation/translation services are the responsibility of the CCBHC and must not be billed to the person served.

8.A.8.3. Auxiliary Aids
Auxiliary aids and services are readily available, Americans with Disabilities Act (ADA) compliant, and responsive to the needs of individuals with disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines, large print for low vision/blind individuals).

8.A.8.4. Document Availability
Documents or messages vital to an individual's ability to access CCBHC services (for example, registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available online and paper format for persons served in languages common in the community served, taking account of literacy levels and the need for alternative formats (for individuals with disabilities such as low vision/blindness). Such materials are provided in a timely manner at intake. The requisite languages will be informed by the CCBHC needs assessment prepared prior to certification, and as updated. All materials must be made available in the languages appropriate to the individuals served within the CCBHC catchment area, and written materials must consider literacy limitations and appropriate reading levels.

8.A.8.5. 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 CCBHC recipient's family and friends, so long as the individual consents or does not object. If a person served is amenable and has the capacity to make health care decisions, health care providers may communicate with an individual's family and friends.

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

8.B.1. CCBHC Environment

The CCBHC provides a safe, functional, clean, and welcoming environment, for person served 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 must align with the standards of trauma informed care as specified in PIHP and CMHSP requirements: https://www.michigan.gov/documents/mdhhs/Trauma-Policy_704460_7.pdf

8.B.2. CCBHC Hours

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

8.B.3. CCBHC Location

The CCBHC provides services at locations that ensure accessibility and meet the needs of the population being served. The CCBHC Community needs assessment, along with direct individual feedback in the form of satisfaction surveys, focus groups, or advisory councils, will be reviewed to determine appropriateness of service site locations. The needs assessment must 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.) must 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 must never be limited due to an individual's residency.

Additions of new clinic locations require approval from MDHHS. Per PAMA Section 223, no payment will be made under the demonstration program to satellite facilities of CCBHCs if such facilities were established after April 1, 2014. The definition of a satellite facility under the Section 223 Demonstration Program for CCBHCs can be found at: https://www.samhsa.gov/sites/default/files/section-223-satellite-facility.pdf.

8.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 person served.

8.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 individuals 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.

8.B.6. Outreach and Engagement

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

- Additional attention must 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.
- Informed and included in the community needs assessment, the CCBHC conducts retention activities to support inclusion and access for underserved individuals and populations. This includes individuals and populations who do not have adequate access to resources or care.
- CCBHCs must 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.

8.B.7. Court Ordered Requirements

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

8.B.8. Continuity of Operations

CCBHCs must have in place a continuity of operations/disaster plan. The continuity of operations/disaster plan must align with any requirements to be established for overall CMHSP certification as well as CMS emergency preparedness standards. Staff must be made aware of the disaster plan and be trained on their relative roles and responsibilities in executing the disaster plan at hire/orientation and at intervals specified in the Training Plan in Section 8.A.7.1 in this Handbook.

8.B.9. Requirements for Timely Access to Services and Initial and Comprehensive Evaluation for New Individuals

8.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 three (3) 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 8.B.5 (SAMHSA Criteria 2.a.5)

- If the screening identifies routine needs, services will be initiated within 14 calendar days.
    - Services must include initial assessment/evaluation and can include services in the service array outside of assessment and evaluation.
    - 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 8.B.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 person served should be seen in person at the next subsequent encounter and the initial evaluation reviewed. Same day and open access scheduling is encouraged.

- “New” CCBHC service recipients are recipients who are requesting services from the CCBHC for the very first time or have not received services from the CCBHC during the previous 6 months.

8.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 person served and in consultation with the primary care provider (if any), when changes in the individual'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 (IPOS) developed through a person-centered planning process (Section 712, added 1996). CCBHCs must implement person- centered planning in accordance with the MDHHS Bureau of Specialty Behavioral Health Services Person-Centered Planning Policy, which can be found on the MDHHS website at Policies & Practice Guidelines (michigan.gov).
- To support person centered treatment, the complexity and timeline for which an IPOS is updated will be determined by the needs and desires of the individual.
    - A comprehensive IPOS update must be completed based on individual need or on program parameters set forth within the Medicaid Provider Manual. The comprehensive treatment plan must be updated by the treatment team, in agreement with and endorsed by the CCBHC recipient no less than annually.
- 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 must be updated every 90 days.

8.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 must be followed, and a note must 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 three hours.

- If an established CCBHC recipient identifies an urgent need, clinical services are provided 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 9.B.5.

8.B.10. Access to Crisis Management Services

8.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 (8.B.10), and must include 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

8.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.

8.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).

8.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 persons served in psychiatric crisis who go to affiliated emergency departments.

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

8.B.10.6. Crisis Planning
Following a psychiatric emergency or crisis involving a person receiving CCBHC services, in conjunction with the person served, 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 person receiving services and their family. Individuals who are served by the CCBHC must be educated on how to access crisis services, including the 988 Suicide & Crisis Lifeline, and overdose prevention if risk is indicated. Risk should be assessed during initial evaluation and engagement of services.

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

8.B.11.1. Ability to Pay

The CCBHC must ensure no individuals are denied behavioral health care services, including, but not limited, to crisis management services, because of an individual's ability to pay for such services (PAMA § 223 (a)(2)(B)). CCBHCs using a waitlist for the non-Medicaid population violate SAMHSA's certification criteria and will be issued corrective action immediately to avoid decertification from the CCBHC Demonstration. Any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance above.

The CCBHC will 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 8.B.11.2 regarding Sliding Fee requirements.)

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

CCBHCs must follow requirements outlined in Chapter 8 of Michigan's Mental Health Code – Financial Liability for Behavioral Health Services (R 330.8005, R 330.8239, R 330.8240, R 330.8242, and R 330.8279) to determine ability to pay.

8.B.11.2. Sliding Fee Discount Schedule

8.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.

8.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.

CCBHCs must follow requirements outlined in Chapter 8 of Michigan's Mental Health Code – Financial Liability for Behavioral Health Services (R 330.8005, R 330.8239, R 330.8240, R 330.8242, and R 330.8279).

8.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 persons served and families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals

seeking services who have LEP or disabilities.

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

8.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.

8.B.12.2. Protocols for Individuals out of Area
CCBHCs have protocols addressing the needs of person served 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. The required protocols must address management of the individual's on-going treatment needs beyond that. Protocols may provide for written agreements with clinics in other localities, allowing CCBHCs to refer and track individuals seeking non-crisis services to the CCBHC or other clinic serving the recipient's county of residence. For distant persons served 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 individual be refused services because of place of residence.

8.C. Program Requirement #3: Care Coordination

8.C.1. General Requirements of Care Coordination

8.C.1.1. Care Coordination
CCBHCs 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 individual's needs and preferences (where information exchange is contemplated in the agreement and consented to by the person served).

Care coordination activities include, but are not limited to:

- Organization of all aspects of a person's served 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 person served contact, with an emphasis on in-person contact (although telephonic contact may be used for lower-risk persons served 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 person served to resources (e.g., smoking cessation, SUD treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.)
- Connection of individuals to peer run drop-in centers for Medicaid and non- Medicaid CCBHC individuals regardless of their ability to pay or county of residence.

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

The PIHP and CCBHC must work with Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs) to coordinate services for eligible persons served who wish to receive CCBHC 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 persons served. 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 CC360 and other Health Information Exchange technology will be critical to the success of the CCBHC and the individual's health status.

8.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.

8.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 must 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.

8.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 WSA. 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. Quarterly reconciliation between the CCBHC 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.

8.C.1.6. Coordination with Medicaid Health Homes

CCBHC Medicaid persons served 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 Substance Use Disorder Health Home (SUDHH). 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 person served. The Health Home care team is responsible for providing the 6 required Health Home services and coordinating care with the CCBHC. The person served will be assigned to both benefit plans in the WSA and CHAMPS.

The staffing time for CCBHC and Medicaid Health Home must be distinct. Health Home costs and expenses cannot be included in the CCBHC cost report.

8.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, Sections 330.1748 and 330.1750 of PA 258 of 1974 (Mental Health Code), and other federal and state privacy laws, including patient privacy requirements specific to the care of minors. The HIPAA Privacy Rule and the Mental Health Code, sec. 748 allows routine – and often critical – communications between health care providers and a

CCBHC recipient's family and friends. Health care providers may always listen to an individual's family and friends. If an individual consents and has the capacity to make health care decisions, health care providers may communicate protected health care information to a CCBHC recipient's family and friends. Given this, the CCBHC ensures person served 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 Consent to Share Behavioral Health (MDHHS-5515 form) must be used unless the entity is held to more stringent requirements under federal law. The only entities who are held to more stringent requirements under federal law are entities receiving funding resulting from the Victims of Crime Act, Violence Against Women Act, or Family Violence Prevention and Services Act. 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.

8.C.3. Referral and Follow-Up

Consistent with requirements of privacy, confidentiality, and individual preference and need, the CCBHC assists individuals 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 must have the ability to track successful referral and follow-up rates for performance monitoring and quality improvement activities.

8.C.4. Person Served Preferences

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

8.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 persons served. The state Prescription Drug Monitoring Program, known as the Michigan Automated Prescription System (MAPS), should be consulted before prescribing controlled substances in accordance with Michigan's Opioid Laws.

MAPS can be found following this link: MI Automated Prescription System (MAPS) (michigan.gov). The CCBHC should provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care.

8.C.6. Freedom of Choice

A CCBHC's agreements for care coordination must NOT limit a person's freedom to choose their provider with the CCBHC or its DCOs. CCBHCs must assist persons receiving services and families to access benefits, including Medicaid, and enroll into programs or supports that may be beneficial to the person served.

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

8.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 person served 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 8.E (SAMHSA Criteria 5). Utilization of MDHHS systems such as CC360 and the WSA are encouraged to coordinate care for CCBHC recipients.

8.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.

8.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 8.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 current "Patient List Creation" criterion (45 CFR §170.314(a)(14)) established by the Office of the National Coordinator (ONC) for ONC's Health IT Certification Program. Clinics can check if they meet this requirement by following this link: CHPL Search (healthit.gov).

8.C.7.4. DCOs Privacy/Confidentiality

The CCBHC will work with DCOs to ensure all steps are taken, including obtaining person served 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 must use the MDHHS-5515 Consent form unless the DCO is held to more stringent requirements under federal law. The only entities who are held to

more stringent requirements under federal law are entities receiving funding resulting from the Victims of Crime Act, Violence Against Women Act, or Family Violence Prevention and Services Act.

8.C.7.5. Health Information 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 must include information on how the CCBHC can support electronic health information exchange (HIE) 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 will 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.

8.C.8. Care Coordination Partnerships

8.C.8.1. Health Care Services Coordination

The CCBHC has a partnership establishing care coordination expectations with Federally Qualified Health Centers (FQHCs) (and, as applicable, Rural Health Clinics (RHCs)) to provide health care services, to the extent the services are not provided directly through the CCBHC. For persons served 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. These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal written agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination.

If a partnership cannot be established with a FQHC or RHC within the time frame of the demonstration project, the CCBHC will 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 written contracts with entities with which they coordinate care if they are not established at the beginning of the demonstration project.

