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Owner	Emily Walz: Director, Quality Improvement
Area	08. Quality Management
Audiences	LifeWays Provider Network, LifeWays Staff

08-02.07 Sentinel Events and Root Cause Analysis

PURPOSE:

To detail the process for review of Sentinel Events, initiating an investigation using a Root Cause Analysis format, and reporting of critical events to the Michigan Department of Health and Human Services (MDHHS) and Commission on Accreditation of Rehabilitation Facilities (CARF).

DEFINITIONS

- **Sentinel Event** – Unexpected occurrences involving death, serious psychological or physical injury (specifically loss of limb or function) or the risk thereof. This includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response (CARF; The Joint Commission (TJC).). Also included is injury or death that occurs as a result of the use of a behavioral intervention (MDHHS Contract Attachment P.1.4.1.). Sentinel Events require root cause analysis and reporting to MDHHS and accrediting entities in accordance with established procedures.
- Root Cause Analysis - A root cause analysis (TJC) or investigation (per Centers for Medicaid and Medicare Services (CMS) approval and MDHHS contractual requirement) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance (TJC, 1998)."

PROCEDURE

INITIATION OF REVIEW

A. The Critical Event Review Team (CERT) is formally notified by the Office of Recipient Rights and/or Quality Management Administrative Assistant of all events that qualify as a reportable critical event that are particularly unusual and/or severe. After initial review of an incident report, the CERT shall determine if the incident warrants a full investigation as a sentinel event.

B. If the incident qualifies as a sentinel event, the date of receipt is recorded and a Root Cause Analysis (RCA) is initiated by **the primary provider within two business days of notification from CERT**.

SENTINEL EVENT REVIEW

A. It is expected that LifeWays and the Network Providers, as a part of their accreditation, are completing a thorough RCA in the event a consumer is involved in a sentinel event. The RCA must be completed using the RCA template that is included in the attachment section of the procedure. Network Providers, including LifeWays, are recommended to use Southeast Dispute Resolution Services (SEDRS) to facilitate the meeting, as all providers serving the individual are expected to participate. To request SEDRS, please request via the Contracts Management Help Request (CRM). The RCA must include all providers serving the individual and the final report to LifeWays shall include the following at minimum:

    1. A detailed summary of what occurred
    2. A detailed sequence of events, including all provider contacts with the individual and the purpose, outcome, and individual's presentation at the contact.
    3. Root Cause/Incidental Findings
    4. Applicable medical treatment
    5. CMH treatment
    6. Medications
    7. Review of applicable policies/procedures
    8. Recommendations to prevent reoccurrence – Quality Improvement activities (if any identified)
    9. Time frames to complete recommendations including evaluation to ensure effective strategies
    10. Documentation of all who participated in the RCA and their credentials

B. The Supervisor of Quality Management or Administrative Assistant, on behalf of CERT, will correspond with the appropriate LifeWays' Clinical Supervisor or Network Provider to request a RCA investigation. The provider will have 14 calendar days to complete the RCA.

RCA TOOL COMPLETION

A. Prior to the RCA meeting to review the case with SEDRS facilitating, the involved provider(s) shall each complete Appendix 1 as referenced in the RCA Tool. Providers are expected to identify all documents that were reviewed and document those as references used in the Appendix.

B. SEDRS shall complete the entire RCA Tool, with the exception of Appendix 1, which will be completed by the participating providers; Appendix 2 shall be completed by the RCA Panel once review of RCA has been completed.

C. At the conclusion of the RCA, SEDRS shall send the RCA to Supervisor of Quality Management or Administrative Assistant within 2 business days.

LIFEWAYS REVIEW

A. Staff involved in the review of RCA must have the appropriate credentials to review the scope of care. For example, RCA that involve death, or other serious medical conditions, must involve a physician or nurse. RCA Panel will involve minimally the Primary Case Holder Organization and Ancillary Providers serving the individual for review of the RCA to answer any follow up questions; coordination will occur by the Quality Management Administrative Assistant. The RCA Panel will determine if potential system-wide issues exist or other quality improvement activities initiated by LifeWays. Otherwise, the RCA results are accepted by the RCA Panel by signature and closed unless CERT is awaiting Death Certificate or toxicology results.

B. LifeWays' RCA Panel will review the completed RCA with the provider staff that participated in it's completion; SEDRS will not be included as the facilitator. Meeting with the RCA Panel shall occur within 14 days of receipt of RCA completion. The peer review by the RCA Panel is focused on using quality improvement strategies to identify causes that can be identified and corrected through system changes, such as policies and procedures, training/education, or increased monitoring.

C. The results of RCAs conducted by LifeWays shall be approved by the RCA Panel; if additional consultation is necessary, LifeWays Executive Leadership will be consulted by the RCA Panel. Any action plans shall be monitored by the RCA Panel or as delegated by the RCA Panel. Provider action plans shall be monitored by the most appropriate entity for quality improvement and prevention of recurrence.

REPORTING OF SENTINEL EVENTS

A. It is required that CARF receive notification of all sentinel events within 30 days of their occurrence in any CARF accredited Program/Service of the Provider. The Quality Management representative on the CERT shall be responsible for sentinel event correspondence with CARF. Notification of the event is conducted using the CARF Ongoing Communication of Administrative Items and Significant Events: Sentinel Event form, which includes a summary of the event, contact information, status of the investigation and action taken to prevent reoccurrence. Once the investigation is complete, CARF must also receive notification of the outcome and action plan of the event.

B. It is required for CMH and SUD services, that any critical incident be determined within 3 business of the event as discovered.

PEER REVIEW PROTECTIONS

A. Material used after care was provided to determine if the care in question was appropriate is considered "peer review record" and are protected under the HIPAA (Health Insurance Portability and Accountability Act of 1996) laws. Therefore, any documentation collected and/or developed as part of a root causes analysis conducted by LifeWays CERT or a LifeWays Provider **may not be disclosed** to any requesting parties without permission by the Privacy Officer.

B. The Mental Health Code requires a peer review process and states that all documents, data, or knowledge pertaining to an assigned peer review function are confidential, shall only be used

for the purpose of the peer review, are not public records, and are not subject to court subpoena. [*Mental Health Code (Public Act 258 of 1974), 30.1143a Review of professional practices; scope; confidentiality; disclosure. Sec. 143a.]*

REFERENCES

U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
CARF: Ongoing Communication and Administrative Items and Significant Events
MDHHS/PIHP & CMHSP Contract

Michigan Mental Health Code ((*Public Act 258 of 1974), 30.1143)*
LifeWays Policies
02-04 Recipient Rights Reporting
05-01 Clinical Care
11-01 Safety and Security
LifeWays Operating Procedures
02-04.04 Abuse and Neglect Reporting
02-04.02 Incident Report Process
02-04.07 Adverse Event Reporting and Review

Attachments

08_02_07_A_Root_Cause_Analysis_Tool _LifeWays.docx

Approval Signatures

Step Description	Approver	Date
Stakeholder/Communication/ Board Approval	Karen Cascaddan: Executive Director, Governance	3/6/2023
Final Approver - CEO	Maribeth Leonard: Chief Executive Officer	3/6/2023
Area Chief Approver - COO	Shannan Clevenger: Chief Operating Officer	3/1/2023
Approver - Area Director	Josh Williams: Director, Quality Management	2/22/2023
Initiate Review/Revisions	Philip Hoffman: Quality Management Supervisor	2/22/2023

Behavioral Health Independent Facilitation

Southeastern Dispute Resolution Services
Positive Communications, Peaceful Resolutions & Improved Relationships

SOUTHEASTERN
DISPUTE RESOLUTION
SERVICES

Marc Stanley
Executive Director

Phone: 517-990-0279
Email: mstanley@sedrs.org

Community Resolution Center for Jackson, Hillsdale, Lenawee, Monroe and Calhoun Counties. We focus on resolving conflict, improving relationships, building community, improving communication and seeking positive outcomes using Alternative Dispute Resolution Processes and Restorative Practices.

http://sedrs.org/

Christy Johnson
Executive Administrator

Phone: 517-990-0279
Email: cjohnson@sedrs.org

Person-Centered Planning/Family-Centered Planning (PCP)

- The person-centered planning process involves families, friends, and professionals as the individual desires or requires (MCL 330.1700(g))
- An adaptable approach to planning that actively explores the full range of resources available to the individual and resources that are or may be made available in the broader community
- The way that the Focus Person, along with the support of family, support person(s), case manager, service provider(s), and community organization(s) identify goals, interests, desires, and choices for a meaningful life and what services and supports the Focus Person needs to accomplish what he/she wants to do

Who is involved in PCP?

- **The Focus Person**
  - The Individual at the **center** of the PCP Process
- Behavioral Health Independent Facilitator
  - Independent third party SeDRS Facilitator
- Primary Case Holder
- Parent(s)/Legal Guardian(s)
- Spouse, family member(s), friend(s), support person(s)
- Advocate(s)/Key individual(s) in Focus Person's life
- Case manager(s)
- Service provider(s)
- Community organization(s)
- Any other individuals the Focus Person may want or need to be involved in creating a service plan to achieve his/her identified goals and objectives

Person-Centered Planning Tools

- Essential Lifestyle Planning (ELP)
- Making Action Plans (MAPS)
- Planning Alternative Tomorrows with Hope (PATH)
- Personal Futures Planning (PFP)
- Group Person-Centered Planning
- Other Tools
    - Hybrids & Non-Specific

E. L. P.

Essential Lifestyle Planning

1. Guided process to learn how Focus Person wants to live and to develop a plan to assist in making that plan happen
2. Adaptable collaborative planning technique developed through a process of asking questions and listening to responses
3. Organize and Communicate in ‘plain language’ Focus Person’s goals, interests, desires, and choices for a meaningful life
4. Prepare a blueprint of the ways in which to support Focus Person in achieving goals

M. A. P. S.

Making Action Plans

1. Identify who the MAP is for and invite all in the room to introduce themselves and describe their relationship with the Focus Person.
2. Focus Person tells his/her story; why we are here. The Focus Person can choose another to tell the story
3. Focus Person identifies what he/she wants to change about life and share his/her dream, aspirations, and hopes
4. Focus person is then asked to talk through fears and worries in preparing for the dream ~ identify his/her nightmare

M. A. P. S.

5. The group identifies and understands Focus Person's gifts, strengths and talents to assist him/her in setting goals and decision-making

6. The group brainstorms about the best way to move towards the Focus Person's dream, and away from the nightmare

7. At this point in the process the group develops the action plan; the actions that need to be taken, a detailed description of the action, who will perform it and when

   It is key to set deadlines for action reviews, progress, and measurable outcomes

P. A. T. H.

Planning Alternative Tomorrows with Hope

INDIVIDUAL ROLES and RESPONSIBILITIES

Independent SeDRS Facilitator

- **Independent** third party
- Neutral and unbiased individual who maintains impartiality throughout the PCP process
- Define and manage the PCP process
- Guide the Focus Person and PCP participants through the conversation and the development of the plan
- Pre-Planning intake with Focus Person and PCP participants
- Assure the opportunity for all to meaningfully participate in the PCP

Focus Person

- Make meaningful decisions concerning his/her health and well-being
- Advocate for him/herself to direct his/her own services
- Have a leadership roles in the design, delivery and evaluation of his/her services and supports
- Be free from involuntary treatment
- Discuss his/her personal resolve and belief in one's self-development, productivity and achievement of personally meaningful life goals
- Discuss his/her economic independence and prosperity
- Self-manage his/her abilities

Primary Case Holder (PCH)

- Work in partnership with the SeDRS Independent Facilitator along with the Focus Person, family, friends, and other allies that the Focus Person requests be invited to the PCP
- Assist the Focus Person in developing an individualized plan making changes to services and goal descriptions as needed
- In cooperation with the SeDRS Independent Facilitator, the PCH will assure that Focus Person controls the planning process
- Ensure that Focus Person is listened to, feels respected and supported throughout the process, is aware of all paid and unpaid services and supports, and is offered choice of both services and providers
- Work with all planning team members involved to ensure that all of the Focus Person’s goals and needed services are included in the service plan

Service Provider(s)

- Be prepared to take the lead in discussing, driving and supporting the PCP process – but only if this is what the Focus Person and/or his/her parent(s)/ legal guardian(s) desire
- Balance the interests of the service providers and the Focus Person's current service needs and the necessary levels of support in each service area.
- Support the directions identified by the Focus Person and the necessary services and supports defined by the PCP participants linking goals to the needed services that will be provided
- Work together to coordinate direct services and provide direct services to the Focus Person according to the service plan developed at the PCP
- *The Focus Person and/or his/her parent(s)/legal guardian(s) may request to direct the process. In this is the case, service provider(s) should be prepared to offer the Focus Person meaningful support in leading the PCP.

Parent(s)/Legal Guardian(s)

- Parent(s)/Legal Guardian(s) should be prepared to practice *supported decision-making* at the PCP
  - Help the Focus Person understand the options for service planning and supporting his/her life choices
- The Parent(s)/Guardian(s) does not make a decision *for* the Focus Person, rather they work *with* the Focus Person to arrive at decisions that accommodate the Focus Person's identified goals
- Should be prepared to talk about the Focus Person's choices and brainstorm options when developing the service plan
- Parent(s)/Legal Guardian(s) should expect to participate in the PCP in good faith with the intention of exploring, developing, and evaluating options for the service plan and necessary supports that accommodate the Focus Person's identified goals

Spouse/Family/Friend(s)

- Should be prepared to make a brief statement about the Focus Person, any concerns or matters in dispute, the outcome sought by the Focus Person, and any other relevant factors/information
- Spouse/Family/Friend(s) should be prepared to practice *supported decision-making* at the PCP
  - Help the Focus Person understand the options for service planning and supporting his/her life choices
- Spouse/Family/Friend(s) should expect to participate in the PCP in good faith with the intention of exploring, developing, and evaluating options for the service plan and necessary supports that accommodate the Focus Person's identified goals

Advocate(s)/Key Individual(s) in Focus Person's Life

- Should be prepared to make a brief statement about the Focus Person, any concerns or matters in dispute, the outcome sought by the Focus Person, and any other relevant factors/information
- Advocate(s)/Key Individual(s) will practice *supported decision-making* at the PCP
  - Help the Focus Person understand the options for service planning and supporting his/her life choices
- Advocate(s)/Key Individual(s) should expect to participate in the PCP in good faith with the intention of exploring, developing, and evaluating options for the service plan and necessary supports that accommodate identified goals

Support Person(s)

- Should be prepared to provide reassurance and emotional support to the Focus Person
- A Support Person is not entitled to intervene or to participate in the PCP process in any other capacity without the agreement of the Focus Person and all PCP Participants.
- If a Support Person wishes to discuss any aspect of the process with the person they support, the proper approach is to suggest to the Focus Person to request of the Independent Facilitator a *time out*.

Community Organization(s)

- May be invited to a PCP, but is NOT directly involved in the PCP process outside of the scope of the specifically identified service area(s)
- Should be prepared to assist indirectly and to be involved in implementing the service plan and action steps
- If the Focus Person is in need of other resources, services and supports, then the Focus Person, along with his/her case manager, family, support person(s), and service provider(s) can brainstorm to explore opportunities to achieve his/her identified goals and objectives

Benefits of Person-Centered/Family-Centered Planning

EMPOWER the FOCUS PERSON to:

- Advocate for him/herself
- Communicate his/her own goals, hopes, interests and preferences for services/supports
- Self-manage disabilities and direct necessary services/supports
- Decide how he/she will work toward and achieve identified goals, including the necessary services/supports
- Contribute to and meaningfully participate in the community

- Work actively, creatively, and collaboratively with the Focus Person and PCP participants to identify, define, and achieve meaningful goals
- Experience fewer disruptions, conflicts, and crises during the PCP process and the implementation of action steps
- Share the responsibility of resource allocation and decision-making with unbiased information on services and supports available, community resources and options
- Build, repair, and maintain TRUST in RELATIONSHIPS

Process Flow for Independent Facilitation

Process Flow for Independent Facilitation Initial Update/Assessment

STEP ONE

During the initial/update assessment, the individual watches a recorded video explanation of independent facilitation.

STEP TWO

If the individual chooses to utilize independent facilitation, the chosen individual/agency is documented in the assessment.*

STEP THREE

The staff member that completed the assessment will enter an admission in LifeWays Electronic Organizer (LEO)for Southeastern Dispute Resolution Services (SeDRS) and an authorization is entered for 3 units of H0032-WQ.

*If individual chooses an independent facilitator other than Southeastern Dispute Resolution Services, the staff member completing the assessment notifies Contracts via Contracts Management Request (CMR). In this circumstance, do not continue with the above process flow.

Process Flow for Independent Facilitation Preplanning Meeting

STEP FOUR

Staff member starts new Treatment Plan to enable SeDRS to complete pre-planning document.

STEP FIVE

SeDRS is notified via LEO that a case has been assigned and reviews the assessment.

*SeDRS can be contacted at 517-990-0279

STEP SIX

SeDRS contacts the individual to provide choice of Independent Facilitator (IF) and schedules pre-planning meeting with the individual within 7 days of receiving authorization request.
Note: PCH does not need to attend pre-planning meeting.

