

Certified Community Behavioral Health Clinic (CCBHC)

Michigan Handbook

Version 3.1

**Michigan Department of Health and Human Services
Health Services Administration**

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The purpose of this Handbook is to provide Medicaid program policy, clinical and financial operations, and systems/information technology 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) created the Certified Community Behavioral Health (CCBHC) Demonstration Handbook to provide Medicaid operational and billing guidance for providers 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. MDHHS will review and update the handbook when state and federal changes occur, or at least annually. CCBHCs will have 30 days to review and provide feedback prior to publishing an updated handbook. All current and future policies and procedures will be maintained on the MDHHS CCBHC website listed below.

The handbook, as well as CCBHC resources and reporting templates, will be maintained on the [CCBHC website](#)

I. Introduction to the 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 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 service 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 substance use disorder (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 (DCOs), to provide a set of nine (9) comprehensive core services to address the complex and myriad needs of people 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 outcomes and quality data which include characteristics of persons served, staffing, access to services, use of services, screening, prevention, 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. Currently certified CCBHC Demonstration sites are located on the [MDHHS CCBHC webpage](#).

Eligible sites must fall into one of the categories outlined in [Section 8.F.1.1.](#), Organizational Authority. 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/SUD services and programming. Historical participation is defined as a minimum of ten (10) years providing behavioral health services within the area identified in the CCBHC community needs assessment.

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. Prior authorization for CCBHC services is not required under the CCBHC Demonstration when services are eligible and determined medically necessary by a qualified provider.

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), Integrated care – MI Health Link (ICO-MC), and Highly Integrated Dual Special Needs Plan (HIDE-SNP-MC).

Medicaid persons served cannot be enrolled in the PACE or Brain Injury Services Benefit Plans concurrently with CCBHC.

Receiving CCBHC services does not prohibit persons served from receiving other 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, [Section 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.

II. CCBHC Requirements

2.A. Minimum General CCBHC Requirements

The State's minimum requirements and expectations for CCBHCs are listed below. CCBHCs are also required to meet all program requirements outlined in [Chapter 8](#) of this Handbook.

- 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. Historical participation is defined as a minimum of ten (10) years providing behavioral health services within the area identified in the CCBHC community needs assessment.
- Must evidence historical and current delivery of behavioral health/SUD services and programming.
- Must be certified as a CCBHC by the State of Michigan.
- Must enroll as providers in the Community Health Automated Medicaid Processing System (CHAMPS).
- Must adhere to all federal and state laws regarding Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA), the federal CARES Act of 2020, and the Bipartisan Safer Communities Act of 2022, including the capacity to perform all CCBHC required services specified by CMS.
- If a CCBHC is also a Community Mental Health Services Program (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.
- CCBHCs must provide persons served with a CCBHC Recipient Handbook. If working with a DCO, the CCBHC is responsible for ensuring the DCO distributes the CCBHC Recipient Handbook appropriately. Refer to section 2.C.6. for minimum requirements.
- Must 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.
- Must participate in ongoing technical assistance (including but not limited to trainings and webinars).
- Must maintain a close working relationship with the assigned MDHHS Certification Specialist, including but not limited to regular communication, coordination of required documentation, collaboration on certification timelines, proactive issue resolution and mutual support to ensure compliance with all CCBHC Demonstration requirements.
- Must support CCBHC team participation in all related activities and trainings, including coverage of travel costs associated with attending CCBHC activities.

- Must adhere to all applicable privacy, consent, and data security statutes.
- Must work to enhance person-served access to behavioral and physical health care.
- Must possess the capacity to electronically report to the State and/or its contracted affiliates information regarding service provision and outcome measures.
- Must 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.
- Must verify diagnosis and eligibility of each person served.
- Must utilize health information technology/health information exchange (HIT/HIE) systems to analyze health data spanning different settings of care for care coordination purposes among Medicaid persons served.
- 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 Prepaid Inpatient Health Plan (PIHP) access center or CMHSP access center when the CCBHC determines the person served may meet criteria for a higher level of care or specialty services. While CCBHCs may identify potential need for higher acuity services through screening and risk assessment, only the PIHP/CMHSP Access Center can make the final determination of eligibility for these services. Referrals must be made for persons served with the following needs:

- Individuals who require a service that is at a higher level of care than the nine (9) 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 and/or present at the PIHP access center meeting CCBHC eligibility, CCBHCs and PIHPs must engage in care coordination 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),
- Providing results of completed screening, risk assessments, and relevant supporting and clinical documentation to the PIHPs, with the individual's consent, to support eligibility determination and service authorization processes.

2.B. Certification Requirements

2.B.1. Certification Overview

Pursuant to Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA), the federal CARES Act of 2020, and the Bipartisan Safer Communities Act of 2022, decisions surrounding certification for CCBHC Demonstration sites are the sole responsibility of MDHHS. CCBHCs must be certified by the State of Michigan in order 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. Certification is valid for three (3) years; however, recertification may be necessary when SAMHSA CCBHC criteria updates or other federal updates require revisions to CCBHC certification requirements. MDHHS reserves the right to request an addendum to the certification application if CCBHC operational changes are necessary.

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/SUD services and programming. Historical participation is defined as a minimum of ten (10) years providing behavioral health services within the area identified in the CCBHC community needs assessment. 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.B.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, the site is subject to decertification. The CCBHC 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 [Section 2.B.3.3.](#) Specific components of a CCBHC site visit are identified in [Section 2.B.3.7.](#)

2.B.1.1. Rural and Frontier Certification Considerations

Rural and Frontier CCBHCs (as identified within the CCBHC community needs assessment) are provided with the opportunity to meet staffing and DCOs requirements as outlined below. Rural CCBHCs are also classified as Micro, and Frontier CCBHCs are also classified as Counties with Extreme Access Consideration (CEAC) see [Section 8.B.3](#) for additional clarification. These considerations are unique to Rural and Frontier CCBHCs and are provided to

assist with barriers associated with service delivery related to network adequacy time/distance requirements 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 on a case-by-case basis by evidencing efforts to actively recruit appropriate staff.
- 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 CCBHC Community Needs Assessment to focus on one physical service delivery location and a limited, defined service area. These CCBHCs may be permitted to increase service delivery options at outlying service sites for an extended time period with advance approval from MDHHS.
- Rural/Frontier sites joining the demonstration must meet full crisis requirements by the end of the three (3) year certification period. These CCBHCs can propose alternative models to meet the 24/7 mobile crisis requirements, including co-response models and virtual options. MDHHS reserves the right to approve or deny alternative models. As CCBHCs work towards meeting the CCBHC crisis requirements, they are held to the “state-sanctioned” crisis services requirements as outlined in the Michigan Mental Health Code.
 - Crisis Phone Line: A telephone that is answered 24 hours a day for dealing with mental health emergencies. The crisis line phone number must be posted publicly on the [CCBHC website](#), shared through electronic means and social media pages, advertised through the telephone book and member handbooks, and shared widely through public information efforts. The phone number and the crisis services provided must also be shared with appropriate agencies.
 - Operate inpatient screening units following crisis screening standards, including but not limited to: offering 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 people in the areas of crisis evaluation, intervention, and disposition. (CCBHCs can define walk in service hours based on needs identified in the CCBHC community needs assessment.)

2.B.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 F](#) of this handbook to ensure

duplicative billing does not occur. Ultimately, the CCBHC is responsible for billing the correct program and understanding 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 claims submission. The NPI must be submitted to the MDHHS CCBHC mailbox.

2.B.2. Certification Application

2.B.2.1. The Behavioral Health Customer Relationship Management System Account Access

To complete the CCBHC initial application or recertification process, the potential or current CCBHC must have an organizational account in the MDHHS Behavioral Health (BH) Customer Relationship Management (CRM) System. Each organizational account is permitted to have several staff who are assigned to the account and each staff member 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), staff title, 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.B.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 Standard 1.b.2 Staffing Requirements/Accreditation, then the staffing plan document must be uploaded to both standards. All documents uploaded must be titled with the name of the document and the standard number (i.e.: 1.a.2 -

ABC Mental Health Staffing Plan). 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.B.3. Certification Levels

2.B.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. The MDHHS CCBHC Team will review the application within 45 days of the submission deadline and determine if the provider meets CCBHC criteria and can enter the demonstration. Providers must achieve full certification status during initial certification to be considered certified under Michigan's CCBHC Demonstration.

2. B.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. CCBHCs are expected to maintain regular and open communication with MDHHS, as well as adhere to deadlines and reporting due dates. CCBHC leadership staff must be committed to supporting their CCBHC's team's participation in all related assistance and trainings, including reimbursement 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.B.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 (CAP)
- Provisional Certification with a Corrective Action Plan (CAP)
- Decertification

2.B.3.3.1. Full Certification

If the CCHBC meets or exceeds all certification criteria during the recertification application process as well as demonstrates successful implementation of all service delivery criteria, including Evidence Based Practices (EBPs), the CCBHC will be awarded Full Certification.

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

2.B.3.3.2. Full Certification with a Corrective Action Plan

If the CCHBC meets or exceeds all criteria during the recertification application process but all service delivery criteria have not been successfully implemented, the CCBHC will be awarded Full Certification with a CAP.

Following the recertification application review, the MDHHS CCBHC team will generate a report within 45 days identifying the findings and resulting corrective action that requires 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 three (3) months in duration in most cases. 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 Compliance Specialist 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 Compliance Specialist to ensure that all compliance issues are remediated within the CAP timeframe. 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 with the established CAP continuing or potentially with an expanded CAP if needed.

If the CAP has been implemented/completed, and criteria has been met by the CCBHC at the conclusion of the CAP process, the Full Certification designation will remain.

2.B.3.3.3. Provisional Certification with a Corrective Action Plan

If the CCHBC does not meet or exceed all CCBHC criteria during the recertification application process as scored with a standardized rubric, including service delivery criteria, the CCBHC will be moved to Provisional Certification with a CAP.

Following the recertification application review, the MDHHS CCBHC team will generate a report within 45 days identifying the findings and resulting corrective action that requires 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 in most cases.

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 Compliance Specialist 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 Compliance Specialist to ensure that all compliance issues are remedied within the CAP timeframe, including a 90-day check-in meeting.

Following the identified timeframe, if the CAP has been implemented/completed, 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.

If the CCBHC site still fails to meet compliance standards as outlined in the CCBHC Handbook and the CAP, provisional certification will continue with the established CAP or potentially with an expanded CAP if needed. Follow-up will be conducted by the MDHHS CCBHC Compliance Specialist to ensure that the compliance issues are remedied within the CAP timeframe, including an additional 90-day check-in meeting.

Following the identified timeframe, if the CAP has been implemented/completed, 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.

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. If the CCBHC disagrees with the decertification determination, the CCBHC may appeal.

Requests for reconsideration must be sent to the CCBHC shared email address at mdhhs-ccbhc-compliance@michigan.gov within 14 business days from the date of the MDHHS decertification notice. Requests must 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.

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 the timeframe MDHHS requires.

2.B.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.B.3.10](#).

2.B.3.4 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 (2) months and biweekly reminders for the last two (2) months.

If a recertification 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 will not be able to receive the PPS-1 payment for CCBHC services. CCBHCs must plan accordingly and work with MDHHS to obtain any technical assistance needed to ensure continuation of certification. CCBHCs with expired certifications may reapply for certification when the next application period reopens.

2.B.3.5. Certification Changes

To keep CCBHC certification documentation accurate and to ensure ongoing compliance with requirements, CCBHCs must notify 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 a change to the cost report. Examples include a change in ability (long or short term; permanent or temporary) to provide any of the nine (9) CCBHC core services, changes in staffing or operations, 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 impact CCBHC fidelity and full-service delivery may result in an immediate six (6) month CAP.

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, moving, or opening a service delivery site,
- Starting, revising, expanding, or terminating a DCO arrangement,
- Staff changes limiting the ability to provide services as required (for example – 24/7 mobile crisis response),
- Changes in staffing at the executive level including the CEO or Executive Director/Project Director and Medical Director,
- Change in capacity to implement all required evidence-based practices to full fidelity.

To support CCBHC Demonstration operational changes, MDHHS reserves the right to request documentation from the CCBHC to ensure all certification requirements are met. This may include, but is not limited to updated policies, procedural documents or revisions to current CCBHC application materials.

2.B.3.6. 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 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.

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 Compliance Specialist 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 by the site anytime during the CAP process.

If a CCBHC is fully certified with a CAP, follow-up will be conducted by the MDHHS CCBHC Compliance Specialist to ensure that all compliance issues are remedied within the CAP timeframe, which is usually three (3) months as described in 2.B.3.3.2 above. 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 with the established CAP continuing or potentially an expanded CAP if needed.

If the CAP has been implemented/completed, and criteria has been met by the CCBHC at the conclusion of the CAP process, the Full Certification designation will remain.

If a CCBHC is provisionally certified, follow-up will be conducted by the MDHHS CCBHC Compliance Specialist to ensure that all compliance issues are remedied within the CAP timeframe, which is six (6) months in most cases as described in 2.B.3.3.3 above. This oversight will include a 90-day check-in meeting.

Following the identified timeframe, if the CAP has been implemented/completed, 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.

If the CCBHC still fails to meet compliance standards as outlined in the CCBHC Handbook and CAP(s), provisional certification will continue with the established CAP or potentially an expanded CAP if needed. Follow-up will be conducted by the MDHHS CCBHC Compliance Specialist to ensure that the compliance issues are remedied within the CAP timeframe, including an additional 90-day check-in meeting.

Following the identified timeframe, if the CAP has been implemented/completed, 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.

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. If the CCBHC disagrees with the decertification determination, the CCBHC may appeal.

Requests for reconsideration must be sent to the CCBHC shared email address at: mdhhs-ccbhc-compliance@michigan.gov within 14 business days from the date of the MDHHS decertification notice. Requests must 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.

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 the timeframe MDHHS requires.

2.B.3.7. On-Site Reviews

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 more frequently at the discretion of MDHHS. A site visit may be scheduled in an effort to support the CCBHC site and provide guidance at any time during the demonstration period. The site review may be in person or virtual and may

occur in a condensed format or in the CRM via the CCBHC's Onsite Review Tab in the CCBHC Certification module. MDHHS staff will review documentation and client records and offer feedback on CCBHC practices. Expectations for all site visits will be provided to the site in advance to aid in preparation for the visit.

Following any type of 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 [Section 2.B.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.B.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 the timeframe MDHHS specifies.

2.B.3.8. Retrospective Reviews

The MDHHS CCBHC Team will conduct retrospective reviews annually. A retrospective review is a type of utilization management function where healthcare services are reviewed after they have been delivered to a person served. Retrospective reviews often involve analyzing enrollee records, including medical history, treatment plans, and billing information. The purpose of the review is to determine if care provided to an individual met the criteria for medical necessity, appropriate level of care, as well as accurate coding of the service(s) provided.

Utilizing a standardized methodology, the retrospective review process analyzes care patterns to identify exemplary care being delivered, as well as any opportunities to enhance quality and efficiency of service delivery. Additionally, the retrospective review also provides a chance to collect data related to the quality of care, compliance with national standards, and additional outcomes data that can be utilized by MDHHS and the CCBHCs to learn more about delivering the right service at the right amount at the right time (amount, scope, duration).

While retrospective reviews will be scheduled annually, a review may also be initiated more frequently at the discretion of MDHHS. A review may be scheduled in an effort to support the CCBHC site and provide guidance at any time during the demonstration period. Expectations for retrospective reviews will be provided to CCBHCs in advance of the review to aid in preparation for the review.

Following the retrospective review process, the MDHHS CCBHC Team will generate a report within 45 days detailing the retrospective review findings and identifying any corrective action needed. Information regarding CAPs can be found under [2.B.3](#). Certification Levels.

If deficiencies related to CCBHC service delivery criteria are found during a retrospective review and results in corrective action, the CCBHC's certification level may be impacted. More information on certification levels related to corrective action can be found in 2.B.3 Certification Levels.

If access to care or the quality of care delivered to persons served is identified during the retrospective review process as a significant and 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 the timeframe that MDHHS specifies.

2.B.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 (SUD)/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):

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

Sites who achieve a three (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.B.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,
- Failure to meet reporting requirements and deadlines,
- Non-compliance with rate setting, including rebasing,
- Misrepresentation of data.

The MDHHS CCBHC Team will give CCBHCs 90 days written notice of the intent to decertify. CCBHCs may either accept the decertification or respond with a detailed CAP to address the identified reasons for decertification within 15 calendar days from the date of the 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 temporarily moved back to provisional status.

The MDHHS CCBHC Compliance Specialist 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 Compliance Specialist to ensure that all compliance issues are remedied within six (6) months after the CAP is approved by the MDHHS CCBHC team, which will include a 90-day check-in meeting. 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.

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 the timeframe MDHHS specifies.

The MDHHS CCBHC Team can also deny the CCBHC's proposed CAP, with formal final notice of decertification subsequently being provided to the CCBHC.

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-compliance@michigan.gov within 14 business days from the MDHHS decertification notice. Requests must 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. Other General Requirements

2.C.1. 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. CCBHCs must follow the Michigan Mental Health Code (MMHC), the Code of Federal Regulations (CFR), and Michigan Compiled Law (MCL).

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 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 422.503; 42 CFR Part 455; the Michigan Medicaid False Claim Act (400.601 et.al.); the Michigan Penal Code, Section 752.1003; the Michigan Whistleblowers' Protection Act; and provisions of the Social Security Act. Please see [Section 7.B.13](#) Program Integrity/OIG Reporting for submission instructions.

2.C.2. Alignment with the Mental Health Framework

CCBHCs will participate in efforts to support the Mental Health Framework standardized assessment and referral policies. An outline of the Mental Health Framework requirements for CCBHCs is listed below and further details regarding standardized assessment and referral policies are forthcoming in Policy Guides.

2.C.2.1. Standardized Assessment

CCBHC-based mental health providers whose scope of practice includes assessment of mental health need and who are Qualified Mental Health Professionals, Child Mental Health Professionals, and Qualified Intellectual Disability Professionals, as defined in the [Medicaid Provider Manual](#), will conduct such assessments for Medicaid persons served, using a State-designated tool (MichiCANS Screener for children and

youth and LOCUS for adults). These assessments will be conducted upon initial mental health use, with reassessment annually and upon change in condition. CCBHC providers will be able to view the most recent date and score for a Medicaid enrollee in CHAMPS, to support timely and appropriate assessment of mental health need. MDHHS will pull these assessment scores to be made viewable in the eligibility inquiry in CHAMPS. All Medicaid mental health providers, including but not limited to CMHSPs and CCBHCs, will be required to honor LOCUS and MichiCANS assessments conducted by other qualified mental health providers and should not complete another assessment unless there is a clinical indication to do so (i.e., change in patient's condition that merits reassessment of mental health needs). 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.