8.C.8.1.1. Inpatient Service Coordination

The CCBHC has care coordination partnerships establishing care coordination expectations with programs that can provide inpatient psychiatric treatment, OTP services, medical withdrawal management facilities and ambulatory medical withdrawal management providers for SUD, and residential programs to provide those services for people receiving

CCBHC services, if any exist within the CCBHC service area. If an OTP does not exist within the CCBHCs service area, the CCBHC should refer to their established OTP partner to provide Methadone and coordination of this service, as needed. If an OTP exists in the CCBHC catchment area, a written care coordination agreement is required. The CCBHC can track when persons served 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 will make and document reasonable attempts to contact all people receiving CCBHC services who are discharged from these settings within 24 hours of discharge. For people receiving CCBHC services being discharged from such facilities who are at risk for suicide or overdose, the care coordination protocols between these facilities and the CCBHC must include a requirement to coordinate consent and follow-up services with the person receiving services within 24 hours of discharge and continues until the person is linked to services. The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric, withdrawal management, 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 prevention and safety, and provision for peer services.

CCBHCs are expected to work toward formal written contracts with entities they coordinate care with if they are not established at the beginning of the demonstration project. Written contracts established through the region can be used to meet this requirement, however the CCBHC is responsible for ensuring care coordination expectations are met.

For persons served with private insurance, CCBHCs are expected to coordinate care with the private insurer where possible.

8.C.8.1.2. Inpatient Follow-Up

The CCBHC has a partnership establishing care coordination expectations with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical withdrawal management inpatient facilities and ambulatory withdrawal management providers, in the area served by the CCBHC, to address the needs of CCBHC persons served within 24 hours of discharge from any listed facility above. 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 shorten time lag between assessment and treatment. The partnership is such that the CCBHC can track when their persons served 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 partnership also provides for transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge.

8.C.8.2. Community Services Coordination

The CCBHC must have a written partnership establishing care coordination expectations with a variety of community or regional services, supports, and

providers. Written partnerships must be in place with:

- Schools
- Child Welfare Agencies
- Indian Health Service or other tribal programs
- Juvenile and Adult criminal justice agencies and facilities (including drug, jail, 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, written partnerships should be prioritized in the most critical areas, and the CCBHC should work on increasing the number of partnerships with other organizations throughout the demonstration period.

8.C.8.3. VA Coordination

The CCBHC has a written partnership 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 partnerships with facilities of each type.

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

8.C.8.4. 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.). 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 (ADT) 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, but 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 facilitate warm handoffs and referrals from MiCAL to the PIHPs/CMHSPs in the most efficient and effective manner for the person in need.
    - Sites will complete and submit a MiCAL attestation form to the CRM during the certification process. This form can be found on the MDHHS CCBHC Demonstration website. CCBHCs must communicate any changes to the CCBHC demonstration team.

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

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

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

8.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 person served

and/or family/caregiver, for directing, coordinating, and managing care and services for the individual. The interdisciplinary team must be composed of individuals who work together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of CCBHC persons served, including, as appropriate, traditional approaches to care for individuals 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.

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

8.D.1. General Service Provisions

All CCBHC services must be provided in accordance with Medicaid policies. Information on provider qualifications, supervision expectations, population limitations and other requirements can be found in the Michigan Medicaid Provider Manual.

8.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 8.D.2. – 8.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 must be directly provided by the CCBHC. Use of a DCO may be considered, if needed, to meet capacity supported through the community needs assessment. Whether directly supplied by the CCBHC or DCO, the CCBHC is ultimately clinically and financially responsible for all care provided.

8.D.1.1.1. Place of Service

CCBHCs are not restricted in the locations in which they provide CCBHC services. Discretion should be exercised when meeting persons served outside the four walls of the clinic to maintain confidentiality, safety, accountability, and professionalism.

8.D.1.1.2. 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 written care coordination agreements, as required in 8.C.8. and should facilitate the transition to outpatient care in CCBHCs upon release.

8.D.1.1.3. Services in Schools

CCBHCs can provide CCBHC services to children in a school setting. CCBHCs must enter into a written agreement with the school to provide services at no cost to the school or family. CCBHCs must follow all requirements for CCBHC service delivery, including care coordination and data collection. Services should not duplicate or replace the existing School Services Program (see Medicaid Provider Manual for more information) or other existing school-based initiatives. Care Coordination expectations should be outlined in agreements with the schools to ensure coordinated care and prevent duplication of services. Agreements between the CCBHCs and schools should detail the responsibilities of both parties in a manner that maximizes resources and best meets the needs of the community.

8.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 persons served 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.

8.D.1.3. Member Appeals, Grievances, and Service Authorization Denial 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, persons served will have access to existing standardized appeals, grievance, and service authorization denial procedures, which satisfy at minimum, the requirements of Medicaid and others that may be mandated by appropriate accrediting entities. If a CCBHC is a non-CMHSP entity, the CCBHC must have a clear process in place with the CMHSP in their service area that guides a CCBHC recipient through the appeal, grievance, and service authorization denial procedure process for both Medicaid and non-Medicaid persons served. This process may be a demonstrated in a written agreement or contract between the non-CMHSP CCBHC and local CMHSP authority. CCBHCs will have the agreement executed within 90 days of the start of the demonstration.

- 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 as required by 42 CFR 438.416. At a minimum, the record must contain:
  1. A general description of the reason for the grievance and/or appeal;
  2. The date received;
  3. The date of each review or, if applicable, 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 and must follow all policies and practices put in place by MDHHS.

8.D.1.3.1. 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, local appeal, and service denial systems for non-Medicaid enrollees and must be consulted for the most current and detailed information. The document can be found on the MDHHS website at Community Mental Health Services under CMHSP Contracts. Select the most recent year's GF/CMHSP Contract, then search for the C6.3.2.1 Attachment (CMHSP Local Dispute Resolution Process) within the contract.

8.D.1.3.2. 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 must be consulted for the most current and detailed information and process to follow. The document can be found on the MDHHS website at Policies & Practice Guidelines (michigan.gov).

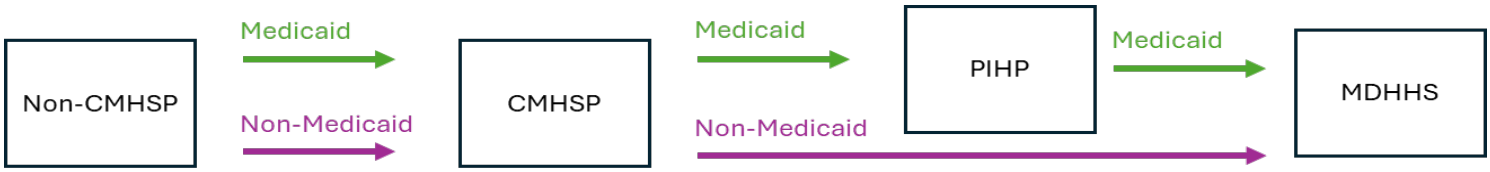
8.D.1.3.3. Reporting Appeals, Grievances, and Service Authorization Denial Procedure

PIHPs are responsible for compiling and submitting all appeals, grievances, and service authorization denials to MDHHS for Medicaid persons served on a quarterly basis. CMHSP CCBHCs will be

responsible for directly submitting any non-Medicaid appeals, grievances, and service authorization denials directly to MDHHS on a quarterly basis.

CCBHCs will use existing appeals and grievance tracking management systems for both Medicaid and non-Medicaid persons served as stated in existing contracts. Medicaid Reports must be submitted to MDHHS by the PIHP 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. Non-Medicaid reports must be submitted to MDHHS by the CMHSP CCBHC by the 15th of the second month following the end of each quarter via the CCBHC mailbox.

CCBHC Grievances and Appeals Reporting Flow Chart



8.D.1.3.4. Grievances and Appeals for MI Health Link Members

Persons served 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 must be adopted and honored by the CCBHC.

8.D.1.3.5. Mediation

Both Medicaid and non-Medicaid CCBHC service recipients have a right to mediation. A recipient or recipient's representative can request mediation at any time when there is a dispute related to service planning or the services, supports provided by a CCBHC or DCO. See Public Act 55 of 2020.

8.D.1.4. Recipient Rights

All CCBHC service recipients have rights that are protected by Michigan's Mental Health Code (Chapters 4, 4A, 7 and 7A). The Mental Health Code

describes the broad set of rights and protections for recipients of public mental health services, as well as the procedures for the investigation and resolution of recipient rights complaints. Service recipients must have access to a statutorily mandated Recipient Rights Office and a Recipient Rights Complaint Process that investigates complaints and provides remedial action as specified in the Mental Health Code (MCL 330.1754 under Public Act 258 of 1974).
MDHHS, CMHSPs, licensed hospitals, and each service provider under contract with MDHHS, a CMHSP, or a licensed hospital must establish written policies and procedures concerning recipient rights and the operation of an office of recipient rights. The policies and procedures shall provide a mechanism for prompt reporting, review, investigation, and resolution of apparent or suspected violations of the guaranteed rights protected by Michigan's Mental Health Code (Chapters 7 and 7A) and shall be designed to protect recipients from, and prevent repetition of, violations of rights guaranteed by Chapters 7 and 7A.

8.D.1.4.1. Requirements for non-CMHSPs
CCBHCs who are not also Community Mental Health Service Providers (CMHSPs) are required to establish a written formal relationship with the CMHSP with jurisdiction over their service area for Recipient Rights complaints. Agreements must be in written form (i.e. a contract) and must ensure that the CMHSP provides or coordinates the protection of recipient rights for all CCBHC service recipients at the CCBHC.

8.D.1.4.2. Designated Collaborating Organizations (DCOs)
CCBHCs are responsible for providing Recipient Rights protection for individuals served at DCOs. CCBHCs that are non-CMHSPs must ensure that individuals receiving services at DCOs are properly informed and made aware of the Recipient Rights office at their local CMHSP. CCBHCs will include recipients served by DCOs in all quality reporting measures, as applicable.

8.D.1.4.3. Record of Alleged Violations
CCBHCs must keep records of all reports of rights violation allegations, outcome information including substantiations and any remedial action taken, and be able to identify if an individual was receiving CCBHC services at the time of the complaint. Non-CMHSPs may keep their own records or work with their partnering CMHSP to identify complaints specific to their CCBHC.

8.D.1.4.4. 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.

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

8.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 persons served needs, preferences, and values, and ensuring both persons served involvement and self-direction of services received. Services for children and youth are family centered, youth-guided, and developmentally appropriate.

8.D.2.2. Cultural Needs

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

8.D.3. Crisis Behavioral Health Services

8.D.3.1. Crisis Behavioral Health Services

The CCBHC will provide robust and timely crisis behavioral health services. General requirements include:

- 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.
- Michigan's "state-sanctioned" crisis system model is under development. CCBHCs must partner with existing crisis providers covering their service area and avoid duplication of crisis services.
- 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. The CCBHC must specify the role of law enforcement during a crisis situation.
- Services provided must include suicide crisis prevention and intervention and services capable of addressing crises related to substance use, intoxication, and overdose, including ambulatory, and withdrawal management and support following a non-fatal overdose.
- The CCBHC or DCOs must offer developmentally appropriate, sensitive de-escalation support and connections to ongoing care.
- CCBHCs or DCOs must specifically focus on the application of trauma-informed approaches during crisis.
- Crisis services are available to individuals of any level of acuity, whether individuals present on their own, with a concerned person, such as a family member, or with a human service worker and/or law enforcement in accordance with state and local laws.
- A crisis situation is defined by the individual or the individual's family.
- CCBHCs are responsible for monitoring services provided by crisis DCOs to ensure they meet the requirements defined below. Expectations must be detailed in written DCO agreements.