STEP SEVEN

During the pre-planning meeting:

a. IF schedules the Person-Centered Planning (PCP) meeting at least 14 calendar days in advance of the effective date of the new Treatment Plan.

b. IF assists in inviting participants chosen by the individual to the PCP meeting.

c. **IF completes the pre-planning form in LEO and uses the 'Send Copy To' function to route a copy to the PCH.**

Process Flow for Independent Facilitation During the PCP meeting

STEP EIGHT

A. IF chairs and facilitates the PCP meeting (or supports the individual to facilitate his or her own PCP meeting), assuring the individual's hopes, interests, desires, preferences and concerns are heard and addressed using a person-centered planning tool chosen by the individual during pre-planning.

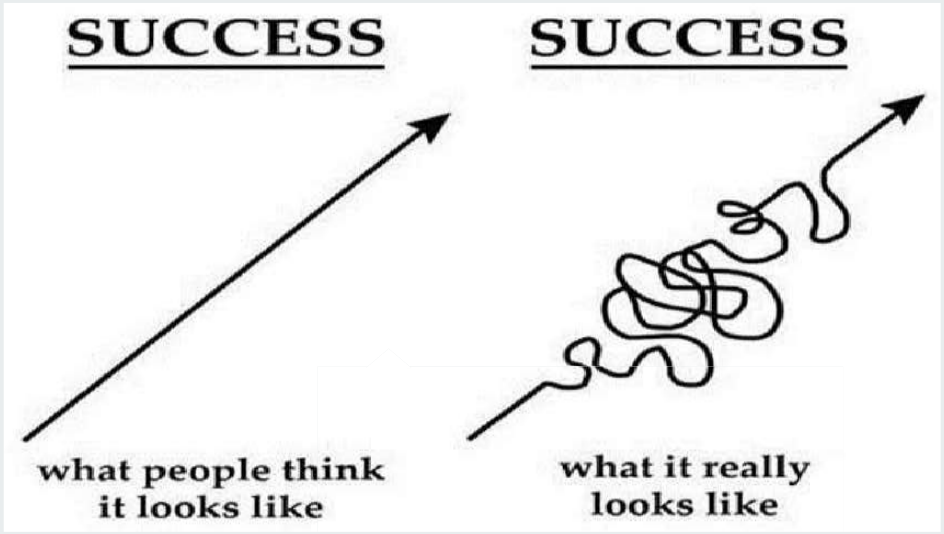
B. PCH participates in the meeting to ensure the individual is aware of available services and supports and offer choice of services and providers.

C. PCH uses collaborative documentation to complete all sections of the PCP Meeting and Treatment Plan form during the PCP meeting.

Process Flow for Independent Facilitation
PCP Completed

STEP NINE

PCH closes SeDRS program assignment in LEO after treatment plan developed



Thank You.

Contact:

Email: mediation@sedrs.org
Phone: (517) 990-0279

MI Certified Community Behavioral Health Clinic (CCBHC) Handbook

Version 1.7

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

October 2023

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

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

1. Contents

Preface

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

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

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

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

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

1.A. Background of CCBHCs in Michigan

In 2016, MDHHS applied to the Centers for Medicare & Medicaid Services (CMS) to become a CCBHC Demonstration state under Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA). That request was approved on August 5, 2020, when the federal CARES Act of 2020 authorized two additional states—Michigan and Kentucky—to join the demonstration. As a result, MDHHS was approved for a two-year demonstration with an anticipated implementation start date of October 1, 2021. The 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 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, the relevant Prepaid Inpatient Health Plans (PIHPs), by utilizing a collaborative and interdisciplinary team-based model of care to ensure the totality of one's needs – physical, behavioral, and/or social. At the end of the demonstration, MDHHS will evaluate the program's impact and assess the potential to continue or expand the initiative under the CMS State Plan option.

1.B. CMS Demonstration and SAMHSA CCBHC Grants

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

1.B.1. SAMHSA 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 has no direct involvement in the oversight or implementation of these grants.

1.B.2. The CMS CCBHC Demonstration

The CMS CCBHC Demonstration is operationalized by the State and uses a Prospective Payment System (PPS) rate for qualifying encounters provided to Medicaid beneficiaries. 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 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 criteria related to care coordination, crisis response and service delivery, and be evaluated by a common set of quality measures. Furthermore, CCBHCs establish a sustainable payment model that differs from the traditional system funded by time-limited grants that only support pockets of innovation for specific populations. Early experiences demonstrate that CCBHCs have shown tremendous progress in building a comprehensive, robust behavioral health system that can meet the treatment demand.

1.C.1. Expanded Service Array

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

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

1.C.2. Expanded Access to Services

CCBHC program requirements stipulate that CCBHCs cannot refuse service to any person based on either ability to pay or residence, expanding the population eligible for the robust service array. Any fees or payments required by the clinic for such services will be reduced or waived to ensure appropriate accessibility and availability. Additionally, CCBHCs must follow standards

intended to make services more available and accessible, including expanding service hours, utilizing telehealth, engaging in prompt intake and assessment processes, offering 24/7 crisis interventions, and following person and family-centered treatment planning and service provision.

1.C.3. Improved Care Coordination and Integrated Care

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

1.C.4. Expanded Person-Centered Treatment

Expansion of person-centered, family-centered, trauma-informed, and recovery-oriented care that integrates physical and behavioral health care to serve the "whole person".

1.C.5. Expanded Data Collection and Quality Reporting

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

1.D. Eligibility

1.D.1. CCBHC Site Eligibility

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. CCBHC Demonstration Sites are located on the MDHHS CCBHC webpage.

1.D.2. CCBHC Recipient Eligibility

Any person with a mental health or substance use disorder (SUD) ICD-10 diagnosis code as cited in Appendix B is eligible for CCBHC services. The mental health or SUD diagnosis does not need to be the primary diagnosis. Individuals with a dual diagnosis of intellectual disability/developmental disability are eligible for CCBHC services. Eligibility review should align with assessment and diagnosis requirements (see 8.D.4.1 for more on requirements) and take place as frequently as specified or as clinically appropriate following the person-centered planning process and must be medically necessary.

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

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

1.D.3. Residency

CCBHCs must serve all individuals regardless of residency or ability to pay. CCBHCS may define service catchment areas for targeted outreach that correspond directly to the required annual needs assessment (See Program Requirements, criteria 8. A.1.) For individuals residing out of state, CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services and should have protocols developed for coordinating care across state lines.

2. PIHP and CCBHC Requirements

2.A. CCBHC General Requirements

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

2.B. PIHP Requirements

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

2.B.1. Minimum Requirements

- PIHPs must be a regional entity as defined in Michigan's Mental Health Code (330.1204b) or organized as the three standalone CMHSPs (i.e., Macomb, Oakland, and Wayne Counties).
- PIHPs must contract or develop a Memorandum of Understanding with all CCBHCs in their region and ensure access to CCBHC services for their enrollees.
- PIHP contracts with CCBHCs must permit subcontracting agreements with DCOs and credentialing of DCO entities and/or practitioners.
- PIHP contracts with CCBHCs must reflect the CCBHC scope of services and ensure compensation for CCBHC services equates to clinic-specific PPS-1 rates. Contracts must not limit the CCBHC's ability to serve all populations with behavioral health needs per CCBHC eligibility requirements.
- PIHPs must understand the CCBHC certification process and certification requirements.
- PIHPs must have the capacity to evaluate, select, and support providers who meet the certification standards for CCBHC, including:
    - Identifying providers and DCOs who meet the CCBHC standards,
    - Establishing an infrastructure to support CCBHCs in care coordination and providing required services, including but not limited to crisis services, SUD services, and primary care services,
    - Collecting and sharing member-level information regarding health care utilization and medications with CCBHCs,
    - Providing implementation and outcome protocols to assess CCBHC effectiveness,
    - Developing training and technical assistance activities that will support CCBHCs in effective delivery of CCBHC services.
- PIHPs must distribute data requests from MDHHS to CCBHCs for data collection.
- PIHPs must validate by reviewing for completion, evaluate for reasonability, and accuracy of data requests prior to sending to MDHHS. This includes but is not limited to quality metrics, cost reports, level of care (LOC) data, reconciliation templates, and ad-hoc requests by MDHHS.

- MDHHS recommends that PIHPs provide training and technical assistance on certification requirements, including helping other potential CCBHC sites in preparing to meet CCBHC requirements.
- PIHPs must utilize Michigan claims and encounter data for the CCBHC population.
- PIHPs must use CareConnect360 to analyze health data spanning different settings of care for care coordination purposes among CCBHC Medicaid beneficiaries.
- PIHPs must provide support to CCBHCs related to Health Information Technology, including WSA, CareConnect360, PIHP EHR, and HIEs.
- PIHPs provide access and utilization management of Medicaid-covered services, including Medicaid-covered services for individuals enrolled in CCBHC. If a PIHP delegates managed care functions to the CCBHC, the PIHP remains the responsible party for adhering to its contractual obligations.

2.B.2. CCBHC Enrollment and Assignment

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

2.B.3. CCBHC Coordination and Outreach

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

2.B.4. CCBHC Payments

- PIHPs are responsible for reimbursing CCBHCs at the site-specific PPS-1 rate for each valid

CCBHC service encounter (note: the PPS-1 payment may only be paid once per day per Medicaid individual regardless of the number of CCBHC service encounters reported for a given day) in accordance with the CCBHC Payment section of the policy and this Handbook (Section 5). PIHPs must reimburse CCBHCs in a timely manner.

- PIHPs will submit encounters to MDHHS in accordance with Section 5.C.1 of this Handbook.

2.B.5. Reporting

2.B.5.1. Cost and Quality Metric Reporting

- Review, audit, and submit CCBHC quality metric reports to MDHHS for MDHHS review and submission to CMS.
- Review quarterly CCBHC required metric templates for accuracy and reasonability.
- Collect and report access data quarterly to include, by CCBHC, the number of individuals requesting services and the number of individuals receiving their first service.
- Review, validate, and submit CCBHC Office of Management and Budget (OMB) Cost Reports to MDHHS and other requested data reports.
- CCBHCs and PIHPs must complete and submit reconciliation templates quarterly. MDHHS anticipates templates to be due 6 weeks after each quarter. For example, quarter 1, October 1 – December 31, templates will be due to MDHHS by February 15. Note: Receipt of quarterly reporting is for reporting purposes only.
- Submit the preliminary PIHP to CCBHC Reconciliation Template (covering the entire demonstration year) for each CCBHC to MDHHS. Final templates should be sent to MDHHS-CCBHC@michigan.gov within 90 days of the end of the demonstration year.

2.B.5.2. Grievance Monitoring and Reporting

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

2.B.5.3. Other Reporting

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

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

2.B.6. Oversight

- Monitor CCBHC performance and lead quality improvement efforts. PIHPs are not responsible for overseeing and monitoring any certification corrective action plan, however MDHHS will share the plans with the PIHP and the PIHP may be asked to assist the CCBHC in meeting goals where appropriate.
- Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on clinical outcomes, experience of care outcomes, and quality of care outcomes at the

population level.
- Designs and develops prevention and wellness initiatives, and referral tracking.
- Network monitoring and performance.
- Cost and quality report audit and compliance review.
- Compliance with other State and/or Federal reporting requirements.

2.C. CCBHC Requirements

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

2.C.1. Minimum Requirements

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

2.C.2. MI CCBHC Certification Requirements

2.C.2.1. Certification Overview

Potential CCBHCs must complete the MDHHS certification process to become a CCBHC under the CMS CCBHC Demonstration. Certification is required to bill the T1040 code and to receive the PPS-1 payment. MDHHS will document and monitor CCBHC certification through the MDHHS CRM database. Potential CCBHCs must provide

justification of meeting CCBHC criteria and upload supporting documentation verifying that standards have been met. Certifications are valid for three years. Whether the site is new or existing to the CCBHC demonstration, MDHHS can issue varying levels of certification based on readiness assessment as well as ability to successfully meet all CCBHC application criteria.

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 including the required Evidence Based Practices. The CCBHC must be in full compliance with CCBHC array of services in its entirety by the first day of their respective CCBHC Demonstration start date. A 30-day corrective action plan may be provided to support a new site in meeting requirements prior to entering the demonstration.

During the demonstration a Corrective Action Plan may be provided to support a CCBHC site that does not fully meet all program requirements. Corrective Action Plans 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 decertification process will begin. The CCBHC along with PIHP will receive 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 of the Corrective Action Plan.

Recertification will take place every three years and MDHHS will conduct site visits to each certified CCBHC during the demonstration period to verify that program requirements are being met and implemented in practice. MDHHS staff will review documentation and client records and offer feedback on CCBHC practices. Specified levels related to certification during the recertification process can be found in 2.C.2.1.3 components of the site visit are identified in section 2.C.2.1.6.

2.C.2.2. Certification Application

2.C.2.2.1. Accounts

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

Requests for MDHHS CRM accounts should be sent to mdhhs-ccbhc@michigan.gov. CCBHCs are responsible for requesting 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 recertification, MDHHS will also attempt to verify that user accounts and access privileges are accurate, however it is the responsibility of the CCBHC to maintain access for recertification purposes.

2.C.2.2.2. Application Process

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

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

2.C.2.2.3. Assigning Certification Levels

During the recertification period and after MDHHS has received and reviewed all materials, MDHHS will assign a certification level based on scoring of application standards. If the CCHBC is found compliant in all application standards, they will be awarded full Certification. Those CCBHC sites with application deficiencies will be categorized as follows:

Full Certification with a Corrective Action Plan

Following the certification/site visit, the CCBHC team will generate a report within 45 days identifying the findings and recommendations that require a response by the CCBHC site. The CCBHC site will have 30 days to provide a Correction Action Plan (CAP) for achieving compliance. The CCBHC site may also present new information to MDHHS that demonstrates it was in compliance with the questioned provisions at the time of the review. (New information can be provided anytime between the certification/site visit and the CAP). The MDHHS CCBHC team will review the CAP, seek clarifying or additional information from the CCBHC site as needed, and issue an approval of the CAP within 30 days of receipt. MDHHS CCBHC team will take steps to monitor the CCBHS site implementation of the CAP as part of performance monitoring. Follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the CAP is approved by the MDHHS CCBHC team. Following the completion of the CAP if CCBHC site fails to meet compliance standards as outlined in the CCBHC Handbook then site will be moved to provisional certification status and required to provide a new 90-day CAP.

Provisional Certification

Following the certification/site visit, the CCBHC team will generate a report

within 45 days identifying the findings and recommendations that require a response by the CCBHC site. The CCBHC site will have 30 days to provide a Correction Action Plan (CAP) for achieving compliance. The CCBHC site may also present new information to MDHHS that demonstrates compliance with the questioned provisions at the time of the review. (New information can be provided anytime between the certification/site visit and the CAP). The MDHHS CCBHC team will review the CAP, seek clarifying or additional information from the CCBHC site as needed, and issue an approval of the CAP within 30 days of receipt. MDHHS CCBHC team will take steps to monitor the CCBHS site implementation of the CAP as part of performance monitoring. Follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the CAP is approved by the MDHHS CCBHC team, with MDHHS CCBHC team quarterly check-ins over 6 months. Following the completion of the CAP if CCBHC site fails to meet compliance standards as outlined in the CCBHC Handbook then an additional 6 months of monitoring with quarterly check-ins will be provided. After 12 months of support and a CAP if site is not able to achieve full certification, then de-certification of the site will begin.

When access or care to individuals is a serious issue, the CCBHC site may be given a much shorter period to initiate corrective actions, and this condition may be established, in writing, as part of the certification application findings. If, during recertification, the MDHHS CCBHC team member identified an issue that places a person served in imminent risk to health or welfare, the MDHHS CCBHC team would invoke an immediate review and response by the CCBHC site, which must be completed in seven calendar days.

2.C.2.2.4. Certification Expiration

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

2.C.2.2.5. Certification Changes

To keep CCBHC certification documentation accurate, CCBHCs must notify PIHPs and MDHHS of any significant change in policy or practice that would impact a clinic's ability to meet certification and/or state budgeting. Examples include a change in ability (long or short term) to provide any of the 9 CCBHC services, annual changes or updates to DCO agreements, or significant changes

in the ability to serve the service population in a timely manner.

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

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

2.C.2.2.6. On-Site Reviews

With the extension of the demonstration, MDHHS will conduct site visits to each certified CCBHC every three years during the demonstration period to verify that program requirements are being met and implemented in practice. Site visits may also be initiated earlier at the discretion of MDHHS. The site review may be in person or virtual. MDHHS staff will review documentation and client records and offer feedback on CCBHC practices. PIHPs will be permitted to accompany MDHHS and will receive the full final report. Deficiencies related to meeting CCBHC criteria found during the site visit can impact level of certification.

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

When access or care to individuals is a serious issue, the CCBHC site may be given a much shorter period to initiate corrective actions, and this condition may be established, in writing, as part of the site review findings. If, during a Site Visit, the MDHHS CCBHC team member identified an issue that places a person served in imminent risk to health or welfare, the MDHHS CCBHC team would invoke an immediate review and response by the CCBHC site, which must be completed in seven calendar days.