2.C.2.2. Standardized Referrals

CCBHCs will support the new State-specified format, process, and timeline policies for mental health referrals by participating in onboarding activities for the Standardized Referrals platform in CareConnect360 (CC360). The goal of the referral's platform is to facilitate timely access to mental health care for Medicaid enrollees across settings of care. CCBHCs will be required to use the standardized referrals platform to initiate referrals to CMHSPs and/or other Medicaid-enrolled mental health providers, if the CCBHC cannot provide the full range of mental health care needed for the individual. CCBHCs will also receive referrals following the State-specified format, process and timeline.

MDHHS encourages CCBHCs to sign up for updates related to this work by visiting [Michigan Department of Health and Human Services](#) and navigating to Medicaid Services > Mental Health Framework upon entry of email. Questions or comments may be submitted to: mdhhs-mentalhlthframework@michigan.gov.

2.C.3. Scope of Service and Evidence Based Practices (See [Appendix A](#) for Codes)

CCBHCs must directly provide the nine (9) core services unless otherwise utilizing DCOs for reasons outlined in Chapter 3 of this handbook. Some crisis services may be provided by the state-sanctioned crisis system (see [Section 3.C](#)). 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 the services needed. To capture the statewide impact of

Veteran Navigators, CCBHC-funded Veteran Navigators must submit a report twice a year that collects data on activities. See [Appendix G](#) 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 in Section 8.D.6.3. 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.

2.C.3.1. Transition Expectations When a DCO becomes a CCBHC

The choice of provider must be offered to CCBHC persons served and documented whenever there is a change in provider. If two (2) 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 claims 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 must not override the individual's choice of provider. Metrics attribution will follow the methodology outlined in Appendix D.

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 must work together closely to determine appropriate clinic assignment, share treatment details, and shift care coordination responsibilities.

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. County of Financial Responsibility (COFR)

CCBHCs may not require a COFR agreement for persons served who seek services outside of the individual's county of residence. For services not included in the CCBHCs eligible service codes outlined in the [CCBHC Code Chart](#) and [Appendix A](#) of the CCBHC Handbook. CMHSP CCBHCs must comply with COFR requirements as outlined in Michigan Mental Health Code (Act 258 of 1974; Section 330.1302-330.1320).

2.C.5. 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 reimbursement of travel costs associated with attending CCBHC activities.

2.C.6. CCBHC Recipient Handbook

The CCBHC is responsible for providing all persons served with a CCBHC Recipient Handbook to serve as guidance and comprehensive reference to clinic policies, procedures, and best practices. If working with a DCO provider, the CCBHC remains responsible for the distribution of the CCBHC Recipient handbook to persons served. The recipient handbook must be available to persons served in paper format, as well as on the [CCBHC's website](#). The CCBHC must provide a copy of the Recipient Handbook to MDHHS, upon request.

Templates are available for many of the items listed at the [MDHHS Customer Services](#) website. These can serve as a guide for creating CCBHC Direct Pay specific language.

The intent of the CCBHC Recipient Handbook is to ensure there is appropriate information being provided to CCBHC persons served regarding CCBHC processes/procedures/requirements. This does not have to be a separate recipient handbook; it can be an insert, addendum, or companion guide to a current service handbook that highlights the differences for CCBHC only recipients, including, but not limited to grievance and appeal rights.

At minimum, the CCBHC Recipient Handbook must include the following:

- Access to customer service and clinic contact information, including hours of operation,
- Mental health, SUD, crisis, and emergency after-hours contact information,
- Language and accessibility accommodations and assistance,
- Tag lines,
- Coordination of Care
- Payment for services,
- A clearly defined process for person centered planning expectations for both mental health and SUD persons served,
- HIPAA Privacy information, including confidentiality and family access to information,
- CCBHC specific grievance, appeals, and service authorization denials processes,
 - Processes must include both Medicaid and non-Medicaid populations.
 - In some situations, a person served may be receiving services at a CCBHC and non-CCBHC services from a different provider. Grievances and appeals must follow the persons served service delivery, with the grievance and appeal responsibilities remaining with the provider where the grievance/appeal occurred. The CCBHC must assist the person served to identify which process must be used and ensure the person served has access to the appropriate grievance/appeal process. See [Section 8.D.1.3](#) for grievance and appeal requirements.
- Recipient Rights reporting processes,
- Contacting the MDHHS Office of Inspector General (OIG) at 1-855-MI FRAUD (643-7283) for reporting fraud, waste, or abuse.

The reporting of fraud, waste, or abuse may be made anonymously. To report via email, send a letter to:
Office of Inspector General
P.O. Box 30062
Lansing, MI 48909

2.C.7. Information Sharing and Retention

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 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, 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 ten (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.8. 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.

Using the MI CCBHC New DCO or Service Location Request Form, 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 DCO/Service Location Request form, the DCO Encounter Attestation Form, the fully executed DCO agreement and receiving approval from MDHHS prior to the initiation of services. MDHHS will notify the CCBHC once a DCO agreement or new service delivery location is approved.

2.C.9. 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 claim 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 with the TF modifier is only required for persons served with M/M mental health needs. Due to Michigan's funding structure, service recipients with a primary diagnosis of SUD or an Intellectual/Developmental Disability (I/DD) will not be identified as M/M for this purpose, therefore 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 M/M severity (which can apply to either adults or children), severe mental illness (SMI) for adults or a serious emotional disturbance (SED) for children. CCBHCs will use the Michigan Child and Adolescent Needs and Strengths Screener (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: M/M or SED/SMI.

The use of LOCUS described in this document to assign individuals to M/M vs. SMI for budget monitoring purposes is specific to Michigan CCBHCs. This approach has been approved by the American Association for Community Psychiatry under its licensing of LOCUS to MDHHS within Michigan's CCBHC system in accordance with the parameters outlined 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 decompensations 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 M/M does not dictate and/or limit which clinical services may be provided and must not be used for clinical decision making. Services are to be determined based on person centered planning, medical necessity, and clinical appropriateness.

Please see [Section 2.C.2](#) for details related to alignment with the Mental Health Framework and [Section 8.D.3](#) for Screening, Assessment, and Diagnosis Service requirements.

2.C.9.1. Thresholds

Children with Mental Illness

- Recommendation Non-Emergency: M/M Level of Need 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 M/M 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 “M/M” vs. who is “SMI”.

2.C.9.2. Reporting and Validation

The modifier TF must be added to the T1040 when submitting claims 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 claims using the TF modifier for reasonability. If a significant discrepancy is identified, MDHHS will work with CCBHCs to validate reported TF modifiers using EMR documentation.

2.C.10. Not Guilty by Reason of Insanity (NGRI)/Assisted Outpatient Treatment (AOT)

The MDHHS/CMHSP General Fund Contract (Attachment C6.9.1.1) contains provisions which describe the responsibilities of an NGRI Committee, the Center for Forensic Psychiatry, regional hospitals, and CMHSPs in the coordination of care, treatment, and transition to community living for persons adjudicated NGRI. These requirements must be adhered to. The contract: [Community Mental Health Services](#).

AOT services are ordered by a court under 330.1468 and/or 330.1469(a) of the Michigan Mental Health Code (MMHC). AOT can be an order to adhere to outpatient services, or it may incorporate both admission to a hospital and assisted outpatient treatment. Through MMHC authority, the local CMHSP is required to recommend and coordinate inpatient hospitalization and assisted outpatient treatment for persons served with this type of court order.

It is **essential** that CCBHCs and CMHSPs engage in care coordination and warm handoffs to ensure the CMHSP can fulfill its required obligations associated with NGRI and court orders while still allowing access to CCBHC services for persons served.

III. 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. 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, revise, terminate, or expand a DCO, a CCBHC must be prepared to translate service gaps identified in the CCBHC 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 (EBPs) (See [Section 3.C](#)).

If a CCBHC wishes to utilize a DCO provider for an EBP service that is required to be monitored for fidelity with a Michigan Fidelity Assistance Support Team (MIFAST) review (ACT, DBT, IDDT), the DCO provider must hold a current MIFAST certification and be operating to full fidelity in order for the CCBHC to have an agreement with the DCO provider.

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.2](#), monitor for duplicate payment and collect claims 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 contract or such other formal written agreement 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.B.8](#) Financial Responsibility 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 delivery of services. 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.

Similarly, CCBHCs are required to obtain approval from the MDHHS CCBHC Team for expansion or addition of services to established DCO agreements. Expansion of services or additions to DCO agreements require a formal written DCO agreement or addendum, and must follow the same requirements as new DCOs, including a new 51% attestation form. The expansion of services or additions to DCO agreements must be identified within the CCBHC Needs Assessment.

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.

DCO agreements must include the following components:

- References to specific DCO requirements,
- Rate of purchased service and corresponding Appendix A service codes, including required modifiers,
- Data sharing expectations and methodology for collecting required metric information (HIE),
- Assurance and evidence that DCO personnel have completed 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 claims rather than through DCOs. Service claims are identified using the T1040 code. Crisis services, as identified in Appendix A of this Handbook, are excluded from the calculation. Service claim totals must include all non-crisis CCBHC services for all payers, including private payers and non-Medicaid.

CCBHCs utilizing a financial DCO partnership must submit the DCO Encounters Attestation Form at certification and/or upon the addition of a new DCO partnership, and the proportion of services will be verified using claims reporting at year end. Verification will occur 90 days following year-end to allow for claim 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.

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 [Section 2.B.3](#) Certification Levels.

3.B.4. Designated DCO Lead Role

The CCBHC must have a designated DCO Lead to ensure all DCO requirements are met as outlined in Chapter 3 of the 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 Health Information Exchange (HIE)

The CCBHC must also be involved in care coordination activities with DCOs, including improving 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 information technology (HIT) system.

CCBHCs and DCOs may choose to share health records and HIT systems, but it is not required. If not utilizing a shared HIT 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.C.7.5](#), 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 [Section 8.A.8.1.](#)).

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 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 appropriate consent forms and following HIPAA requirements.
- Ensure DCO licensure and credentialing are accurate and monitored for Fraud, Waste, and Abuse (FWA),
- Immediately notify MDHHS via your CCBHC's designated Certification Specialist 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 daily visits will be treated as CCBHC daily visits 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 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) with 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 this Handbook. CCBHCs must collect and submit DCO claims 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.

3.B.9. Service Reporting

Claims 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 C](#) for an example.

3.C. Agreements for Crisis Services

3.C.1. Expectations for Coordination with State-sanctioned Crisis Providers

CCBHCs who are not Community Mental Health Services Providers (CMHSPs) must utilize existing state-sanctioned crisis providers to ensure appropriate coverage across the CCBHC's service area and to avoid the 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 and must be provided:

- 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 posted publicly on websites, shared through electronic means and social media pages, advertised through the telephone book and member handbooks, and shared widely through public information efforts.

The phone number and the crisis services provided must also be shared with appropriate agencies.

- B. Operate inpatient screening units following crisis screening standards, including, but not limited to: Offering 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 people in the areas of crisis evaluation, intervention, and disposition.

3.C.1.1. Crisis Service Coordination Agreements

CCBHCs who are not also CMHSPs or their delegated crisis service provider must establish a Crisis Service Coordination Agreement with the CMHSP in their service area for the provision of some or all state-sanctioned crisis services (SSCS) and coordination with the Crisis Hub (see Crisis Services Agreement Requirement Table below). The agreement must clearly describe coordination expectations, including processes for data sharing, referrals, and follow-up, among all parties providing crisis services. Crisis Service Coordination Agreements must be approved by MDHHS.

3.C.2. DCO Agreements for Crisis Services

Required CCBHC crisis services that are not defined as state-sanctioned services (3.C.1) must be provided by the CCBHC directly, or through a DCO agreement (see [Section 3.B.2](#) for DCO agreement requirements). CCBHCs must have the internal capacity to provide immediate crisis stabilization services for 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 DCO agreements to provide extended access to Behavioral Health Urgent Care services.

Crisis Service Agreement Requirement Table

Crisis Service	CCBHC Requirements		State-Sanctioned Crisis Service	Type of Agreement Required
	Coordination	Service Delivery		
MiCAL/988 Coordination	X		X	MiCAL 988/Agreement (see Section 8.C.8.4)
Crisis Hub	X		X	Crisis Service Coordination Agreement (see section 3.C.1.1)
24-hour mobile crisis response		X (with MDHHS approval)		If not provided directly by CCBHC, DCO Agreement is required. If provided directly by the CCBHC, an agreement is not required.
Preadmission Screening This is an eligible service, not required for CCBHC		X (if delegated by CMHSP)	X	Crisis Service Coordination Agreement (see section 3.C.1.1)
Behavioral Health Urgent Care (BHUC)		X		If not provided directly by CCBHC, a DCO Agreement is required. If provided directly by the CCBHC, an agreement is not required.

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 (EBPs). 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 EBPs to fidelity or who have active CCBHC CAPs related to the proposed DCO services. CCBHCs engaging in DCO relationships with other CCBHCs must follow all requirements as outlined in [Section 3.B.](#)

3.D.1. Crisis Service Coordination Agreements between CCBHCs

CCBHCs who are also the CMHSP state-sanctioned crisis provider in their service area must meet all CCBHC criteria for crisis services as outlined in [Section 8.D.2.](#) 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 service area, and detail coordination expectations with other CCBHCs in the service area regarding crisis care via Crisis Service Coordination 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 an individual receiving CCBHC eligible services at another CCBHC.

3.E. Adding New DCO Relationships

Adding new DCO relationships after initial certification requires approval by MDHHS and requires updates to the CCBHC's Certification Module of the CRM. 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.8.](#) (New Service Delivery Locations) and [3.B.2](#) (DCO Agreement Requirements). The addition of a new DCO or expansion of an existing 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 claims 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.

Similarly, CCBHCs are required to obtain approval from the MDHHS CCBHC Team for expansion or addition of services to established DCO agreements. Expansion of services or additions to DCO agreements require a formal written DCO agreement or addendum, and must follow the same requirements as new DCOs, including submission of the "New CCBHC Location or New DCO Agreement Request Form" and new 51% attestation form. The expansion of services or additions to DCO agreements must be identified within the CCBHC Needs Assessment.

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 the type and capacity of services provided by the DCO will continue at the CCBHC.

IV. Identification of CCBHC Persons Served and Benefit Plan Enrollment

4.A. Medicaid Persons Served Identification and CCBHC FFS Benefit Plan Enrollment

Any individual with a qualifying behavioral health diagnosis as outlined in Appendix B is eligible to receive CCBHC services. A CCBHC service is defined as a service delivered to an individual who has been assigned the CCBHC Fee for Service (FFS) benefit plan and is billed using procedure code T1040. Medicaid persons served are automatically enrolled into the CCBHC-FFS benefit plan in Michigan's Medicaid Management Information System (MMIS), known as the Community Health Automated Medicaid Processing System (CHAMPS) if they meet statewide eligibility criteria. MDHHS administrative claims data from the MDHHS Data Warehouse is used to identify eligible persons served statewide on having a primary or secondary mental health and/or SUD diagnosis within the last 18 months. In addition, anyone who received a CCBHC service in the last 18 months will be assigned the benefit plan. For purposes of program administration and reporting, only services billed under procedure code T1040 are recognized as CCBHC services. Assignment of the CCBHC-FFS benefit plan signifies eligibility for CCBHC services but does not serve as confirmation that CCBHC services have been delivered.

For Medicaid persons served not identified using the above methodology, CCBHC's must determine beneficiary eligibility of the CCBHC-FFS benefit by checking CHAMPS. If the beneficiary does not have the benefit plan assigned in CHAMPS, the CCBHC provider must submit a T1040 claim to CHAMPS after a service is rendered to assign the benefit plan. If the claim includes a qualifying diagnosis, the CCBHC-FFS benefit plan will be assigned. The CCBHC will need to check eligibility again in CHAMPS and resubmit the claim once the beneficiary meets eligibility (by having the CCBH-FFS benefit plan assigned in CHAMPS). The benefit plan will be back dated to the first of the month. Persons served will remain enrolled in the CCBHC FFS benefit plan in perpetuity if they continue to meet eligibility requirements and do not require disenrollment following discharge of services.

4.A.1. CCBHC and Enrollment for 1915(i) State Plan Amendment (iSPA) Services

Medicaid persons served who are receiving only CCBHC services do not have to complete the eligibility determination and enrollment process in the Waiver Support Application (WSA) for iSPA services. If the person served is receiving CCBHC services and iSPA services (not offered under CCBHC and/or listed in Appendix A) then they must be enrolled in the WSA for iSPA. For example, an individual receiving both CCBHC prevention services (service code H0025) and iSPA community living support (CLS) services (service code H2016) must be enrolled in the iSPA program in the WSA. Persons served cannot receive CLS services (service code H2016) from iSPA and respite services (service code H0045 and T1005) from the CCBHC benefit plan concurrently as these supports are inclusive of caregiver relief and supervision. Beneficiaries can receive iSPA CLS services (service code H2015) and CCBHC respite services (service code H0045 and T1005) concurrently, however, the PIHP/iSPA provider must do coordination to ensure what is authorized for the CLS and respite is medically necessary for the person served and does not exceed authorization limits. For more information on case management expectations, please navigate to [Section 8.D.7. Targeted Case Management Services](#).

4.A.1.1. CCBHC and iSPA Service Overlap

For persons served eligible for both the CCBHC Demonstration and the 1915(i) State Plan Amendment (SPA) benefits, providers must assign each service to only one program and ensure that overlapping services are not delivered or billed across both programs. Persons served receiving CCBHC services does not limit or replace access to 1915(i) services, and providers may not require exhaustion of CCBHC services prior to accessing 1915(i). When services are available under both programs, providers must select the single most appropriate program based on service definition and medical necessity and maintain clear documentation supporting that determination.

4.A.2. CCBHC and Enrollment for Waiver Services

Individuals whose level of care meets enrollment requirements for the Habilitation Supports Waiver (HSW), the Children's Waiver Program (CWP), or the Waiver for Children with Serious Emotional Disturbances (SEDW) must be assessed for enrollment into the waivers. Medical necessity criteria must be used in determining the amount, scope, and duration of services and supports provided under the waiver.

Given that CCBHCs must serve anyone with a behavioral health diagnosis, including individuals with a primary I/DD diagnosis, it is possible for individuals to be concurrently enrolled in the CCBHC-FFS benefit plan and the HSW, CWP, or SEDW benefit plans. In such instances, CCBHCs are not permitted to receive the CCBHC PPS-1 payment for services covered by both benefit plans. When services overlap, the waiver benefit plan serves as the payer of those overlapping services and CCBHCs must align with all service delivery requirements as identified within the individual's plan of service (IPOS). See [Appendix A](#) for more information and a list of overlapping service codes. For more information on case management expectations, please navigate to [Section 8.D.7](#). Targeted Case Management Services.