- All crisis stabilization services are ideally available 24 hours per day 7 days a week. Stabilization services may also follow psychiatric hospitalization events to prevent readmission. CCBHCs or DCOs must coordinate treatment to higher levels of care when appropriate.
- All crisis services and hours of availability are to be communicated with service recipients, posted publicly on the CCBHC website, and shared widely with the community.
- CCBHCs must ensure that all individuals receiving CCBHC crisis services, either directly or through a state-sanctioned crisis provider acting as a DCO, are provided with information about CCBHC services and offered a follow up appointment at a CCBHC following the resolution of the crisis event.

8.D.3.2. 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. The array of services provided by the CCBHC or through the state-sanctioned crisis provider include.

8.D.3.2.1. Phone/Text Services:

1. 988/MiCAL

   CCBHCs must advertise the 988 crisis line and warmline numbers to provide telephone/chat support to those who do not need face to face intervention.
   - CCBHC's are required to have an agreement with MiCAL, the Michigan 988 Crisis Call Center, that outlines the procedure for tracking and response to referrals and crisis care follow up.
   - Centralized calls to MiCAL can also connect directly to the CCBHC. MiCAL can be used to conduct a warm handoff to the CCBHC.

2. Crisis Phone Line

   CCBHCs will operate a telephone line that is answered 24 hours a day for assessing crisis situations.
   - This phone line must be answered by someone who can immediately dispatch face-to-face crisis services (including telehealth or mobile crisis response). Answering services that require clinicians to be paged and return calls to the answering service are not permitted.
   - This phone number must be made widely available in the community.
   - CCBHCs cannot use answering machines to answer phone calls during or after business hours, automated messages referring callers to the emergency room or an urgent care or use non-clinical staff to answer phone calls if staff do not also have access to a clinician if needed.

8.D.3.2.2. Face to Face Services

1. 24-hour Mobile Crisis Response

   Mobile crisis services represent community-based support where people in crises are, either at home or a location in the community within their service area. Mobile crisis teams must be available 24 hours per day, seven days a week to respond to adults, children, youth, and their families. Mobile crisis services are expected to arrive within one hour (two hours for rural settings) from the time of dispatch, with the overall response time not to exceed three hours. CCBHCs are responsible for tracking response time for each mobile crisis response activity (see metric requirements for I-SERV Supplemental).
   - Telehealth/telemedicine may be used to provide crisis care to individuals when remote travel distances make the 2-hour response time unachievable, but the ability to provide an in-person response must be available when it is necessary to assure safety.
   - Technology may be used to provide crisis care to individuals in the interim during travel time.

   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 must include the following components:
   - Assessment
   - Crisis de-escalation
   - Planning
   - Crisis and safety plan development
   - Brief therapy
   - Referral

   CCBHCs Mobile crisis response for children must 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 must be enrolled with MDHHS, and must meet the requirements for team, response timeliness, etc.

   CCBHCs can propose alternate models of mobile crisis response that meet the needs of their community, particularly in rural settings.

2. Crisis Receiving/Stabilization Services – Behavioral Health Urgent Care (BHUC)

   Crisis receiving/stabilization services must at a minimum include urgent care/walk in mental health and SUD services for voluntary

individuals who have acute needs that cannot wait for routine appointments. Stabilization services must be voluntary and very short term, always providing less than 23 hours of care.

Walk in hours should be determined via the community needs assessment and posted publicly. It is not the expectation that the CCBHC provide care in a crisis receiving/stabilization setting to those who need a higher level of care but should facilitate the transition to a higher level of care when appropriate. No referrals are necessary for urgent care services.

At time of certification, CCBHCs must provide urgent care/walk in services that identify the immediate needs, de-escalate the crisis, and connect an individual to a safe and least-restrictive setting for ongoing care. At the end of the first demonstration year, the CCBHC must implement and meet the following requirements for a BHUC:

Physical Space

BHUCs can operate at a physical location or operate as partially or fully virtual. A BHUC can also be co-located with a Crisis Stabilization Unit (CSU), provided the urgent care services are provided in an unlocked area, or co-located with a physical health urgent care.

If a BHUC operates at a physical location, the BHUC must be housed in an unlocked, outpatient section of the facility. Private assessment rooms and exam rooms should be available, in sufficient numbers to provide services in a timely manner. BHUCs should have a shared waiting room with natural light and trauma informed spaces. If possible, children's waiting rooms must be separate from adults.

Staffing

CCBHCs can share staffing resources between the BHUC and other service programs, if staff is available to meet demand as needed.

BHUC staffing requirements include:

- Nursing staff
- Behavioral Health Clinicians
- Prescriber (may be available virtually)
- Peer Support/Recovery Coaches (optional but encouraged)

Service Delivery

Access/Triage/Assessment

- BHUC mandatory triage will determine if an individual is appropriate for services at an urgent care or needs to be transitioned elsewhere. Triage includes a physical health screen for basic medical needs and should screen out people for whom it is apparent that they have acute physical health needs that require immediate attention or a higher level of care such as psychiatric hospitalization. Preadmission screening for hospitalization can take place at the BHUC.

- Life threatening conditions should be transferred to the emergency department.
- If a higher level of care is determined, the CCBHC should facilitate the transition to the higher level of care.

- Assessment touching all life domains including social determinants focused on the precipitating events for the crisis with a disposition with a level of care determination for immediate stabilization needs and ongoing service needs.
- Psychiatric Assessment as needed.

3. Stabilization Services

Stabilization services should be voluntary and short term. All services should maximize involvement of natural supports and be delivered in a developmentally appropriate, culturally competent manner. Services should include:

- Peer/Recovery coaching.
- Medication management, including injections/medications for psychiatric conditions.
- Crisis counseling.
- Crisis stabilization planning.

4. Facilitated Transitions

- If higher level of care needs are identified, the CCBHC will coordinate the transition including transportation if necessary.
- If another source of care is not identified, CCBHCs must provide a next day appointment at the CCBHC.
- If another source of care is identified, CCBHC provides a warm handoff to the care provider and care coordination to ensure ongoing services are offered.

8.D.3.3. Medical Withdrawal Management Requirements

The revised American Society of Addiction Medicine (ASAM) criteria list five levels of Withdrawal Management for Adults. As part of Handbook Section 8.D.3.1 (SAMHSA Criteria 4.c.1), it is required that CCBHCs 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 individuals, 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 by the CCBHC or through a referral with a care coordination partner. CCBHCs may utilize existing PIHP network providers.
- 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 by the CCBHC or through a referral with a care coordination partner. CCBHCs may utilize existing PIHP network providers.

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

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

The CCBHC must be equipped to provide all 9 core services and may consider the use of a DCO provider to address capacity needs supported and identified in the clinic's community needs assessment. The CCBHC provides screening, assessment, and diagnosis, including risk assessment and behavioral health conditions, 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.

8.D.4.1.1. Evaluation Timeframe

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

8.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 person served or other people who are significantly involved; (4) identification of the persons served immediate clinical care needs related to the diagnosis for mental and SUD disorders; (5) a list of current prescriptions and over-the counter medications, herbal remedies, dietary supplements, and the use of any alcohol and/or other drugs the person receiving services may be taking; (6) an assessment of whether the person served is a risk to self or to others, including suicide risk factors; (7) an assessment of whether the person served 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.

8.D.4.1.3. Specific Substance Use Disorder (SUD) 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/deliver SUD services must utilize the specified assessment tools – the ASAM Continuum Assessment for adults and the GAIN for adolescents. CCBHCs should coordinate with PIHPs to have CCBHC staff enrolled in upcoming training cohorts as available.

8.D.4.1.4. Mental Health Level of Care Determination Requirements
CCBHCs must follow existing Medicaid requirements for determining level of care, including the use of specific assessments for specific populations (Devereux Early Childhood Assessment (DECA), MichiCANS, LOCUS, ASAM, etc.). Level of care assessments must not be used as the sole instrument for determining the need for supports and services, unless otherwise specified in Medicaid policy. More guidance on the use of the newly developed MichiCANS screening tool is outlined below and can be found on the MichiCANS website and CCBHCs must follow the MichiCANs policy effective October 1, 2024.

All CCBHCs are required to use the MichiCANS tools and DECA tools for all CCBHC service recipients under age 21. All tools are required for all service recipients, regardless of insurance type. The MichiCANS tools consists of the MichiCANS Screener and MichiCANS Comprehensive.

The MichiCANS Screener will be the required tool at the point of access for all infants, toddlers, children, youth, and young adults ages birth through 20 (day prior to 21st birthday).

A MichiCANS Comprehensive will be used at the CCBHC's initial evaluation (see criteria 8.B.9.1. for additional requirements) with children, youth, and young adults ages birth through 20, to provide recommendations for levels of care and elevate treatment planning for IPOS goals. The MichiCANS Comprehensive will be completed at intake, annually, and at the time of exit. In addition, providers will update specific targeted domains within the tool when there is a notable change in the child/youth's life and/or the need for treatment plan updates.

MDHHS will also require the use of the DECA at Initial Evaluation and treatment planning, based on the results of the MichiCANS screener, for infants, toddlers, and children ages 1 month through 5 (day prior to 6th birthday) who have (1) an SED or (2) an SED and I/DD.

The following tools must be used for the age groups noted below:

- DECA for Infants 1 month through 18 months
- DECA for Toddlers (DECA-T) 18 through 36 months

- DECA Clinical (DECA-C) 2 years through 5 years

Questions related to the MichiCANS and DECA should be directed to MDHHS-MichiCANS@michigan.gov.

8.D.4.2. Diagnostic and Treatment Planning Evaluations

8.D.4.2.1. General Overview

A comprehensive person-centered and family-centered diagnostic and treatment planning evaluation is completed within 60 days by a licensed behavioral health professional who, in conjunction with the person served, 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.

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

Although a comprehensive diagnostic and treatment planning evaluation is required for all CCBHC persons served, the extent of the evaluation will depend on the individual 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 recipient'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);
4. A diagnostic assessment, including current mental status, mental health (including depression screening) and SUD disorders (including tobacco, alcohol, and other drugs);
5. 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);
6. Basic competency/cognitive impairment screening (including the recipient's ability to understand and participate in their own care);
7. A drug profile including the recipient'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;
8. A description of attitudes and behaviors, including cultural and environmental factors, that may affect the persons served treatment plan;

9. The recipient's strengths, goals, and other factors to be considered in recovery planning;
10. Pregnancy and parenting status;
11. 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);
12. Assessment of the social service needs of the person served, with necessary referrals made to social services and, for pediatric persons served, to child welfare agencies as appropriate; and
13. Depending on whether the CCBHC directly provides primary care screening and monitoring of key health indicators and health risk pursuant to (SAMHSA criteria 4.G), either:
    a. an assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the persons served primary care provider (with appropriate referral and follow-up), or
    b. a basic physical assessment as required by (SAMHSA criteria 4.G). All remaining necessary releases of information are obtained by this point.

8.D.4.3. Screening and Assessment

8.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 will 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.

8.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.

8.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.

8.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 recipient is provided or referred for a full assessment and treatment, if applicable.

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

8.D.5.1. Treatment Planning Services

The CCBHC must be equipped to provide all 9 core services and may consider the use of a DCO provider to meet capacity needs identified and supported in the community needs assessment. 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 8.D.5.2. below and is aligned with the requirements of Section 2402(a) of the Affordable Care Act, including person served involvement and self-direction.