2.C.2.2.7. CCBHC Decertification

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

Reasons for decertification include:

- Failure to provide MDHHS with requested documentation demonstrating CCBHC requirements are met
- Failure to correct identified deficiencies in meeting certification requirements
- Consumer complaints related to non-compliance with CCBHC policies or not meeting CCBHC certification criteria

- Failure to maintain required licensures and certifications
- Non-compliance with rate setting, including rebasing
- Misrepresentation of data

MDHHS will give CCBHCs and PIHPs 90 days written notice of the intent to decertify. CCBHCs may either accept the decertification or respond with a detailed plan of corrections to address the identified reasons for decertification. If MDHHS approves the plan, the CCBHC will be reverted to Provisional Certification status (2.C.2.2.3) while the correction plan is being implemented. PIHPs will support the development, implementation, and monitoring of the corrective action plan. MDHHS may also deny the request for corrections, and formal notice of decertification will be provided to the CCBHC and PIHP.

If CCBHCs disagree with the decertification determination, they may appeal. Requests for reconsideration must be sent to the director of the Office of Strategic Partnerships and Medicaid Administrative Services within 14 business days from the receipt of the notice to decertify. Requests should detail reasons why the CCBHC disagrees with the determination and include supporting documentation. The director will review the request and provide written response affirming, reversing, or modifying the initial determination.

If a CCBHCs status is terminated by MDHHS or if its certification lapses with no provisional status issued by MDHHS, the provider must continue providing CCBHC services for six months without receiving the PPS-1 payment. MDHHS will recoup any PPS payments made after the decertification date.

2.C.3. Medicaid Requirements

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

2.C.4. Behavioral Health Treatment Episode Data Set (BHTEDS)

BHTEDS data must be collected for all CCBHC recipients receiving services at a CCBHC Demonstration site per current BHTEDS reporting requirements. Every CCBHC recipient is required to have an active BHTEDS episode during the time they are receiving any CCBHC services, regardless of which state administered funds are used.

The type of BHTEDS records required for treatment episodes is determined by the treatment type. For integrated services, treatment type and substance use funding source determine the type of BHTEDS records required. Report mental health treatment Admission (M), Update (U) and Discharge (E) records for persons receiving

mental health services funded in whole or part with State of Michigan administered funds. Report substance use treatment Admission (A), Update (S), and Discharge (D) for persons receiving substance use services funded in whole or part with State of Michigan administered funds. When integrated mental health and substance use services are provided, the BHTED record type is based on the funding source for the substance use services. When mental health dollars are used for the mental health and substance use services of an integrated treatment episode, report M, U, E records. When substance use dollars are used for the mental health and substance use services of an integrated treatment episode, report A, S, E records.

BHTEDS records should be submitted by the CCBHC even if the individual's county of origin is out of the service area.

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

2.C.5. Community Outreach and Education

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

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

2.C.6. Staffing

CCBHCs are responsible for maintaining an appropriate staff (both clinical and non-clinical) that meets standards of the state governing body and accreditation authorities. Staff are hired to meet the needs of the community as identified in a comprehensive needs assessment. CCBHC staff will follow a training plan which must address, among other requirements, cultural competence (including implicit bias training); person-centered and family-centered, recovery-

oriented, evidence-based, and trauma-informed care; and primary care/behavioral health integration. The training plan must also address training for DCO staff providing services to CCBHC beneficiaries. CCBHCs are also able to provide translation and interpretation services to those consumers with limited English proficiency.

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

2.C.7. Availability and Accessibility

The CCBHC must provide a functional, safe, clean, and welcoming environment for consumers and staff and are subject to all state standards for provision. Services are delivered at times and in locations that meet the needs of the population to be served, offering transportation, mobile in-home services, and telehealth/telemedicine when appropriate to guarantee access (See Chapter 8: Program Requirements, 8.B.1-8 B.4). Consumers are to be served regardless of ability to pay, insurance, or place of residence. Although there is technically no limit on the amount or duration of services offered, the amount, scope, and duration of services are determined through a person-centered planning process based on service eligibility and medical necessity criteria.

2.C.8. County of Financial Responsibility (COFR*)*

County of financial responsibility (COFR) agreements between clinics, who are both CCBHCs, should not occur for CCBHC eligible services regardless of the individual's county of residence. It is recommended that CCBHCs assist during the person-centered planning process with connecting individuals to providers near their residing county and can meet their needs. COFR agreements should still be honored for non-CCBHC services rendered.

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

2.C.9. Care Coordination

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

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

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

2.C.10. Scope of Service and Evidence Based Practices

CCBHCs must provide the 9 core services. Crisis services may be provided by the state-sanctioned crisis system. All services, including those provided directly or via DCOs, must be person and family-centered, recovery-oriented, and respectful of the individual consumer's needs, preferences, and values, with both consumer involvement and self-direction of services. Services to children and youth must be family-centered, youth guided, and developmentally appropriate. CCBHCs must also be equipped to meet the additional needs of transition age youth.

Additionally, 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 abuse, housing, and other common issues that impact Veterans to support healthier lifestyles, lower stigma and reduce suicidal ideation. CCBHCs should work with their PIHP to coordinate Veteran's services with the PIHP Veteran Navigator. Together, regions should determine a staffing strategy that maximizes resources to best fit the needs of Veterans and military family members in the community. In some instances, this will likely mean the CCBHC will need to utilize their own resources and directly hire a Veteran Navigator to provide needed services.

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

2.C.10.1. Required EBPs:

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

2.C.10.2. *Recommended EBPs:*

- An EBP of the CCBHC's choice addressing trauma in adult populations
- An EBP of the CCBHC's choice addressing needs of transition age youth (such as the Transition to Independence Process [TIP] model)
- An EBP of the CCBHC's choice to addressing older adult population (such as Wellness Initiative for Senior Education or Wellness Recovery Action Plan)
- An EBP of the CCBHC's choice addressing chronic disease management
- Dialectical Behavior Therapy for Adolescents (DBT-A)
- Permanent Supportive Housing
- Supported Employment (IPS model) Please contact MDHHS-CPI-Section@michigan.gov for criteria and steps to be recognized as providing fidelity-measured Individual Placement and Support model services.

2.C.11. Quality and Reporting

Both CCBHCs and MDHHS are required to report on cost and quality measures. Please see Section 7: CCBHC Evaluation and Monitoring for more information.

2.C.11.1. *Reporting DCO Information*

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

2.C.11.2. *Data Collection*

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

- CCBHC recipient characteristics
- Staffing
- Access to services
- Use of services
- Screening, prevention, and treatment
- Care coordination
- Other processes of care
- Costs
- CCBHC recipient outcome

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

2.C.11.3. *Continuous Quality Improvement (CQI) Plan*

CCBHCs must use the data outlined in 2.C.10.3 to develop, implement, and maintain a continuous quality improvement (CQI) plan for clinical services and clinical management. This plan must address suicide, hospital readmissions, and other events as specified by the state. (See certification criteria 8.E.2. Continuous Quality Improvement (CQI) Plan.)

2.C.11.4. Metric Reporting

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

2.C.12. Organizational Governance

The CCBHC must meet one of the following criteria: a non-profit organization, exempt from tax under Section501(c)(3) of the United States Internal Revenue Code; a part of a local government behavioral health authority (which includes all forms of CMHSPs); an organization operated under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C.450 et seq.); an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian HealthCare Improvement Act (25 U.S.C. 1601 et seq.). Board members are to be a representative of those served by the CCBHC and must incorporate meaningful participation from adult consumers, individuals in recovery, and families. CCBHCs must also adhere to all applicable state policy, accreditation, certification, and/or licensing requirements.

2.C.13. Training and Technical Assistance

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

2.C.14. Information Sharing and Retention

CCBHCs must ensure that PIHPs have access to information necessary to execute responsibilities outlines in Section 2.B of this Handbook. The SAMHSA CCBHC Criteria Item 5.a.3 states that data to be collected and reported and quality measures to be reported may relate to services CCBHC enrollees receive through DCOs. Collection of some of the data and quality measures that are the responsibility of the CCBHC may require access to data from PIHP/DCOs and it is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship with PIHPs/DCOs and to ensure adequate consent as appropriate.

Additionally, in accordance with 42 CFR 438.3(h) and 42 CFR 438.230(c), the PIHP, State, CMS, Office of Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the CCBHC, and/or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of the completion of any audit, whichever is later.

2.C.15. 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 shall be made under the demonstration program to satellite facilities of CCBHCs if such facilities were established after April 1, 2014.

Requests should be sent to PIHPs and mdhhs-ccbhc@michigan.gov. MDHHS will respond to the request once all supporting documentation is received for new service delivery sites, including DCOs, within 60 days. CCBHC services delivered by a DCO prior to MDHHS approval should 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 signed DCO agreement prior to the initiation of services.

2.C.16. Identification of Beneficiaries with Mild to Moderate Behavioral Health Needs

CCBHC services provided to individuals with mild to moderate mental health needs must be identified on the encounter by adding the TF modifier to the T1040. This identification is necessary for budget monitoring and rate setting purposes related to funding these services with supplemental funds.

Identification is only required for individuals with mild to moderate mental health needs. Individuals with a primary diagnosis of substance use disorder (SUD) or an Intellectual/Developmental Disability (I/DD) will not be considered mild to moderate for this purpose unless their primary diagnosis becomes a mental health one.

Individuals with mental illness can have a diagnosis/illness identified to be either a mild to moderate condition, severe mental illness (SMI) and/or a serious emotional disturbance (SED). CCBHCs will use CAFAS and LOCUS scores determine which category of mental health severity an individual may be assigned to: Mild to Moderate or SED/SMI. Children under age 6 will be considered SED for this purpose.

Individuals are not permanently assigned to one category or another. The clinical severity of individuals changes over time along with their LOCUS and CAFAS score, either getting better or getting worse, therefore causing a change in category assignment. A clinical re-evaluation using the CAFAS and LOCUS must be conducted to demonstrate a change in category of the SMI/SED or M/M designation, the level of clinical need, medically necessary services, and/or the person-centered plan. These changes should be documented in the EHR.

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

2.C.16.1. Thresholds

Youth/Young Adults:

- CAFAS < 50 is the mild/moderate population (per the Medicaid Manual identifying <50 score is mild to moderate and a score 50+ is SED)

Adults with Mental Illness:

- LOCUS level of care identified; Level I 10-13 score/Level II 14-16 score would be identified as mild to moderate intensity.

2.C.16.2. Encounter Reporting and Validation

The modifier TF should be added to the T1040 when submitting encounters for mild to

moderate individuals. MDHHS will review and validate encounters submitted with the TF modifier for individuals with mild to moderate needs using the LOCUS data from BHTEDS and CAFAS data submitted periodically by CCBHCs.

3. Designated Collaborating Organization (DCO) Requirements

3.A. DCO Overview

A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. Persons receiving CCBHC services from DCO personnel under the contract are CCBHC recipients. DCOs must meet CCBHC requirements for scope of services and must be appropriately credentialed. DCO-provided services must be provided in a manner aligned with the requirements of Section 2402(a) of the Affordable Care Act, titled "Removal of Barriers to Providing Home and Community-Based Services." Under this section, services must reflect person- and family-centered, recovery-oriented care; be respectful of the individual consumer's needs, preferences, and values; and ensure consumer involvement and self-direction of services. Services for children and youth should be family-centered, youth-guided, and developmentally appropriate. DCOs may be private, for-profit organizations.

3.B. CCBHC Agreements with DCOs

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

CCBHCs cannot have DCO agreements with other CCBHCs participating in the demonstration. Exceptions include agreements with state-sanctioned crisis services offered by an existing CCBHC or a CCBHC that serves an entirely different service area.

- Formal agreements between the CCBHC and DCO must be submitted to MDHHS during the certification process or as soon as an agreement is executed. Agreements must include the minimum following provisions: a purchase of one or more CCBHC services, unless the DCO relationship is with state-sanctioned crisis providers,
- The CCBHC maintains financial and clinical responsibility for services provided by the DCO,
- The CCBHC retains responsibility for care coordination,
- The DCO must have the necessary certifications, licenses and/or enrollments to provide the services,

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

3.C. CCBHC Clinical and Financial Responsibilities of DCOs

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

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

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

3.E. Adding New DCO Relationships

Adding new DCO relationships after initial certification requires updates to the CCBHC Certification and approval by MDHHS. Currently, only MDHHS is authorized to make changes to certification documents in the CRM. CCBHCs should submit a request and all supporting documentation to MDHHS as soon as possible as outlined in Section 2.C.14 New Service Delivery Locations. MDHHS will provide receipt of confirmation when certification documentation updates have been made in the CRM for CCBHC review. PIHPs are not responsible for monitoring certification updates but CCBHCs must inform PIHPs of new DCO relationships.

3.F. Termination of DCO Relationships

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

4. CCBHC Recipient Enrollment, Assignment, and Disenrollment

4.A. Beneficiary Identification, Enrollment, and Assignment

Any individual with a qualifying behavioral health diagnosis (See Appendix B) is eligible to receive CCBHC services. Eligible CCBHC recipients are identified using a multifaceted approach for both Medicaid beneficiaries and non-Medicaid persons. Eligibility and assignment is tracked using the Waiver Support Application (WSA). MDHHS reserves the right to review and verify all enrollments and assignments.

CCBHC Recipient Status Defined:

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

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

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

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

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

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

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

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

For Medicaid beneficiaries not identified or enrolled into the CCBHC Benefit Plan by MDHHS, CCBHCs are permitted to recommend eligible beneficiaries for enrollment into the CCBHC benefit plan to the PIHP via the WSA. CCBHC providers must provide documentation that indicates a potential CCBHC enrollee meets eligibility for the CCBHC benefit, including diagnostic verification. The completion of the Consent to Share Behavioral Health Information for Care Coordination Purposes (MDHHS-5515) or other approved consent form (if held to more

stringent requirements under federal law) should be used when appropriate. The PIHP must review and process all recommended enrollments in the WSA. The PIHP is responsible for verifying eligibility criteria but cannot deny enrollment of an individual with a qualifying diagnosis. Once processed by the PIHP, the beneficiary is assigned to the recommending CCBHC in the WSA and the record is sent to CHAMPS, which enrolls the beneficiary in the CCBHC Benefit Plan. MDHHS reserves the right to review and verify all enrollments and assignments.

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

Medicaid beneficiaries who are receiving only CCBHC services do not have to complete the eligibility determination process in the WSA for 1915(i) services. Functionality has been built into the WSA to alert users who input cases where individuals are enrolled in another waiver. The warning does not prevent the user from adding the case but rather helps the user consider the appropriate funding sources prior to enrollment. Individuals receiving only services covered under both 1915(i) and CCBHC, are permitted to be assigned to CCBHC.

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

Individuals whose level of care meets enrollment requirements for the Habilitation Supports Waiver (HSW), should be assessed for enrollment into the HSW and medical necessity criteria should be used in determining the amount, scope, and duration of services and supports offered on the waiver. Since CCBHCs must serve anyone with a behavioral health diagnosis, even if the individual has a primary I/DD diagnosis it is likely that beneficiaries may be enrolled into the CCBHC benefit plan and the HSW benefit plan simultaneously. CCBHCs cannot receive PPS-1 payment for overlapping services offered on both programs. See Appendix A for more information and a list of overlapping service encounter codes. Functionality has been built into the WSA to alert users who input cases where individuals are enrolled in another waiver to determine eligibility and the appropriate funding source. CCBHC and HSW share an overlapping service set, and beneficiaries should be assigned to a CCBHC only if they are receiving CCBHC services outside the scope of the overlapping service set.

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

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

MDHHS identifies non-Medicaid CCBHC-eligible recipients in counties with CCBHCs by utilizing BH-TEDS data from the MDHHS Data Warehouse. These recipients will be identified as CCBHC-eligible by having a current/open BH-TEDS record with a mental health and/or SUD diagnosis, or a service end date in the last 18 months, and not previously identified in the Medicaid process specified in 1.A. above. MDHHS will utilize the PIHP Consumer ID or the Medicaid beneficiary ID (if applicable) to identify these CCBHC-eligible recipients. Unlike the Medicaid beneficiaries, non-Medicaid recipients will not be assigned to the CCBHC benefit plan in CHAMPS (since they do not have Medicaid). Rather, the WSA will be leveraged to track the non-Medicaid CCBHC recipients. The CCBHCs must still submit the pertinent encounter codes for these enrollees to the PIHPs and the PIHPs must submit these “look-alike encounters” to MDHHS via CHAMPS per the existing process for submitting claim/encounter information for non-Medicaid persons.

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

Utilizing the WSA, MDHHS will provide PIHPs the list of CCBHC-eligible non-Medicaid recipients for their respective PIHP region. PIHPs must work with CCBHCs in their region to assign these eligible recipients to the pertinent CCBHC within the WSA. The assignment must include

diagnostic verification. The Consent to Share Behavioral Health Information for Care Coordination Purposes (MDHHS-5515) or other approved consent form (if held to more stringent requirements under federal law) by the CCBHC-eligible non-Medicaid recipient must also be collected.

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

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

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

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

4.D. Beneficiary Consent

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

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

4.E. CCBHC Recipient Disenrollment

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

disenrolled for the following reasons:

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

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

CCBHC Disenrollment Reasons Defined:

CCBHC Disenrollment Reason	Definition
Administrative Dismissal	CCBHC recipient is unable to continue participating in services due to inability to follow agency rules, violence toward staff, etc.
Assigned in Error	CCBHC recipient was assigned to the wrong CCBHC.
Beneficiary is Unresponsive	CCBHC recipient stopped participating in services for a minimum of 90 days, CCBHC is unable to contact the recipient.
Deceased	CCBHC recipient is deceased.
Hospice	CCBHC recipient enrolled in hospice services.
Moved	CCBHC recipient moved out of state or moved into a non-CCBHC county and is no longer receiving services.
Voluntary Disenrollment	CCBHC recipient voluntarily disenrolled from services or no longer needs CCBHC services. Recipient's case is closed for Mental Health or SUD services with the CCBHC.