4.B. Non-Medicaid Persons Served Enrollment

Unlike Medicaid persons served, non-Medicaid persons served will not be enrolled in the CCBHC FFS benefit plan in CHAMPS (since they do not have Medicaid). Rather, a non-Medicaid reporting tab will be added to the claims reconciliation template and will be used to gather information on persons served who do not have Medicaid. It is important to track non-Medicaid (and Medicaid) CCBHC persons served by using a unique 11-digit ID (previously known as the PIHP Consumer ID or CONID) for BH-TEDS and other reporting requirements. For more information on the requirements for generating such unique 11- digit IDs, please navigate to [Section 7.B.2](#). BH-TEDS Data Sets.

4.C. Persons Served Consent

CCBHCs must follow Public Act 129 for persons served consent.

More information: [Michigan Behavioral Health Consent Form](#).

All questions can be directed to MDHHS-BHConsent@michigan.gov.

4.D. CCBHC Persons Served Transfers

While the CCBHC persons served individualized plan of care will be utilized to determine the appropriate setting and CCBHC provider of care, persons served 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 persons served to establish a lasting relationship with their chosen CCBHC provider. However, if a person served 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 person served. At minimum, the following documents must be made available to the future CCBHC provider to ensure appropriate care coordination and continued service delivery:

- Care Plan
- MDHHS 5515 Consent to Share Behavioral Health Information (if applicable)

V. CCBHC Payment

5.A. General Provisions for CCBHC Payment

MDHHS utilizes the 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 Medicaid individuals. Prior authorization for CCBHC services is not required under the CCBHC Demonstration, when services are eligible and determined medically necessary by a qualified provider.

CCBHCs are not reconciled to actual costs. Per federal guidance, states are prohibited from making additional payments to CCBHCs at the end of the demonstration year if actual costs are higher than the amount received via PPS rate. CCBHCs are at risk for all services provided throughout the demonstration period.

CCBHCs are also eligible to receive Quality Bonus Payments (QBPs) based on meeting or exceeding benchmarks on CMS defined quality metrics. These metrics are reviewed annually and are specific to Medicaid persons served. Details related to QBPs can be found in [Section 5.D](#), [Appendix D](#), and [Appendix E](#) of this CCBHC Demonstration Handbook.

Clinics that are dually certified as a CCBHC and provide services in the Medicaid program must be reimbursed by the CCBHC clinic-specific PPS rate whenever they provide any of the nine (9) statutory CCBHC services covered by the State's scope of services (outlined in [Appendix A](#) of this Handbook). CCBHCs are prohibited from billing Medicaid for services covered by the Demonstration and must bill CCBHC for all eligible CCBHC services, as documented in the CCBHC cost report. For any service not covered by the CCBHC Demonstration, clinics will continue to receive payment through the authorized Medicaid state plan or waiver, unless otherwise stated in [Section 4.B.2](#).

MDHHS reserves the right to implement alternative payment models, as permitted by federal guidance, for CCBHCs participating in the CMS Demonstration.

5.B. CCBHC Prospective Payment System (PPS) Methodology

As part of the CCBHC PPS-1 rate development, each CCBHC site must submit a cost report annually to MDHHS. The cost report is used to develop a clinic-specific PPS-1 rate based on the average expected daily cost to deliver core CCBHC services listed in Appendix A. Costs for providing CCBHC services are calculated regardless of payer, but the PPS rate is only paid for Medicaid-eligible beneficiaries.

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.

The PPS-1 rates will be included in the CCBHC Code Chart and posted on: [Information Specific to Different Providers](#). Future PPS rates will be determined based on a review of submitted cost reports and will be published on the [CCBHC Demonstration website](#) and included in final rate letters. All PPS-1 rates are subject to final approval from CMS.

Additional information on the PPS-1 methodology at: [Section 223 Certified Community Behavioral Health Clinic Demonstration Prospective Payment System \(PPS\) Guidance](#).

5.B.1. Non-Medicaid Payment Methodology

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 to offset the costs of providing non-Medicaid services. 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 without Medicaid, 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 throughout the country have leveraged multiple funding mechanisms to cover the unreimbursed costs of serving the non-Medicaid population. If available, General Fund Dollars 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 uninsured daily visits provided by each CCBHC during previous demonstration year (October 1 – September 30). Final FY Non-Medicaid Service Summary Reports will be used to determine the distribution amounts, with a cutoff date of December 31 (three months following the end of the demonstration year). MDHHS will distribute funds by the end of the calendar year. CCBHCs will not be expected to cost settle if they do not need the full amount to cover non-Medicaid expenses.

5.C. CCBHC Payment Operations

5.C.1. CCBHC CHAMPS Provider Enrollment and Claim Submission

5.C.1.1. Provider Enrollment

CCBHCs are required to be certified as a CCBHC Demonstration Site by MDHHS and must be a Medicaid-enrolled provider to seek reimbursement for Medicaid persons served. PPS payments for non-Medicaid persons served are not permitted.

To enroll as a CCBHC Provider Type, a CCBHC must have a Type 2 (Group) National Provider Identifier (NPI) specific to CCBHC services and must complete an online application in the Community Health Automated Medicaid Processing System (CHAMPS). CCBHCs must have received certification documentation from MDHHS prior to enrolling as a CCBHC provider type. CCBHC's must enroll under the "specialty programs" enrollment type. No subspecialty is required.

- Questions regarding Medicaid billing and/or claims are encouraged to review posted resources [Professional](#) or the CHAMPS website.
 - Providers can contact [Provider Support](#) or [Medicaid Providers](#) and selecting Provider Alerts.
- Questions regarding Provider Enrollment are encouraged to review posted resources on the [Provider Enrollment](#) website.
 - Providers can contact Provider Enrollment at 1-800-292-2550, option 4 or providerenrollment@michigan.gov, the [Medicaid Providers](#) website and visiting [Provider Enrollment](#).
- CCBHCs that will be using a billing agent to submit claims are their behalf are encouraged to review related HIPAA companion guides

for additional information and instructions. Michigan Medicaid utilizes the HIPAA compliant ASC X12 Version 5010 format for HIPAA transactions. Companion guides should be used in conjunction with 837P Health Care Claim: Professional Technical Report 3 (TR3).

- [MDHHS HIPAA Companion Guides](#) or [HIPAA 5010 837P](#) – Professional FFS, and find to the “Fee-for-Service (FFS)” section.
- [CHAMPS Pay Cycle Calendar](#)

5.C.1.2. Claim Reporting Details and Submission

CCBHCs are expected to generate a claim and send it to MDHHS for processing. MDHHS reserves the right to further define and standardize data elements, file formats, and transmission methods in the future. CCBHC claims must be submitted in accordance with policies, rules, and procedures stated in the Billing & Reimbursement for Professionals Chapter of the [Medicaid Provider Manual](#).

5.C.1.2.1. Provisions for Claim Reporting

For Medicaid persons served, claims must include a T1040 and be submitted utilizing the persons served Medicaid ID. Claims must include a qualifying CCBHC diagnosis code, but CCBHCs should include appropriate International Classification of Diseases 10 (ICD-10) diagnosis codes within the range of Z55-Z65 to describe any relevant social determinants of health. All CCBHC service claims, whether provided directly or through a DCO, must be submitted 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 C](#)). If the DCO is not eligible for an NPI, contact mdhhs-ccbhc@michigan.gov.

Submitted charge 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 in this way allows for the identification of CCBHC services while retaining consistency with reporting methodology of previous years and of non-CCBHC services. These amounts are for reporting purposes only and do not drive payment. There is no expectation that the sum of the charged or paid amounts will equal the PPS rate. Additionally, the submitted charge amount on the T1040 service line does not have to be the PPS rate. CHAMPS will approve the clinic-specific PPS rate that has been approved based on the date of service, less any reported payment collected by third parties/other insurance.

See Example of CCBHC claim reporting in [Appendix C](#). In this example, the CCBHC is reporting \$0.00 on the T1040 line.

5.C.1.2.2. Identification of CCBHC Services

The T1040 code is the dedicated CCBHC demonstration procedure code and is used solely to identify a CCBHC service. The combination of the T1040 code, the qualifying CCBHC procedure code, and a qualifying diagnosis **must** be submitted for the services to be

recognized as a CCBHC service. Reporting systems must have the capacity to report at least two service lines and at least two diagnoses. 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. Omitting either the T1040 code or the CCBHC procedure code will preclude payment at the PPS-1 rate.

5.C.1.2.3. Qualifying Procedure Code Set

Qualifying CCBHC procedure codes can be found in [Appendix A](#) of this handbook. Unless otherwise specified, all potential appropriate modifiers must be used with CCBHC procedure codes. MDHHS reserves the right to add and remove procedure codes provided they fit within the required CCBHC service array.

5.C.1.2.4. Coordination of Benefits

For all CCBHC services, whether provided directly or through a DCO, CCBHCs must first bill any applicable third-party payors, including Medicare, prior to submitting the claim to MDHHS for CCBHC PPS-1 payment.

In a scenario where certain third-party payors may not allow the CCBHC to bill on behalf of a DCO; the DCO must provide any payment received from the third-party payor to the CCBHC.

CCBHCs will report all applicable third-party payment/COB/other revenue collected for CCBHC services on the service claim in accordance with the Coordination of Benefit chapter of the Medicaid Provider Manual for Medicaid persons served. If CCBHC services are billed to a Medicaid MCO, the CCBHC is required to report any received reimbursement as an offset to the PPS payment. MDHHS will reimburse the balance of remaining CCBHC service costs up to the PPS-1 rate.

5.C.1.2.5. Additional Claim Reporting Requirements

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 seven (7) and up receiving CCBHC services with Mild-to-Moderate behavioral health needs (refer to [Section 8.D.4.1.4](#) for mental health level of care (LOC) determination requirements). Mild-to-Moderate identification is used for reporting and rate setting purposes only.

The Place of Service (POS) Code “20” should be used on the service line to designate services provided at the Behavioral Health Urgent Care (BHUC). See section 8.D.3 for BHUC requirements. If an alternate POS code is required to adhere to primary payer rules, including documentation of telehealth activities, the “20” can be listed on the T1040.

Applicable ICD-10-CM Z diagnosis codes should be submitted, as applicable, with the CCBHC claims 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.1.2.6. Provisions for Claim Submission

CCBHC claims must be submitted in accordance with policies, rules, and procedures stated in the Billing & Reimbursement for Professionals Chapter of the [Medicaid Provider Manual](#). The CCBHC must validate claims to ensure the inclusion of appropriate details, including any third party or other applicable payments.

CCBHCs have two options for claims submission:

1. Direct Data Entry (DDE): Claims can be submitted directly in CHAMPS using the Claims Direct Data Entry (DDE) function, [quick reference guide](#). To directly enter claims, users must have a MiLogin account and appropriate CHAMPS access profiles established (See [Provider Enrollment](#) resources.)
2. Electronic Submission: The CCBHC or associated billing agent can use the DTMB File Transfer Service (FTS) (formerly the DEG) to submit and retrieve claim-related files electronically with MDHHS. [DTMB FTS login](#). (Refer to Section 6: Health Information Technology, of this handbook for additional information relating to the DTMB FTS.)

The CCBHC or their billing agent can submit 837 HIPAA Claim Files through the DTMB FTS to MDHHS and will recognize files that MDHHS returns to the billing agent “mailbox”. When submitting CCBHC claims, the Class ID/file number 5475 should be used for claim files. If the submission is deemed by CHAMPS to be HIPAA-compliant, a 999-acknowledgement file will be sent to the submitter’s mailbox. The 999 file does not indicate that all claims submitted were accepted, only that the file was compliant and was accepted. Once the 837 file is processed by CHAMPS, CCBHC or their authorized billing agent may receive a 4987 file, also known as the Health Care Claim Payment Electronic Remittance Advice (835/ERA) file, which will provide details on approved and denied claims.

Claim adjustment reason codes (CARC) and remittance advice remark codes (RARC) are returned for each claim on the electronic remittance

advice (835), paper Remittance Advice, or displayed remittance advice (835) or displayed within CHAMPS claim inquiry. CARC and RARC definitions are located on the X12 website [External Code Lists | X12](#).

CCBHCs and/or their billing agents are encouraged to review the “Electronic Submissions Manual (ESM)” for additional information and instructions related to the DTMB FTS. This manual can be found at: [HIPAA - Companion Guides](#) and under “Resources” to ESM.

CCBHCs may work with registered billing agents to electronically submit claims on their behalf. For more information on billing agents, [How to Become An E-Biller](#) or automatedbilling@michigan.gov.

5.C.1.3. Reimbursement Limitations

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).

CCBHCs are not eligible to receive the PPS-1 payment for CCBHC services that are available in bundled rates, including those services encompassed within any specialized residential settings. A bundled rate is a separate daily or monthly Medicaid payment that covers a defined set of services, including residential or crisis services. Since the bundled rate already includes payment for those services, the CCBHC must ensure services are not billed under both the bundled rate and the PPS-1 rate. This prevents duplicative billing.

It is the responsibility of each CCBHC to review the services included in applicable bundled rates and ensure that no duplicative services are billed or occur. CCBHCs must only bill the PPS rate at certified CCBHC locations, using the CCBHC specific billing NPI. Both DCO contracts and services provided at DCOs must be approved by MDHHS to be billed by the CCBHCs for the PPS rate.

CCBHC services are eligible for reimbursement following preliminary screening and risk assessment, with an eligible diagnosis. In the event that screening and assessment does not result in a behavioral health diagnosis, the visit is not eligible for the PPS rate.

CCBHCs must not submit a claim to the State and an encounter to the PIHP for the same beneficiary, for the same service, on the same date of service. CCBHCs are responsible for establishing internal controls and coordination processes to prevent duplicate submissions and to ensure that services are billed or reported through the appropriate funding and delivery system.

Crisis visits also require an eligible diagnosis. If a non-established person served receives crisis demonstration services provided by a state-sanctioned crisis service acting as a DCO, the crisis service is covered upon receipt of:

- Crisis assessment (inclusive of a screening and risk assessment) AND
- Another eligible CCBHC service (See [Appendix A](#)) delivered by the CCBHC within ten (10) business days of the person served receiving the crisis services.

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 in [Appendix E](#).

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 five percent (5%) of the total CCBHC Medicaid Demonstration Year (DY) costs. The DY total costs will be calculated using all daily visits received through January 15th following the end of the fiscal year. This cutoff allows sufficient time for claims submission after the end of the fiscal year.

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

Please reference: [Appendix E](#) – 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 awarded CCBHC(s). If a measure has sub-measures, the performance benchmarks must be met for all sub-measures in order for the parent measure to be considered met. If a sub-measure has a denominator of fewer than 30, the remaining sub-measures must meet their benchmarks for the parent measure to be considered met.

CCBHCs are eligible to receive 5% of the clinic's annual Medicaid costs (defined as the total 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 E](#).

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

Final annual CCBHC-reported quality measures are to be submitted to MDHHS within six (6) months after the end of the measurement year (by June 30). MDHHS will distribute QBP payments to the CCBHCs within nine (9) months following the end of the measurement year (by September 30). CCBHCs are afforded an opportunity, prior to the final award distribution, to dispute QBP results and engage in a consultation period to validate.

5.D.2.2.1. Note on QBP Timeline for DEP-REM-6 Measure

The DEP-REM-6 numerator measurement period extends eight (8) months past the end of the measurement year. However, to align with QBP payment timelines, the QBP determination for the DEP-REM-6 measure QBP determination is based on CCBHC-reported rates as of May 31 following the measurement year. While this adjustment excludes numerator data from June through August from the QBP calculation, the benchmark methodology ensures fairness, as each CCBHC will be assessed using the same cutoff date.

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](#)

VI. CCBHC and Health Information Technology (HIT)

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 for support: mdhhs-ccbhc@michigan.gov.

6.B. CareConnect 360 (CC360)

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. This will allow CCBHCs 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.

Quarterly integrated measure performance results for state reported measures are provided in CC360. CCBHCs will only have access to individuals that are established as patients of record within their practice (having received a CCBHC service in the previous 12 months). Finally, with appropriate consent, CC360 facilitates the sharing of cross-system information, including behavioral health, physical health, and social support services. Risk Stratification member lists and joint care plans with the Medicaid Health Plans (MHPs) and Prepaid Inpatient Health Plans (PIHPs) will be housed within CC360 (see [Section 7.B.14](#), Joint Care Planning).

Users will access the CC360 through [MILogin](#), but will not have access to the integrated measures until summer 2026. MDHHS will send CCBHCs their quarterly integrated measure performance results in the interim.

6.C. DTMB File Transfer Service (DTMB FTS) – Billing and Claims

The [DTMB File Transfer Service](#) (formerly DEG) is used by enrolled billing agents to send electronic claim files (837) to MDHHS. See [Section 5.C](#) CCBHC Payment Operations above. This requires billing agents at CCBHCs to have a DTMB FTS mailbox setup once they are approved as a billing agent. The billing agents will use the DTMB FTS to store, maintain, submit and retrieve files electronically with MDHHS. MDHHS has established an internet connection to the DTMB FTS, which is a Secure Sockets Layer (SSL) connection. This connection is independent of the platform used to transmit data.

CCBHCs are encouraged to review the “Electronic Submissions Manual (ESM)” for additional information and instructions related to the DTMB FTS. This manual can be found by navigating here: [HIPAA - Companion Guides](#) and under “Resources” to ESM.

6.D. MILogin File Transfer Application (FTA) – Administrative and Data

Sometimes called the “DCH File Transfer,” the MDHHS data submission portal is the MILogin File Transfer Application (FTA). The MILogin FTA was developed to answer a specific need for external and internal customers conducting business with MDHHS. The MILogin FTA is an efficient and secure way to transfer documents containing sensitive data between MDHHS and providers. The MILogin FTA offers the ability to share files while keeping them secure. Typical uses of the MILogin FTA include supplemental cost reporting, cost settlements, other financial files, BH-TEDs, quarterly reporting, and other administrative and confidential reporting.

CCBHCs can submit large data files securely utilizing the MILogin FTA site, when appropriate. A CCBHC who is also a CMHSP will have an assigned Area called “BHDDA CMHSP [Name of Entity].” A non-CMHSP CCBHC will have an assigned Area called “BHDDA CCBHC [Name of Entity].” When submitting files, please utilize the “Share File” option to transmit the files and include the name of the appropriate MDHHS CCBHC staff in the “Comments” field. CCBHCs are strongly encouraged to review the MILogin FTA User Manual, located here: [File Transfer](#).