8.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 person served, the individual's family to the extent the person served so wishes, or family/caregivers of youth and children, and is coordinated with staff or programs necessary to carry out the plan. See Person Centered Planning Policy for additional guidance.

8.D.5.2.1. Assessments inform Plan
The CCBHC uses person served assessments to inform the treatment plan and services provided.

8.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 recipient's words or ideas and, when appropriate, those of the recipient's family/caregiver.

8.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.

8.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).

8.D.5.2.5. Advanced Wishes
The treatment plan documents the person served advance wishes related to treatment and crisis management and, if the person served does not wish to share their preferences, that decision is documented.

8.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. Documentation of the treatment plan must be individualized based on the outcome of the person-centered planning process.

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

8.D.6.1. Outpatient Services

The CCBHC must provide outpatient mental health and SUD services directly but may consider the use of a written DCO agreement to meet capacity needs supported and identified in the clinic's community needs assessment. Services must be evidence-based or best practice and consistent with needs identified within the treatment plan. When the assessment and/or treatment plan indicates the need for a specialized service that is outside the expertise of the CCBHC (e.g., eating disorders, specialized medications for SUDs) the CCBHC will coordinate appropriate services through a DCO or referral. CCBHCs are not required to refer recipients to the PIHP for screening or referral of services unless an assessment and/or treatment plan indicates the need for a level of care or service that is outside the expertise or licensure of the CCBHC or DCO. Telehealth/telemedicine services may be utilized when necessary and appropriate.

8.D.6.2. CCBHCs and SUD Services

CCBHCs must provide outpatient SUD services, including SUD primary services and Integrated Dual Diagnosis Treatment. Appropriate services must be offered to anyone diagnosed with a SUD. Services must be delivered by the CCBHC or a DCO. PIHPs cannot prohibit a CCBHC from delivering required SUD services and must panel a CCBHC or assist the CCBHC in securing a written a DCO agreement with a paneled SUD provider.

SUD treatment and services must be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 and include treatment of tobacco use disorders. When recipients are engaged in high-risk substance use, CCBHCs are encouraged to utilize harm reduction strategies to promote safety and/or reduce use.

8.D.6.3. 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 professional staff with appropriate training and credentials and establish a process for monitoring model fidelity with Michigan Fidelity Assistance Support Team (MIFAST) visits. It is the CCBHC's responsibility to ensure that MIFAST visits and certifications are current.

MDHHS is committed to supporting the ongoing expansion of evidence-based practices via staff training and fidelity monitoring. The Community Based Practices & Innovation (CPI) Section is located in the of Division of Adult Home and Community-Based Services 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.

MIFAST visits are required to be scheduled within three months for the first available appointment following the approval and implementation of Assertive Community Treatment (ACT), Dialectical Behavior Therapy (DBT), and Integrated Dual Disorder Treatment (IDDT). MIFAST visits are required

for ACT, DBT, and IDDT to ensure fidelity is met for intensity and required components. MIFAST teams are available for previously listed required CCBHC EBP's for the adult population. MIFAST team visits are prioritized and scheduled as capacity is available. Questions about MIFAST visits can be directed to MDHHS-MIFAST@michigan.gov.

EBPs for children, youth, and families are overseen by the Bureau of Children's Coordinated Health Policy & Supports who offer ongoing training for TF-CBT, PMTO/PTC, and MI for children and adolescents.

For statewide consistently the CCBHCs must use one of the following tools listed below when providing SBIRT services.

Alcohol Use
NIDA Single Question Alcohol Screen
NIAAA Youth Alcohol Screen
AUDIT-C
AUDIT
USAUDIT

Illicit and Prescription Drug Misuse
NIDA Single Question Drug Screen
DAST-10
ASSIST
ASSIST-FC
Single Question on Drug Use

Additional Screening Tools
S2BI
BSTAD
CRAFFT
GAIN-SS

8.D.6.3.1. 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

8.D.6.3.2. 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 to addressing older adult population (such as Wellness Initiative for Senior Education or Wellness Recovery Action Plan)
- 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) Please contact MDHHS-CPI-Section@michigan.gov for criteria and steps to be recognized as providing fidelity-measured Individual Placement and Support model services.

8.D.6.4. Treatment Appropriate for Phase of Life

Treatments are provided that are appropriate for the recipient'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'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.

8.D.6.5. 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.

8.D.6.6. Treatment Appropriate for Level of Care

In alignment with the person-centered treatment planning process and policy, CCBHC service packages must align with the needs and desires of the person served and based on medical necessity. Treatment plan development and documentation of treatment plan reviews may be demonstrated within service documentation for an individual receiving only prescription and medication management services through the CCBHC, with assurances that they are assessed for and still have access to the full array of CCBHC services, including primary care screening and monitoring and support addressing social determinants of health. Ongoing reassessment of individual need and development of an individualized treatment plan must be completed by a qualified member of the treatment team to ensure the individual has ongoing access to the full array of CCBHC services and

supports.

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

The CCBHC must be equipped to provide all 9 core services and may consider the use of a DCO providers to address capacity needs supported and identified in the clinic's community needs assessment. The CCBHC is responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk. Whether directly provided by the CCBHC or through a DCO, the CCBHC is responsible for ensuring these services are received in a timely fashion. Required primary care screening and monitoring of key health indicators and health risk provided by the CCBHC include those for which the CCBHC will be accountable pursuant to Program Requirement #5: Quality and Other Reporting and the metrics listed in Section 8.E of this handbook. The CCBHC must not take non-inclusion of a specific metric Section 8.E 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 prevents a CCBHC from providing other primary care services. The Medical Director establishes protocols that conform to screening recommendations with scores of A and B, of the United States Preventive Services Task Force Recommendations (these recommendations specify for which populations screening is appropriate) for the following conditions:

- HIV and viral hepatitis
- Primary care screening pursuant to CCBHC Program Requirement #5 Quality and Other Reporting
- The Medical Director can select a Social Determinants of Health (SDOH) screening tool from the four (4) recommended tools below:
    - Accountable Health Communities Health Related Social Needs Screening Tool,
    - The Protocol for Responding to and Assessing Patients' Risks and Experiences Tool,
    - WellRx Questionnaire, or
    - American Academy of Family Physicians Screening Tool

8.D.8. Targeted Case Management Services

The CCBHC must be equipped to provide all 9 core services directly and may consider the use of a DCO provider to address capacity needs supported or identified in the clinic's community needs assessment. 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 must include supports for persons deemed at high risk of suicide or overdose, particularly during times of transitions such as from an

Emergency Department or psychiatric hospitalization. CCBHC targeted case management must also be accessible during other critical periods, such as homelessness or transitions to the community from jails or prisons.

8.D.9. Psychiatric Rehabilitation Services

The CCBHC must be equipped to provide all 9 core services and may consider the use of a DCO provider to address capacity needs supported or identified in the clinic's community needs assessment. The CCBHC is responsible for evidence-based and other psychiatric rehabilitation services for both mental health and substance use disorders. Services must include supported employment programs designed to provide those receiving services with on-going support to obtain and maintain competitive, integrated employment (e.g., evidence-based supported employment, customized employment programs, or employment supports run in coordination with Vocational Rehabilitation or Career One-Stop services). Other psychiatric rehabilitation services that might be considered include:

- Medication education;
- Self-management; training in personal care skills; dietary and wellness education
- Individual and family/caregiver psychoeducation;
- Community integration services;
- Recovery support services including Illness Management & Recovery;
- Find and maintain stable housing.

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

The CCBHC must be equipped to provide all 9 core services directly and may consider the use of a DCO provider to address capacity needs supported or identified in the clinic's community needs assessment. The CCBHC is responsible for peer specialists and recovery coaches, peer counseling, and family/caregiver supports. CCBHCs are required to offer, either directly or through DCOs, peer services 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.

To ensure peer services and level of care needs align with state and federal requirements, peer staff must be fully trained and/or certified according to their role. Training and Certification requirements can be found beginning in Section 3.21 – Peer-Delivered or Operated Support Services in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of the Medicaid Provider Manual, as well as the MDHHS Peer Recovery Information website at: Peer Recovery Information and the MDHHS Parent Support Partner/Youth Peer Support Partner website at: Children, Youth and Families.

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

The CCBHC must be equipped to provide all 9 core services directly and may consider the use of a DCO provider to address capacity needs supported or identified in the clinic's community needs assessment. 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.

8.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.

8.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.

8.D.11.1.2. Serving Veterans

If the individual is not enrolled in the VHA, the CCBHC should assist in the application process for VHA services. The CCBHC will continue to provide CCBHC services throughout the duration of the application process even prior to application approval. 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.

8.D.11.2. Integrating Care for Veterans

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

8.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.

8.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.

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

All veteran 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 must have 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 must receive cultural competency training, including Implicit/Unconscious Bias. Military and Veteran Culture and Care training must be completed at hire/orientation and at intervals specified in the Training Plan in Section 8.A.7.1 in this Handbook.

8.D.11.6. Treatment Plan for Veterans

In keeping with the general criteria governing CCBHCs, there must be 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.

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

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

8.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) person served 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) person served outcomes.

8.E.1.2. Annual Data Reporting
Reporting is annual and data is required to be reported for all CCBHC persons served, or where data constraints exist (for example, the measure is calculated from claims), for all Medicaid enrollees in the CCBHCs. (See Appendix H for all data reporting requirements.)

8.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.

8.E.1.4. State Encounter Reporting
MDHHS will provide federal demonstration evaluators with CCBHC-level Medicaid claims or encounter data annually.

8.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 five months after the end of each demonstration year (February 28) 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 March 7, 2024, will be used through the remainder of the demonstration.

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

8.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. The CQI plan includes an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and address how the CCBHC will use disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health disparities. One or more professional staff are designated as responsible for operating the CQI program.

8.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 recipient suicide deaths or suicide attempts; (2) fatal and non-fatal overdoses; (3) all-cause mortality among people receiving CCBHC services; (4) CCBHC persons served 30 day hospital readmissions for psychiatric or substance use reasons; and (5) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.

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

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

8.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.).

8.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 American Indian/Alaskan Native (AI/AN) persons and to inform the provision of services to those individuals. To the extent the CCBHC and such entities jointly provide services, the CCBHC and those collaborating entities must satisfy the requirements of these criteria.

8.F.1.3. Independent Audit

An independent financial audit is performed annually to meet initial certification requirements and for the duration of the demonstration in accordance with federal audit requirements, complying with Generally Accepted Auditing Standards (GAAS). If indicated, a corrective action plan is submitted addressing all findings, questioned costs, reportable conditions, and material weakness cited in the Audit Report. CCBHCs are required to comply with financial and auditing laws and regulations that include but are not limited to: The Michigan Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (2 CFR 200), the Michigan Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).

8.F.2. Governance

8.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 persons served with mental illness, adults recovering from SUDs, and family members of CCBHC persons served, either through 51 percent of the board being families, persons served, and/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 persons served, people in recovery and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services.

8.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.

8.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 persons served, persons in recovery, and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services.

8.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 persons served, families, and communities. Efforts to ensure responsiveness will focus on the full range of individuals, 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 persons served and families. Each organization will make available the results of their efforts in terms of outcomes and resulting changes.

8.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.

8.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.

8.F.3. Accreditation

8.F.3.1. Accreditation and Licensing

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

8.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 will be granted, nor does it guarantee CCBHC certification.