4.F. CCBHC Recipient Transfer

While the CCBHC recipient's individualized plan of care will be utilized to determine the appropriate setting and CCBHC provider of care, recipients will have the ability to change CCBHC providers to the extent feasible within the CCBHC network. To maximize continuity of care and the patient-provider relationship, MDHHS expects recipients to establish a lasting relationship with their chosen CCBHC provider. However, if a recipient decides to transfer to a different CCBHC, they should notify their current CCBHC provider immediately if they intend to do so. The current and future CCBHC providers must discuss the timing of the transfer and communicate transition options to the recipient.

4.G. CCBHC Transfer Process

A beneficiary who is assigned to a CCBHC can be transferred to another CCBHC via the WSA within the

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

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

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

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

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

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

5. CCBHC Payment

5.A. General Provisions for CCBHC Payment

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

5.B. CCBHC Prospective Payment System Methodology

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

The PPS rate methodology and rebasing will follow applicable federal requirements. Given the different

timelines of sites joining the demonstration, rate rebasing methodology may differ amongst CCBHC sites. Rate development details will be documented in relevant draft and finalized rate materials shared with demonstration participants.

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

5.C. CCBHC Payment Operations

5.C.1. General Provisions for Encounter Reporting

5.C.1.1. Required CCBHC Service Encounter Codes

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

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

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

5.C.1.1.A Encounter Code Set

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

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

The use of modifier "TF" must be submitted in conjunction with the T1040 code to solely identify CCBHC services provided to the mild to moderate population. CCBHCs are required to utilize the Child and Adolescent Functional Assessment Scale (CAFAS) and Level of Care Utilization System (LOCUS) assessments to identify individuals ages 7

and up receiving CCBHC services with mild to moderate behavioral health needs for reporting and rate setting purposes (refer to section 8.E.1.6. for data reporting requirements).

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

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

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

With the exception of encounters submitted for the SUD Block Grant, PIHPs may determine what amount should be reported for the T1040 Claim Charge Amount and the Payment Amount. SUD Block Grant encounters must be reported as $0. Charge and Payment amounts reported on the individual CCBHC service lines should align with historical reporting, with the Charge amount representing estimated actual costs and Payment Amount representing historically paid amounts. Reporting encounters in this way allows for the identification of CCBHC services while retaining consistency with reporting methodology of previous years and of non-CCBHC services. There is no expectation that the sum of the charged or paid amounts will equal the PPS rate.

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

5.C.1.4. Timely and Complete CCBHC Service Encounter Code Submission

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

5.C.1.5. Documenting ICD-10-CM "Z-Codes"

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

- Z55 Problems related to education and literacy
- Z56 Problems related to employment and unemployment
- Z57 Occupational exposure to risk factors
- Z59 Problems related to housing and economic circumstances

- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Other problems related to primary support group, including family circumstances
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances

5.C.1.6. Encounter Submission

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

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

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

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

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

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

5.C.2.1. PIHP CCBHC Capitation Payment

MDHHS will integrate the CCBHC PPS-1 payment into the PIHP capitation rates for CCBHC-eligible services (see Appendix A). Because CCBHC services reflect services traditionally provided through the PIHP delivery system, a portion of the CCBHC payment is comprised by the PIHP's "base" capitation. To make whole the PPS-1 rate, MDHHS will prospectively provide PIHPs a "supplemental" CCBHC capitation payment. The supplemental CCBHC capitation payment reflects the difference between the PPS-1 rate and the amount in the PIHP's base capitation based on anticipated utilization of CCBHC services for Medicaid beneficiaries enrolled in the CCBHC benefit plan. MDHHS will also provide an amount for PIHP CCBHC administration and the Quality Based

Payment in the supplemental CCBHC capitation payment. The supplemental CCBHC payment is considered non-risk and will be reconciled annually as cited in 5.C.2.1.1. The base CCBHC payment, which reflects the payment that would normally be made to the PIHPs regardless of the CCBHC Demonstration, will be at risk per current policy.

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

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

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

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

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

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

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

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

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

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

CCBHCs throughout the country have leveraged multiple funding mechanisms to cover the

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

5.C.3.1 DY1 and DY2 General Fund Distribution
General fund dollars, if available, will be distributed to support non-Medicaid service expenses. Funds will be dispersed prior to the end of the demonstration year.

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

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

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

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

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

- For *Medicaid beneficiaries*, the PIHP will utilize Medicaid capitation to reimburse the balance of CCBHC service costs less the third-party/COB payments.

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

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

5.D. Quality Bonus Payments (QBP)

MDHHS affords a QBP for CCBHCs meeting CMS-defined quality benchmarks.* To receive a QBP, a CCBHC must achieve or exceed the threshold for all QBP-eligible measures as specified by CMS. The QBP is based on 5% of the total CCBHC Medicaid Demonstration Year Costs.

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

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

Performance Measure Number	Measure Name and NQF # (if applicable)	Measure Steward	Benchmark	Technical Specification Document (see 5.D.3. for link)	Technical Specification Document Page Number
1.	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)*	AMA-PCPI	23.9%	SAMHSA Metrics and Quality Measures (2016)	74
2.	Major Depressive Disorder: Suicide Risk Assessment (SRA-A)*	AMA-PCPI	12.5%	SAMHSA Metrics and Quality Measures (2016)	82
3.	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)^*	CMS	58.5%	CMS Adult Core Set (2023)	138
4.	Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)^*	NCQA	58%	CMS Adult Core Set (2023)	66
5.	Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)^*	NCQA	70%	CMS Child Core Set (2023)	71
6.	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)*	NCQA	Initiation – 25%	CMS Child Core Set (2023)	193

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

5.D.2. QBP Distribution Methodology

5.D.2.1. 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.

Per federal guidance, all performance benchmarks must be met by a CCBHC site for QBP to be awarded. CCBHCs must meet the minimum denominator requirements (n=30) for the calculation of a QBP measure for it to be included in the determination. For example, a clinic meeting the minimum denominator size for 5 of 6 measures must still meet or exceed the benchmarks for the 5 eligible measures

to qualify for payment.

If performance benchmarks are met, MDHHS will provide the QBP payment to the PIHP for distribution to the awarded CCBHC(s). CCBHCs are eligible to receive 5% of the clinic's annual Medicaid costs (defined as the reported Medicaid daily visits x demonstration year PPS rate).

If a CCBHC does not meet all benchmarks for QBP measures, the potential distribution amount will be added to a QBP Redistribution pool for CCBHCs who either hit or exceeded benchmarks.

5.D.2.2. Timelines

MDHHS will distribute QBP payments to the PIHPs within one year of the end of the demonstration year (DY). During the measurement year (MY), MDHHS will identify baseline values for the performance metrics to be measured against during the subsequent payment years. Final clinic reported measures are to be submitted to MDHHS by March 31st of each year, or 6 months after DY end.

5.D.3. QBP Technical Specifications

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

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

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

- CMS Medicaid Core Set Technical Specifications and Resource Manual:
  - Adult Core Set (2023)
  - Child Core Set (2023)

6. CCBHC and Health Information Technology

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

The MDHHS CRM is the platform in which MiCAL and other MDHHS business processes are housed. The CRM is a customized technological platform designed to automate and simplify procedures related to the regulatory relationship between MDHHS and its customers (PIHPs, CMHSPs, CCBHCs, SUD entities, Michiganders, etc.). The MDHHS CRM will house the CCBHC certification process for the demonstration. Each CCBHC will have an account and will complete all certification processes using the MDHHS CRM including submitting the CCBHC application and pertinent documents and completing the on-site review process.

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

6.B. Waiver Support Application (WSA)

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

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

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

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

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

6.C. CareConnect 360

CareConnect360 will help HIT-supported care coordination activities for the CCBHC Demonstration. Broadly, it is a statewide care management web portal that provides a comprehensive view of individuals in multiple health care programs and settings based on paid Medicaid claims and encounters. This will allow the PIHP and CCBHCs with access to CareConnect360 the ability to analyze health data spanning different settings of care for people with Medicaid. In turn, this will afford CCBHCs a more robust snapshot of a beneficiary and allow smoother transitions of care. It will also allow the PIHP to make better and faster decisions for the betterment of the beneficiary. Quarterly integrated measure performance results are provided in CareConnect360 and are based on state or national specifications. CCBHCs who do not have access to CareConnect360 should coordinate closely with their PIHP to share appropriate information, performance measure data, and facilitate transitions in and out of the CCBHC. Providers will only have access to individuals that are established as patients of record within their practice. Finally, with appropriate consent, CareConnect360 facilitates the sharing of cross-system information, including behavioral health, physical health, and social support services.

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

6.D. File Transfer Service (FTS)

Michigan's data-submission portal is the File Transfer Service (FTS); however, it has previously been referred to as the Data Exchange Gateway (DEG). Some documents may still reference the (DEG); be aware that a reference to the DEG portal is a reference to the FTS. Billing agents will use the FTS to submit and retrieve files electronically with MDHHS. MDHHS has established an internet connection to the FTS, which is a Secure Sockets Layer connection. This connection is independent

of the platform used to transmit data. Every billing agent receives a "mailbox", which is where their files are stored and maintained. Billing agents can access this mailbox to send and retrieve files.

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

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

7. CCBHC Monitoring and Evaluation

7.A. CCBHC Monitoring & Evaluation Requirements

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

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

7.A.1. CCBHC Reported Measures

Measure Name	Measure Steward	Technical Specification Document	Technical Specification Page Number
Time to Initial Evaluation (I-EVAL)	SAMHSA	SAMHSA Metrics and Quality Measures (2016)	30
Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	CMS	SAMHSA Metrics and Quality Measures (2016)	44
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)^	NCQA	CMS Child Core Set (2023)	100
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	AMA-PCPI	SAMHSA Metrics and Quality Measures (2016)	66
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	AMA-PCPI	SAMHSA Metrics and Quality Measures (2016)	69
Child and Adolescent Major Depressive Disorder (MDD):	AMA-PCPI	SAMHSA Metrics and Quality Measures (2016)	74

Suicide Risk Assessment (SRA-BH-C)*			
Major Depressive Disorder: Suicide Risk Assessment (SRA-A)*	AMA-PCPI	SAMHSA Metrics and Quality Measures (2016)	82
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)^	CMS	CMS Adult Core Set (2023)	47
Depression Remission at Twelve Months (DEP-REM-12)	MNCM	SAMHSA Metrics and Quality Measures (2016)	95

7.A.2. State Reported Measures

Measure Name	Measure Steward	Technical Specification Authority and Reference	Technical Specification Page Number
Housing Status (HOU)	SAMHSA	SAMHSA Metrics and Quality Measures (2016)	101
Patient Experience of Care Survey (PEC)	SAMHSA	SAMHSA Metrics and Quality Measures (2016)	109
Youth/Family Experience of Care Survey (Y/FEC)	SAMHSA	SAMHSA Metrics and Quality Measures (2016)	111
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA	CMS Adult Core Set (2023)	113
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	NCQA	CMS Adult Core Set (2023)	118
Plan All-Cause Readmission Rate (PCR-AD)^	NCQA	CMS Adult Core Set (2023)	116
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD-AD)^	NCQA	CMS Adult Core Set (2023)	145
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)^*	CMS	CMS Adult Core Set (2023)	138
Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)^*	NCQA	CMS Adult Core Set (2023)	66
Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)^*	NCQA	CMS Child Core Set (2023)	71
Follow-up care for children prescribed ADHD medication (ADD-CH)^	NCQA	CMS Child Core Set (2023)	15
Antidepressant Medication Management (AMM-AD) ^	NCQA	CMS Adult Core Set (2023)	14
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)*	NCQA	CMS Adult Core Set (2023)	193

^Denotes updated technical specification from the original 2016 measure

*Denotes the measure is both a quality measure AND a quality bonus payment measure

7.A.3. CCBHC Metric Specifications

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

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

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

- CMS Medicaid Core Set Technical Specifications and Resource Manual:
  - Adult Core Set (2023)
  - Child Core Set (2023)

7.A.3.1. Deviation from Technical Specifications

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

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

7.A.3.2. Reporting Requirements

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

During a CCBHC clinic's initial DY year, CCBHCs are required to participate in a mid-year trial exercise to ensure clinics can acquire the appropriate data and complete the template reporting. Year-end clinic reported metrics will be calculated based on a measurement period of October 1 through March 31st and be submitted to MDHHS 6 months after DY end.

PIHPs should collect, validate, and submit the final templates to MDHHS within 6 months of the end of the Demonstration Year. Final templates should be sent via email to mdhhs-ccbhc@michigan.gov by March 31 of each year.

CCBHCs should complete the clinic-reported measures on the reporting template quarterly. PIHPs should review the measures, evaluate for reasonability, and assist with validation activities if needed. Templates should be sent to PIHPs by the end of the month following the measurement period (specified in the table below). PIHPs will also make the quarterly templates available to MDHHS or external evaluators purposes of monitoring and evaluation planning.

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

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

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

Rejected encounters are excluded, and continuous enrollment measure requirements are met based on Medicaid continuous enrollment rather than CCBHC continuous enrollment. Individuals are attributed to the CCBHC with the highest share of service delivery (i.e. submitted the highest number of T1040s for an individual). In the event that more than one CCBHCs submitted the same number of T1040 service codes, the individual is attributed to clinic that provided the most recent service. The population for Housing Status (HOU) includes all individuals receiving CCBHC services.

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

7.A.3.4. *Measurement Periods*

Measure specifications may include measurement periods based on the CCBHC demonstration year. Michigan's demonstration years follow the State Fiscal Year reporting structure, beginning October 1st and ending September 30th.

Demonstration Year	Time Period
DY1	October 1, 2021 – September 30, 2022

DY2	October 1, 2022 – September 30, 2023
DY3	October 1, 2023 – September 30, 2024
DY4	October 1, 2024 – September 30, 2025
DY5	October 1, 2025 – September 30, 2026
DY6	October 1, 2026 – September 30, 2027

7.B. Additional Monitoring Requirements

7.B.1. CCBHC Ad Hoc Reporting

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

7.B.1.1. Level of Care Information Reporting

CCBHCs must collect and report on the experience of CCBHC service recipients with mild to moderate levels of need. CCBHCs should use the data fields identified in the state-supplied collection template of each given demonstration year. Data are required to be reported for all CCBHC enrollees. A minimum of 30 days' notice will be given to respond to this data request.

Data collected may include:

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

7.C. Evaluation Requirements

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

8. MI CCBHC Certification Criteria—Program Requirements

8.A. Program Requirement #1: Staffing

8.A.1. General Staffing Requirements

8.A.1.1. Needs Assessment

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

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

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

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

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

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

8.A.1.2. Staffing Plan

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

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

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

8.A.2. Management

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

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

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

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

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

The CCBHC must maintain liability/malpractice insurance adequate for the staffing and scope of services provided. CCBHCs are responsible for verifying DCOs also maintain appropriate liability/malpractice insurance. Please note that CMHSPs automatically meet

liability/malpractice insurance requirement per compliance with CMHSP Certification R330.2808 Fiscal Management.

8.A.4. Licensure and Credentialing of Providers

8.A.4.1. Licensure and Credentialing

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

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

8.A.5. Staffing Requirements/Accreditation

The CCBHC staffing plan must meet the requirements of the state behavioral health authority and any accreditation standards required by the state and must include clinical and peer staff. In accordance with the staffing plan, the CCBHC must maintain a core staff comprised of employed and as needed, contracted staff, as appropriate to the needs of CCBHC consumers as stated in consumers' individual treatment plans and as required by Handbook Sections 9.C and 9.D. Unless otherwise specified, staff must meet the MDHHS PIHP/CMHSP Provider Qualifications as described for CCBHC services.
https://www.michigan.gov/documents/mdhhs/PIHP-MHSP_Provider_Qualifications_530980_7.pdf

Required staffing disciplines include:

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

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

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

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

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

- Substance Abuse Treatment Practitioner (SATP)

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

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

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

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

providers, MDHHS will allow the following:

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

8.A.6. Cultural Competence and Other Training

8.A.6.1. Training Plan

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

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

Recommended Training

- LGTBQIA+
- Diversity Equity and Inclusion
- Social Determinants of Health

Training shall be aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality of services, and eliminate disparities. Cultural competency training should reflect the diversity within the population being served, as defined by the annual needs assessment. Per Section 3.3.3I of the CMHSP Contract, CMHSPs must also use the community needs assessment to demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area.

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

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

8.A.6.3. Skills/Competence

The CCBHC will assess the skills and competence of each individual furnishing services

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

8.A.6.4. Training Documentation
The CCBHC documents in the staff personnel records that the training and demonstration of competency are successfully completed. Verification of training documentation will take place at CCBHC certification site visits and should be demonstrated via the initial certification application.

8.A.6.5. Trainer Qualifications
Individuals providing staff training are qualified as evidenced by their education, training, and experience.

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

8.A.7.1. Access for individuals with Limited English Proficiency (LEP)
If the CCBHC serves individuals with Limited English Proficiency (LEP) or with language-based disabilities, the CCBHC takes reasonable steps to provide meaningful access to their services. If the individual is unable to read or understand any of the CCBHC program written materials, every effort shall be made to explain them to him or her in a language he or she understands.