Access the FTA through [MILogin](#)

VII. 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 (2) 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. 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 CCBHC core measures and other federal requirements are outlined below:

7.A.1. CCBHC Reported Measures

Measure Name and Designated Abbreviation	Steward	Required 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 (PEC)	SAMHSA	Required
Youth/Family Experience of Care Survey (Y/FEC)	SAMHSA	Required

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

7.A.2. State Reported Measures

Note: The National Committee for Quality Assurance (NCQA) has retired the Antidepressant Medication Management (AMM) measure, effective for the calendar year (CY) 2025 measurement year (MY). As a result, AMM-AD will no longer be calculated or reported beginning with the CY 2025 reporting period (December 2025 integrated measures report). As AMM-AD was a state-reported measure only and is not tied to QBPs, does not affect CCBHC reporting requirements or QBP eligibility.

Measure Name and Designated Abbreviation	Steward	Required or State Added
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
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)	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. PLACEHOLDER: State-Specific Measures

Measure Name and Designated Abbreviation	Steward
Forthcoming: Joint Care Planning (JCP30)	MDHHS

7.A.4. 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.5. CCBHC Metric Reporting Requirements

CCBHC-reported measures will be compiled by the CCBHC using the MI CCBHC Data Demonstration Template for the appropriate MY (e.g., “MI CCBHC Data Demonstration Templates (CY25).xlsx”). 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). CCBHCs are not required to enter data for the State-reported measures (green colored tabs).

As in the past, primary responsibility for ensuring the accuracy and completeness of CCBHC-reported data rests with participating CCBHCs. Given recent changes, MDHHS anticipates that additional or updated state-level validation processes may be implemented and that it may conduct its own reviews or validation activities of CCBHC-reported and State-reported quality measure as appropriate. MDHHS will communicate any updates or additional guidance as necessary.

7.A.5.1. Quarterly Reporting

CCBHCs must complete the clinic-reported measures quarterly on the MI CCBHC Data Demonstration Template for the appropriate measurement year (e.g., “MI CCBHC Data Demonstration Templates (CY25).xlsx). Templates must be sent to the assigned CCBHC Certification Specialist and the CCBHC Mailbox (mdhhs-ccbhc@michigan.gov) by the end of the month following the measurement period. For example, for the quarter ending June 30th, templates are due July 31st. MDHHS will work with CCBHCs to remedy data collection issues to ensure accuracy of metric reporting. MDHHS reserves the right to request an additional quarterly submission after review.

The MDHHS review will 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),
- Calculation of relative standings for percentile-based QBP benchmarks (if applicable).

7.A.5.1.1. Quarterly Quality Measure Reporting Periods

Quarter	Dates Included	Submission Due
CY26 Q1	January 01 – March 31	April 30, 2026
CY26 Q2	April 01 – June 30	July 31, 2026
CY26 Q3	July 01 – September 30	October 31, 2026
CY26 Q4	October 01 – December 30	January 31, 2027

7.A.5.2. Annual Reporting

Year-end clinic reported measures will be calculated based on a measurement period of January 01 through December 31. Data is required to be reported for all CCBHC persons served annually unless data constraints exist and are reported to MDHHS (e.g., the metric is specific to only the Medicaid-enrolled population). MDHHS will work with the CCBHCs in their region to collect, validate, and submit the final clinic-reported templates to MDHHS within six (6) months of the end of the measurement year (by June 30).

Final templates must be sent via email to the CCBHC’s assigned Certification Specialist and the CCBHC Mailbox (mdhhs-ccbhc@michigan.gov).

7.A.5.2.1. Note on DEP-REM-6 Measure:

Annual reporting of clinic-reported measures should include data for the DEP-REM-6 measure as of May 31 following the end of the MY.

7.A.5.2.2. Annual Quality Measure Reporting Periods

Measure specifications may include measurement periods based on the CCBHC demonstration year (DY) or calendar year (CY).

Michigan's demonstration uses a CY measurement period for quality measures, beginning January 01 and ending December 31.

The CCBHC demonstration transition to CY quality measure reporting began January 1, 2025.

DY	Quality Measurement Period
DY1	October 01, 2021 – September 30, 2022
DY2	October 01, 2022 – September 30, 2023
DY3	October 01, 2023 – September 30, 2024
DY4 (Transition to CY)	January 01, 2025 – December 31, 2025
DY5	January 01, 2026 – December 31, 2026
DY6	January 01, 2027 – December 31, 2027

7.A.6. 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). Broadly, CCBHC persons served have received an eligible CCBHC service with a corresponding T1040. The denominator-eligible population for each measure includes CCBHC persons served who satisfy the measure-specific eligibility criteria that may include requirements such as age and continuous enrollment.

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. Those dually eligible for Medicare and Medicaid are excluded from state-reported measures. Rejected claims are excluded. Continuous enrollment requirements are met based on Medicaid continuous enrollment rather than CCBHC continuous enrollment. The Medicaid ID must be included in the submitted claim. Services provided by a State-sanctioned crisis provider to persons served by a CCBHC are excluded from State-reported measures. This exclusion does not apply to CCBHC-reported measures, as CCBHCs must include these services.

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). If more than one CCBHC submitted the same number of T1040 service codes, the individual is attributed to the clinic that provided the most recent service. 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).

Quality Measure technical specifications will indicate the population that must be included in each measure and the reporting unit for the measure (e.g. recipients or visits). See [Appendix D](#): Metric Guidance for additional information.

7.A.7. Metrics and Measures Technical Assistance (TA)

7.A.7.1. Metric-Related Technical Assistance

MDHHS will provide TA for metric-related questions on an as needed basis. TA requests should be sent via email to the CCBHC's assigned CCBHC Certification Specialist and the CCBHC Mailbox: mdhhs-ccbhc@michigan.gov.

7.A.7.2. CareConnect360 (CC360) Quarterly Integrated Measures Report

Quarterly integrated measure performance results are provided in CC360, as outlined in Section 6.B. CCBHCs will have access to the quarterly integrated performance measure results upon their access to CC360 (expected June 2026). MDHHS will send CCBHCs their quarterly integrated measure performance results until CC360 access is granted. CC360-related TA requests should be sent via email to the [CCBHC Mailbox](#).

7.B. Additional Monitoring and Reporting Requirements

7.B.1. CCBHC Ad Hoc Reporting

CCBHCs must collect, report, and track 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 unless a different time frame is agreed to by all parties.

7.B.2. Behavioral Health Treatment Episode Data Set (BH-TEDS)

BHTEDS 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 federal and BHTEDS reporting requirements. BHTEDS records must be submitted monthly. Records are due by the end of the month following the month for which the record was created. For example, the BHTEDS record for an admission occurring on 10/11/2025 must be submitted by 11/30/2025.

Episodes lasting more than a year require an annual update BHTEDS record be completed and submitted to MDHHS.

For Medicaid and non-Medicaid persons served, a unique 11-digit ID (previously known as the PIHP Consumer ID or CONID) must be generated by the CCBHC and included on BH-TEDS record reporting. The ID must follow the following logic and guidance:

- Include 11 characters/numbers
- Begin with a prefix unique to the CCBHC (such as MDHHS using prefix DHS)
- Include 0's with any numerical components, to add up to 11 characters (for example, DHS00001111)
- Unique IDs should be submitted with both Medicaid and non-Medicaid BH-TEDS records.

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, use the LARA ID as the State Provider ID and A-S-D records.
- For providers that do not have a CMHSP ID, but no LARA ID, use the CCBHC ID as the State Provider ID and 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](#).

State Provider ID	Service Type	Required BH-TEDS Records
CCBHC ID	Mental Health/Integrated Mental Health and SUD	M and E Annual U for episodes open longer than 1 year
LARA ID	SUD/Substance Use Integrated with Mental Health	A and D Annual S for episodes open longer than 1 year

7.B.3. 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.

7.B.4. Data Collection

CCBHCs must collect, report, and track 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
- Sentinel Events
- Sentinel Event Mortality Reviews
- Other processes of care
- Costs
- CCBHC recipient outcome
- Financial reporting requirements (i.e., Financial Status Reports, the Encounter Quality Initiative, and Standard Cost Allocation) will follow MDHHS guidance released by the accounting and actuarial areas.

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 unless a different time frame is agreed to by all parties. (See [Section 7.B](#) Additional Monitoring Requirements.)

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

CCBHCs must use the data outlined in [Section 7.B.4.](#) to develop, implement, and maintain a continuous quality improvement (CQI) plan for clinical services and clinical management. This plan must address sentinel event mortality reviews, including suicides, hospital readmissions, and other events as specified by the state. (See certification criteria [Section 8.E.2.](#) CQI Plan.)

7.B.6. Metric Reporting

CCBHCs must collect and report on CCBHC-reported performance metrics quarterly and annually as outlined in Sections [7.A.4.1](#) and 7.A.4.2.

7.B.7. 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 (Policy 21-39): [Reporting Requirements](#)

7.B.8. CCBHC Cost Report and Quarterly Claims Reconciliation

CCBHCs must submit CCBHC Office of Management and Budget (OMB) Cost Reports annually. CCBHCs must complete and submit claims reconciliation templates quarterly. Templates are due to the MDHHS actuarial mailbox (gmpmeasures@michigan.gov) by the due date identified in the claims reconciliation template instructions.

To better align reconciled numbers with what is stored in the MDHHS data warehouse, each CCBHC must report the claim submission cut-off date they used on the attestation tab of the template.

Note: Receipt of quarterly reporting is to assist with data monitoring throughout the year. The final data cut off date for final daily visits and cost reporting is December 31.

Quarterly (Q) Report Timeframes			
Q1	Q 2	Q 3	Q4 (year-end)
Oct. 01 - Dec. 31	Oct. 01 - March 31	Oct. 01 - June 30	Oct. 01- Sept. 30

7.B.9. Supplemental Cost Reporting for CCBHCs

CCBHCs must submit a Supplemental Cost Report each year with their annual CCBHC Cost Report submission. Non-CMH CCBHCs must include an Audited Financial Statement with their submission of the Supplemental Cost Report. The Supplemental Cost Report collects additional information about organizational funding sources and expenses for CCBHCs. The audited financial statement must report CCBHC costs separately from non-CCBHC costs to assist in validation of the cost reports. CMHSP CCBHCs must use the Financial Status reports (FSR) as their Audited Financial Statement, which is submitted separately.

7.B.10. Quarterly Member Grievances, Member Appeals, and Service Authorization Denials

CCBHCs are responsible for compiling and submitting Medicaid and non-Medicaid CCBHC service-related appeals, grievances, and service authorization denials to the MDHHS CCBHC Team on a quarterly basis. See [Section 8.D](#) Scope of Services and Appendix G for submission details.

7.B.11. Veteran Navigator Reporting

CCBHC-funded Veteran Navigators must submit a report twice a year that collects data on Veteran Navigator activities. See [Appendix G](#) for submission details.

7.B.12. CCBHC Critical Incident and Event Notification Reporting

MDHHS requires CCBHC Demonstration sites to report, review, investigate, and act upon death-related incidents and specific events defined below for persons receiving CCBHC-only services. Persons receiving CCBHC-only services are defined as individuals whose services are covered under the CCBHC Fee for Service (FFS) benefit plan and billed using procedure code T1040.

Individuals receiving CCBHC services and any service payable through the managed care system are considered dual. Death and event reporting to the MDHHS CCBHC section is not required for dual individuals.

CCBHC beneficiaries who receive any services funded through the PIHP must follow the [MDHHS Critical Incident, Event Notification, and Substance Use Disorder \(SUD\) Sentinel Event Reporting Requirements](#).

If the person served has been both hospitalized and has received Medicaid services within the past year prior to death, the person served would be considered a dual individual and would be reported in the managed care system. Hospitalization is defined as PIHP-funded inpatient hospitalization, which includes partial hospitalization and crisis residential.

CCBHC sites are required to report the Critical Incident classified deaths as listed below in the MDHHS Behavioral Health Customer Relationship Management (MDHHS BH CRM) System. Please note that the aggregate reporting form for CCBHC Events & Incidents is no longer required after April 30th, 2026.

Reportable incident and event types are classified as follows:

Critical Incidents - Suicide (Event Sub-Types - Suicide, Overdose Death), Non-Suicide Death (Event Sub-Types - Death of Unknown Cause, Natural Causes, Homicide, and Accidental). Please note that a root cause analysis (RCA) and mortality review is **not** required for deaths classified as "Natural Causes". RCA submission is not required unless requested by the MDHHS CCBHC team.

Email notification to MDHHS is **not** required for Critical Incident classified deaths. Critical Incident classified death reporting must be reported through the MDHHS BH CRM **only**. Submissions received via email will be returned for submission through the MDHHS BH CRM. Critical Incident reporting must follow the timelines outlined in the [MDHHS Critical Incident, Event Notification, and Substance Use Disorder \(SUD\) Sentinel Event Reporting Requirements](#).

Immediately Reportable Events - Newsworthy/Community Crisis Critical Incidents

These types of events may be newsworthy or represent a community crisis and must be reported to MDHHS immediately at: mdhhs-ccbhc-compliance@michigan.gov when the CCBHC receives knowledge of any Immediately Reportable Events - Newsworthy/Community Crisis Critical Incident.

These types of events must **not** be reported in the MDHHS BH CRM system. Submissions received via the MDHHS BH CRM will be returned for submission through the CCBHC Compliance email address above.

These reports must include the following information:

- Date of Incident
- Date and Time the CCBHC was Notified of Incident
- CCBHC Contact Person Name and Email Address (for follow-up and additional information)
- Place/Address of Incident
- Indication if this is/was a media event
- Link to news article (if applicable)
- Medicaid ID or CCBHC Member ID (Non-Medicaid)
- Name of Beneficiary
- Summary of Incident

The MDHHS CCBHC Team will internally review and provide any final determinations and follow-up actions, if necessary. The CCBHC site will receive a formal notification once the incident or event is closed.

7.B.12.1. Sentinel Event Mortality Reviews

CCBHCs must develop and maintain mortality review processes for the review and follow-up of sentinel events for CCBHC persons served. These processes must be made available to MDHHS upon request.

1. At a minimum, sentinel events must be reviewed and acted upon as appropriate, with root cause analyses to commence within two (2) business days of knowledge of the sentinel event.
2. Staff involved in reviewing and analyzing the sentinel event must have the appropriate credentials to review the scope of care (e.g. a physician or nurse).
3. Documentation of the mortality review process, findings, and recommendations must be maintained.
4. Use of mortality information to address quality of care must occur through the CCBHC Quality Improvement Committee's CQI Plan.
5. Aggregation of mortality data over time to identify possible trends must be maintained.
6. Mortality review documentation must be available to MDHHS upon request.

7.B.13. Program Integrity/OIG Reporting

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 422.503;

42 CFR Part 455; the Michigan Medicaid False Claim Act (400.601 et.al.); the Michigan Penal Code, Section 752.1003; the Michigan Whistleblowers' Protection Act; and provisions of the Social Security Act.

For persons served who are receiving CCBHC services only, the CCBHC is required to promptly report potential fraud, directly to the MDHHS Office of Inspector General. Referrals of potential fraud to MDHHS OIG should not be shared with the provider(s) in question.

Allegations of fraud can be reported at 855-MI-FRAUD or in writing to:

MDHHS Office of Inspector General
P.O. Box 30062
Lansing, MI 48909

Or report online: [Report Medicaid Fraud and Abuse](#)

Instances of identified overpayments linked to waste or abuse should have claims with MDHHS voided and/or adjusted accordingly. The CCBHC should follow internal processes to pursue applicable actions with the provider, including but not limited to, recovery, corrective action plans, and/or education.

For persons served receiving services through both a CCBHC and a PIHP, Program Integrity/OIG reporting responsibilities will follow the service. For example, if a provider identifies a suspicion of fraud (with an overpayment over \$5,000) where the service was billed to/paid by the PIHP, the PIHP is responsible for presenting the case to OIG/Medicaid Fraud Control Unit (MFCU). If the service was provided by the CCBHC, then the CCBHC is responsible for reporting as described above. For purposes of PIHP OIG quarterly reporting, only services provided by the PIHP should be included on the quarterly report.

For more information: [MDHHS Office of Inspector General](#).

7.B.14. PLACEHOLDER: CCBHC Joint Care Planning with MHPs and PIHPs

Care coordination measure implemented by FY27.

7.B.15. Evaluation Requirements

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

VIII. MI CCBHC Certification Criteria - Program Requirements

8.A. Program Requirement #1: Staffing

8.A.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 (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 Template. The 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 include staffing plans, quality and comprehensive service delivery, and the use of DCOs

Each site must complete the 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 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 three (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 Template. If completing an amendment to the CCBHC Community Needs Assessment, the site needs only to update the applicable section of the 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 [Section 8.D.10](#) (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](#)

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.7](#)) 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. MDHHS reserves the right to approve or deny the waiver request.
 - 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

[MDHHS Credentialing and Re-Credentialing Processes](#)

- Pursuant to the requirements of the statute PAMA §223(a)(2)(A), all CCBHC individual practitioners who furnish clinical services (direct hire and contracted), including individual practitioners working toward licensure, must be legally authorized to do so in accordance with federal, state, and local laws, must be appropriately licensed and credentialed, and must 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. CCBHCs must ensure and monitor that appropriate supervision is in place at all clinical levels and in accordance with applicable state law.
- All CCBHCs must have written credentialing policies and procedures for requiring and ensuring that their direct hire and contracted individual practitioners rendering services to persons served, as well as DCOs as an organizational provider, are appropriately credentialed within the state and are qualified to perform their services. This includes all applicable licensing, scope of practice, contractual, Medicaid Provider Manual (MPM)

requirements, and the requirements in this Handbook. The policies and procedures must include oversight and processes for monitoring its own staff, as well as any DCO organizational credentialing and clinical staff's credentialing records. Credentialing must take place every three (3) years and must follow the credentialing and re-credentialing processes established by MDHHS.

- Pursuant to the requirements of the statute PAMA §223(a)(2)(A), all CCBHCs who work with one or more DCOs to furnish clinical services under a formal agreement must require and monitor that the DCO as an organizational provider is legally authorized to do so in accordance with federal, state, and local laws, is appropriately licensed and credentialed, and acts only within the scope of its-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.
- The DCO as an organizational provider must ensure and monitor that its clinical staff (direct-hire and contracted individual practitioners), including individual practitioners working toward licensure, are legally authorized to do so in accordance with federal, state, and local laws, are appropriately licensed and credentialed, and act only within the scope of their respective licenses, certifications, privileging and credentialing, registrations, and in accordance with all applicable laws and regulations, including any applicable state Medicaid billing regulations or policies. DCOs must ensure and monitor that appropriate supervision is in place at all clinical levels and in accordance with applicable state law.