Appendix A: CCBHC Demonstration Service Encounter Codes

CMS issued a dedicated 223 CCBHC Demonstration encounter billing code, T1040. CCBHC services will be identified usingT1040 code in conjunction with at least one of the CCBHC service encounter codes cited in the tables below. The table below is Michigan's Scope of Services and Activities list which identifies the services that trigger the PPS rate along with how they align with the each of the nine required CCBHC services. The requirements for each service category below can be found in Section 8 of this handbook (MI CCBHC Certification Criteria – Program Requirements). Individual services must be provided in accordance with the most recent Behavioral Health Code Chart and Provider Qualifications document, available at Reporting Requirements (michigan.gov).

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. To be counted as an eligible CCBHC Demonstration service, CCBHC Mild-to-Moderate encounters must be submitted with the TF modifier, T1040 code, and one of the proceeding service encounter codes. Encounters must be submitted for all services, regardless of Medicaid benefits (see Section 5.C.1). 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 Reporting Requirements (michigan.gov). CCBHC services utilizing modifiers should follow code sets and guidance cited on the BPHASA Mental Health & Substance Use Disorder Reporting Requirements website at Reporting Requirements (michigan.gov) 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.

Note: HSW overlapping services are identified °
Code included in multiple service categories *
Code covers outpatient day camp respite only and excludes overnight room and board costs ^

CCBHC Encounter Identifier

Code	Description
T1040	Certified community behavioral health clinic services, per diem
TF	Certified community behavioral health clinic Mild-to-Moderate modifier

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
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

Code	Description
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
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
T1007	Alcohol and/or substance abuse services, treatment plan development or modification

Service Category: Outpatient Mental Health and Substance Use Services

Code	Description
90832	Psychotherapy, 30 minutes

Code	Description
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)
96372	Medication Administration, therapeutic, prophylactic, or diagnostic injection (specify substance or drug), subcutaneous or intramuscular
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
99506	Medication Administration, home visit for intramuscular injections
H0004	Behavioral health counseling and therapy, per 15 minutes (SUD)
H0005	Alcohol and/or drug services; group counseling by a clinician
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
H0022	Alcohol and/or drug intervention service (planned facilitation)
H0025v	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0033	Oral medication administration, direct observation (Use for Buprenorphine or Suboxone **administration** and/or service – provision of the drug), per encounter.
H0034	Medication training and support, per 15 minutes

Code	Description
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0039 *	Assertive community treatment, face-to-face, per 15 minutes
H0050	Alcohol and/or drug services, brief intervention, per 15 minutes
H2035	Alcohol and/or drug treatment program, per hour
H2036	Alcohol and/or drug treatment program, per diem
H2010	Comprehensive medication services, per 15 minutes
H2019	Therapeutic behavioral services, per 15 minutes (DBT)
H2021	Community-based wrap-around services, per 15 minutes
J2315	Injection, naltrexone, depot form, 1mg, per encounter
T1027	Family training and counseling for child development, per 15 minutes
Q9991	Injection, buprenorphine extended release (Sublocade), less than or equal to 100 mg, per encounter
Q9992	Injection, buprenorphine extended release (Sublocade), greater than 100 mg, per encounter

Service Category: Outpatient Clinic Primary Care Screening and Monitoring

Code	Description
T1001 *	Nursing assessments, per encounter
T1002 *	RN services, up to 15 minutes

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
H2025 °	Job coaching, ongoing support to maintain employment, per 15 minutes
H2030	Mental health clubhouse services, per 15 minutes
H0039 *	Assertive community treatment, face-to-face, per 15 minutes
T2038	Housing assistance, community transition, per service

Service Category: Recovery Coach/Peer/Family Support

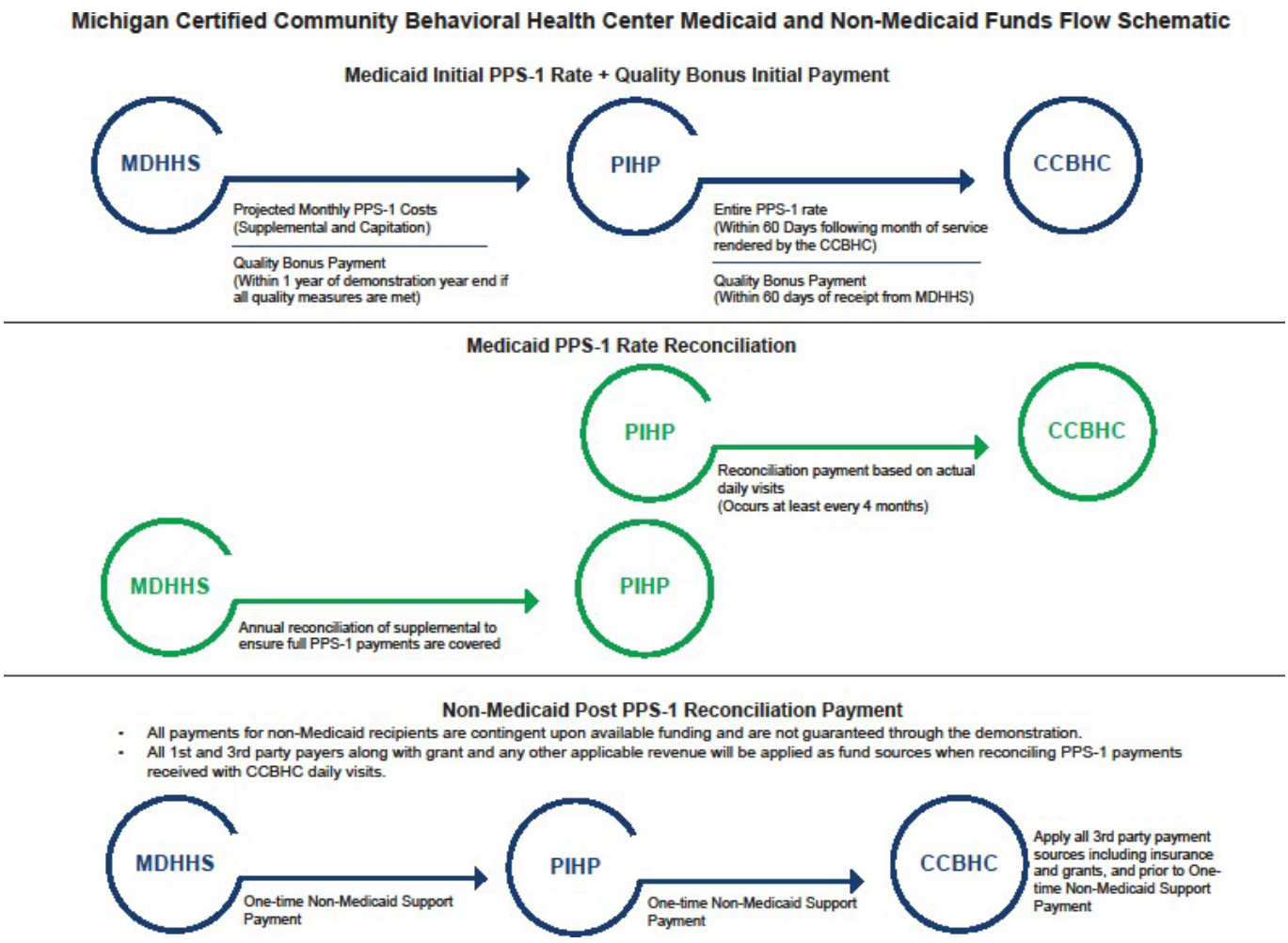
Code	Description
H0038	Self-help/peer services, per 15 minutes
H0045 °^	Respite care services, not in the home, per diem
H2014 °	Skills training and development, per 15 minutes
H2027	Psychoeducational service, per 15 minutes
S5110	Home care training, family; per 15 minutes
S5111 °	Home care training, family; per session

Code	Description
T1005 °	Respite care services, up to 15 minutes
T1012	Alcohol and/or substance abuse services, skills development

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

- Any individual with a mental health and/or SUD 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 SUD, including all codes in the following ranges:
        - F10-F19: Mental and behavioral disorders due to psychoactive substance use

Appendix C: MI CCBHC Funds Flow Schematic



Appendix D: Encounter Reporting Example

In this example, an individual received two eligible CCBHC services – H0031 and 99202 – 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 99202 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

Loop	Claim	Notes
2400:	**Line 3** SV1∗HC:99201∗20∗UN∗1∗11∗∗1:2:3∗∗N~	Line Item Charge Amount SV102
2430:	SVD∗11122333∗10∗HC:99202∗∗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 loop 2420 Service Facility Location (service line level)

2420C Loop – SERVICE FACILITY LOCATION NAME – Service Line 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

Appendix E: Metric Guidance

CCBHC Clinic-Reported Measures

CMS has defined reporting requirements and guidance for the CCBHC Demonstration. CCBHCs are responsible for the collection and reporting of 9 measures as described below.

Eligible Population for Measurement:
Per CMS guidance, the eligible population for these measures includes all CCBHC recipients served by a CCBHC provider. 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. Broadly, CCBHC recipients have received an eligible CCBHC service with a corresponding T1040. See Section 7.A.5. for more information.

EHR reporting modules will set the population for measure calculation based upon assignment to CCBHC "programs" or "insurance types". It is the responsibility of the CCBHC to ensure that all eligible CCBHC service recipients are appropriately assigned and included in the calculation. This should include both Medicaid and non-Medicaid participants. CCBHCs may wish to cross-reference T1040 encounter reporting and WSA clinic assignment to correctly assign as many CCBHC service recipients as possible.

CCBHC QBP Benchmarks and Targets
State-calculated measures use the T1040 attribution methodology described above. Quality Bonus Payment (QBP) benchmarks are derived from data reported by Michigan CCBHC demonstration sites in DY1 and DY2 and must be met to receiving a QBP award (See Section 5.D.1: QBP Measures, Measure Stewards, and Benchmarks.)

MDHHS will share demonstration targets for non-QBP measures as data from previous demonstration years is collected, reported, and averaged throughout the demonstration. These targets can provide a point of reference for performance and guide CCBHCs as they set goals.

Stratification by Payer Type
To the extent possible, CCBHCs should report on the entire recipient population (every insurer) for each CCBHC-reported measure. Rates should be provided for the following mutually exclusive categories:

- Individuals who are Medicaid only
- Individuals who are dually eligible for Medicare and Medicaid
- All remaining individuals ("Other"), including uninsured, commercially insured, and those with Medicaid coverage that does NOT cover CCBHC services (for example, Medicaid for family planning services only).

CCBHC Template
CCBHCs should complete the MI CCBHC Data Demonstration Templates (FY25) (xlsx file) for each clinic-reported measure. Section E of each template provides cells that indicate whether different types of individuals are in the denominator (e.g., Medicaid, Title XIX-eligible CHIP population, commercially insured). That is to help the national evaluators understand the population makeup in the denominator; there does not need to be some of each insurance type. In Section E of each template, note any deviation from the technical specifications related to the calculation of the

measure or population included in the denominator. That information is to be provided overall, for ethnicity and race, and for each payer type (Medicaid, Dual, Other).