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

8.A.7.2. Interpretation/Translation Services are Appropriate and Timely
Interpretation/translation service(s) are provided that are appropriate and timely for the size/needs of the LEP CCBHC consumer population (e.g., bilingual providers, onsite interpreters, language telephone line). To the extent interpreters are used, such translation service providers are trained to function in a medical and, preferably, a behavioral health setting. The cost of interpretation/translation services are the responsibility of the CCBHC and should not be billed to the person served.

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

8.A.7.4. Document Availability
Documents or messages vital to a consumer's ability to access CCBHC services (for example, registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available for consumers in languages common in the community served, taking account of literacy levels and the need for alternative formats (for consumers with disabilities). Such materials are provided in a timely manner at intake. The requisite languages will be informed by the needs

assessment prepared prior to certification, and as updated. All materials shall be made available in the languages appropriate to the individuals served within the CCBHC catchment area, and written materials should consider literacy limitations and appropriate reading levels.

8.A.7.5. Confidentiality/Privacy

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

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 consumers and staff, conducive to the provision of services identified in program requirement.

- The CCBHC must comply with all relevant federal, state, and local laws and regulations regarding client and staff safety, facility cleanliness, and accessibilities. The CCBHC is responsible for overseeing the environmental conditions of contracted DCOs and guaranteeing these regulations are met.
- The CCBHC environment should align with the standards of trauma informed care (see https://www.michigan.gov/documents/mdhhs/Trauma-Policy_704460_7.pdf associated PIHP requirements).

8.B.2. CCBHC Hours

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

8.B.3. CCBHC Location

The CCBHC provides services at locations that ensure accessibility and meet the needs of the consumer population to be served. The annual needs assessment, along with direct consumer feedback in the form of satisfaction surveys, focus groups, or advisory councils, should be reviewed to determine appropriateness of service site locations. The needs assessment should consider availability and accessibility for all eligible individuals, not just those currently being served. For office or site-based mental health services, the individual's primary service providers (e.g., case manager, psychiatrist, primary therapist, etc.) should be within 30 miles or 30 minutes of the individual's residence in urban areas, and within 60 miles or 60 minutes in rural areas. ("Primary provider" excludes community inpatient, state inpatient, partial

hospitalization, extended observation beds and any still existing day programs.) This requirement aligns with existing CMHSP Access Standards. However, services should never be limited due to an individual's residency.

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

8.B.4. Transportation

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

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 consumers have access to all required services.

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

8.B.6. Outreach and Engagement

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

- Additional attention should be paid to outreach and engagement activities targeting individuals with new service access under the CCBHC, including those without Medicaid and with mild/moderate levels of behavioral health needs.
- CCBHCs should monitor outreach and engagement activities closely to ensure that efforts are effectively expanding access to CCBHC services.
- MDHHS will promote CCHBC activities statewide and will provide marketing materials to CCBHC sites.

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

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

New Consumers

8.B.9.1. Timeliness for New CCBHC Recipients

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

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

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

- If the screening identifies routine needs, services will be initiated within 14 calendar days
    - Services must include initial assessment/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 9.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 consumer should be seen in person at the next subsequent encounter and the initial evaluation reviewed.
- "New" CCBHC services recipients are requesting services from the CCBHC for the very first time or have not received services from the CCBHC during the previous 6 months.

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

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

- The Michigan Mental Health Code establishes the right for all recipients to have

an Individual Plan of Service (IPOS) developed through a person-centered planning process (Section 712, added 1996). CCBHCs shall implement person-centered planning in accordance with the MDHHS Person-Centered Planning Practice Guideline, Behavioral Health and Developmental Disabilities Administration, Person-Centered Planning Practice Guideline (michigan.gov).

- The comprehensive treatment plan should be updated. To support person centered treatment, the extent to which an IPOS is updated will be determined by the needs and desires of the individual. A comprehensive IPOS update should be completed based on individual need or on program parameters set forth within the Medicaid Provider Manual. Specifically, an update would occur no less frequently than every 90 days for more severe and no less than 180 days for appropriate mild to moderate individuals. The comprehensive treatment plan should be updated by the treatment team, in agreement with and endorsed by the CCBHC recipient no less than annually.
    - CCBHCs must develop clear protocols for transitioning a CCBHC recipient with mild/moderate needs to a higher level of care without a major disruption in the individual's treatment experience. Without such protocols, treatment plans for all CCBHC recipients should be updated every 90 days.

8.B.9.3. Timely Access to Outpatient Services

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

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

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

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

- If an established CCBHC recipient identifies an urgent need, clinical services are provided, and the initial evaluation completed within one business day of the time the request is made.
    - Face-to-face meetings with professionals are preferred, however telehealth visits can occur if standards and reporting requirements are met as specified in Handbook Section 9.B.5.

8.B.10. Access to Crisis Management Services

8.B.10.1. Crisis Service Availability

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

8.B.10.2. Crisis Continuum

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

8.B.10.3. Education on Crisis Services/Advanced Directives

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

8.B.10.4. Crisis Coordination with Emergency Departments (EDs)

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

8.B.10.5. Protocols Following Crisis

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

8.B.10.6. Crisis Planning

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

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

8.B.11.1. Inability to Pay

The CCBHC ensures: (1) no individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual's inability to pay for such services (PAMA § 223 (a)(2)(B)), and (2) any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1).

The CCBHC should have in place policies or procedures for verifying ability to pay including specifications for when and how to reduce or waive fees (see Handbook Section 8.B.11.2 regarding Sliding Fee requirements.)

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

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 consumers 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 consumers who do not live close to a CCBHC or within the CCBHC catchment area as established by the CCBHC's annual

needs assessment. CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence. The required protocols should address management of the individual's on-going treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing CCBHCs to refer and track consumers seeking non-crisis services to the CCBHC or other clinic serving the consumer's county of residence. For distant consumers within the CCBHC's catchment area, CCBHCs should consider use of telehealth/telemedicine to the extent practicable. In no circumstances (and in accordance with PAMA § 223 (a)(2)(B)), may any consumer be refused services because of place of residence.

8.C. Program Requirement #3: Care Coordination

8.C.1. General Requirements of Care Coordination

8.C.1.1. Care Coordination

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

Care coordination activities include, but are not limited to:

- Organization of all aspects of a beneficiary's care.
- Management of all integrated primary and specialty medical services, behavioral health services, physical health services, and social, educational, vocational, housing, and community services.
- Information sharing between providers, patient, authorized representative(s), and family.
- Resource management and advocacy.
- Maintaining beneficiary contact, with an emphasis on in-person contact (although telephonic contact may be used for lower-risk beneficiaries who require less frequent face-to-face contact).
- Appointment making assistance, including coordinating transportation.
- Development and implementation of care plan.
- Medication adherence and monitoring.
- Referral tracking.
- Use of facility liaisons.
- Use of patient care team huddles (short, daily meetings where the care team can discuss schedules, address care coordination needs, and problem solve).
- Use of case conferences.
- Tracking of test results.
- Requiring discharge summaries.
- Providing patient and family activation and education.
- Providing patient-centered training (e.g., diabetes education, nutrition

education, etc.).

- Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.)
- Connection of individuals to peer run drop-in centers for Medicaid and non-Medicaid CCBHC individuals regardless of their ability to pay or county of residence.

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

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

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

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

8.C.1.4. Care Coordination and Duplicative Services

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

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

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

CCBHC recipients are permitted to receive CCBHC eligible services at multiple CCBHC locations. In this scenario, one CCBHC must become the lead for CCBHC care

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

8.C.1.6. Coordination with Medicaid Health Homes

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

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, and other federal and state privacy laws, including patient privacy requirements specific to the care of minors. The HIPAA Privacy Rule allows routine – and often critical – communications between health care providers and a consumer's family and friends. Health care providers may always listen to a consumer's family and friends. If a consumer consents and has the capacity to make health care decisions, health care providers may communicate protected health care information to a consumer's family and friends. Given this, the CCBHC ensures consumers' preferences, and those of families of children and youth and families of adults, for shared information are adequately documented in clinical records, consistent with the philosophy of person and family-centered care.

Necessary consent for release of information should be obtained from CCBHC service recipients for all care coordination relationships. The MDHHS-5515 Consent to Share Behavioral Health and Substance use Disorder Information should be utilized if possible. Alternate consents can be used if held to more stringent requirements under federal law. Consents must be collected and stored in the recipient's health record with attestation in the WSA.

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

8.C.3. Referral and Follow-Up

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

8.C.4. Consumer Preferences

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

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 consumers and, upon appropriate consent to release of information, to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care.

8.C.6. Freedom of Choice

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

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

8.C.7.1. <u>Health IT System</u>

The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records. The health IT system has the capability to capture structured information in consumer records (including demographic information, diagnoses, and medication lists), provide clinical decision support, and electronically transmit prescriptions to the pharmacy. To the extent possible, the CCBHC will use the health IT system to report on data and quality measures as required by Handbook Section 13.E (SAMHSA Criteria 5). Utilization of MDHHS systems such as CareConnect360 and the Waiver Support Application are encouraged to coordinate care for CCBHC recipients.

8.C.7.2. <u>Population Health</u>

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

8.C.7.3. <u>New Health IT Systems</u>

If the CCBHC is establishing a health IT system, the system will have the capability to

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

8.C.7.4. DCOs Privacy/Confidentiality

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

8.C.7.5. Health Info Exchange Plan

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

8.C.8. Care Coordination Agreements

8.C.8.1. Health Care Services Coordination

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

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

8.C.8.2. Inpatient Service Coordination

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

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

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

8.C.8.2.1. *Inpatient Follow-Up*

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

8.C.8.3. Community Services Coordination

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

- Schools
- Child Welfare Agencies
- Indian Health Service or other tribal programs
- Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans, and other specialty courts)
- Homeless shelters/housing services
- Employment services
- Services for older adults, including aging and disability resource centers)
- Specialty providers of medications for treatment of opioid or alcohol dependence

- End of life/palliative care
- Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food, and transportation programs), depending on the needs of the population identified in the annual needs assessment

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

8.C.8.4. VA Coordination

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

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

8.C.8.5. MiCAL Coordination

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

- Receive crisis alerts from CCBHCs for individuals who are within the service area County of the CCBHC and likely to go into crisis. MiCAL staff will use the crisis alert guidance to prospectively plan for providing support to the individual. MiCAL staff will also provide follow up reports to the CCBHC for any support provided to the individual including a safety plan if one was developed. (Please note that each 42 CFR Part 2 covered entity is responsible for ensuring that any information they share with MiCAL meets 42 CFR Part 2 requirements.)
- Provide daily activity reports to PIHPs/CCBHCs for callers who:
    - Call in on the CCBHC crisis/access line while it is forwarded to MiCAL and share relevant information, including but not limited to, protected health information for purposes of care coordination.
    - Call, chat, or text MiCAL or the National Suicide Prevention Lifeline (NSPL), report they receive services from a CCBHC, and would like information on the support provided by MiCAL to be shared with a CCBHC.

- Call, chat, or text MiCAL or the NSPL, receive services from a CCBHC as determined by Active Care Relationship and/or Admission-Discharge-Transfer data and do not specifically prohibit information being shared with a CCBHC.
- Share an individual's information with relevant parties as necessary to trigger face to face crisis interventions in crisis situations.
- Provide afterhours or emergency crisis coverage for PIHPs/CMHSPs through the forwarding of CCBHC phone lines or other mediums of crisis inquiry.
- Receive in real time all necessary crisis service information from the PIHPs/CMHSPs to directly trigger the provision of face-to-face crisis services, including not limited to the afterhours on call process, preadmission screening process, mobile crisis, and other crisis stabilization services.
- Receive in real time all necessary service information from the PIHPs/CMHSPs to make warm handoffs and referrals from MiCAL to the PIHPs/CMHSPs in the most efficient and effective manner for the person in need.

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

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

CCBHCs should utilize a collaborative care model to provide an interdisciplinary team-based set of services to ensure the totality of one's needs – physical, behavioral, and/or social – are met through the provision of CCBHC services. CCBHCs can adopt or define their own collaborative care model.

8.C.9.3. Care Coordination by DCOs

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

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

8.D.1. General Service Provisions

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 13.D.2-13.D.11 (SAMHSA Criteria 4.B through 4.K):

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

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

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 consumers outside the four walls of the clinic to maintain confidentiality, safety, accountability, and professionalism.

8.D.1.1.2. Services to Incarcerated Individuals

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

8.D.1.1.3. Services in Schools

CCBHCs can provide CCBHC services to children in a school setting. CCBHCs must enter into an agreement with the school to provide services at no cost to the school or family. CCBHCs must follow all requirements for CCBHC service delivery, including care coordination and data collection. Services should not duplicate or replace the existing School Services Program (see Medicaid

Provider Manual for more information) or other existing school-based initiatives. Care Coordination expectations should be outlined in agreements with the schools to ensure coordinated care and prevent duplication of services. Agreements between the CCBHCs and schools should detail the responsibilities of both parties in a manner that maximizes resources and best meets the needs of the community.

8.D.1.2. Freedom to Choose

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

8.D.1.3. Member Appeals and Grievance Procedures

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

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

8.D.1.3.1. Non-Medicaid Enrollees

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

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

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

8.D.1.3.2. Medicaid Enrollees

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

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

1. A written appeal process (one level only) which enables enrollees to challenge an Adverse Benefit Determination.
2. A written grievance process.
3. The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other service complaints.
4. Access to the State Fair Hearing process to further appeal an Adverse Benefit Determination, after receiving notice that the Adverse Benefit Determination has been upheld by the CCBHC level appeal.
5. Information that if the CCBHC fails to adhere to notice and timing requirements as outlined in the appeal process, the enrollee is deemed

to have exhausted the CCBHC's Appeal Process and the enrollee may then initiate a State Fair Hearing.

6. The right to request and have Medicaid covered benefits continued while the CCBHC Appeal and/or the State Fair Hearing is pending.

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

1. Prior written notice of an adverse action;
2. A fair hearing before an impartial decision maker;
3. Continued benefits pending a final decision; and
4. A timely decision measured from the date that complaint is first made.

8.D.1.3.3. *Reporting*

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

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

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

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

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

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

8.D.1.3.5. *Mediation*

Both Medicaid and non-Medicaid CCBHC service recipients have a right to mediation. A recipient or recipient's representative can request mediation at

any time when there is a dispute related to service planning or the services, supports provided by a CCBHC or DCO. See Public Act 55 of 2020.

8.D.1.4. DCO Quality Standards

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

8.D.1.5. DCO Mandatory Criteria

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

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

8.D.2.1. Person/Family Centered Care

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

8.D.2.2. Cultural Needs

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

8.D.3. Crisis Behavioral Health Services

8.D.3.1. Crisis Behavioral Health Services

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

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

sanctioned crisis system to ensure they meet the requirements defined below. Expectations should be detailed in DCO agreements.

8.D.3.1.1. *24-hour Mobile Crisis*

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

At a minimum, mobile crisis teams must incorporate:

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

Mobile crisis response should include the following components:

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

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

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

8.D.3.1.2. *Emergency Crisis Intervention Services*

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

Service components include:

- A telephone that is answered 24 hours a day for dealing with crisis situations. This phone number should be made widely available by the CCBHC. When regionally available, MiCAL can provide telephone crisis response coverage.

- Face-to-face services to individuals in the areas of crisis evaluation, intervention, and disposition.

8.D.3.1.3. Crisis Stabilization Services

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

8.D.3.2. Medical Detoxification Requirements

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

- 1-WM: Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery. The CCBHC or a DCO must directly provide 1-WM.
- 2-WM: Moderate withdrawal with all-day withdrawal management support and supervision; at night, has supportive family or living situation, likely to complete withdrawal management. The CCBHC is encouraged to directly provide 2-WM. While the CCBHC must have the 2-WM level of ambulatory withdrawal management available and accessible to eligible consumers, it is not a requirement that this service be provided directly, although it is encouraged.
- 3.2-WM: Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery. May be provided directly either by the CCBHC or through a DCO relationship or by referral.
- 3.7-WM: Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, or nursing monitoring. May be provided directly either by the CCBHC or through a DCO relationship or by referral.

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

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

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

8.D.4.1.1. Evaluation Timeframe

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

8.D.4.1.2. *Evaluation Components*

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

Required evaluation components may be updated throughout the demonstration depending on age, specific behavioral health needs, and intensity of needs.

8.D.4.1.3. *Specific Substance Use Disorder Assessment Requirements*

To align with the requirements outlined in the Medicaid 1115 Demonstration Waiver for Substance Use Disorder (SUD) Services, CCBHCs and DCOs who provide substance use disorder services must utilize the specified assessment tools – the ASAM Continuum Assessment for adults and the GAIN for adolescents. CCBHCs should coordinate with PIHPs to have CCBHC staff enrolled in upcoming training cohorts as available.

8.D.4.1.4. *Mental Health Level of Care Determination Requirements*

CCBHCs should follow existing Medicaid requirements for determining level of care, including the use of specific assessments for specific populations (DECA, PECFAS, CAFAS, LOCUS, ASAM, SIS). Level of care assessments should not be used as the sole instrument for determining the need for supports and services, unless otherwise specified in Medicaid policy.