8.A.5.2. *Organizational and Individual Practitioner Credentialing Overview*

CCBHC credentialing and re-credentialing are completed and maintained in the Universal Credentialing section of the MDHHS Behavioral Health Customer Relationship Management System (MDHHS BH CRM). This includes CCBHC clinical staff (individual practitioner) applications and related records, as well as CCBHC and DCO (organizational provider) applications and supporting documentation. Opportunities for reciprocity will be available to avoid administrative burden and duplication of efforts.

CCBHCs should refer to the MDHHS [Credentialing and Re-credentialing Process Policy](#) and the Universal Credentialing Job Aids found in the CRM for guidance on navigating and completing the credentialing process.

- The CCBHC must complete, monitor, and provide oversight of the DCO organizational provider credentialing in the CRM, ensuring that the DCO is completing the privileging and credentialing process in a timely manner.
- The CCBHC must maintain processes that align with the MDHHS [Credentialing and Re-credentialing Process Policy](#) to monitor compliance with licensure, credentialing, and certification for DCO clinical staff (direct-hire and contracted individual practitioners), with periodic review of staff personnel files to ensure all required documentation is included. During the periodic review, 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.

- CCBHCs must ensure that DCOs residing and providing services in bordering states meet all applicable licensing and certification requirements within that bordering state.

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 CCBHCs must maintain a core staff comprised of employed and as needed, contracted staff, appropriate to the needs of CCBHC persons served as stated in the recipient's treatment plan.

CCBHCs must notify MDHHS by email (mdhhs-ccbhc-compliance@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 for Opioid Use Disorders (MOUDs) 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)
CCBHCs must ensure that SATS have the appropriate licensure and credentialing and are working within their scope of practice as described in the Medicaid Provider Manual.
- 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 working within the scope of practice of their licensure 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 links noted:
 - Certified Peer Support Specialist ([CPSS](#))
 - Certified Peer Recovery Coach ([CPRC](#))
 - Parent Support Partner ([PSP](#))
 - Youth Peer Support Partner ([YPSP](#))
- Recommended Staffing Disciplines:
 - Community Health Worker
 - Veteran Navigator
 - Care Coordinator
 - SOAR Navigator
 - Medical Billing Staff
 - Health Information Technology Specialist

It is preferred the CCBHC 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 DCO staff 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 should see [Section 2.B.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 staff 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
- Conflict of Interest (See [Section 8.D.1.2](#) for required topics)
- CCBHC Continuity of Operations/Disaster Plan
- 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
- Cultural competence (including Implicit/Unconscious Bias)
- Limited English Proficiency
- CCBHC Informational Training for DCOs

Recommended Trainings:

- LGTBQIA+
- Diversity Equity and Inclusion
- Social Determinants of Health (SDOH)
- 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 90 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
Conflict of Interest	Within 90 days of hire and every two years
CCBHC Continuity of Operations/Disaster Plan	Within 90 days of hire and every three years
Co-occurring Mental Health and SUD	Within 120 days of hire and every two years
Military and Veteran Culture and Care	Within 120 days of hire and every two years
Older adult culture and care	Within 120 days of hire and every two years
Primary care/behavioral health integration	Within 120 days of hire and every two years
Recovery-oriented, evidence-based, and trauma-informed care	Within 120 days of hire and every two years
Cultural competence (including Implicit / Unconscious Bias)	Within 120 days of hire and every three years
Limited English Proficiency	Within 120 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 needs assessment 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 (3) years. This session is provided by the CCBHC and must include topics such as CCBHC Demonstration background and structure, review of most current CCBHC Handbook, six (6) CCBHC principles, nine (9) core CCBHC services, and CCBHC measures and metrics. 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](#). If necessary, trainings may be provided online. 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 LEP or 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 LEP.

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, member handbook) 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 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 persons 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 accessibility. 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](#).

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 (Large Metro or Metro) areas, and within 60 miles or 60 minutes in Rural (Micro or Rural) areas. ("Primary provider" excludes community inpatient, state inpatient, partial hospitalization, extended observation beds and any still existing day programs.) 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 01, 2014. Please see the definition of a satellite facility under the [Section 223 Demonstration Program](#) for CCBHCs.

Please note that MDHHS Network Adequacy Standards were revised in FY2025 by the MDHHS Division of Contracts and Quality Management, and some CCBHCs may have seen a change in their geographic designation. This change was based on decennial census data in compliance with 42 CFR methodologies.

Currently, CCBHC geographic designations will not change for any existing CCBHC demonstration sites. However, during the next recertification period, geographic designations must align with 42 CFR standards and the assignment by MDHHS Contracts and Quality Management. MDHHS recommends the CCBHCs review any discrepancies in designations before the next recertification period (anticipated for FY2028 unless there are SAMHSA criteria changes) to ensure continued compliance with CCBHC criteria.

During the next recertification process, the network adequacy standards for time and distance will change to the following:

Designation	Standard
Large Metro	20 minutes/10 miles
Metro	45 minutes/30 miles
Micro	70 minutes/53 miles
Rural	75 minutes/60 miles
Counties with Extreme Access Consideration (CEAC)	118 minutes/105 miles

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 claims.
- [Telemedicine Database](#)
- 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 CCBHC 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.

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 (completed within 60 days), 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 (1) 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 this 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 six (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, designed to promote an individual’s right to self-determination 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 (MCL 330.1700(g)) defines person-centered planning as “a process for planning and supporting the individual receiving services that builds upon the individual’s capacity to engage in activities that promote community life and that

honors the individuals' preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires. MCL 330.1712 establishes the right for all recipients to have an Individual Plan of Service (IPOS) developed through a person-centered planning process to verify each individual exercises self-determination. CCBHCs are required to implement person-centered planning in alignment with the Michigan Mental Health Code. The MDHHS Bureau of Specialty [Behavioral Health Services Person-Centered Planning Policy](#) provides helpful guidance on the person-centered planning process and can serve as a valuable reference for providers. All individuals (except for those individuals who receive short-term outpatient therapy only, medication only, or those who are incarcerated) are entitled to use pre-planning to ensure successful person-centered planning.

- The PPS-1 payment methodology does not support self-directed services within the CCBHC model. Accordingly, a person served requesting self-directed services should be considered dual eligible for the purposes of service coordination. Any service provided through self-direction must be coordinated with the CMHSP/PIHP and not eligible for the PPS-1 reimbursement. Self-directed services are not considered CCBHC eligible services, therefore cannot be submitted with the T10140 code and the managed care system is responsible for oversight and the budget of services provided.
- 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 written and 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.
- 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 (1) 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 8.B.5](#).

8.B.9.4. Wait Lists and Interim Services

CCBHCs cannot maintain wait lists for access to behavioral health services for Medicaid or Non-Medicaid enrollees. In circumstances where immediate access to a specific treatment type or Evidence Based Practice is not available, CCBHCs must provide timely interim services that meet the individual's immediate needs and level of acuity. These services must include care coordination and support services that promote engagement until services can be initiated.

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 (3) hours. Crisis management service as required by Handbook [Section 8.B.10](#) (SAMHSA Criteria 4.C) 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 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.5.10. 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 Ability 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 [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 the 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 care coordination are achieved primarily through referrals and through the exchange of health information and 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, the enrollee, 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 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 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 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 enrollees. CCBHCs and health plans will work collaboratively and participate in a joint care planning measure, housed within CC360, for shared enrollees who meet a set of criteria (see [Section 7.B.14.](#)) 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 HIE 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. Care coordination activities would not be eligible for payment under the CCBHC 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. 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 outreach to the new CCBHC to ensure a warm hand off transition of care.

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 six (6) required Health Home services and coordinating care with the CCBHC. The person served will be assigned to both benefit plans in 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.1.7. Coordination for Persons Enrolled in MI Coordinated Health (MICH)

On January 1, 2026, MDHHS transitioned the MI Health Link program for dual-eligible individuals into MI Coordinated Health (MICH). MICH will be available to individuals enrolled in both Medicare and Medicaid in select counties in 2026 and 2027 before expanding statewide. Previous MI Health Link enrollees had the option of moving into MI Coordinated Health with no break in coverage.

MICH is a Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) for Michigan residents. It offers a broad range of medical and behavioral health services, pharmacy, home and community-based services and nursing home care, all in a single program designed to meet individual needs.

For individuals enrolled in MICH, CCBHCs are responsible for billing the appropriate Dual Eligible Special Needs Plan (D-SNP) for the Medicare portion of CCBHC eligible services prior to submitting the claim to MDHHS for PPS reimbursement. Contracts with MICH plans should include a billing and reimbursement process for CCBHC services that specifies that the Medicaid portion of the services are covered by CCBHC. CCBHCs should treat the D-SNP payment as any other insurance payment and follow the Coordination of Benefits requirements described in Section [5.C.1.2.4](#) of this Handbook. MICH enrollment information, and plan contact information, will be available in CHAMPS.

Services to MICH beneficiaries will require a high level of care coordination. Although MICH will assign a care coordinator at enrollment, it is the expectation that the CCBHC acts as the lead care coordinator for the nine core CCBHC services as long as behavioral health services are provided by the CCBHC.

Additional information on MICH can be found at [MI Coordinated Health \(MICH\)](#). Questions can be directed to mdhhs-dsnp@michigan.gov.

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 must follow the Public Act 129 and requirements outlined on the [Michigan Behavioral Health Standard Consent Form](#) website. 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.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. The CCBHC should provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care.

8.6.C. 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 Information Technology Systems

8.C.7.1. Health Information Technology (HIT) System

The CCBHC establishes or maintains a HIT system that includes, but is not limited to, electronic health records. The HIT 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 HIT 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 are encouraged to coordinate care for CCBHC recipients.

8.C.7.2. Population Health

The CCBHC uses its existing or newly established HIT 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 establishes a HIT system, the system will have the capability to capture structured information in the HIT system (including demographic information, problem lists, and medication lists). CCBHCs establishing a HIT system will adopt a product certified to meet requirements in [Section 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 HIT systems will adopt a HIT 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 HIT Certification Program](#). Clinics can [check](#) if they meet this requirement.

8.C.7.4. DCOs Privacy/Confidentiality

The CCBHC will work with DCOs to ensure all steps are taken, including obtaining person served consent, if applicable, 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 (Public Act 129), including patient privacy requirements specific to the care of minors. Regarding Public Act 129, 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 (HIE) Plan

Whether a CCBHC has an existing HIT system or is establishing a new HIT 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 HIT system.

This plan must include information on how the CCBHC can support electronic HIE to improve care transition to and from the CCBHC

using the HIT 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 HIT are an allowable CCBHC cost and should be included in 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 also 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.

FQHC partnerships must be supported by a formal, signed agreement detailing the roles of each party. With other primary care providers, 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. 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, in person or via telehealth 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, 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 CCBHC 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. Department of Veteran Affairs (VA) Coordination

The CCBHC has a written partnership establishing care coordination expectations with the nearest VA 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 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. Michigan Crisis and Access Line (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 /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 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.
 - CCBHCs must communicate any changes to the CCBHC demonstration team.
 - Sites will complete and submit a MiCAL attestation form to the CRM during the certification process: [MDHHS CCBHC Demonstration](#).

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' 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 (AI/AN).

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.

A list of eligible procedure codes is listed in [Appendix A](#).

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. Once the CCBHC is contacted by an incarcerated individual, at a minimum, the CCBHCs must provide an intake appointment and a path for service delivery

following a discharge from the justice system as well as coordinate with the assigned agent as needed. CCBHC services provided to incarcerated individuals should be considered non-Medicaid 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. PLACEHOLDER: Section 5121 of the Consolidated Appropriations Act (CAA) Coordination

8.D.1.1.4. 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. Conflict of Interest (COI)

The CCBHC must establish and maintain policies, procedures, and COI standards. Federal regulations and state law require the person-centered planning process be separate and independent from eligibility determination, assessment, and service provision responsibilities. Failure to keep responsibilities separate presents a potential COI in:

- Assuring and honoring CCBHC person served free choice.
- Overseeing quality and outcomes.
- The fiduciary relationship (potential overutilization or underutilization of services).

The CCBHC must establish and maintain COI policies and procedures that ensure the staff conducting assessments of functional need and person-centered planning development processes are not:

- Related by blood or marriage to the service recipient, or to any paid caregiver of the service recipient.
- Financially responsible for the service recipient.
- Empowered to make financial or health-related decisions on behalf of the service recipient.
- Service recipients who would benefit financially from the provision of assessed needs and services.

The CCBHC must ensure that its staff, and any DCO staff, are trained and understand CCBHC Conflict of Interest requirements. Training must be provided at hire/orientation and at regular intervals. Trainings must include the above requirements, as well as review of CCBHC specific policies and procedures related to

conflict of interest. This training can be in a group setting where the information is shared with staff, and there is a training attestation form with attendee names printed and available to MDHHS on request. For information on Conflict Free Access and Planning Requirements, see [Section 8.D.4.4.](#)

8.D.1.3. Member, Grievances, Appeals, and Service Authorization Denial Procedures

CCBHC persons served have rights that are protected by Michigan's Mental Health Code ([Chapters 7 and 7A](#)) and many other Federal and State Laws. All persons served 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 must have access to existing standardized appeals, grievance, and service authorization denial procedures, which satisfy at minimum, the requirements of Medicaid and/or others that may be mandated by appropriate accrediting entities. The CCBHC is responsible for administering any DCO related grievances, complaints, and/or appeals.

The CCBHC Appeal and Grievance Resolution Processes can be found on the [MDHHS CCBHC website](#). The procedural document contains grievance and appeal information for both Medicaid and Non-Medicaid persons served, as well as letter templates to be used for person served notifications. CCBHCs are strongly encouraged to utilize the templates created by MDHHS to avoid errors. The exact terms, language, timeframes, addresses, and processes must be used when creating person served/beneficiary notices if a CCBHC chooses not to use the letter templates created by MDHHS. CCBHCs cannot use existing PIHP/CMHSP letter templates as managed care rules and requirements are different than Direct Pay rules and requirements.

All CCBHC recipients must have access to the same array of services and supports, regardless of their level of need, residence, insurance, or eligibility for Medicaid. All CCBHC recipients will receive annual written notice of their rights guaranteed by the Mental Health Code along with a written explanation of the grievance and appeals processes. All recipients will receive notices in a format and manner that is easily understood, readily accessible by persons served, and meets the needs of those with limited English proficiency and/or limited reading proficiency.

All CCBHCs must have clear written descriptions and mechanisms to address DCO grievances and complaints, and an appeals system to resolve disputes that comply with policy. The CCBHC is responsible for administering any DCO related grievances, and/or appeals at the DCO provider.

All CCBHCs must have an established process to receive, track, and maintain records of each grievance and/or appeal received both orally and in writing as required by federal and state regulations. The records must be accurately maintained and reviewed by the CCBHC on a regular basis as part of the CCBHC's quality strategy. The records must be available to MDHHS upon request. Please refer to the MDHHS CCBHC Appeal and Grievance Resolution Processes for record keeping requirements.

In some situations, a person served may be receiving CCBHC eligible services at a CCBHC and non-CCBHC services from a different provider. Grievances and appeals must follow the persons served service delivery, with the grievance and appeal responsibilities remaining with the provider where the grievance/appeal occurred. The CCBHC must assist the person served to identify which process must be used and ensure the person served has access to the appropriate grievance/appeal process.

Responsibilities may change with the evolution of the demonstration and CCBHCs must follow all policies and practices put in place by MDHHS.

8.D.1.3.1. Grievance Process for Medicaid and Non-Medicaid Persons Served

All CCBHCs must develop and maintain a grievance procedure, entitling all persons served with the means to express dissatisfaction about any matter other than a Negative Action Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as the rudeness of a provider or employee, or failure to respect the person served's rights regardless of whether remedial action is requested. The grievance must be filed with the CCBHC department that is responsible for facilitating the resolution of grievances. A grievance may be filed by the person served, their guardian, their authorized representative, or parent of a minor child. A person served can file a grievance either orally or in writing. A grievance can be filed at any time.

The CCBHC must provide reasonable assistance to the person served to complete forms.

Please refer to the MDHHS CCBHC Appeal and Grievance Resolution Processes for grievance notification, timelines, and process requirements. Questions related to these processes: mdhhs-ccbhc-compliance@michigan.gov.

8.D.1.3.2. Appeal Process - Non-Medicaid Enrollees

The Michigan Mental Health Code guarantees a broad set of rights and protections for recipients of public mental health services, including CCBHC services. The CCBHC must have a written local appeal/internal review process called a local dispute resolution process, addressing decisions by CCBHCs that impact a person served's access to services and supports. The process must be in writing and available for review by MDHHS. The process must promote the resolution of concerns, and should be timely, fair to all parties, an uncomplicated process, objective, easily understood, cost efficient, and subject to review.

NOTE: Denials or Actions taken (termination, suspension, or reduction) as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action, unless the treatment plan was signed in dispute.

The process should not interfere with communications between persons served and the service provider and should ensure that both the person served and the service provider in the dispute are free from discrimination and/or retaliation. An appeal may be filed by the person served, their guardian, their authorized representative, or parent of a minor child. A person served can file an appeal either orally or in writing.

Please refer to the MDHHS CCBHC Appeal and Grievance Resolution Processes for the local appeal/internal review, timelines, and dispute resolution process requirements for non-Medicaid persons served. Questions related to these processes: mdhhs-ccbhc-compliance@michigan.gov.

8.D.1.3.3. Appeal Process - Medicaid Enrollees

Medicaid beneficiaries are entitled to Due Process whenever their Medicaid benefits/services are denied, reduced, suspended, or terminated. Due Process requires that beneficiaries receive:

1. Advance written notice of the negative action.
2. A hearing before an impartial decision maker.
3. Continued benefits pending a final decision.
4. A timely decision measured from the date the appeal is first received.

Medicaid beneficiaries have the right to request a hearing to contest any negative action involving the denial, reduction, suspension, or termination of the Medicaid benefits/services under the authority of the Social Security Act (SSA) and its federal regulations found at 42 CFR 431 Subpart E, which articulate federal requirements regarding appeals for Medicaid beneficiaries.

Note: Denials or Actions taken (termination, suspension, or reduction) as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action, unless the treatment plan was signed in dispute.

Federal law requires the State of Michigan to ensure that a Hearing system is in place for Medicaid beneficiaries. The system must be accessible to persons who are limited English proficient and persons who have disabilities consistent with 42 CFR 435.905(b).

The CCBHC must have a written policy/procedure addressing the CCBHC Appeals/Internal Review and the State Administrative Hearing system for Medicaid beneficiaries. The policy must be available for review by MDHHS if requested.