1. Time to Services (I-SERV)

Name: I-SERV	**Steward:** SAMHSA	******Quality Bonus Payment Metric***

Description/Sub-Measures		**QBP Benchmark**
1.A	Average Number of Days until Initial Evaluation for New Clients	Rate is less than or equal to the 75th percentile of all CCBHC demonstration site performance rates at year end.
1.B	Average Number of Days until Initial Clinical Service for New Clients	
1.C	Average Number of Hours until Provision of Crisis Services following a first Crisis Episode Contact.	
1.c.1	Average Number of Hours until Provision of Crisis Services following a mobile Crisis Episode Contact.	(NA)
1.c.2	Average Number of Hours until Provision of Crisis Services following an Urgent Care Crisis Episode Contact.	(NA)
1.c.3	Average Number of Hours until Provision of Crisis Services following any other Crisis Episode Contacts	(NA)

Stratification

- Age: Child (0-11 years), adolescent (12-17 years of age), adult (18 years of age and older)
- Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid)
- Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown
- Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, more than one race, or Unknown

Additional Guidance:

- To align with other Michigan Reporting requirements, CCBHCs should deviate from the specifications as written and use calendar days to calculate the I-SERV measures.
- Reporting for children age 0-11 is a Michigan requirement, not a demonstration requirement. Although CCHBCs are required to report I-SERV measures for the 0-11 population, only rates for age 12+ will be included in federal reporting and quality bonus payment calculations.
- For I-SERV 1.A and I-SERV 1.B, The clock should start at first contact. First contact is defined in the I-SERV specifications as: the first time that an individual and/or guardian contacts a CCBHC to obtain services for the individual in a six-month period. First contact may be by telephone and should include the required preliminary screening and risk assessment questions and collection of basic data, including insurance information. Contact must be between a prospective client and/or guardian and the CCBHC.
- CCBHCs must report the number Exclusions on the I-SERV (MI Supplemental) tab of the metric reporting template, including:
    - Number of Eligible New Clients presenting with routine needs that did not receive an Initial Evaluation.
    - Number of Eligible New Clients presenting with emergency needs that did not receive Crisis Services.
- Evaluation and Crisis Services include those provided by either a CCBHC or DCO. In service areas where CCBHCs have a DCO agreement with a state sanctioned crisis provider, CCBHCs should account for the state sanctioned crisis services provided to persons served at CCBHCs. DCO agreements should clearly outline data sharing expectations necessary to calculate this measure. This does not apply if the state sanctioned crisis DCO is also a CCBHC, as that CCBHC will be reporting I-SERV data for all crisis service provision.
- The I-SERV quarterly reporting should be on a rolling basis, representing the year to date excluding

Name: I-SERV	**Steward:** SAMHSA	******Quality Bonus Payment Metric***

the most recent month:

Quarter	Months Included	30 day F/U Window
FY25- Q2	January, February	March
FY25- Q3	January – May	June
FY25- Q4	January – August	September
FY26-Q1	January – November	December

- Reference Technical Specifications: Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual Disclaimers | SAMHSA

2. Depression Remission at 6 months (DEP-REM-6)

Name: DEP-REM-6	**Steward:** MN Community Measurement	*****Quality Bonus Payment Metric**

Description/Sub-Measures	**QBP Benchmark**
2. Percentage of clients (12 years of age or older) with Major Depression or Dysthymia who reach Remission Six Months (+/- 60 days) after an Index Event Date.	Rate is greater than or equal to the 25th percentile of the CCBHC demonstration site average at year end.

Stratification

- Age: Adolescent (12-17 years of age), adult (18 years of age and older)
- Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid)
- Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown
- Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, more than one race, or Unknown

Additional Guidance:

- DEP-REM-6 is an adaptation of DEP-REM-12, which has been discontinued for FY25. The Measure Assessment period for each client remains at 14 months (12 months +/- 60 days) to accommodate both 6- and 12-month measures. The 12- month measure is not required.
- Although the tool has not been validated, the PHQ-9M is a modification of the PHQ-9 that is widely used. The APA recommends using the PHQ-9M for adolescents ages 11 to 17 to assess symptom severity.
- The most recent PHQ-9 or PHQ-9M score less than five obtained during this four-month period is deemed as remission at six months, values obtained prior to or after this period are not counted as numerator compliant (remission).
- Reference Technical Specifications: Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual Disclaimers | SAMHSA

3. Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)

Name: ASC	**Steward:** NCQA

Description/Sub-Measures	
3.A	Percentage of clients aged 18 years and older who were screened for unhealthy alcohol use using a Systematic Screening Method at least once within the last 12 months

3.B	Percentage of clients aged 18 years and older who were identified as unhealthy alcohol users (in sub measure 3A) who received Brief Counseling

Stratification

- Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid)
- Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown
- Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown

Additional Guidance:

- For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include:
- AUDIT Screening Instrument (score ≥ 8)
- AUDIT-C Screening Instrument (score ≥4 for men; score ≥3 for women)
- Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response ≥2)
- Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5–15 minutes, which may include feedback on alcohol use and harms, identification of high-risk situations for drinking and coping strategies, increased motivation, and the development of a personal plan to reduce drinking.
- Reference Technical Specifications: Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual Disclaimers | SAMHSA

4. Screening for Social Drivers of Health (SDOH)

Name: SDOH	**Steward:** CMS

Description/Sub-Measures

4.	Percentage of clients (18 years of age or older) screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

Stratification

- Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid)
- Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown
- Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown

Name: SDOH	**Steward:** CMS

Additional Guidance:

- Although this measure is currently limited to adults for reporting, CCBHCs are encouraged to use a validated SDOH screening tool for children as well.
- CCBHCs must use a standardized screening tool. Information collected as part of other screening and assessment do not meet this requirement, however CCBHCs should work to align questions to maximize efficiency and reduce burden on persons served.
- CCBHCs can screen for SDOH more frequently than once a year.
- Sites have the option to select a SDOH screener from the SAMHSA approved screeners:
    - PRAPARE
    - Well Rx
    - Accountable Health Communities
    - AAFP Social Needs Screening Tool
- Sites should use additional tools to assist the provider in asking the questions to the client. Sites still should be submitting Z codes associated with the SDOH items discussed from the screener. The state will review SDOH Z codes bi-annually and identify regional needs based on information submitted from each site.
- CCBHCs are expected to follow up on social needs identified
- Reference Technical Specifications: Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual Disclaimers | SAMHSA

5. Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)
6. Screening for Depression and Follow-Up Plan: Age 12 to 17 (CDF-CH)

Name: CDF-AD / CDF- CH	**Steward:** NCQA

Description/Sub-Measures

5. Percentage of clients aged 18+ screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow- up plan is documented on the date of the positive screen.
6. Percentage of clients aged 12-17 for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow- up plan is documented on the date of the positive screen.

Stratification

- Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid)
- Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown
- Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown

Additional Guidance:

- This measure requires administration of a standardized instrument at each encounter if a diagnosis does not already exist. Screening instruments can be brief and can be administered at any point within 14 days prior to the encounter.
    - For example: if a client who is not diagnosed with depression or bipolar disorder is screened on Day 1, is seen by a provider on Day 1, and the screening is negative for depression on Day 1, subsequent visits for the next 14 days do not trigger a screening requirement. However, a visit on Day 15 would require a screening. See technical specifications for more examples.
- The depression screening tool must have been appropriately normalized and validated for the population in which it is being utilized, and the name of the tool must be documented in the medical record.

Name: CDF-AD / CDF- CH	**Steward:** NCQA
• Reference Technical Specifications: Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual Disclaimers | SAMHSA	

7. Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)

Name: TSC	**Steward:** NCQA
Description/Sub-Measures	
7.A Percentage of clients aged 18 years and older who were screened for Tobacco Use one or more times within the Measurement Year	
7.B Percentage of clients aged 18 years and older who were identified as a tobacco user during the Measurement Year in sub-measure 1 and who received a Tobacco Cessation Intervention during the Measurement Year or in the six months prior to the Measurement Year	
Stratification • Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) • Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown • Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown	
Additional Guidance: • The tobacco use measure includes "any type of tobacco," including e-cigarette use. • Type of screening for tobacco use is not specified. ~~The tobacco use measure includes "any type of tobacco," including e-cigarette use.~~ ~~• Type of screening for tobacco use is not specified.~~ • Tobacco cessation interventions can include brief counseling (3 minutes or less) and/or pharmacotherapy. Referrals to outside interventions cannot replace a brief intervention by the CCBHC. Other concepts such as written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies do not qualify for the numerator. Counseling also may be of longer duration or be performed more frequently, as evidence shows that higher-intensity interventions are associated with higher tobacco cessation rates. • Reference Technical Specifications: Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual Disclaimers | SAMHSA	

8. Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)
9. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)

Name: SRA-A/ SRA-BH-C	**Steward: Mathematica**	******Quality Bonus Payment Metric***
Description/Sub-Measures		**QBP Benchmark**
8. Percentage of recipients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.		73%
9. The percentage of recipient visits for those recipients aged 6 through 17 years with a diagnosis of Major Depressive Disorder (MDD) with an assessment for suicide risk.		57%

Name: SRA-A/ SRA-BH-C	**Steward: Mathematica**	******Quality Bonus Payment Metric***
Stratification • Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) • Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown • Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown		
Additional Guidance: • For adults, a suicide risk assessment should be completed at every visit during which a new diagnosis of Major Depressive Disorder, single or recurrent episode, was identified during the measurement period. • For children, a suicide risk assessment should be completed at every visit within an episode of treatment for Major Depressive Disorder. • The assessment can include: o Specific inquiry about suicidal thoughts, intent, plans, means, and behaviors o Identification of specific psychiatric symptoms (e.g., psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas o Assessment of past and, particularly, recent suicidal behavior • The Columbia-Suicide Severity Rating Scale is a recommended tool but is not required. • The diagnosis of depression and the assessment for suicide risk do not have to be performed by the same provider or clinician. Suicide risk assessments can be completed via telehealth. • Reference Technical Specifications: Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual Disclaimers | SAMHSA		

10. Patient Experience of Care Survey (PEC)

Name: PEC	**Steward:** SAMHSA
Description/Sub-Measures	
10. Annual completion and submission of Mental Health Statistics Improvement Program (MHSIP) Adult Recipient Experience of Care Survey, identifying results separately for BHCs and comparison clinics and oversampling those clinics.	
Additional Guidance: • The MHSIP survey should be the basis of the survey distributed. • Clinics should oversample, with a goal of distribution 300 surveys to adults. • CCBHCs with non-CCBHC populations must be able to identify CCBHC service recipients. • Respondents must have had a CCBHC service during the demonstration year. • If a clinic wishes to use an adaptation of the MHSIP, the clinic must request approval from MDHHS and ensure the questions can be translated into the survey domains of the MHSIP surveys. • URS Tables 9, 11, and 11a must be completed in addition to the PEC tab in the template. The tables should be completed according to the appropriate year's SAMHSA Uniform System FY Table Reporting Instructions available on the SAMHSA Uniform Reporting System (URS) website.	

11. Youth/Family Experience of Care Survey (Y/FEC)

Name: Y/FEC	**Steward:** SAMHSA
Description/Sub-Measures	
11. Annual completion and submission of the Youth Services Survey for Families (YSS-F), identifying results separately for BHCs and comparison clinics and oversampling those clinics.	
Additional Guidance:	

Name: Y/FEC	**Steward:** SAMHSA
• The YSS-F survey should be the basis of the survey distributed. • Clinics should oversample, with a goal of distributing 300 surveys to youth/parents or guardians. • Respondents must have had a CCBHC service during the demonstration year. • If a clinic wishes to use an adaptation of the YSS-F, the clinic must request approval from MDHHS and ensure the questions can be translated into the survey domains of the YSS-F surveys. • URS Tables 9, 11, and 11a must be completed in addition to the Y/FEC tab in the template. The tables should be completed according to the appropriate year's SAMHSA Uniform System FY Table Reporting Instructions available on the SAMHSA Uniform Reporting System (URS) website.	