8.D.4.2. Diagnostic and Treatment Planning Evaluations

8.D.4.2.1. *General Overview*

A comprehensive person-centered and family-centered diagnostic and treatment planning evaluation is completed within 60 days by licensed behavioral health professionals who, in conjunction with the consumer, are members of the treatment team, performing within their state's scope of practice. Information gathered as part of the preliminary screening and initial evaluation may be considered a part of the comprehensive evaluation. This requirement that the comprehensive evaluation be completed within 60

calendar days does not preclude either the initiation or completion of the comprehensive evaluation or the provision of treatment during the intervening 60-day period.

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

Although a comprehensive diagnostic and treatment planning evaluation is required for all CCBHC consumers, the extent of the evaluation will depend on the individual consumer and standards required by both MDHHS and applicable accreditation bodies. As part of certification, CCBHCs should demonstrate the following components are included: (1) reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the consumer's presentation to the CCBHC; (2) a psychosocial evaluation including housing, vocational and educational status, family/caregiver and social support, legal issues, and insurance status; (3) behavioral health history (including trauma history and previous therapeutic interventions and hospitalizations); (4) a diagnostic assessment, including current mental status, mental health (including depression screening) and substance use 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 consumer's ability to understand and participate in their own care); (7) a drug profile including the consumer's prescriptions, over-the-counter medications, herbal remedies, and other treatments or substances that could affect drug therapy, as well as information on drug allergies; (8) a description of attitudes and behaviors, including cultural and environmental factors, that may affect the consumer's treatment plan; (9) the consumer'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 consumer, with necessary referrals made to social services and, for pediatric consumers, 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 Handbook Section 13.D.7 (SAMHSA criteria 4.G), either: (a) an assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the consumer's primary care provider (with appropriate referral and follow-up), or (b) a basic physical assessment as required by Handbook Section 13.D.7 (SAMHSA criteria 4.G). All remaining necessary releases of information are obtained by this point.

8.D.4.3. Screening and Assessment

8.D.4.3.1. Overview and CCBHC Indicators

Screening and assessment by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to required CMS reporting metric criteria. The CCBHC should not take non-inclusion of a specific metric as a reason not to provide clinically indicated behavioral health

screening or assessment and the state may elect to require specific other screening and monitoring to be provided by the CCBHCs beyond those listed in Section 7: Monitoring and Evaluation, of this handbook.

8.D.4.3.2. *Standardized Screening and Assessment Tools*
The CCBHC uses standardized and validated screening and assessment tools and, where appropriate, brief motivational interviewing techniques.

8.D.4.3.3. *Culturally and Linguistically Appropriate Screening Tools*
The CCBHC uses culturally and linguistically appropriate screening tools, and tools/approaches that accommodate disabilities (e.g., hearing disability, cognitive limitations), when appropriate.

8.D.4.3.4. *SUD Brief Intervention and Referral*
If screening identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the consumer is provided or referred for a full assessment and treatment, if applicable.

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

8.D.5.1. Treatment Planning Services
The CCBHC directly provides person-centered and family-centered treatment planning or similar processes, including but not limited to risk assessment and crisis planning. Person-centered and family-centered treatment planning satisfies the requirements of 13.D.5.2 below and is aligned with the requirements of Section 2402(a) of the Affordable Care Act, including consumer involvement and self-direction.

8.D.5.2. Person/Family Centered Planning
An individualized plan integrating prevention, medical and behavioral health needs and service delivery is developed by the CCBHC in collaboration with and endorsed by the consumer, the adult consumer's family to the extent the consumer so wishes, or family/caregivers of youth and children, and is coordinated with staff or programs necessary to carry out the plan.

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

8.D.5.2.2. *Treatment Plan Includes Needs, Strengths, Preferences*
Treatment planning includes needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the consumer's words or ideas and, when appropriate, those of the consumer's family/caregiver.

8.D.5.2.3. *Comprehensive Treatment Plan*
The treatment plan is comprehensive, addressing all services required, with provision for monitoring of progress towards goals. The treatment plan is built upon a shared decision-making approach.

8.D.5.2.4. *Consultation Sought During Treatment Planning*
Where appropriate, consultation is sought during treatment planning about special emphasis problems, including for treatment planning purposes (e.g., trauma, eating disorders).

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

8.D.5.2.6. *State Standards for Treatment Planning*
CCBHCs must meet all additional requirements for person-centered planning and the development and monitoring of an Individual Plan of Service, as described in the Michigan Mental Health Code, the Medicaid Provider Manual, and person-centered planning guidance.

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

8.D.6.1. Outpatient Services
The CCBHC provides outpatient mental and substance use disorder services that are evidence-based or best practices, consistent with the needs of individual consumers as identified in their individual treatment plan, either directly or through a DCO arrangement. In the event specialized services outside the expertise of the CCBHC are required for purposes of outpatient mental and substance use disorder treatment (e.g., treatment of sexual trauma, eating disorders, specialized medications for substance use disorders), the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine services. The CCBHC also provides or makes available through formal arrangement traditional practices/treatment as appropriate for the consumers served in the CCBHC area.

8.D.6.2. Evidence Based Practices
The CCBHC must offer, either directly or through a DCO, a minimum set of evidence-based practices as defined by the state.

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

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

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

8.D.6.2.1. *Required EBPs*

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

8.D.6.2.2. *Recommended EBPs*

- An EBP of the CCBHC's choice addressing trauma in adult populations
- An EBP of the CCBHC's choice addressing needs of transition age youth (such as the Transition to Independence Process [TIP] model)
- An EBP of the CCBHC's choice to addressing older adult population (such as Wellness Initiative for Senior Education or Wellness Recovery Action Plan)
- An EBP of the CCBHC's choice addressing chronic disease management
- Dialectical Behavior Therapy for Adolescents (DBT-A)
- Permanent Supportive Housing
- Supported Employment (IPS model) Please contact MDHHS-CPI-Section@michigan.gov for criteria and steps to be recognized as providing fidelity-measured Individual Placement and Support model services.

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

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

8.D.6.4. Family Driven/Youth Guided
Children and adolescents are treated using a family/caregiver-driven, youth guided and developmentally appropriate approach that comprehensively addresses family/caregiver, school, medical, mental health, substance abuse, psychosocial, and environmental issues.

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

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

8.D.8. Targeted Case Management Services

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

8.D.9. Psychiatric Rehabilitation Services

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

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

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

trauma support, peer support for older adults, and other peer recovery services. Potential family/caregiver support services that might be considered include family/caregiver psychoeducation and parent training.

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

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

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

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

8.D.11.1.1. Serving Current Military Personnel

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

Military personnel who are Active Duty and Active Reserve (Guard/Reserve) and reside more than 50 miles from a military hospital or clinic must use TRICARE PRIME Remote and use the network Primary Care Manager or authorized TRICARE provider as the Primary Care Manager. CCBHCs should contact the Primary Care Manager for care coordination and referral for services.

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

8.D.11.1.2. Serving Veterans

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

8.D.11.2. Integrating Care for Veterans

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

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

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

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

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

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

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

All behavioral health care is provided with cultural competence, and staff will receive specific training on military and veteran's culture. Specifically, any staff who is not a veteran has training about military and veterans' culture to be able to understand the unique experiences and contributions of those who have served their country. As described in staffing requirements, all staff should receive cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity.

8.D.11.6. Treatment Plan for Veterans

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

- The treatment plan includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis.
- The treatment plan includes approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself.
- As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness.
- The plan is recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments.
- The treatment plan is developed with input from the veteran, and when the veteran consents, appropriate family members. The veteran's verbal consent to the

treatment plan is required pursuant to VHA Handbook 1004.1.

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

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

8.E.1.1. Data Collection and Reporting Capacity
The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including but not limited to data capturing: (1) consumer characteristics; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) consumer outcomes.

8.E.1.2. Annual Data Reporting
Reporting is annual and data are required to be reported for all CCBHC consumers, or where data constraints exist (for example, the measure is calculated from claims), for all Medicaid enrollees in the CCBHCs.

8.E.1.3. DCOs and Data Reporting
Although most data reporting requirements will be the responsibility of the PIHPs or MDHHS, some data may relate to services CCBHC recipients receive through DCOs. Collection of this data is the responsibility of the CCBHC. The CCBHC should arrange for access to data in DCO agreements and is responsible for ensuring adequate consent and releases of information are obtained for each affected CCBHC recipient.

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

8.E.1.5. Annual Cost Reporting
CCBHCs annually submit a cost report with supporting data within four months after the end of each demonstration year to the PIHP. The PIHP will review the submission for completeness and submit the report and any additional clarifying information within five months after the end of each demonstration year (February 28) to MDHHS. The timelines should reflect other cost reporting timelines required by MDHHS. The CCBHC Cost Report template OMB #0398-1148/ CMS-10398 (#43) dated December 14, 2015 will be used for Demonstration Year 1 and 2.

8.E.1.6. CAFAS Assessment Data Reporting
CCBHCs are required to submit CAFAS assessment data to MDHHS mid-year and end of year utilizing the MDHHS provided CAFAS template. PIHPs are responsible for reviewing, validating, and submitting the CAFAS data template to MDHHS via the File Transfer Service (FTP) by due date of request provided.

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

8.E.2.1. Annual CQI Plan
The CCBHC develops, implements, and maintains an effective, CCBHC-wide data-driven continuous quality improvement (CQI) plan for clinical services and clinical

management. The CQI projects are clearly defined, implemented, and evaluated annually. The number and scope of distinct CQI projects conducted annually are based on the needs of the CCBHC's population and reflect the scope, complexity, and past performance of the CCBHC's services and operations. The CCBHC-wide CQI plan addresses priorities for improved quality of care and client safety and requires all improvement activities be evaluated for effectiveness. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance. The CCBHC documents each CQI project implemented, the reasons for the projects, and the measurable progress achieved by the projects. One or more individuals 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 consumer suicide deaths or suicide attempts; (2) CCBHC consumer 30 day hospital readmissions for psychiatric or substance use reasons; and (3) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.

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

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

8.F.1.1. Organizational Authority

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

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

8.F.1.2. IHS Agreements

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

8.F.1.3. Independent Audit

An independent financial audit is performed annually for the duration of the

demonstration in accordance with federal audit requirements, and, where indicated, a corrective action plan is submitted addressing all findings, questioned costs, reportable conditions, and material weakness cited in the Audit Report.

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 consumers with mental illness, adults recovering from substance use disorders, and family members of CCBHC consumers, either through 51 percent of the board being families, consumers or people in recovery from behavioral health conditions, or through a substantial portion of the governing board members meeting this criteria and other specifically described methods for consumers, people in recovery and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services.

8.F.2.2. Board Composition Plan

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

8.F.2.3. Alternative to Board Requirement

To the extent the CCBHC is comprised of a governmental or tribal entity or a subsidiary or part of a larger corporate organization that cannot meet these requirements for board membership, the state will specify the reasons why the CCBHC cannot meet these requirements and the CCBHC will have or develop an advisory structure and other specifically described methods for consumers, 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 consumers, families, and communities. Efforts to ensure responsiveness will focus on the full range of consumers, services provided, geographic areas covered, types of disorders, and levels of care provided. The state will determine if this alternative approach is acceptable and, if it is not, will require that additional or different mechanisms be established to assure that the board is responsive to the needs of CCBHC consumers and families. Each organization will make available the results of their efforts in terms of outcomes and resulting changes

8.F.2.4. Board Member Expertise and Interests

Members of the governing or advisory boards will be representative of the communities in which the CCBHC's service area is located and will be selected for their

expertise in health services, community affairs, local government, finance and banking, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. No more than one half (50 percent) of the governing board members may derive more than 10 percent of their annual income from the health care industry.

8.F.2.5. MDHHS Verification

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

8.F.3.Accreditation

8.F.3.1. Accreditation and Licensing

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

8.F.3.2. State Accreditation Requirements

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

Appendix A: CCBHC Demonstration Service Encounter Codes

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

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

Note: HSW overlapping services are identified °

CCBHC Encounter Identifier

Code	Description
T1040	Medicaid certified community behavioral health clinic services, per diem
TF	Medicaid 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
S9484	Crisis intervention mental health services, per hour
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter

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

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

96121	Neurobehavioral status examination by qualified health care professional with interpretation and report, additional 60 minutes
96127	Brief emotional or behavioral assessment
96130	Psychological testing evaluation by qualified health care professional, first 60 minutes
96131	Psychological testing evaluation by qualified health care professional, additional 60 minutes
96132	Neuropsychological testing evaluation by qualified health care professional, first 60 minutes
96133	Neuropsychological testing evaluation by qualified health care professional, additional 60 minutes
96136	Psychological or neuropsychological test administration and scoring by qualified health care professional, first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by qualified health care professional, additional 30 minutes
96138	Psychological or neuropsychological test administration and scoring by technician, first 30 minutes
96139	Psychological or neuropsychological test administration and scoring by technician, additional 30 minutes
96146	Psychological or neuropsychological test administration and scoring by single standardized instrument via electronic platform with automated result
H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility for admission to treatment program
H0031	Mental health assessment, by non-physician
H2000*	Comprehensive multidisciplinary evaluation
90887*	Explanation of psychiatric, medical examinations, procedures, and data to other than patient
90785	Interactive complexity (list separately in addition to the code for primary procedure)

Service Category: Treatment Planning

Code	Description
H0032	Mental health service plan development by non-physician
90887*	Explanation of psychiatric, medical examinations, procedures, and data to other than patient
H2000*	Comprehensive multidisciplinary evaluation
T1007	Alcohol and/or substance abuse services, treatment plan development or modification

Service Category: Outpatient Mental Health and Substance Use Services

Code	Description
90832	Psychotherapy, 30 minutes
90833	Psychotherapy, 30 minutes
90834	Psychotherapy, 45 minutes
90836	Psychotherapy, 45 minutes
90837	Psychotherapy, 60 minutes
90838	Psychotherapy, 60 minutes
90846	Family psychotherapy, 50 minutes

90847	Family psychotherapy including patient, 50 minutes
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
96372	Medication Administration, therapeutic, prophylactic, or diagnostic injection (specify substance or drug), subcutaneous or intramuscular
99202	New patient office or other outpatient visit, typically 20 minutes
99203	New patient office or other outpatient visit, typically 30 minutes
99204	New patient office or other outpatient visit, typically 45 minutes
99205	New patient office or other outpatient visit, typically 60 minutes
99211	Established patient office or other outpatient visit, typically 5 minutes
99212	Established patient office or other outpatient visit, typically 10 minutes
99213	Established patient office or other outpatient visit, typically 15 minutes
99214	Established patient office or other outpatient, visit typically 25 minutes
99215	Established patient office or other outpatient, visit typically 40 minutes
99341	New patient home visit, typically 20 minutes
99342	New patient home visit, typically 30 minutes
99343	New patient home visit, typically 45 minutes
99344	New patient home visit, typically 60 minutes
99345	New patient home visit, typically 75 minutes
99347	Established patient home visit, typically 15 minutes
99348	Established patient home visit, typically 25 minutes
99349	Established patient home visit, typically 40 minutes
99350	Established patient home visit, typically 60 minutes
99506	Medication Administration, home visit for intramuscular injections
H0004	Behavioral health counseling and therapy, per 15 minutes (SUD)
H0005	Alcohol and/or drug services; group counseling by a clinician
H0014	Alcohol and/or drug services; ambulatory detoxification ASAM WM-1
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
H0022	Alcohol and/or drug intervention service (planned facilitation)
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
H0038	Self-help/peer services, per 15 minutes
H0045 °	Respite care services, not in the home, per diem
H2014 °	Skills training and development, per 15 minutes
H2027	Psychoeducational service, per 15 minutes
S5110	Home care training, family; per 15 minutes
S5111 °	Home care training, family; per session
T1005 °	Respite care services, up to 15 minutes
T1012	Alcohol and/or substance abuse services, skills development

*Code included in multiple service categories.