The system must provide CCBHC beneficiaries with:

1. A CCBHC Appeal/Internal Review process for beneficiaries to dispute Negative Action Determinations made by the CCBHC/DCO should the beneficiary decide to;
2. Access to the State's Administrative Hearing process without requiring the exhaustion of the CCBHC Appeal/Internal Review;
3. The right to concurrently file a CCBHC Appeal or State Administrative Hearing request to dispute Negative Action, and a Grievance following the appropriate process in policy regarding other service complaints should the beneficiary choose to do so;
4. Information that states if the CCBHC/DCO fails to adhere to notice and timing requirements as required, the beneficiary can initiate a request for a State Administrative Hearing to contest the negative action regarding Medicaid benefits/services;
5. The right of the beneficiary to have the affected Medicaid services continued while the CCBHC Appeal Process and State Administrative Hearing is pending when timely filed, and;
6. An explanation that a beneficiary may represent himself/herself or use legal counsel, a relative, a friend, or other spokesperson.

Please refer to the MDHHS CCBHC Appeal and Grievance Resolution Processes for the appeal, timelines, and state administrative hearing process requirements for Medicaid beneficiaries. Questions related to these processes: mdhhs-ccbhc-compliance@michigan.gov.

8.D.1.3.4. Reporting Appeals, Grievances, and Service Authorization Denials

CCBHCs are responsible for compiling and submitting all CCBHC appeals, CCBHC grievances, and CCBHC service authorization denials directly to MDHHS for both Medicaid and Non-Medicaid persons served on a quarterly basis utilizing templates developed by MDHHS.

The appeals, grievances, and service authorization denials must **only** include CCBHC recipients being denied or grieving **only** CCBHC services, as identified by the service codes in this handbook and on the reporting template.

All reports must be submitted to MDHHS by the 15th of the second month following the end of each quarter via the MiLogin File Transfer Application (FTA) “Share File” option. Please refer to Section 6.D. of the Handbook for more information regarding the FTA. Questions related to reporting Appeals, Grievances, and Service Authorization Denials can be directed to the MDHHS CCBHC Compliance email address at mdhhs-ccbhc-compliance@michigan.gov.

8.D.1.3.5. MICH Grievances and Appeals (formerly MI Coordinated Health Link)

Persons served enrolled with a MI Coordinated Health (MICH) health plan are entitled to all grievance and appeal opportunities available to persons enrolled in both Medicare and Medicaid. Behavioral health services provided by a MICH Plan are subject to appeals and grievances through the MICH plan. The MI Community, Home, and Health Ombudsman (MI CHHO) 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, 8:00 a.m. – 5:00 p.m. by calling 1- 888-746-6456. If more than one appeal or grievance is pursued by a MICH member at the same time, the outcome that is most favorable to the member must be adopted and honored by the CCBHC

8.D.1.3.6. 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 and/or 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 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 that are **not** designated as CMHSPs **must** establish a clear process, in collaboration with the CMHSP serving the CCBHC's geographic area, to guide persons served through the Recipient Rights process for both Medicaid and non-Medicaid persons served.

The process **must** be formalized in a written agreement between the non-CMHSP CCBHC and local CMHSP. The agreement must ensure that the CMHSP provides Recipient Rights protections and associated reporting for all CCBHC service recipients at the non-CMHSP CCBHCs. Documentation of this agreement must be maintained and made available for review by MDHHS, if requested.

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 Recipient 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.1.5. Behavior Treatment Plan Review Committee (BTPRC)

Limitations of the recipient's rights, any intrusive behavior treatment techniques, or any use of psycho-active drugs for behavior control purposes shall be reviewed and approved by a specially constituted body, the Behavior Treatment Plan Review Committee (BTPRC).

CCBHCs who are CMHSPs must utilize their existing BTPRCs if needed for CCBHC service recipients, and follow the requirements for outlined in the [Behavior Treatment Plans Technical Requirement](#).

Non-CMHSPs must use the MDHHS BTPRC. Requests for MDHHS BTPRC review and approval must be sent to the CCBHC's assigned CCBHC Certification Specialist.

8.D.1.6. Freedom to Choose

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

8.D.2. Crisis Behavioral Health Services

8.D.2.1. 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, 365 days a year. 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, 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.2.2. 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 the following:

8.D.2.2.1. 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 or coordinate with the state-sanctioned crisis hub to provide access to a telephone line that is answered 24 hours a day to assess 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 center or use non-clinical staff to answer phone calls if staff do not also have access to a clinician if needed.

8.D.2.2.2. 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 (7) days a week to respond to adults, children, youth, and their families. Mobile

crisis services are expected to arrive within one (1) hour (two (2) hours for rural settings) from the time of dispatch, with the overall response time not to exceed three (3) hours. CCBHCs are responsible for tracking response time for each mobile crisis response activity (see metric requirements for I-SERV Supplemental).

CCBHCs are responsible for coordinating closely with all mobile crisis providers in the service area. Mobile crisis services will require a DCO Agreement with an MDHHS-approved mobile crisis provider if services are not provided directly by CCBHC. CCBHC's may provide mobile crisis services directly only if the mobile crisis teams are approved and certified by MDHHS.

- Telehealth/telemedicine may be used to provide crisis care to individuals when remote travel distances make the two (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. Alternate models must be approved by MDHHS prior to implementation.

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. CCBHCs are able to DCO with another provider for BHUC services or the CCBHC must provide BHUC services directly.

Walk in hours should be determined via the CCBHC 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 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's needs are 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 the 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.2.3. Medical Withdrawal Management Requirements

The revised American Society of Addiction Medicine (ASAM) [criteria](#) list levels of Withdrawal Management for Adults that has been integrated into the main continuum of the ASAM levels of care. Programs that offer Levels 3.2 and 3.7 will be required to maintain a Residential Detoxification license.

It is required that CCBHCs have services for the listed four (4) levels readily available and accessible to people experiencing a crisis at the time of the crisis. The levels include:

- *ASAM Level 1.7* – Medically Managed Outpatient: Mild to Moderate signs or symptoms; Organized outpatient service, which may be delivered in an office setting, health care or addiction treatment facility, mobile facility, or in an individual's home by medical professionals who provide medically supervised evaluation and management of detoxification, withdrawal, biomedical

concerns and common low complexity psychiatric concerns. The CCBHC or DCO must directly provide ASAM Level 1.7.

- *ASAM Level 2.7* – Medically Managed Intensive Outpatient Treatment: Moderately severe to severe signs or symptoms, no imminent risk to self or others; This level is an organized service that can be delivered in an Intensive Outpatient Program (IOP), Opioid Treatment Program (OTP), partial hospitalization programs and office-based specialty addiction treatment practices. The CCBHC is encouraged to directly provide ASAM Level 2.7. While the CCBHC must have the ASAM Level 2.7 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.
- *ASAM Level 3.2* – Clinically Managed Residential Withdrawal Management: Moderately severe to severe sign or symptoms; Organized service that is delivered by appropriately trained staff, who provide 24-hour supervision, observation and support for individuals who are intoxicated or experiencing withdrawal. This level of care (LOC) provides services for clients with severe intoxication/withdrawal signs and symptoms that require 24-hour structure and support. May be provided directly by the CCBHC or through a referral with a care coordination partner. CCBHCs may utilize existing PIHP network providers. This service is not eligible for CCBHC PPS-1 payment reimbursement.
- *ASAM Level 3.7* – Medically Monitored Inpatient Withdrawal Management: Moderately severe to severe sign or symptoms and requires IV medication. This level of withdrawal management is an organized service delivered by medical and nursing professionals that provide 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting. May be provided directly by the CCBHC or through a referral with a care coordination partner. CCBHCs may utilize existing PIHP network providers. This service is not eligible for CCBHC PPS-1 payment reimbursement.

8.D.3. Screening, Assessment, and Diagnosis

8.D.3.1. Screening, Assessment, and Diagnosis Services

The CCBHC must be equipped to provide all nine (9) core services and may consider the use of a DCO provider to address capacity needs supported and identified in the clinic's CCBHC 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. CCBHCs shall determine the appropriate path of service delivery based on the results of the comprehensive assessment and screening process for each individual. Regardless of whether the identified service path falls under managed care or the CCBHC FFS benefit plan, individuals remain eligible to receive managed care services through the PIHP even when they meet CCBHC eligibility criteria.

8.D.3.1.1. 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.3.1.2. 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. For children, the MichiCANS Screener is required at the point of access for all infants, toddlers, children, youth, and young adults ages birth through 20 (day prior to 21st birthday), regardless of insurance type. MichiCANS Screener requirements and additional information is available on the [MichiCANS website](#). Completion of the MichiCANS Comprehensive satisfies the requirement for the MichiCANS Screener; therefore, a separate screener is not necessary when the comprehensive assessment has been completed.

8.D.3.1.3. Mental Health Level of Care Determination Requirements

CCBHCs must follow existing Medicaid requirements for determining level of care, including the use of specific screening and assessment tools 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.

See [Section 2.C.2.](#) for alignment with related Mental Health Framework requirements.

8.D.3.2. Diagnostic and Treatment Planning Evaluations

8.D.3.2.1. 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.3.2.2. 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:
 14. 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
 15. a basic physical assessment as required by (SAMHSA criteria 4.G). All remaining necessary releases of information are obtained by this point.

8.D.3.2.3. Assessment Requirements for Substance Use Disorder (SUD)

To align with the requirements outlined in the Medicaid 1115 Demonstration Waiver for SUD Services, CCBHCs and DCOs who provide SUD services must utilize validated assessment tools that generate the appropriate ASAM level of care.

MDHHS approved assessments include:

- ASAM Continuum for adults
- GAIN I-CORE for adults and adolescents

8.D.3.2.4. Assessment Requirements for Children with Serious Emotional Disturbance (SED)

If the results of the MichiCANS Screener recommend a “Crisis Continuum of Care Services Need” or “Severe/Serious Level of Need”, a MichiCANS Comprehensive will be used at the CCBHC’s initial evaluation 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. Every time a MichiCANS Comprehensive is completed, recommendations for level of care will be updated.

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 Devereux Early Childhood Assessment ([DECA](#)) at Initial Evaluation and treatment planning, based on the results of the MichiCANS screener, for infants, toddlers, and children ages one month through five (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 one month through 18 months
- DECA for Toddlers (DECA-T) 18 through 36 months
- DECA Clinical (DECA-C) two (2) years through five (5) years

MichiCANS and DECA questions: mdhhs-michicans@michigan.gov

8.D.3.2.5. Assessment Requirements for Children with Mild to Moderate Needs

When the results of the MichiCANS Screener recommend a “Mild to Moderate Level of Need”, a MichiCANS Comprehensive and/or a DECA are optional.

MichiCANS and DECA questions: mdhhs-michicans@michigan.gov

8.D.3.3. Screening and Assessment

8.D.3.3.1. 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. 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.3.3.2. Standardized Screening and Assessment Tools

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

8.D.3.3.3. 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.3.3.4. Substance Use Disorder (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.4. Person-Centered and Family-Centered Treatment Planning

8.D.4.1. Treatment Planning Services

The CCBHC must be equipped to provide all nine (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.4.2. 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 and meet medical necessity. Additional guidance: [Person Centered Planning Policy](#).

For purposes of CCBHC service delivery and person-centered planning an individual is not considered a "new" CCBHC beneficiary unless a CCBHC service has not been provided to the individual during the last six (6) months. As such, the individuals' record should be updated and needs addressed based on person served or family preference and medical necessity.

8.D.4.2.1. Assessments Inform Plan

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

8.D.4.2.2. 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.4.2.3. 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.4.2.4. 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.4.2.5. Advanced Wishes

The treatment plan documents the person served advanced 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.4.2.6. State Standards for Treatment Planning

CCBHCs must meet all additional requirements for person-centered planning and the development and monitoring of the appropriate designated Individual Plan of Services, 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 and to address medical necessity.

8.D.4.3. Requirements for Person Centered and Family Centered Care

8.D.4.3.1. 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.4.3.2. 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.4.4. Conflict Free Access and Planning

Conflict-free access and planning provisions established as part of the 2014 Home and Community-Based Services (HCBS) final rule do not apply to CCBHCs as long as the HCBS services are provided as a part of the nine (9) required CCBHC services reimbursed through the PPS. Other HCBS services authorized under traditional Medicaid waiver or state plan requirements outside of the CCBHC demonstration and separate from CCBHC services are still subject to the rules under the waiver or other formal Medicaid payment authorities.

8.D.5. Outpatient Mental Health and Substance Use Disorder (SUD) Services

8.D.5.1. Outpatient Services

The CCBHC must provide outpatient mental health and SUD services directly but may consider the use of a DCO agreement to meet capacity needs supported and identified in the clinic's CCBHC community needs assessment. Services must be evidence-based or reflect best practices and must align with the 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 must refer to and engage in care coordination with the PIHP for services when an assessment and/or treatment plan indicates the need for a higher level of care or a specialized 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.5.2. CCBHCs and SUD Services

CCBHCs must provide outpatient SUD services, as described in the American Society of Addiction Medicine Levels of Care. This includes SUD primary services and Integrated Dual Diagnosis Treatment. Appropriate services must be delivered by the CCBHC or DCO and offered to anyone diagnosed with a SUD. In the event specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of outpatient SUD treatment, the CCBHC makes them available through referral or other formal arrangement with other providers in alignment with state and federal laws and regulations.

- *ASAM Level 1.5* – Outpatient therapy services that provide less than nine (9) hours of structured clinical services per week consisting primarily of psychotherapy, counseling and psychoeducation to address addiction and co-occurring mental health conditions
- *ASAM Level 2.1* - Intensive Outpatient Treatment which are programs that provide nine (9) to nineteen hours of structured clinical services per week consisting of primarily counseling, psychoeducation, and psychotherapy to address addiction and co-occurring mental health conditions.

CCBHCs must continue to maintain the appropriate ASAM LOC Designation within the BH CRM system for the SUD services they are providing. CCBHCs are expected to maintain all required SUD State licensures at the locations SUD services are provided. CCBHCs will receive notifications of any upcoming expirations of their ASAM LOC Designations and must complete the applications to continue to provide SUD services.

When coordinating care with PIHPs, CCBHCs must comply with all applicable federal and state confidentiality and privacy laws, including 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code. This includes information that is collected during assessments, such as the ASAM Continuum Assessment tool. Prior to any disclosure of any health information, CCBHCs are required to obtain consent from the individual using the MDHHS-5515 form. This collaborative exchange of necessary health information is essential to ensuring continuity of care across the treatment spectrum.

8.D.5.3. Evidence Based Practices (EBPs)

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

CCBHCs must follow the EBP approval process as outlined in the Medicaid Provider Manual. CCBHCs will be responsible for ensuring that EBPs are provided by professional staff with appropriate training and credentials, meet Network Adequacy and establish a process for monitoring model fidelity with Michigan Fidelity Assistance Support Team (MIFAST) visits.

It is CCBHC's responsibility to ensure that MIFAST visits and certifications are current. If a DCO provider is being utilized to implement an EBP, the DCO provider must hold a current MIFAST certification and be operating to full fidelity in order for the CCBHC to have an agreement to meet certification requirements.

MIFAST visits are required to be scheduled within three (3) 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: mdhhs-mifast@michigan.gov.

The Community Based Practices & Innovation (CPI) Section, located in the 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. If a CCBHC is delivering a required EBP, but consideration is needed to operate the EBP outside the established fidelity framework, a request for EBP fidelity exception(s) must be submitted to and approved by the Community Practices and Innovation Section (CPI) and then 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): mdhhs-cpi-section@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, IMH, and MI for children and adolescents.

For statewide consistency, the CCBHCs must use one of the following tools listed below when providing SBIRT services:

Purpose of Screening	Appropriate Tools
Alcohol Use	<ul style="list-style-type: none"> National Institute on Drug Abuse (NIDA) Single Question Alcohol Screen National Institute on Alcohol Abuse and Alcoholism (NIAAA) Youth Alcohol Screen Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) Alcohol Use Disorders Identification Test (AUDIT) - Full Screen United States adapted Alcohol Use Disorders Identification Test (USAUDIT)
Illicit and Prescription Drug Misuse	<ul style="list-style-type: none"> National Institute on Drug Abuse (NIDA) Single Question Drug Screen Drug Abuse Screening Test (DAST)-10 Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) Alcohol, Smoking and Substance Involvement Screening Test- Frequency and Concern (ASSIST-FC) Single Question on Drug Use for Children and Adolescents
Additional Screening Tools	<ul style="list-style-type: none"> Screening to Brief Intervention (S2BI) Brief Screener for Tobacco, Alcohol, and other Drugs (BSTAD) Car, Relax, Alone, Forget, Friends, and Trouble (CRAFT) Global Appraisal of Individual Needs- Short Screener (GAIN-SS)

8.D.5.3.1. Required and Alternative Evidence-Based Practices (EBPs)

CCBHCs are required to implement EBPs and are expected to use interventions that are supported by empirical research and demonstrate positive outcomes in behavioral health. MDHHS has outlined the CCBHC Demonstration EBP implementation requirements; however, sites may request an alternative for EBPs when special considerations are identified. Considerations may include but are not limited to practice effectiveness and population needs that require alternative approaches.

Required EBP	Potential Alternative EBP
"Air Traffic Control" Crisis Model with MiCAL	-
Assertive Community Treatment (ACT)	Yes, upon request
Cognitive Behavioral Therapy (CBT)	-
Dialectical Behavior Therapy (DBT)	-
Infant Mental Health	Yes, upon request
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)	Yes, upon request
Zero Suicide	-

An EBP alternative must adequately address the needs of specific populations or demographic such as early childhood, childhood trauma and community-based treatment, with approved types provided below. These alternatives have been vetted for their efficacy, relevance, and alignment with the CCBHC model. This is not an exhaustive list, and a site can submit another EBP alternative for consideration:

- Child Parent Psychotherapy for IMH
- Eye Movement Desensitization and Reprocessing for TF-CBT
- Intensive Community Management for ACT

For consideration to be given to EBP flexibility requests, the CCBHC must demonstrate reason and support and clearly identify the EBP alternative need within the CCBHC Community Needs Assessment. Additionally, the CCBHC must consider all elements listed below when selecting a potential EBP alternative:

- Adequately addressed the needs of the specific populations or demographic such as early childhood, childhood trauma and community-based treatment
- Culturally and linguistically appropriate
- Clearly identified rationale for the request
- Eligible for Medicaid reimbursement
- Employ staff that exhibit clinical experience and required training

CCBHCs must complete and submit the EBP Alternative Request form along with the identified sections from the CCBHC Community Needs Assessment that supports the need for an alternative EBP to: mdhhs-ccbhc@michigan.gov.