CCBHC State-Reported

States participating in the CCBHC demonstration are responsible for the collection and reporting of 15 additional measures as described below. States use administrative encounter data from Medicaid populations to calculate the measures.

CCBHC Population Definition

The CCBHC population is defined as Medicaid persons served who had a CCBHC service. CCBHC service is defined as an encounter with procedure code T1040. Rejected encounters are excluded. The Medicaid person served ID must be in the encounter submitted.

Continuous enrollment measure requirements are met based on Medicaid continuous enrollment rather than CCBHC continuous enrollment.

CCBHC Attribution

All CCBHC service recipients will be attributed to a single CCBHC for state-reported metric reporting Individuals are attributed to the CCBHC with the highest share of service delivery (i.e. submitted the highest number of T1040s for an individual). In the event that more than one CCBHC submitted the same number of T1040 service codes, the individual is attributed to clinic that provided the most recent service. ~~The population for Housing Status (HOU) includes all individuals receiving CCBHC services.~~

CCBHC QBP Benchmarks and Targets

State-calculated measures use the T1040 attribution methodology described above. Quality Bonus Payment (QBP) benchmarks are derived from data reported by Michigan CCBHC demonstration sites in DY1 and DY2 and must be met to receiving a QBP award (See Section 5.D.1: QBP Measures, Measure Stewards, and Benchmarks.)

MDHHS will share demonstration targets for non-QBP measures as data from previous demonstration years is collected, reported, and averaged throughout the demonstration. These targets can provide a point of reference for performance and guide CCBHCs as they set goals.

Specifications and Measurement Years

Measurement stewards for state-calculated measures update their specifications on a regular basis, most commonly once a year.

Measurement Year End	CMS Specification	HEDIS Specification
12/31/2026	FFY2027	HEDIS MY2026
12/31/2025	FFY2026	HEDIS MY2025
9/30/2024	FFY2024	HEDIS MY2023

CMS Core Set manual, specifications, and value set directories:
Adult Core Set Reporting Resources | Medicaid
Child Core Set Reporting Resources | Medicaid

12. Follow-up Care for Children Prescribed ADHD Medication (ADD-CH)

Name: ADD-CH	**Steward:** NCQA
Description/Sub-Measures	
12.A	Initiation Phase: Percentage of children ages 6 to 12 as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication who had one follow- up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
12.B	Continuation and Maintenance (C&M) Phase: Percentage of children 6 to 12 years old as of the IPSD with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation
Stratification • Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) • Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown • Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown	
Additional Guidance: • Age to include recipients aged 6 years as of 10 months before the measurement year begins to age 12 as of 2 months after the measurement year begins Technical specifications must be used to obtain both the numerator and the denominator. CMS Core Set Measures specifications can be found at: Child Core Set Reporting Resources | Medicaid	

13. Antidepressant Medication Management (AMM-AD)

Name: AMM-AD	**Steward:** NCQA
Description/Sub-Measures	
13.A	Effective Acute Phase Treatment: Percentage of persons served who remained on an antidepressant medication for at least 84 days (12 weeks).
13.B	Effective Continuation Phase Treatment: Percentage of persons served who remained on an antidepressant medication for at least 180 days (6 months).
Stratification • Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) • Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown • Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More	

Name: AMM-AD	**Steward:** NCQA
than one race, or Unknown	
Additional Guidance: Technical specifications must be used to obtain both the numerator and the denominator. CMS Core Set Measures specifications can be found at: Adult Core Set Reporting Resources | Medicaid	

14. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (adult) (FUA-AD)
15. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (child/adolescent) FUA-CH)

Name: FUA-AD/FUA-CH	**Steward:** NCQA
Description/Sub-Measures	
14.A	Percentage of emergency department (ED) visits for clients ages 18 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 30 days of the ED visit (31 days total).
14.B	Percentage of emergency department (ED) visits for clients ages 18 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 7 days of the ED visit (8 days total).
15.A	Percentage of emergency department (ED) visits for clients ages 13 to 17 years with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 30 days of the ED visit (31 days total).
15.B	Percentage of emergency department (ED) visits for clients ages 13 to 17 years with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 7 days of the ED visit (8 days total).
Stratification • Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) • Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown • Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown	
Additional Guidance: • Technical specifications must be used to obtain both the numerator and the denominator. CMS Core Set Measures specifications can be found at: Adult Core Set Reporting Resources | Medicaid and Child Core Set Reporting Resources | Medicaid	

16. Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)
17. Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)

Name: FUH-AD/FUH-CH	**Steward:** NCQA	****Quality Bonus Payment Metric***
Description/Sub-Measures		**QBP Benchmark**

Name: FUH-AD/FUH-CH	**Steward:** NCQA	****Quality Bonus Payment Metric***
16.A	Percentage of discharges for clients aged 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days.	75%
16.B	Percentage of discharges for clients aged 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 7 days.	48%
17.A	Percentage of discharges for clients ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days.	88%
17.B	Percentage of discharges for clients ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 7 days.	60%

Stratification

- Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid)
- Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown
- Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown

Additional Guidance:

- Technical specifications must be used to obtain both the numerator and the denominator. CMS Core Set Measures specifications can be found at: Adult Core Set Reporting Resources | Medicaid and Child Core Set Reporting Resources | Medicaid

18. Follow-Up After Emergency Department Visit for Mental Illness (Adult) (FUM-AD)
19. Follow-Up After Emergency Department Visit for Mental Illness (Child) (FUM-CH)

Name: FUM-AD/FUM-CH	**Steward:** NCQA
Description/Sub-Measures	
18.A	Percentage of discharges for clients aged 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days of the ED visit (31 total days).
18.B	Percentage of discharges for clients aged 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 7 days of the ED visit (8 total days).
19.A	Percentage of emergency department (ED) visits for clients ages 6 to 17 with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness within 30 days of the ED visit (31 total days).
19.B	Percentage of emergency department (ED) visits for clients ages 6 to 17 with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness within 7 days of the ED visit (8 total days).
Stratification	
• Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid)	

Name: FUM-AD/FUM-CH	**Steward:** NCQA
• Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown • Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown	
Additional Guidance: • Technical specifications must be used to obtain both the numerator and the denominator. CMS Core Set Measures specifications can be found at: Adult Core Set and Child Core Set Reporting Resources | Medicaid	

20. Glycemic Status Assessment for Patients with Diabetes (GSD-AD)

Name: GSD-AD	**Steward:** NCQA	****Quality Bonus Payment Metric***
Description/Sub-Measures		**QBP Benchmark**
20.A	Percentage of clients ages 18 to 75 with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) was controlled during the measurement year: HbA1c control (<8.0%).	Rate is greater than or equal to the 25th percentile of the CCBHC demonstration site performance rates at year end.
20.B	Percentage of clients ages 18 to 75 with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) was poorly controlled during the measurement year: HbA1c control (>9.0%).	Rate is less than or equal to the 75th percentile of the CCBHC demonstration site performance rates at year end.
Stratification • Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) • Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown • Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown		
Additional Guidance: • Technical specifications must be used to obtain both the numerator and the denominator. CMS Core Set Measures specifications can be found at: Adult Core Set Reporting Resources | Medicaid		

21. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)

Name: IET-AD	**Steward:** NCQA	****Quality Bonus Payment Metric***
Description/Sub-Measures		**QBP Benchmark**
21.A	Initiation of SUD Treatment: The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.	41%
21.B	Engagement of SUD Treatment: The percentage of new SUD episodes that have evidence of treatment engagement within 34	14%

Name: IET-AD	**Steward:** NCQA	****Quality Bonus Payment Metric***
days of initiation		
Stratification • Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) • Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown • Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown		
Additional Guidance: Reference Technical Specifications for Core Set Measures- Adult Core Set Reporting Resources | Medicaid		

22. Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)

Name: OUD-AD	**Steward:** CMS
Description/Sub-Measures	
22.A	Percentage of Medicaid clients ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year (any medication).
22.B	Percentage of Medicaid clients ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed buprenorphine for the disorder during the measurement year.
22.C	Percentage of Medicaid clients ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed oral naltrexone for the disorder during the measurement year.
22.D	Percentage of Medicaid clients ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed long-acting, injectable naltrexone for the disorder during the measurement year.
22.E	Percentage of Medicaid clients ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed methadone for the disorder during the measurement year.
Stratification • Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) • Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown • Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown	
Additional Guidance: • Technical specifications must be used to obtain both the numerator and the denominator. CMS Core Set Measures specifications can be found at: Adult Core Set Reporting Resources | Medicaid	

23. Plan All Cause Readmission (PCR-AD)

Name: PCR-AD	**Steward:** NCQA	****Quality Bonus Payment Metric***
Description/Sub-Measures		**QBP Benchmark**
23. For clients ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission - Observed Readmission Rate (Count of Observed 30-Day Readmissions/ Count of Index Hospital Stays)		<=10%
Stratification • Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) • Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown • Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown		
Additional Guidance: • Data are reported in the following categories: o Count of Index Hospital Stays (HIS) o Count of Observed 30-day Readmissions o Count of Expected 30-Day Readmissions • Reference Technical Specifications for Core Set Measures- Adult Core Set Reporting Resources | Medicaid		

24. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)

Name: SAA-AD	**Steward:** NCQA
Description/Sub-Measures	
24. Percentage of clients ages 18 and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.	
Stratification • Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) • Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown • Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown	
Additional Guidance: • Technical specifications must be used to obtain both the numerator and the denominator. CMS Core Set Measures specifications can be found at: Adult Core Set Reporting Resources | Medicaid	

25. Child and Adolescent Well-Care Visits (WCV-CH)

Name: WCV-CH	**Steward:** NCQA
Description/Sub-Measures	

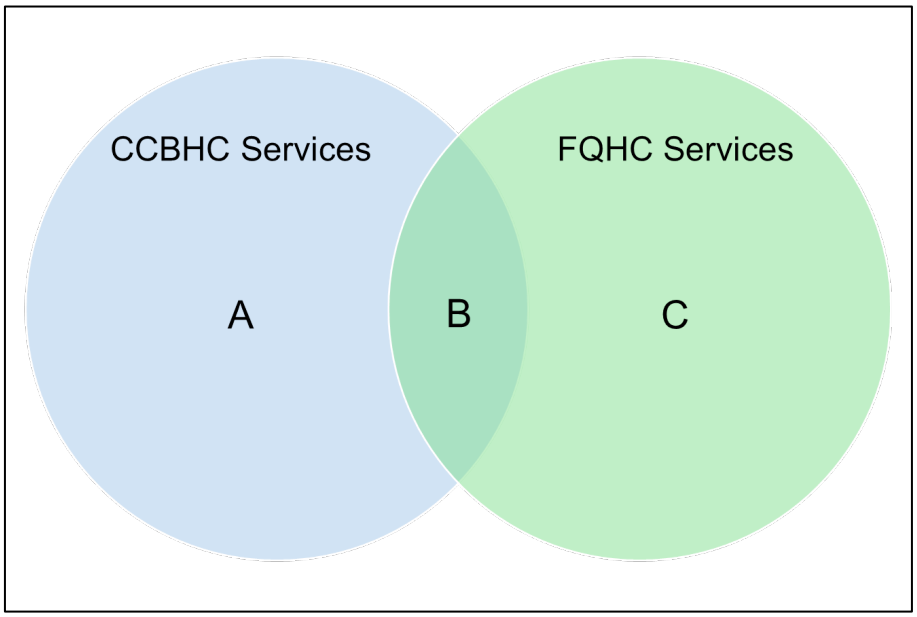
25.	Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year.
Stratification • Age: Ages 3 to 11 years, Ages 12-17 years, Ages 18-21 years • Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) • Ethnicity: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown • Race: A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown	
Additional Guidance: • Michigan Demonstration specific measure Technical specifications must be used to obtain both the numerator and the denominator. CMS Core Set Measures specifications can be found at: Child Core Set Reporting Resources | Medicaid	