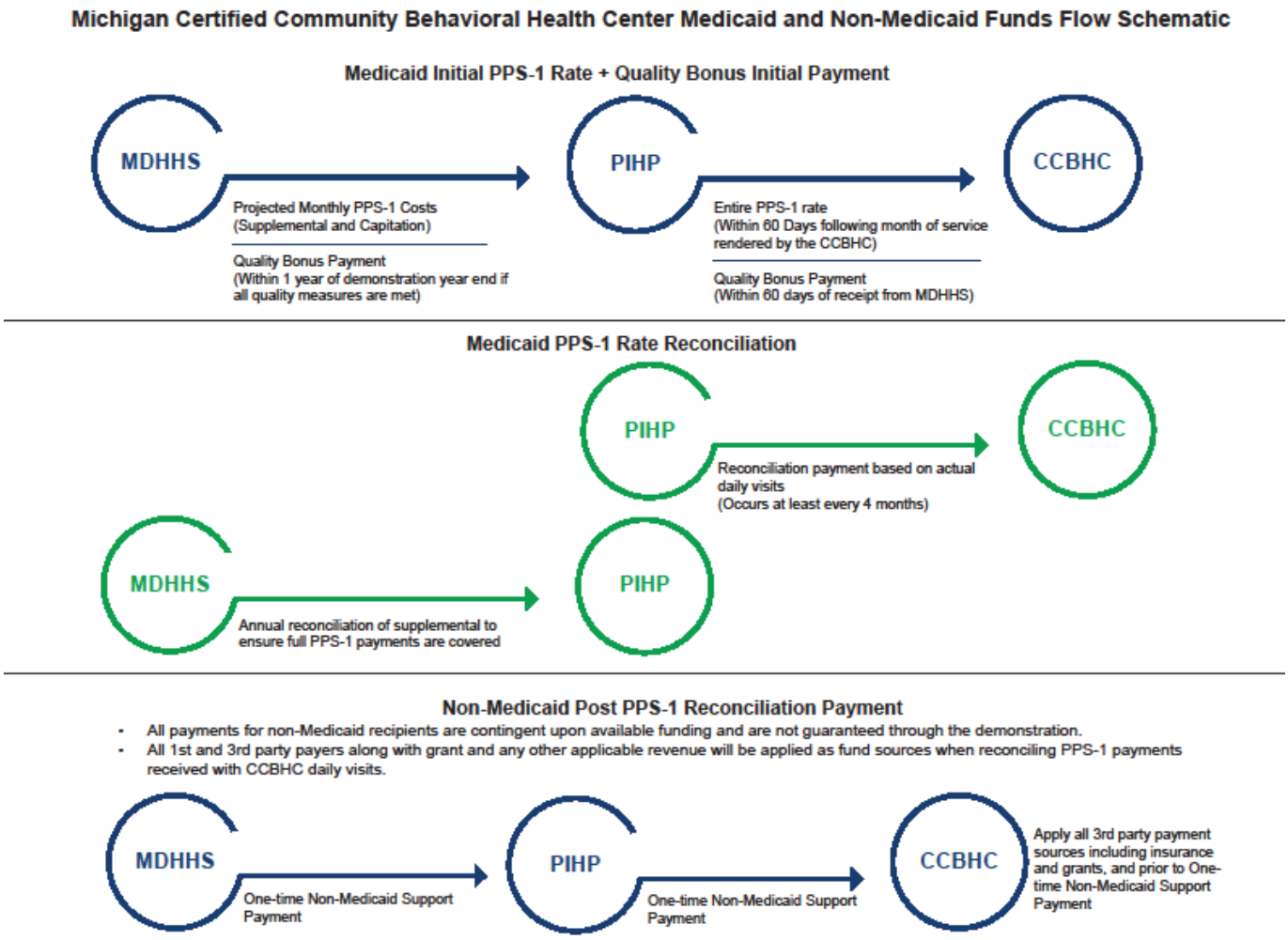
Appendix B: List of CCBHC-eligible ICD-10 Diagnosis Codes

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

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

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

Appendix C: MI CCBHC Funds Flow Schematic



Appendix D: Encounter Reporting Example

In this example, an individual received two eligible CCBHC services – H0031 and 99202 – on a given day. The Procedure Code T1040 is used as flag to indicate a CCBHC enrollees receiving CCBHC services. In this example, no payments are associated with the T1040. Payments to the CCBHC are shown on actual services H0031 and 99202 but reflect historical fee structures rather than the PPS-1 rate.

Loop	Claim	Notes
2300:	CLM✻A37YH556✻40✻✻✻11:B:1✻Y✻A✻Y✻I✻P~	Total Claim Charge Amount - CLM02
2320:	AMT✻D✻25~	Total Payment Amount - AMT02
2330B:	NM1✻PR✻2✻**Payer Name**✻✻✻✻✻PI✻11122333~	Payer ID – NM1O9 - Must match 2430 SVD01
2400:	**Line 1** SV1✻HC:T1040✻0✻UN✻1✻11✻✻1:2:3✻✻N~	Line Item Charge Amount - SV102
2430:	SVD✻11122333✻0✻HC:T1040✻✻3~	Service Line Paid Amount - SVD02; Payer ID – SVD01 Must match 2330B NM109
2430:	CAS✻OA✻93✻0~	Line Adjustment Amount - CAS03, Other Adjustment – CAS01
2430:	DTP✻573✻D8✻20130203~	Remittance Date
2400:	**Line 2** SV1✻HC:H0031✻20✻UN✻1✻11✻✻1:2:3✻✻N~	Line Item Charge Amount - SV102
2430:	SVD✻11122333✻15✻HC:H0031✻✻3~	Service Line Paid Amount - SVD02; Payer ID – SVD01 Must match 2330B NM109
2430:	CAS✻OA✻93✻5~	Line Adjustment Amount - CAS03, Other Adjustment – CAS01
2430:	DTP✻573✻D8✻20130203~	Remittance Date
2400:	**Line 3** SV1✻HC:99201✻20✻UN✻1✻11✻✻1:2:3✻✻N~	Line Item Charge Amount SV102
2430:	SVD✻11122333✻10✻HC:99202✻✻2~	Service Line Paid Amount SVD02; Payer ID – SVD01 Must match 2330B NM109
2430:	CAS✻OA✻93✻10~	Line Adjustment Amount - CAS03, Other Adjustment – CAS01
2430:	DTP✻573✻D8✻20130203~	Remittance Date

Reporting Instructions for the Designated Collaborating Organization (DCO)

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

2310C Loop – SERVICE FACILITY LOCATION NAME – Claim Level

NM1*77 segment – Service Location

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

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

Appendix E: Metric Guidance

CCBHC Clinic-Reported Measures

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

Eligible Population for Measurement:

Per CMS guidance, the eligible population for these measures includes all CCBHC consumers served by a CCBHC provider. The denominator-eligible population for each measure includes CCBHC consumers who satisfy the measure-specific eligibility criteria that may include requirements such as age and continuous enrollment. Broadly, CCBHC consumers have received an eligible CCBHC service with a corresponding T1040. See Section 7.A.3. for more information.

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

CCBHC Benchmarks

When available, benchmarks are provided in the tables below to provide a point of reference for performance and guide CCBHCs as they set goals. The program benchmarks are for reference only and represent the average reported performance of Cohort 1 CCBHCs during DY1. Quality Bonus Payment (QBP) benchmarks are derived from various sources, including state and national standards, and must be met to receiving a QBP award.

Stratification by Payer Type

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

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

CCBHC Template

CCBHCs should complete the SAMHSA Section 223 Data Reporting Template (xlsx file) for each clinic-reported measure. This template was developed in 2016 for original demonstration states, and the worksheets cannot be edited. As such, the measure steward and dates identified at the top of each sheet may be outdated, specifically for the CMS Core Set measures. CCBHCs should follow the specifications listed in the CCBHC Demonstration Handbook. Section E of each template provides cells that indicate whether different types of individuals are in the denominator (e.g., Medicaid, Title XIX-eligible CHIP population, commercially insured). That is to help the national evaluators understand the population makeup in the denominator; there does not need to be some of each insurance type. Further down in Section E of each template, please 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, and for each payer type (Medicaid, Dual, Other).

1. Time to Initial Evaluation (I-EVAL)

Name: I-EVAL	Spec: SAMHSA (2016)	Benchmark:
Program Benchmark: First Contact: 57.8% Days to Eval: 20.8		
Description: 1. The percentage of new consumers with initial evaluation provided within 10 business days of first contact. 2. The mean number of days until initial evaluation for new consumers.		
Measurement Period: For both metrics, the measurement period for the denominator is the measurement year excluding the last 30 days of the measurement year including the 6 months preceding the measurement year. The measurement period for the numerator is the measurement year.		
Additional Guidance: • "New" CCBHC services recipients are requesting services from the CCBHC for the very first time or have not received services from the CCBHC during the previous 6 months. • First contact must be made by the person who is seeking services or by his or her family if the person is a child. • It is likely that some new consumers will not have an appointment within 10 days because of their own schedules and non-urgent need. This situation is a recognized limitation of this measure that will affect all clinics. There are no populations excluded in this calculation. • If a person contacts a clinic more than once to initiate services, the first contact should count as initiation and the time initial evaluation counts from that point. • All individuals who contact the clinic to request services are included in the first metric.		

2. Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)

Name: BMI-SF	Spec: SAMHSA (2016)	Benchmark:
Program Benchmark: All: 32.5%		
Description: The percentage of consumers aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter. • Age 18 - 64 years BMI > 18.5 and < 25 kg/m2 • Age 65 years and older BMI > 23 and < 30 kg/m2		
Measurement Period: The measurement period for the denominator is the measurement year. The measurement period for the numerator is the measurement year and the previous 6 months.		

Additional Guidance:

- There is no diagnosis associated with this measure. This measure is to be reported a minimum of once per measurement year for consumers seen during the reporting year.
- If more than one BMI is reported during the measure period, the most recent BMI will be used to determine if the performance has been met.
- A follow-up plan must be documented during the same encounter as the BMI screening or have been documented at some point in the previous six months.
- A consumer is not eligible if one or more of the following reasons are documented:
  - Consumer is receiving palliative care
  - Consumer is pregnant
  - Consumer refuses BMI measurement (refuses height and/or weight)
  - Any other reason documented in the medical record by the provider why BMI measurement was not appropriate
  - Consumer is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the consumer's health status
- BMI can be generated at the CCBHC or provided by a DCO. If a clinic must obtain this information from a non-DCO provider (for example, a PCP), a care coordination agreement is needed.
- If a CCBHC acquires documentation of the BMI screening from another provider (such as a PCP), the original provider can develop and implement the follow-up plan. The CCBHC should be able to confirm that the follow-up happened.

Alternate Codes for Administrative Calculation:

Code	Document BMI - Description
G8420	BMI is documented within normal parameters and no follow up plan is required
G8417	BMI is documented above normal parameters and a follow-up plan is documented
G8418	BMI is documented below normal parameters and a follow-up plan is documented
G8421	BMI not documented and no reason is given
G8419	BMI documented outside normal parameters, no follow-up plan documented, no reason given

Code	Identify Exclusions - Description
G8422	BMI not documented, with documentation the consumer is not eligible for BMI calculation.
G8938	BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation shows the consumer is not eligible.

3. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)

Name: WCC-CH	Spec: CMS Child Core Set (2023)	Benchmark:
Program Benchmark: All: 44.3%		
Description: The percentage of children ages 3 to 17 who had an outpatient visit with a primary care practitioner (PCP) or obstetrical/gynecological (OB/GYN) practitioner and who had evidence of body mass index (BMI) percentile documentation during the measurement year.		

Measurement Period: The measurement period for the denominator is the measurement year.
Additional Guidance: • Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than the absolute BMI value. • A BMI percentile is included in the numerator count if the specified documentation is present, regardless of the primary intent of the visit. A BMI without a percentile is not acceptable for inclusion in the numerator count. • In the context of the CCBHC demonstration, the BMI screening may be conducted by medical personnel at either the CCBHC or a DCO without regard to whether they are a PCP or OB/GYN for the consumer, as long as they are operating within the scope of practice for their licensure. Because this is a deviation from the measure Technical Specification, however, it should be so indicated in the section of the data reporting template where adherence or non-adherence to the Technical Specification is reported.

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

Name: TSC	Spec: SAMHSA (2016)	Benchmark:
Program Benchmark: All: 48.7%		
Description: Percentage of consumers aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.		
Measurement Period: The measurement period for the denominator is the measurement year and, for the numerator, is the measurement year and the prior year.		
Additional Guidance: • 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.		

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

Name: ASC	Spec: SAMHSA (2016)	Benchmark:
Program Benchmark: All: 48.6%		

Description: Percentage of consumers aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user.
Measurement Period: The measurement period for the denominator is the measurement year and, for the numerator, is the measurement year and the prior year.
Additional Guidance: • For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include: o AUDIT Screening Instrument (score ≥ 8) o AUDIT-C Screening Instrument (score ≥4 for men; score ≥3 for women) o Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response ≥2) • Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5–15 minutes, which may include feedback on alcohol use and harms, identification of high-risk situations for drinking and coping strategies, increased motivation, and the development of a personal plan to reduce drinking.

6. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)

Name: SRA-BH-C	Spec: SAMHSA (2016)	QBP Benchmark: 23.9%
Quality Bonus Payment Metric		
Program Benchmark: All: 47.9%		
Description: The percentage of consumer visits for those consumers aged 6 through 17 years with a diagnosis of Major Depressive Disorder (MDD) with an assessment for suicide risk.		
Measurement Period: For both the denominator and the numerator, the measurement period is the measurement year.		

Additional Guidance:

- Measure is based on consumer visits, not individuals. A minimum of two encounters are required during the measurement period for inclusion in the measure. The two encounters do not have to be with the same clinician, but need to be from the same clinic.
- A suicide risk assessment should be performed at every visit for Major Depressive Disorder during the measurement period. The assessment can include:
  - 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.

7. Major Depressive Disorder: Suicide Risk Assessment (SRA-A)

Name: SRA-A	Spec: SAMHSA (2016)	QBP Benchmark: 12.5%
Quality Bonus Payment Metric		
Program Benchmark (Adult): Child: 67.7%		
Description: Percentage of consumers 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.		
Measurement Period: For both the denominator and the numerator, the measurement period is the measurement year.		

Additional Guidance:

- Measure is based on consumer visits, not individuals. A minimum of two encounters are required during the measurement period for inclusion in the measure.
- A suicide risk assessment should be performed at every visit for Major Depressive Disorder during the measurement period. The assessment can include:
  - 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 measure description outlined in the header for this measure states, 'consumers aged 18 years and older' while the logic statement states, '>= 17 year(s) starts before start of "Measurement Period."' The logic statement, as written, captures consumers who turn 18 years old during the measurement period so that these patients are included in the measure.
- If sessions are performed with the parents of a child without the child present, those visits should be excluded from both the denominator and the numerator. CCBHCs should indicate in the "Additional Notes" section of the data reporting template that SRAs couldn't be conducted for a child when only the parents were present.

8. Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)

Name: CDF-AD	Spec: CMS Child Core Set (2023)	Benchmark:
Program Benchmark (Adult): Child: 37.2%		
Description: Percentage of consumers aged 12 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.		
Measurement Period: The measurement period for the denominator and the numerator is the measurement year.		

Additional Guidance:

- The date of encounter and screening must occur on the same date of service; if a consumer has more than one encounter during the measurement year, the consumer should be counted in the numerator and denominator only once based on the most recent encounter.
- 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.
- Proposed outline of treatment to be conducted as a result of clinical depression screening. Follow-up for a positive depression screening must include one (1) or more of the following:
  - Additional evaluation
  - Suicide risk assessment
  - Referral to a practitioner who is qualified to diagnose and treat depression
  - Pharmacological interventions
  - Other interventions or follow-up for the diagnosis or treatment of depression

- The documented follow-up plan must be related to positive depression screening, for example: "Patient referred for psychiatric evaluation due to positive depression screening."
- Exclude consumers if one or more of the following conditions are documented in the patient medical record:
  - Consumer has an active diagnosis of Depression or Bipolar Disorder
  - Consumer refuses to participate
  - Consumer is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the consumer's health status
  - Situations where the consumer's functional capacity or motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools (for example, certain court-appointed cases or cases of delirium).

Alternate Codes for Administrative Calculation

Code	Document Depression Screen - Description
G8431	Positive screen for clinical depression using a standardized tool and a follow-up plan documented.
G8510	Negative screen for clinical depression using standardized tool, patient not eligible/appropriate for follow-up plan documented.

Code	Identify Exclusions - Description
G8433	Screening for clinical depression not documented patient not eligible/appropriate.
G8940	Screening for clinical depression documented, follow-up plan not documented, patient not eligible/appropriate.
Depression	F320, F321, F322, F323, F324, F325, F328, F329, F330, F331, F332, F333, F3340, F3341, F3342, F338, F339, F341
Bipolar Disorder	F310, F3110, F3111, F3112, F3113, F312, F3130, F3131, F3132, F314, F315, F3160, F3161, F3162, F3163, F3164, F3170, F3171, F3172, F3173, F3174, F3175, F3176, F3177, F3178, F3181, F3189, F319, F3010, F3011, F3012, F3013, F302, F303, F304, F308, F309

9. Depression Remission at Twelve Months (DEP-REM-12)

Name: DEP-REM-12	Spec: SAMHSA (2016)	Benchmark:
Program Benchmark (Adult): Child: 13%		
Description: Percentage of consumers aged 12 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.		
Measurement Period: The measurement period for the denominator and the numerator is the measurement year.		

Additional Guidance:

- The date of encounter and screening must occur on the same date of service; if a consumer has more than one encounter during the measurement year, the consumer should be counted in the numerator and denominator only once based on the most recent encounter.
- 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.
- Proposed outline of treatment to be conducted as a result of clinical depression screening. Follow-up for a positive depression screening must include one (1) or more of the following:
    - Additional evaluation
    - Suicide risk assessment
    - Referral to a practitioner who is qualified to diagnose and treat depression
    - Pharmacological interventions
    - Other interventions or follow-up for the diagnosis or treatment of depression
- The documented follow-up plan must be related to positive depression screening, for example: "Patient referred for psychiatric evaluation due to positive depression screening."
- Exclude consumers if one or more of the following conditions are documented in the patient medical record:
    - Consumer has an active diagnosis of Depression or Bipolar Disorder
    - Consumer refuses to participate
    - Consumer is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the consumer's health status
    - Situations where the consumer's functional capacity or motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools (for example, certain court-appointed cases or cases of delirium).

CCBHC State-Reported Measures

States participating in the CCBHC demonstration are responsible for the collection and reporting of 13 additional measures as described below. States use administrative encounter data from Medicaid populations to calculate the measures.