A CCBHC must obtain written approval from MDHHS before an alternative EBP can be used to meet CCBHC certification requirements. MDHHS reserves the right to accept or deny any EBP alternatives submitted for consideration.

8.D.5.4. 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. MDHHS recommends an EBP such as Wellness Initiative for Senior Education, Wellness Recovery Action Plan or an EBP to address chronic disease management. When treating individuals with developmental or other cognitive disabilities, level of functioning is considered, and appropriate evidence-based treatments are provided. These treatments are delivered by staff with specific training in treating the segment of the population being served.

CCBHCs are encouraged to reach out to the general email: mdhhs-ccbhc@michigan.gov for assistance in identifying additional recommended EBP's as needed in order to provide appropriate services across the lifespan.

8.D.5.5. 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.5.6. 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.6. Outpatient Clinic Primary Care Screening and Monitoring

The CCBHC must be equipped to provide all nine (9) core services and may consider the use of a DCO provider to address capacity needs supported and identified in the clinic's CCBHC 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 or this Handbook 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.7. Targeted Case Management (TCM) Services

The CCBHC must be equipped to provide all nine (9) core services directly and may consider the use of a DCO provider to address capacity needs supported or identified in the clinic's CCBHC needs assessment. The CCBHC is responsible for high quality targeted case management (TCM) 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 TCM as defined in the Medicaid Provider Manual and will follow any policy guidance intended to standardize and/or improve case management services. TCM must include supports for persons deemed at high risk of suicide or overdose, particularly during times of transition such as from an ED or psychiatric hospitalization. CCBHC TCM must also be accessible during other critical periods, such as homelessness or transitions to the community from jails or prisons.

TCM services cannot be provided by a CCBHC if another entity serves as the lead case manager, as defined by creating and managing the Individual Plan of Service (IPOS). In this scenario, the CCBHC should not seek reimbursement for targeted case management services (T1017). Instead, the CCBHC is expected to coordinate with the designated case manager to ensure CCBHC services are integrated into the IPOS. Additionally, CCBHCs are not required to create a separate IPOS if one exists and they should not assume the role of lead case manager related to the existing IPOS.

For behavioral health 1915(i) State Plan Amendment (iSPA) and waiver beneficiaries who are receiving services through both a CCBHC and PIHP, the PIHP- contracted provider of iSPA or waiver services will take the role of lead case manager as defined by creating and managing the IPOS. Services provided by the CCBHC should be incorporated into the IPOS through care coordination activities between the CCBHC and the PIHP-contracted provider of iSPA or waiver services. Conversely, if a CCBHC is the provider of iSPA or waiver services, other providers are expected to coordinate with the designated CCBHC case manager and not assume the role of the lead case manager related to the existing IPOS.

8.D.8. Psychiatric Rehabilitation Services

The CCBHC must be equipped to provide all nine (9) core services and may consider the use of a DCO provider to address capacity needs supported or identified in the clinic's CCBHC needs assessment. The CCBHC is responsible for evidence-based and other psychiatric rehabilitation services for both mental health and SUD. 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 (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, 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.9. Peer Supports, Peer Counseling, and Family/Caregiver Supports

The CCBHC must be equipped to provide all nine (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, parent 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 4](#) – 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](#) and the [MDHHS Parent Support Partner/Youth Peer Support Partner website](#).

8.D.10. Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans

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

8.D.10.1. 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 with responses recorded in the individual's record.

8.D.10.1.1. Serving Current Military Personnel

Active-Duty military personnel must use their servicing Military Treatment Facility (MTF). CCBHCs must 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 must 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 must help facilitate this transition to services.

8.D.10.1.2. Serving Veterans

If the individual is not enrolled in the VHA, the CCBHC must 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.10.2. 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.10.3. Principal Behavioral Health Provider (PBHP) for Veterans

Every veteran seen for behavioral health services is assigned a 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.10.4. 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.10.5. 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.8.1 in this Handbook.

8.D.10.6. 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 meet 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 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 G](#) for all data reporting requirements.)

8.E.1.3. DCOs and Data Reporting

Although most data reporting requirements will be the responsibility of 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 Claims Reporting

MDHHS will provide federal demonstration evaluators with CCBHC-level Medicaid claims 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 MDHHS. The CCBHC 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 throughout 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 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 to 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 addresses how the CCBHC will use disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health disparities. 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 sentinel events, including suicide deaths or suicide attempts; (2) fatal and non-fatal overdoses; (3) all-cause mortality among people receiving CCBHC services, including sentinel event mortality reviews; (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, Finances, 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. Indian Health Service (IHS) Agreements

To the extent CCBHCs are not operated under the authority of the IHS, 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 that 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 certification requirements in accordance with federal audit requirements, complying with Generally Accepted Auditing Standards (GAAS). If indicated, a corrective action plan will be 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.1.4. Compliance Examination and Audit Reviews

All CCBHCs are required to contract annually with a certified public accountant (CPA)/independent practitioner in the practice of public accounting to examine the CCBHC's compliance with specified requirements in accordance with the American Institute of Certified Public Accountants (AICPA) Statements on Standards for Attestation Engagements (SSAEs). The objective of the CPA's/independent practitioner's examination procedures is to express an opinion on the CCBHC's compliance based on the specified criteria and requirements, which include Financial Reporting, Procurement, Third-Party Reimbursement/Coordination of Benefits (including duplicate billing/payments), and Quality Bonus Payments (QBP). The CPA/independent practitioner seeks to obtain reasonable assurance that the CCBHC has complied, in all material respects, based on the specified criteria.

The Compliance Examination process works to ensure the accuracy and integrity of financial reporting and related documents and to allow MDHHS the opportunity to provide comments, findings and to identify any needed adjustments to the CCBHC. The Compliance Examination also serves to inform internal and external stakeholders of any significant challenges or successes, and to provide status updates as needed.

Please refer to the CCBHC Compliance Examination Guidelines for information regarding the criteria, examination report submission methods and timelines, the required documents for submission, penalties, incomplete or inadequate examinations, and management decisions. There is also a compliance exam appeal process available to the CCBHCs which can be found on the [MDHHS CCBHC website](#).

8.F.1.5. Financial Risk Assessment

Prior to joining the CCBHC Demonstration, a potential site must participate in and successfully complete an initial financial risk assessment. This risk assessment requires a potential site to submit their Federal ID number (FEIN or EIN), as well as the most recent independent financial audit results, including an audited financial statement, and any findings, questioned costs, reportable conditions, and material weaknesses cited.

The audit must comply with Generally Accepted Auditing Standards (GAAS). CCBHCs are required to comply with financial and auditing laws and regulations including the Michigan Mental Health Code, the Michigan Medicaid Provider Manual, the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, and Generally Accepted Accounting Principles (GAAP).

This information will be requested during the CCBHC Certification Application Process. Once received, the MDHHS CCBHC Team will work with the MDHHS Bureau of Audit to complete the financial risk assessment.

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% 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 develops 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 ensure 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%) of the governing board members may derive more than 10% of their annual income from the health care industry.

8.F.2.5. MDHHS Verification

MDHHS 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], Social Current/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 Codes

CMS issued a dedicated 223 CCBHC Demonstration encounter billing code, T1040. CCBHC services will be identified using a T1040 code in conjunction with at least one of the CCBHC service procedure 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 each of the nine (9) 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). The CCBHC Code Chart can be found on [Information Specific to Different Providers](#). 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 claims must be submitted with the T1040 code in addition to one (1) of the proceeding service codes to be counted as a CCBHC Demonstration service. To be counted as an eligible CCBHC Demonstration service, CCBHC Mild-to-Moderate services must be submitted with the TF modifier, T1040 code, and one (1) of the proceeding service codes. CCBHC services provided via telemedicine should follow the Health Services coding requirements and Health Services Telemedicine Database. These materials can be found hyperlinked at the top of the Health Services Reporting Requirements website at [Reporting Requirements \(michigan.gov\)](#). CCBHC services utilizing modifiers must follow code sets and guidance cited on the Health Services 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 must be used with CCBHC service codes. Services provided at the Behavioral Health Urgent Care (BHUC) should be identified using the Place of Service (POS) code of "20".

CPT codes, descriptions and two-digit modifiers only are copyright American Medical Association. All Rights Reserved.

The information in this document serves as a reference only. It does not guarantee that services are covered. Providers are instructed to refer to the Michigan Medicaid Provider Manual, MMP Bulletins and other relevant policies for specific coverage and reimbursement policies. This information can be found on the Medicaid Policy, Letters & Forms webpage. If there are discrepancies between the information in this document and the Medicaid Provider Manual, such as rate or coverage determinations, they will be resolved in favor of the Medicaid Provider Manual language.

Superscript Notes:

° Overlapping waiver services are identified°

* Code included in multiple service categories*

^Code covers outpatient day camp respite only and excludes overnight room and board costs^

CCBHC Claim 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
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

Code	Description
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
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

Code	Description
H0022	Alcohol and/or drug intervention service (planned facilitation)
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0033	Oral medication administration, direct observation (Use for Buprenorphine or Suboxone administration and/or service – provision of the drug), per encounter.
H0034	Medication training and support, per 15 minutes
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
98960	Education and training for patient self-management; (individual patient)
98961	Education and training for patient self-management; (2-4 patients)

Code	Description
98962	Education and training for patient self-management; (5-8 patients)
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
S9482	Infant Mental Health
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: Claim 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 enrollee 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.

L o o p	Claim	Notes
2 3 0 0 :	CLM*A37YH556*40***11:B:1* Y*A*Y*I *P~	Total Claim Charge Amount - CLM02
2 3 2 0 :	AMT*D*25~	Total Payment Amount - AMT02
2 3 3 0 B :	NM1*PR*2*Payer Name*****PI*11122333~	Payer ID – NM109 - Must match 2430 SVD01
2 4 0 0 :	Line 1 SV1*HC:T1040*0*UN*1*11**1 :2:3**N ~	Line Item Charge Amount - SV102
2 4 3 0 :	SVD*11122333*0*HC:T1040**3 ~	Service Line Paid Amount - SVD02; Payer ID – SVD01 Must match 2330B NM109
2 4 3 0 :	CAS*OA*93*0~	Line Adjustment Amount - CAS03, Other Adjustment – CAS01
2 4 3 0 :	DTP*573*D8*20130203~	Remittance Date
2 4 0 0 :	Line 2 SV1*HC:H0031*20*UN*1*11** 1:2:3** N~	Line Item Charge Amount - SV102
2 4 3 0 :	SVD*11122333*15*HC:H0031** 3~	Service Line Paid Amount - SVD02; Payer ID – SVD01 Must match 2330B NM109
2 4	CAS*OA*93*5~	Line Adjustment Amount - CAS03, Other Adjustment – CAS01

L o o p	Claim	Notes
3 : 0		
2 4 3 0 : :	DTP*573*D8*20130203~	Remittance Date
2 4 0 0 : :	Line 3 SV1*HC:99201*20*UN*1*11** 1:2:3** N~	Line Item Charge Amount SV102
2 4 3 0 : :	SVD*11122333*10*HC:99202** 2~	Service Line Paid Amount SVD02; Payer ID – SVD01 Must match 2330B NM109
2 4 3 0 : :	CAS*OA*93*10~	Line Adjustment Amount - CAS03, Other Adjustment – CAS01
2 4 3 0 : :	DTP*573*D8*20130203~	Remittance Date
Reporting Instructions for the Designated Collaborating Organization (DCO)		

For CCBHC services 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 D: 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 11 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 claims reporting and clinic assignment to correctly assign as many CCBHC service recipients as possible.

CCBHC Quality Bonus Payment (QBP) Benchmarks and Targets

Only designated QBP measures are eligible for a QBP award, and the benchmark for each measure must be met to qualify for the award for that specific measure. When a measure includes sub-measures, all associated sub-measure benchmarks must be met for the overall measure to be considered met (See Appendix E: Quality Bonus Payment Measures, Measure Stewards, and Benchmarks). If a CCBHC does not meet the required benchmarks, the associated funds will be added to a redistribution pool.

For each measure, QBP benchmarks are calculated as the weighted average of reported performance across in DY1, DY2, and DY3, weighted by denominator, with an additional one percent (1%) applied to support continuous improvement.

The quality measures introduced in DY4 (I-SERV, DEP-REM-6, GSD) currently lack sufficient historical data to establish QBP benchmarks. Benchmarks for these measures will be determined after all data from the CY25 measurement period has been collected and analyzed. Once finalized, the QBP benchmarks will be incorporated into the relevant sections of the Quality Measures Manual and included in a future update to the CCBHC Handbook.

The QBP benchmarks provided in this handbook apply only to DY5 quality measures, which are used for the CY26 measurement period. Please refer to Handbook Version 2.1 for DY4 QBP Benchmarks.

MDHHS will share demonstration targets for non-QBP measures as data from prior DYs are collected, reported, and averaged over time. These targets will serve as reference points for performance and help guide CCBHCs in setting 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 Metric Reporting Template

CCBHCs should submit the MI CCBHC Data Demonstration Template for the appropriate measurement year (e.g., “MI CCBHC Data Demonstration Templates (CY25).xlsx) in alignment with the reporting requirements described in Sections 7.A.4.1 and 7.A.4.2, and Appendix G: CCBHC Reporting Requirements.

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).

CCBHC Clinic-Reported Measure Guidance

* QBP Benchmarks denoted with an asterisk (*) will be calculated after the submission and processing of annual data from the CY25 measurement period. This section will be updated once finalized.

1. Time to Services (I-SERV)

Name: I-SERV		Steward: SAMHSA	***Quality Bonus Payment Metric
Description/Sub-Measures		QBP Benchmark	
1.A Sub-Measure 1	Average Number of Days until Initial Evaluation for New Persons Served	*	
1.B Sub-Measure 2	Average Number of Days until Initial Clinical Service for New Persons Served		
1.C Sub-Measure 3	Average Number of Hours until Provision of Crisis Services following a first Crisis Episode Contact.		
I-SERV Supplemental Reporting			
1.C.1 Sub-Measure 3.A	Average Number of Hours until Provision of Crisis Services following a <u>mobile Crisis</u> Episode Contact.	(NA)	
1.C.2 Sub-Measure 3.B	Average Number of Hours until Provision of Crisis Services following an <u>Urgent Care Crisis</u> Episode Contact.	(NA)	
1.C.3 Sub-Measure 3.C	Average Number of Hours until Provision of Crisis Services following any other Crisis Episode Contacts	(NA)	
Stratification			
<ul style="list-style-type: none"> • <u>Age</u>: Child (0-11 years of age), adolescent (12-17 years of age), adult (18 years of age and older) • <u>Payer</u>: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) • <u>Ethnicity</u>: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown • <u>Race</u>: 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:			
<ul style="list-style-type: none"> • To align with other Michigan Reporting requirements, CCBHCs should deviate from the specifications as written and use <u>calendar days</u> to calculate the I-SERV measures. • Reporting for children aged 0-11 years is a Michigan supplemental requirement, not a demonstration requirement. Although CCHBCs are required to report I-SERV measures for the 0-11 year old population, only rates for age 12 years and older with Medicaid coverage will be included in federal reporting and quality bonus payment calculations. • For I-SERV Sub-Measures 1 & 2, 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 person served 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: <ul style="list-style-type: none"> • Number of Eligible New Persons Served presenting with routine needs that did not receive an Initial Evaluation. • Number of Eligible New Persons Served presenting with emergency needs that did not receive Crisis Services. 			

Name: I-SERV	Steward: SAMHSA	***Quality Bonus Payment Metric
<ul style="list-style-type: none"> Evaluation and Crisis Services include those provided by either a CCBHC or DCO, or through Crisis Service Coordination Agreements. In service areas where CCBHCs partner with a state-sanctioned crisis provider, CCBHCs must account for the state-sanctioned crisis services provided to persons served at CCBHCs. DCO and/or Crisis Service Coordination Agreements should clearly outline data sharing expectations necessary to calculate this measure. This requirement does not apply if the State-sanctioned crisis DCO or Crisis Service Coordination Agreement partner is also a CCBHC, as that CCBHC will report I-SERV data for all crisis service provision. 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 persons served (12 years of age or older) with Major Depression or Dysthymia who reach Remission Six Months (+/- 60 days) after an Index Event Date.		*
Stratification		
<ul style="list-style-type: none"> <u>Age</u>: Adolescent (12-17 years of age), adult (18 years of age and older) <u>Payer</u>: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) <u>Ethnicity</u>: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown <u>Race</u>: 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:		
<ul style="list-style-type: none"> DEP-REM-6 is an adaptation of DEP-REM-12, which was discontinued for CY25. The Measure Assessment period for each person served remains at 14 months (12 months +/- 60 days) to accommodate both 6- and 12-month measures. Reporting of 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 Sub-Measure 1	Percentage of persons served 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 Sub-Measure 2	Percentage of persons served aged 18 years and older who were identified as unhealthy alcohol users (in sub-measure 1) who received Brief Counseling
Stratification	
<ul style="list-style-type: none"> <u>Payer</u>: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) <u>Ethnicity</u>: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown <u>Race</u>: A member of which of the following racial groups: White or Caucasian, Black or African American, 	

Name: ASC	Steward: NCQA
American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown	
Additional Guidance: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 ≥1) 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 persons served aged 18 years or older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.	
Stratification <ul style="list-style-type: none"> <u>Payer</u>: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) <u>Ethnicity</u>: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown <u>Race</u>: 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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 person served. 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	

Name: CDF-AD / CDF- CH		Steward: NCQA
5.	Percentage of persons served aged 18 years and older 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 persons served aged 12-17 years 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.	
Stratification		
<ul style="list-style-type: none"> • <u>Payer</u>: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) • <u>Ethnicity</u>: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown • <u>Race</u>: 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:		
<ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> ○ For example: if a person served 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. • 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 Sub-Measure 1	Percentage of persons served aged 18 years and older who were screened for Tobacco Use one or more times within the Measurement Year	
7.B Sub-Measure 2	Percentage of persons served 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		
<ul style="list-style-type: none"> • <u>Payer</u>: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) • <u>Ethnicity</u>: A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown • <u>Race</u>: 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:		
<ul style="list-style-type: none"> • 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 		

Name: TSC	Steward: NCQA
<u>Specifications and Resource Manual Disclaimers SAMHSA</u>	

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 persons served 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.	76% or higher
9.	The percentage of persons served aged 6-17 years with a diagnosis of Major Depressive Disorder (MDD) with an assessment for suicide risk.	60% or higher
Stratification		
<ul style="list-style-type: none"> • 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:		
<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ Specific inquiry about suicidal thoughts, intent, plans, means, and behaviors ○ 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 ○ 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: <u>Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual Disclaimers SAMHSA</u> 		

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:	
<ul style="list-style-type: none"> • 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 	

Name: PEC	Steward: SAMHSA
<p>completed according to the appropriate year’s SAMHSA Uniform System FY Table Reporting Instructions available on the SAMHSA Uniform Reporting System (URS) website.</p> <ul style="list-style-type: none"> ○ <u>CCBHC Data Submission Requirements:</u> <ul style="list-style-type: none"> • <u>DY4 (CY25 measurement period):</u> MDHHS will utilize the 2025 PEC individual responses data that the CCBHCs shared with CHRT. MDHHS will calculate and enter data into URS tables 9, 11, and 11a. • <u>DY5 (CY26 measurement period):</u> CCBHCs are required to submit the 2026 PEC individual responses data to MDHHS. MDHHS will calculate and enter data into URS tables 9, 11, and 11a. ○ <u>CCBHC Quality Measure Template Reporting Requirements:</u> <ul style="list-style-type: none"> • Complete the PEC tab • Complete the check boxes in the green section headers on URS Tables 9, 11. (No data entry is required in the orange section headers of URS tables 9 and 11. No data entry is required in URS table 11a.) 	