Appendix F: Quality Bonus Payment Measures, Measure Stewards, and Benchmarks (FY25)

QBP	Measure Name	Steward	Benchmark	Award Methodology
1.	GSD-AD: Glycemic Status Assessment for Patients with Diabetes	NCQA	For submeasure HbA1c controlled (Glycemic Status <8.0%): Rate is greater than or equal to the 25th percentile of the CCBHC demonstration site performance rates at year end. For submeasure HbA1c poorly controlled (Glycemic Status >9.0%): Rate is less than or equal to the 75th percentile of all CCBHC demonstration site performance rates at year end	10% of Eligible QBP
2.	DEP-REM-6: Depression Remission at 6 months	MN Community Measurement	Rate is greater than or equal to the 25th percentile of the CCBHC demonstration site average at year end.	5% of Eligible QBP
3.	I-SERV: Time to Services	SAMHSA	Rate is less than or equal to the 75th percentile of all CCBHC demonstration site performance rates at year end for each sub-measure: Time to Evaluation Time to Clinical Service Time to Crisis Response	15% of Eligible QBP
4.	FUH-AD: Follow-Up After Hospitalization for Mental Illness, ages 18+	NCQA	30 day: >=75% 7 day: >=48%	15% of Eligible QBP
5.	FUH-CH: Follow-Up After Hospitalization for Mental Illness, ages 6 to 17	NCQA	30 day: >=88% 7 day: >=60%	15% of Eligible QBP
6.	IET-AD: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA	Initiation: >=41% Engagement: >=14%	10% of Eligible QBP
7.	PCR-AD: Plan All-Cause Readmissions Rate	NCQA	<=10%	10% of Eligible QBP
8.	SRA-A: Adult Major Depressive Disorder: Suicide Risk Assessment	Mathematica	>=73%	10% of Eligible QBP
9.	SRA-C: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Mathematica	>=57%	10% of Eligible QBP

Appendix G: Dual FQHC and CCBHC Guidance

To assist in reporting, FQHC providers that become certified CCBHCs must develop a new NPI number specifically for CCBHC service reporting. Additionally, dual FQHC and CCBHC sites must determine which program each service should be billed to using the guidance below to ensure duplicative billing does not occur.



An FQHC should follow the guidance below when providing a CCBHC and/or FQHC service to an individual on the same day.

A=CCBHC services that do not overlap with CCBHC services.

B=Overlapping CCBHC and FQHC services.

C=FQHC eligible services that do not overlap with CCBHC services.

1. A= The site receives the CCBHC PPS rate
2. C= The site receives the FQHC PPS rate
3. A+B= The site receives CCBHC PPS rate
4. B+C= The site receives the FQHC PPS rate
5. A+C = The site receives both the FQHC and CCBHC PPS rate
6. B = The site receives the higher of the two PPS rates
    a. The provider must decide which PPS rate is higher
7. A+B+C = The site receives both the FQHC and CCBHC PPS rate

Overlapping FQHC/CCBHC Service Codes ("B" in Venn Diagram)

Service Category: Crisis Services

Code	Description
90839	Psychotherapy for crisis, first 60 minutes
H2011	Crisis intervention service, per 15 minutes

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
96116	Neurobehavioral status examination by qualified health care professional with interpretation and report, first 60 minutes
96127	Brief emotional or behavioral assessment
96130	Psychological testing evaluation by qualified health care professional, first 60 minutes
96132	Neuropsychological testing evaluation by qualified health care professional, first 60 minutes
96136	Psychological or neuropsychological test administration and scoring by qualified health care professional, first 30 minutes
96138	Psychological or neuropsychological test administration and scoring by technician, first 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
90887*	Explanation of psychiatric, medical examinations, procedures, and data to other than patient

Service Category: Outpatient Mental Health and Substance Use Services

Code	Description
90832	Psychotherapy, 30 minutes
90834	Psychotherapy, 45 minutes
90837	Psychotherapy, 60 minutes
90847	Family psychotherapy including patient, 50 minutes
90853	Group psychotherapy (other than of a multiple-family group)
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
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
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

Appendix H: CCBHC Reporting Requirements

Note: The following reporting requirements and designated due dates are for certified CCBHC Demonstration clinics during and/or after their initial year of entering the demonstration. In addition, CCBHCs will be required to respond to any MDHHS ad hoc data requests needed to support the success of the demonstration (a minimum of 30 days' notice will be given to respond to such requests). PIHPs and CMHSPs must follow all other reporting requirements as detailed in existing contracts with MDHHS (e.g. FSR, EQI, Compliance Exam Reports, etc.).

In the table below, the "Report" column includes a link to the relevant handbook section.

Report	Description	Submission Instructions	Deadline
Quarterly Metric Template for Clinic-Reported Measures *Handbook Section 7. A.4.1.*	All CCBHCs must complete the clinic-reported measures on the MI-CCBHC Data Demonstration Templates (FY25).xlsx template quarterly and send to the PIHPs. CCBHCs must complete the I-SERV (supplemental) tab, and the patient experience survey tabs (PEC, YFEC, URS-Tables 9 URS-Table 11, URS-Table 11a). CCBHCs are responsible for completing the "Case Load Characteristics" sheet and the reporting sheets for the clinic-reported measures (blue colored tabs).	PIHP must review reports each quarter and make available to MDHHS or external evaluators, when needed or requested. PIHP reviews the following: • Verify the template has been completed, • Compare against previous quarter/year or to regional or state averages, • Verify counts (i.e., the numerator is smaller than the denominator), • Review calculations (i.e., no zeros or broken formulas).	CCBHCs complete and send to PIHP by the end of the month following the quarter. For example, for the quarter ending June 30th, templates are due to PIHP July 31st. PIHP must submit the second quarter template of a clinic's initial demonstration year to MDHHS as a trial submission of data collection
Reconciliation Templates (Quarterly and Year-End) *Handbook Section 2. B.5.1*	All CCBHCs and PIHPs must complete and submit reconciliation templates quarterly. Each CCBHC/PIHP must report the encounter submission cut-off date they used in the supplied comments section of the template. Note: Receipt of quarterly reporting is to assist with monitoring reconciliation throughout the year. Submission does not impact reconciliation throughout the year, the final reconciliation takes place at the end of the year utilizing the FSR.	PIHP must complete template with input from CCBHC. PIHPS must submit templates to MDHHS.	PIHPs must submit the completed templates for their respective regions to the MDHHS actuarial mailbox (qmpmeasures@michigan.gov) after the end of the reporting quarter. See FY Reconciliation Template Guidance for exact due dates.
Quarterly Member Grievances, Members Appeals, and Service	For Medicaid persons served, PIHPs are responsible for compiling and submitting all appeals, grievances, and service authorization denials, to	Medicaid reports must be submitted as outlined in Schedule E of the PIHP/MDHHS contract through the DCH- File Transfer.	Quarterly, or on the 15th of the second month following the end of each quarter.

Report	Description	Submission Instructions	Deadline
Authorization Denials *Handbook Section 8. D. 1.3.3.*	MDHHS on a quarterly basis as demonstrated in the PIHP contract. For non-Medicaid persons served, CMHSP CCBHCs must collect and submit all appeals, grievances, and service authorization denials directly to MDHHS on a quarterly basis (including those reported from contracted non-CMHSP CCBHC).	Non-Medicaid reports must be submitted even if there is no information to report directly to the CCBHC mailbox at mdhhs-ccbhc@michigan.gov by CMHSP CCBHCs (including those reported from contracted non-CMHSP CCBHCs).	
Cost Reports	All CCBHCs must submit a cost report within four months after the end of each demonstration year. The cost report may be used to determine the clinic-specific PPS-1 rate and to annually report demonstration costs. The template and instructions can be found here: CCBHC Cost Report CCBHC Cost Report Instructions	CCBHCs complete cost reporting template and send to the PIHPs. PIHPs must review, validate, and submit CCBHC cost reports annually. • PIHPs must provide supports to CCBHCs completing their cost reports, including providing encounter information for daily visit calculation. • PIHPs must review cost reports for accuracy and sustainability. • PIHPs must provide feedback to the site related to the cost report and technical assistance, as needed.	PIHPs must submit cost reporting template to the CCBHC mailbox (MDHHS) by February 28th (five months after end of demonstration year).
Supplemental Cost Report and Audited Financial Statements *Handbook Section 2. C.11.6.*	CCBHCs must submit a Supplemental Cost Report and non-CMHSPs must include an audited financial statement each year with their annual CCBHC Cost Report submission. The Supplemental Cost Report collects additional information about organizational funding sources and expenses for CCBHCs.	CCBHCs must submit report and audited financial statement (non-CMHSPs) directly to the CCBHC mailbox (mdhhs-ccbhc@michigan.gov).	CCBHCs must submit report and audited financial statement (non-CMHSPs) by February 28th (five months after end of demonstration year).

Report	Description	Submission Instructions	Deadline
Behavioral Health Provider Staffing and Expense Survey *Handbook Section 2. C.11.5.*	All CCBHCs must participate in the Behavioral Health Provider Staffing and Expense Survey to collect staffing, wages, and other compensation, and provider expense information from contracted behavioral health providers. Survey instructions and resources can be found here: Reporting Requirements (michigan.gov) under Policy 21-39 Reporting Requirements.	All CCBHCs can email survey templates to the CCBHC mailbox (MDHHS). mdhhs-ccbhc@michigan.gov.	Due: March 15
Annual Metric Reporting – Clinic and State Measures *Handbook Section 7. A.4.2.*	PIHPs should work with all CCBHCs in their region to collect, validate, and submit the final clinic-reported measures to MDHHS. PIHPs will share final data from the end of year metric upload in CC360 to assist the CCBHC in completing the state-reported metrics sheet in the following template: MI-CCBHC Data Demonstration Templates (FY25).xlsx template. Demonstration Year 4 (DY4) transitions the measurement period to calendar year (January – December).	Year-end final templates must be submitted by the PIHP to MDHHS via the CCBHC mailbox mdhhs-ccbhc@michigan.gov.	Due to MDHHS within 6 months of the end of the calendar year, or by June 30th.
Veteran's Navigator Reporting *Handbook Section 7.A.4.2*	CCBHCs with CCBHC-funded Veteran's Navigators must submit a narrative report twice a year. CMHs with Veteran Navigators who already submit a report quarterly to MDHHS do not have to complete this report.	Completed forms must be sent to mdhhs-ccbhc@michigan.gov and mdhhs-bhdda-veterans@michigan.gov.	Due April 15 and October 15.
Non-Medicaid Encounter Annual Report *Handbook Section 7.B.2*	CCBHCs must submit an annual aggregate summary of non-Medicaid CCBHC services that were not submitted through the PIHP.	Year-end templates must be submitted to MDHHS via the CCBHC mailbox. mdhhs-ccbhc@michigan.gov	Due February 28