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

Name: Y/FEC	Steward: SAMHSA
Description/Sub-Measures	
<p>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.</p>	
<p>Additional Guidance:</p> <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> ○ <u>CCBHC Data Submission Requirements:</u> <ul style="list-style-type: none"> • <u>DY4 (CY25 measurement period):</u> MDHHS will utilize the 2025 Y/FEC individual responses data that the CCBHCs shared with CHRT. MDHHS will calculate and enter data into URS tables 9, 11, and 11a. • <u>DY5 (CY26 measurement period):</u> CCBHCs are required to submit the 2026 Y/FEC individual responses data to MDHHS. MDHHS will calculate and enter data into URS tables 9, 11, and 11a. ○ <u>CCBHC Quality Measure Template Reporting Requirements:</u> <ul style="list-style-type: none"> • Complete the Y/FEC tab • Complete the check boxes in the green section headers on URS Tables 9, 11. (No data entry is required in the orange section headers of URS tables 9 and 11. No data entry is required in URS table 11a.) 	

CCBHC State-Reported Measures

States participating in the CCBHC demonstration are responsible for the collection and reporting of 12 additional measures as described below. States use administrative claims and encounter data from Medicaid populations to calculate the measures.

CCBHC Population Definition

The CCBHC population is defined as Medicaid persons served who received CCBHC service(s) within the measurement periods specified for each measure. CCBHC service is defined as a claim with procedure code

T1040. Those dually eligible for Medicare and Medicaid are excluded. Rejected claims are excluded. The Medicaid ID must be in the submitted claim.

Continuous enrollment 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). If more than one CCBHC submitted the same number of T1040 service codes, the individual is attributed to clinic that provided the most recent service. Services provided by a State-sanctioned crisis provider to persons served by a CCBHC are excluded from State-reported measures. This exclusion does not apply to CCBHC-reported measures, as CCBHCs must include these services.

CCBHC Quality Bonus Payment (QBP) Benchmarks and Targets

Only designated QBP measures are eligible for a QBP award, and the benchmark for each measure must be met to qualify for the award for that specific measure. When a measure includes sub-measures, all associated sub-measure benchmarks must be met for the overall measure to be considered met (See Appendix E: Quality Bonus Payment Measures, Measure Stewards, and Benchmarks). If a CCBHC does not meet the required benchmarks, the associated funds will be added to a redistribution pool.

For each measure, QBP benchmarks are calculated as the weighted average of reported performance across in DY1, DY2, and DY3, weighted by denominator, with an additional one percent (1%) applied to support continuous improvement.

The quality measures introduced in DY4 (I-SERV, DEP-REM-6, GSD) currently lack sufficient historical data to establish QBP benchmarks. Benchmarks for these measures will be determined after all data from the CY25 measurement period has been collected and analyzed. Once finalized, the QBP benchmarks will be incorporated into the relevant sections of the Quality Measures Manual and included in a future update to the CCBHC Handbook.

The QBP benchmarks provided in this handbook apply only to DY5 quality measures, which are used for the CY26 measurement period. Please refer to Handbook Version 2.1 for DY4 QBP Benchmarks.

MDHHS will share demonstration targets for non-QBP measures as data from prior DYs are collected, reported, and averaged over time. These targets will serve as reference points for performance and help guide CCBHCs in setting goals.

Specifications and Measurement Years (MY)

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 Sub-Measure 1	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 Sub-Measure 2	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		
<ul style="list-style-type: none"> • Payer: Medicaid only or Other (including those dually eligible for Medicare and Medicaid) • Payer stratification is included in SAMHSA's CCBHC quality measure reporting template, However, Medicaid-only data are reported, and individuals dually eligible for Medicare and Medicaid are excluded from State-reported quality measure data reporting. 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:		
<ul style="list-style-type: none"> • 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 <p>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</p>		

13. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (adult) (FUA-AD)**14. 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 Sub-Measure 1	Percentage of emergency department (ED) visits for persons served 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 Sub-Measure 2	Percentage of emergency department (ED) visits for persons served 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 Sub-Measure 1	Percentage of emergency department (ED) visits for persons served 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 Sub-Measure 2	Percentage of emergency department (ED) visits for persons served 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		
<ul style="list-style-type: none"> • 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: FUA-AD/FUA-CH	Steward: NCQA
Additional Guidance:	
<ul style="list-style-type: none"> 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. 	

15. Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)**16. 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
16.A Sub-Measure 1	Percentage of discharges for persons served 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.	71% or higher
16.B Sub-Measure 2	Percentage of discharges for persons served 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.	47% or higher
17.A Sub-Measure 1	Percentage of discharges for persons served 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.	83% or higher
17.B Sub-Measure 2	Percentage of discharges for persons served 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.	61% or higher
Stratification		
<ul style="list-style-type: none"> 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:		
<ul style="list-style-type: none"> 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. 		

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

Name: FUM-AD/FUM-CH	Steward: NCQA
Description/Sub-Measures	
18.A Sub-Measure 1	Percentage of discharges for persons served 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 <u>30 days</u> of the ED visit (31 total days).
18.B Sub-Measure 2	Percentage of discharges for persons served 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 <u>7 days</u> of the ED visit (8 total days).
19.A Sub-Measure 1	Percentage of emergency department (ED) visits for persons served 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 <u>30 days</u> of the ED visit (31 total days).

Name: FUM-AD/FUM-CH		Steward: NCQA
19.B Sub-Measure 2	Percentage of emergency department (ED) visits for persons served 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 <u>7 days</u> of the ED visit (8 total days).	
Stratification		
<ul style="list-style-type: none"> • Age (FUM-AD only): Ages 18-64, and age 65 and older (as applicable) • 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:		
<ul style="list-style-type: none"> • 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 		

19. 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 Sub-Measure 1	Percentage of persons served 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%).	*	
20.B Sub-Measure 2	Percentage of persons served 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%).	*	
Stratification			
<ul style="list-style-type: none"> • 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:			
<ul style="list-style-type: none"> • 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 			

20. 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 Sub-Measure 1	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.	42% or higher	
21.B Sub-Measure 2	Engagement of SUD Treatment: The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation	14% or higher	
Stratification			
<ul style="list-style-type: none"> • 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 			

Name: IET-AD	Steward: NCQA	**Quality Bonus Payment Metric
Unknown		
<ul style="list-style-type: none"> 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		

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

Name: OUD-AD	Steward: CMS
Description/Sub-Measures	
22.A Sub-Measure 1	Percentage of Medicaid persons served ages 18 to 64 years 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 Sub-Measure 2	Percentage of Medicaid persons served ages 18 to 64 years 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 Sub-Measure 3	Percentage of Medicaid persons served ages 18 to 64 years 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 Sub-Measure 4	Percentage of Medicaid persons served ages 18 to 64 years 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 Sub-Measure 5	Percentage of Medicaid persons served ages 18 to 64 years 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	
<ul style="list-style-type: none"> 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:	
<ul style="list-style-type: none"> 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 	

22. Plan All Cause Readmission (PCR-AD)

Name: PCR-AD	Steward: NCQA	**Quality Bonus Payment Metric
Description/Sub-Measures		QBP Benchmark
23.	For persons served ages 18 to 64 years, 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% or lower
Stratification		
<ul style="list-style-type: none"> 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 		

Name: PCR-AD	Steward: NCQA	**Quality Bonus Payment Metric
<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Data are reported in the following categories: <ul style="list-style-type: none"> Count of Index Hospital Stays (HIS) Count of Observed 30-day Readmissions Count of Expected 30-Day Readmissions Reference Technical Specifications for Core Set Measures- Adult Core Set Reporting Resources Medicaid 		

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

Name: WCV-CH	Steward: NCQA
Description/Sub-Measures	
25. Percentage of children ages 3 to 21 years 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	
<ul style="list-style-type: none"> 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:	
<ul style="list-style-type: none"> 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 	

State-Specific Measures

[Placeholder for information about the Joint Care Measure]

24. Joint Care Planning (JCP30)

Name: JCP30	Steward: MDHHS
Description/Sub-Measures	
25. Specifications for this measure are currently under development. Once finalized, this section of the handbook will be updated.	

Appendix E: Quality Bonus Payment Measures, Measure Stewards, and Benchmarks (CY26)

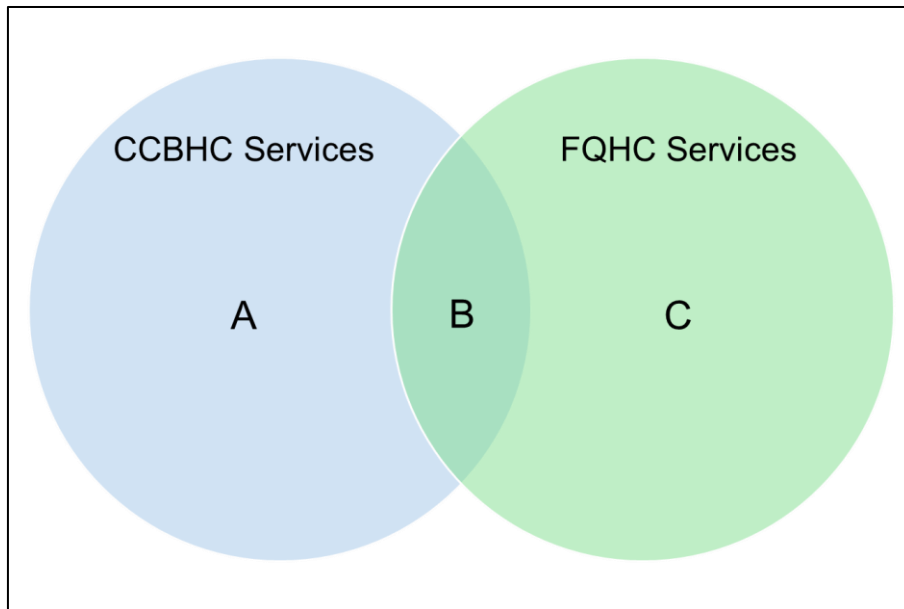
The QBP benchmarks provided in this handbook apply only to DY5 quality measures, which are used for the CY26 measurement period. Please refer to Handbook Version 2.1 for DY4 QBP Benchmarks.

QBP Benchmarks denoted with an asterisk () will be calculated after the submission and processing of CY25 annual data. This section will be updated once finalized.

Measure Name	Benchmark	Award Methodology	Steward
I-SERV: Time to Services	Average time to Initial Evaluation: *	15% of Eligible QBP	SAMHSA
	Average time to clinical services *		
	Average time to crisis services: *		
DEP-REM-6: Depression Remission at 6 months	*	5% of Eligible QBP	MN Community Measurement
GSD-AD: Glycemic Status Assessment for Patients with Diabetes	Adequate Control (<8.0%): *	10% of Eligible QBP	NCQA
	Poor Control (>9.0%): *		
FUH-AD: Follow-Up After Hospitalization for Mental Illness, ages 18+	7-Day: 47% or higher	15% of Eligible QBP	NCQA
	30-Day: 71% or higher		
FUH-CH: Follow-Up After Hospitalization for Mental Illness, ages 6 to 17	7-Day: 61% or higher	15% of Eligible QBP	NCQA
	30-Day: 83% or higher		
IET-AD: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation: 42% or higher	10% of Eligible QBP	NCQA
	Engagement: 14% or higher		
PCR-AD: Plan All-Cause Readmissions Rate	10% or lower	10% of Eligible QBP	NCQA
SRA-A: Adult Major Depressive Disorder: Suicide Risk Assessment	76% or higher	10% of Eligible QBP	Mathematica
SRA-C: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	60% or higher	10% of Eligible QBP	Mathematica

Appendix F: 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

Code	Description
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 G: CCBHC Reporting Requirements

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 unless a different time frame is agreed to by all parties). Failure to comply with reporting requirements and reporting deadlines may result in a corrective action plan (CAP). CMHSPs must follow all other reporting requirements as detailed in existing contracts with MDHHS. 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	<p>All CCBHCs must complete the clinic-reported measures on the MI-CCBHC Data Demonstration Templates (CY26).xlsx template quarterly and send to MDHHS.</p> <p>CCBHCs are responsible for completing the "Case Load Characteristics" sheet and the reporting sheets for the clinic-reported measures, (blue colored tabs) including the I-SERV (Supplemental) tab. The patient experience survey tabs (PEC, YFEC, URS-Tables 9 URS-Table 11, URS-Table 11a) are not required to be completed for Quarterly Metric Reporting. CCBHCs are not required to enter data for the State-reported measures (green colored tabs)</p>	<p>CCBHCs must complete reports each quarter and send to their designated CCBHC Certification Specialist and the CCBHC mailbox (mdhhs-ccbhc@michigan.gov).</p> <p>The MDHHS review will include, but is not limited to, the following:</p> <ul style="list-style-type: none"> • 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), • Calculation of relative standings for percentile-based QBP benchmarks (if applicable). <p>CCBHCs must also make reports available to MDHHS or external evaluators, when requested.</p>	<p>Due by the end of the month following the quarter.</p> <p>For example, for the quarter ending June 30th, templates are due to MDHHS by July 31st.</p> <p>CCBHCs must submit the second quarter template of a clinic's initial demonstration year to MDHHS as a trial submission of data collection</p>
<p><i>Handbook Section 7.A.4.1.</i></p>			
BHTEDS Record Submission	<p>All CCBHCs must submit BH-TEDs records to the File Transfer Service (FTS) for individuals receiving CCBHC services only.</p> <p>For more information, please navigate to the coding instructions: Reporting Requirements</p>	<p>Record submissions should be sent through the secured file transfer data service (FTS) mailboxes.</p>	<p>Due by the end of the month following the month of the record.</p>

Report	Description	Submission Instructions	Deadline
<p><u>Cost Reports</u></p> <p>Handbook Section 7.B.8</p>	<p>compliance@michigan.gov.</p> <p>All CCBHCs must submit a cost report within five months after the end of each demonstration year.</p> <p>The cost report may be used to determine the clinic-specific PPS-1 rate and to annually report demonstration costs.</p> <p>CCBHCs should use December 31 (three months after the end of the demonstration year) as a cutoff for financial reporting.</p> <p>The template and instructions can be found here:</p> <p><u>CCBHC Cost Report</u></p> <p><u>CCBHC Cost Report Instructions</u></p>	<p>CCBHCs complete cost reporting template and send to MDHHS.</p> <p>CCBHCs must review, validate, and submit CCBHC cost reports annually.</p> <ul style="list-style-type: none"> • MDHHS will provide support to CCBHCs completing their cost reports, including providing claim information for daily visit calculation. • CCBHCs and MDHHS must review cost reports for accuracy and sustainability. • MDHHS must provide feedback to the site related to the cost report and technical assistance, as needed. <p>CCBHCs must submit cost reporting template to the CCBHC mailbox (<u>mdhhs-ccbhc@michigan.gov</u>).</p>	<p>Due by February 28th (five months after end of demonstration year).</p>
<p><u>Supplemental Cost Report and Audited Financial Statements</u></p>	<p>CCBHCs must submit a Supplemental Cost Report. CMHSP CCBHCs must use the FSR as their Audited Financial Statement.</p> <p>Non-CMHSP CCBHCs must submit 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. The Audited Financial Statement must separate CCBHC costs from non-CCBHC costs to assist in validation of the cost reports.</p> <p>We understand given the due date of the supplemental cost</p>	<p>CCBHCs must submit report and audited financial statement directly to the CCBHC mailbox (<u>mdhhs-ccbhc@michigan.gov</u>).</p>	<p>Due February 28th (five months after end of the demonstration year).</p>

Report	Description	Submission Instructions	Deadline
Handbook Section 7.B.9.	report that audited financial statements may be submitted in draft form. If follow-up is needed, we will request a finalized version once completed.		
<u>Behavioral Health Provider Staffing and Expense Survey</u> Handbook Section 7.B.7.	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 email survey templates to the CCBHC mailbox (MDHHS). mdhhs-ccbhc@michigan.gov .	Due: March 15 th
<u>Annual Metric Reporting – Clinic and State Measures</u> Handbook Section 7.A.4.2.	All CCBHCs must complete the clinic-reported measures (blue colored tabs) on the MI-CCBHC Data Demonstration Templates (CY26).xlsx, including the “Case Load Characteristics” sheet, the I-SERV (Supplemental) tab, and the patient experience survey tabs (PEC, YFEC, URS-Tables 9 URS-Table 11, URS-Table 11a). CCBHCs are not required to enter data for the State-reported measures (green colored tabs). Annual reporting of clinic-reported measures will be calculated based on a measurement period of January 01 through December 31. Annual reporting of clinic-reported measures should include data for the DEP-REM-6 measure as of May 31 following the end of the measurement year.	Year-end final templates and year-end DEP-REM-6 data must be submitted by the CCBHCs to their designated CCBHC Certification Specialist and the CCBHC Mailbox (mdhhs-ccbhc@michigan.gov). PEC and Y/FEC Survey Reporting Guidance: <ul style="list-style-type: none"> • DY4 (CY25): MDHHS will utilize the 2025 PEC and Y/FEC individual responses data that the CCBHCs submitted to CHRT. • DY5 (CY26): CCBHCs are required to submit the 2026 PEC and Y/FEC individual responses to MDHHS. • MDHHS will calculate and enter data into URS Tables 9, 11, and 11a. • CCBHCs are responsible for completing the PEC and Y/FEC tabs, as well as completing the check boxes in the green section headers of URS Tables 9, 11, and 11a. (No data entry is required) 	Year-end final templates are due to MDHHS within six (6) months of the end of the measurement year (by June 30) Annual DEP-REM-6 measure data is due to MDHHS within one (1) month of the end of the numerator measurement period (by September 30)