CCBHC Population Definition

For all state-reported measures *except* Housing Status (HOU), the CCBHC population is defined as Medicaid beneficiaries who had a CCBHC service. CCBHC service is defined as an encounter with procedure code T1040. Rejected encounters are excluded. The Medicaid beneficiary ID must be in the encounter submitted. Continuous enrollment measure requirements are met based on Medicaid continuous enrollment rather than CCBHC continuous enrollment.

CCBHC Attribution

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

CCBHC Benchmarks

When available, benchmarks are provided in the tables below to provide a point of reference for performance and guide CCBHCs as they set goals. State-calculated measures used the T1040 attribution methodology described above. The program benchmarks are for reference only and represent the average reported performance of Cohort 1 CCBHCs during DY1. Quality Bonus Payment (QBP) benchmarks are derived from various sources, including state and national standards, and must be met to receiving a QBP award.

1. Housing Status (HOU)

Name: HOU	Spec: SAMHSA (2016)	-

Description:
The percentage of consumers in 10 categories of living situation:

1. Private residence
2. Foster home
3. Residential care
4. Crisis residence
5. Residential treatment center
6. Institutional setting
7. Jail (correctional facility)
8. Homeless (shelter)
9. Other
10. Not available

Measurement Period:
The measurement period is the measurement year, divided into two equal parts.

Additional Guidance:

- Data for this measure does not need to be stratified by insurance payer.
- For the purposes of this metric, the data should be collected at least twice during the measurement year, including at admission (intake) and/or discharge where relevant. When collected at a point other than admission or discharge, the living situation should be the one reported at the last assessment of housing status during the measurement period.
- The CCBHC population is defined as any individual who had a CCBHC service and have a case in WSA in any status since 10/1/2021. CCBHC service is defined as an encounter with procedure code T1040. Rejected encounters are excluded. All individuals with regardless of coverage (e.g., Medicaid coverage, other insurance, uninsured) are included. The Medicaid beneficiary ID must be in both the encounter and in the WSA case record to be matched and included. A second match by PIHP ID and PIHP Person ID between the encounter and WSA case record is done to include Non-Medicaid individuals. CCBHC attribution is based on WSA most recent assignment. PIHP attribution is based on CCBHC assignment.

Housing Crosswalk to BHTEDS Living Arrangement Descriptions	
Reporting Categories from Spec:	BHTEDS Living Arrangement Descriptions:
Private Residence	• Living in a private residence not owned or controlled by the PIHP • Living in a private residence that is owned and/or controlled by the PIHP • Living in a private residence with natural or adoptive family member(s).
Foster Home	Foster Home/Foster Care

Residential Care	Residential care/AFC (MH Only)
Crisis Residence	Crisis Residence
Institutional Setting	Institutional Setting
Jail/Correctional Facility	Jail/Correctional/Other Institutions
Homeless	Homeless and SUD Homeless
Other	SUD Dependent Living SUD Independent Living
Unavailable	

2. Patient Experience of Care Survey (PEC)

Name: PEC	Spec: SAMHSA (2016)	-
Description: Annual completion and submission of Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey, identifying results separately for BHCs and comparison clinics and oversampling those clinics		
Additional Guidance: • The MHSIP survey should be the basis of the survey distributed. • Clinics should oversample, with a goal of distribution 300 surveys to adults. • CCBHCs with non-CCBHC populations must be able to identify CCBHC service recipients. • Respondents must have had a CCBHC service during the demonstration year. • If a clinic wishes to use an adaptation of the MHSIP, the clinic must request approval from MDHHS and ensure the questions can be translated into the survey domains of the MHSIP surveys.		

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

Name: Y/FEC	Spec: SAMHSA (2016)	-
Description: Annual completion and submission of Youth/Family Services Survey for Families (YSS-F) Experience of Care Survey, identifying results separately for BHCs and comparison clinics and oversampling those clinics		
Additional Guidance: • 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 MHSIP, the clinic must request approval from MDHHS and ensure the questions can be translated into the survey domains of the YSS-F surveys.		

4. Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Name: FUM	Spec: CMS Adult Core Set (2023)	

Program Benchmark: 30 day: 77.2 7 day: 62.1
Description: Percentage of emergency department (ED) visits for beneficiaries age 6 years and older with a Primary diagnosis of mental illness, who had an outpatient visit, an intensive outpatient visit, or a partial hospitalization for mental illness. Two rates are calculated: • Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit
Measurement Period: The measurement period for the denominator is the measurement year (e.g., for CCBHCs, DY1 or DY2) absent the last 30 days of the measurement year. The measurement period for the numerator is the measurement year.
Additional Guidance: • The denominator for this measure is based on ED visits, not on beneficiaries.

5. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

Name: FUA	Spec: CMS Adult Core Set (2023)	-
Program Benchmark: 30 day: 63.6 7 day: 21.5		
Description: The percentage of emergency department (ED) visits for consumers 13 years of age and older with a primary diagnosis of alcohol or other drug (AOD) dependence, who had an outpatient visit, an intensive outpatient encounter or a partial hospitalization for AOD. Two rates are reported: • Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit. • Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit.		
Measurement Period: The measurement period for the denominator is the measurement year (e.g., for CCBHCs, DY1 or DY2) absent the last 30 days of the measurement year. The measurement period for the numerator is the measurement year.		

Additional Guidance:

- The denominator for this measure is based on ED visits, not on beneficiaries.
- This is similar to the FUA-AD and FUA-CH measure in the Adult and Child Core Sets. For HEDIS, this measure has four reportable rates – ages 13 to 17, ages 18 to 64, age 65 and older, and total (age 13 and older). The Child Core Set measure applies to beneficiaries ages 13 to 17 and the Adult Core Set measure applies to beneficiaries age 18 and older. CCBHC reporting for this measure should include the total (age 13 and older).
- Diagnosis at follow-up does not need to be a perfect match to the diagnosis at ED visit. For example, if a person has an ED visit and is given a primary diagnosis of opioid dependence, and then there is follow-up at the BHC and a primary diagnosis of opioid misuse (or even some non-opioid-related substance use diagnosis listed as the primary follow-up diagnosis), it still would count as long as it is a substance use code and it is in the primary position. CCBHCs should not be changing their diagnosis simply to satisfy the measures.

6. Plan All-Cause Readmissions Rate (PCR-AD)

Name: PCR-AD	Spec: CMS Adult Core Set (2023)	-
Program Benchmark: Readmission Rate: 12.1		
Description: For consumers age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. Data are reported in the following three categories: • Count of Index Hospital Stays (IHS) (denominator) • Count of 30-Day Readmissions (numerator) • Readmission Rate		
Measurement Period: The measurement period for the denominator is measured from the discharge date and encompasses the measurement year (e.g., for CCBHCs, DY1 or DY2) less the last 30 days. The measurement period for the numerator is the measurement year.		
Additional Guidance: • CCBHC demonstration suggests that states report unadjusted rates for this measure (no risk adjustment) • CMS follows slightly different specifications than the HEDIS measure.		

7. Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD-AD)

Name: SSD-AD	Spec: CMS Adult Core Set (2023)	-
Program Benchmark: Adults: 80.9		

Description: The percentage of consumers 18-64 years of age with Schizophrenia or Bipolar Disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
Measurement Period: The measurement period for the denominator is the measurement year and the year prior to the measurement year. The measurement period for the numerator is the measurement year (e.g., for CCBHCs, DY1 or DY2).
Additional Guidance: • Measure reports individuals, not visits

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

Name: SAA-AD	Spec: CMS Adult Core Set (2023)	QBP Benchmark: 58.5%
Quality Bonus Payment Metric		
Program Benchmark: Adults: 56.7		
Description: Percentage of enrollees ages 19 to 64 with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.		
Measurement Period: For both the denominator and the numerator, the measurement period is the measurement year.		
Additional Guidance: • Measure is listed in the reporting template as "Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)". Measure has been updated to reflect technical specifications for CMS Adult Core Set 2021, yet name is not changed in reporting template. • Measure reports individuals, not visits		

9. Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)

Name: FUH-AD	Spec: CMS Adult Core Set (2023)	QBP Benchmark (30 day): 58.0%
Quality Bonus Payment Metric		
Program Benchmark: 30 day: 70.1 7 day: 46.0		
Description: The percentage of discharges for consumers age 18 and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported:		

1. Percentage of discharges for which the consumer received follow-up within 7 days of discharge 2. Percentage of discharges for which the consumer received follow-up within 30 days of discharge
Measurement Period: *Denominator*: The measurement period for the denominator is the measurement year minus the last 30 days of the measurement year. *Numerator*: The measurement period for the numerator is the measurement year.
Additional Guidance: • The denominator for this measure should be the same for the 30-day rate and the 7-day rate. • The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate • Measure is listed in the reporting template as "Follow-up After Hospitalization for Mental Illness (FUH-BH-A)". Measure has been updated to reflect technical specifications for CMS Adult Core Set 2021, including different age categories, yet name is not changed in reporting template. • To be consistent with CMS Adult Core Set (2023) specifications, this measure is reported in two age categories, 18-64 and 65+.

10. Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)

Name: FUH-CH	Spec: CMS Child Core Set (2023)	QBP Benchmark (30 day): 70%
Quality Bonus Payment Metric		
Program Benchmark: 30 day: 83.5 7 day: 70.1		
Description: Percentage of discharges for children and adolescents ages 6 to 17 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported: 1. Percentage of discharges for which children received follow-up within 7 days of discharge 2. Percentage of discharges for which children received follow-up within 30 days of discharge		
Measurement Period: *Denominator*: The measurement period for the denominator is the measurement year minus the last 30 days of the measurement year. *Numerator*: The measurement period for the numerator is the measurement year.		

Additional Guidance:

- The denominator for this measure should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate
- Measure is listed in the reporting template as "Follow-up After Hospitalization for Mental Illness (FUH-BH-A)". Measure has been updated to reflect technical specifications for CMS Adult Core Set 2021, including different age categories, yet name is not changed in reporting template.
- To be consistent with CMS Adult Core Set (2023) specifications, this measure is reported for age 6-17.

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

Name: ADD-CH	Spec: CMS Child Core Set (2023)	-

Program Benchmark:
Initiation: 63.4
C & M: 69.7

Description:
Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.
Two rates are reported.

- Initiation Phase: Percentage of children ages 6 to 12 as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
- Continuation and Maintenance (C&M) Phase: Percentage of children 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 Phase ended.

Measurement Period:
For the denominator, two measurement periods are used:

- Index prescription start date (IPSD): 10 months before the measurement year begins to 2 months after the measurement year begins
- Negative medication history review: The time period between 120 days before the IPSD measurement period begins and 120 days before the IPSD measurement period ends

For the numerator, two measurement periods are used:

- Initiation Phase: The time period between 30 days after the IPSD measurement period begins and 30 days after the IPSD measurement period ends
- Continuation and Maintenance Phase: The time period between 300 days after the IPSD measurement period begins and 300 days after the IPSD measurement period ends

Additional Guidance:

- This measure is named "ADD-BH" in the demonstration measure template
- Age to include consumers aged 6 years as of 10 months before the measurement year begins to age 12 as of 2 months after the measurement year begins
- Note to us: Preliminary data is difficult to calculate due to the historical measurement period

12. Antidepressant Medication Management (AMM-BH)/(AMM-AD)

Name: AMM-AD	Spec: CMS Adult Core Set (2023)	-
Program Benchmark: Acute: 49.1 Continuation: 29.8		
Description: The percentage of consumers age 18 and older who were treated with antidepressant medication, had a diagnosis of Major Depression and who remained on an antidepressant medication treatment. Two rates are reported: 1. Effective Acute Phase Treatment. Percentage of consumers who remained on an antidepressant medication for at least 84 days (12 weeks). 2. Effective Continuation Phase Treatment. Percentage of consumers who remained on an antidepressant medication for at least 180 days (6 months).		
Measurement Period: For the denominator, two measurement periods are used: 1. Index prescription start date (IPSD): The time period between 7 months before the measurement year begins and 4 months after the measurement year begins 2. Negative medication history review: The time period between 105 days before the IPSD measurement period begins and 105 days before the IPSD measurement period ends For the numerator, two measurement periods are used: 1. Acute Phase: The time period between 114 days after the IPSD measurement period begins and 114 days after the IPSD measurement period ends 2. Continuation Phase: The time period between 231 days after the IPSD measurement period begins and 231 days after the IPSD measurement period ends		
Additional Guidance: • Measure is named “AMM-BH” in the reporting template but has been updated to “AMM-AD” in CMS Adult Core Set (2023). • Measure is listed in the reporting template as “AMM-BH”. Measure has been updated to reflect technical specifications for CMS Adult Core Set 2021.		

13. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)

Name: IET-BH	Spec: CMS Adult Core Set (2023)	QBP Benchmark: -- Initiation – 25%
Quality Bonus Payment Metric		
Program Benchmark (Adult): 14 day: 43.9 30 day: 12.4		

Description:
The percentage of consumers age 13 and older with a new episode of alcohol or other drug (AOD) dependence who received the following:

1. Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis
2. Initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit

Measurement Period:
Denominator: For the denominator, two measurement periods are used:

- The Index Episode Start Date (IESD) measurement period is the first 10 months and 15 days of the measurement year.
- The Negative Diagnosis History Review measurement period looks back 60 days prior to the IESD. It begins 60 days prior to the measurement year and ends 60 days prior to the last possible date of the IESD during the measurement year.

Numerator: For the numerator, two measurement periods are used:

- The measurement period for Initiation of AOD Treatment covers the 13 days following the IESD. It begins on the 1st day of the first month and ends 13 days after the measurement period for the IESD ends.
- The measurement period for Engagement of AOD Treatment covers the 29 days following Initiation of AOD Treatment. It begins on the 2nd day of the first month and ends 29 days after the measurement period for Initiation of AOD Treatment ends.

Additional Guidance:

- Age is determined as of the last day of the demonstration year.
- Benchmarks have been lowered for due to the change in statewide technical specifications for IET-BH in 2022.

Home and Community Based Services Individualized Plan of Service Requirements Guidance

The purpose of this guidance document is to provide clarity around the requirements of the Home and Community Based Services (HCBS) rule related to the use of restrictive and or intrusive techniques when utilizing Medicaid funding for HCBS services.

This document does not address the requirements regarding Behavior Treatment Plans (BTP) or the policies of MDHHS related to those plans. The existence of a BTP *has no bearing* on the requirement that any and all restrictions must be identified in the persons Individual Plan of Service (IPOS) consistent with the requirements outlined in the Medicaid Provider Manual (MPM).

The Centers for Medicare and Medicaid Services (CMS) and the Michigan Department of Health and Human Servies (MDHHS) require that any restrictions upon a person's freedoms must be documented in the person's Individual Plan of Service (IPOS) and developed utilizing the person-centered planning process (PCP) as outlined in the HCBS Final Rule.

No restriction may be placed upon a person's freedoms or rights unless the restriction is based upon a documented health and/or safety issue.

All restrictions on a person's rights must be documented in the individual's IPOS without exception. It is important to be aware of any limitations put upon a person's freedoms however small. You may be able to address these issues with setting staff and others involved in the care of the person to see if the restriction(s) are needed or have become a habit or way of doing business.

Should a PIHP/CMHSP believe that there is sufficient evidence that warrants restricting a person's rights based upon an identified health or safety need for the person or the greater community, a specific process must be followed in order to access Medicaid funding for services rendered under authority of the HCBS Final Rule.

If an individual is adjudicated and or determined NGRI, and the court imposes restrictions, these are taken into account; however, all the requirements of this document must be upheld to the fullest extent possible.

The required process is identified in the Michigan Medicaid Provider Manual. The following is an excerpt with additional clarification in some areas.

Document that any modifications of the HCB settings requirements are based upon a specific assessed health and safety need and justified in the person-centered service plan:

- Identify the specific assessed need(s)

This requires the need to be identified by an individual who has expertise in the area impacted. For instance, if the issue is related to the health of a person an MD or similar professional is required to identify the need. A person who provides services to the individual and is not a qualified medical professional may not substitute their opinion for that of a medical professional related to health matters. A service provider may not determine someone should not smoke and then restrict them on that basis alone. A guardian similarly may not restrict a person's freedoms or right without the documented support of a medical professional in this instance if Medicaid funding is desired.

Similarly, if it is believed that a person is at risk due to symptomatology of a mental illness or developmental delay a behavioral health professional must provide the basis of the need.

If a court order is in place as the basis of the restriction this must be identified in the IPOS and the documentation from the order must be present in the individuals record and available for review upon request. All other requirements outlined apply to court ordered restrictions to the fullest extent possible.

Document the positive interventions and supports used previously *The IPOS must cite the identification of evidence that less restrictive interventions have been tried and were not effective and should provide information related to what was tried within the IPOS itself. Detailed evidence must be available in the record for review upon request.*

Document less intrusive methods that were tried and did not work, including how the methods were implemented and why they did not work *Interventions should begin with the least restrictive option likely to be effective and move to more restrictive options only when the less restrictive options are not successful. Document in the record why the intervention chosen is the least restrictive option for this person at this time. These previous interventions must be elaborated upon to identify what was tried, when, and for how long. Detailed evidence supporting the assertion that less intrusive methods were tried must be documented in the record and available upon request.*

Include a clear description of the condition that is directly proportionate to the assessed need *The IPOS must clearly identify the health or safety need for which the intervention is being developed. The intervention itself must be focused on the specific need identified and be the least restrictive option that will provide for the health or safety of the person or others.*

- Include regular collection and review of data to measure the effectiveness of the modification.

Home and Community Based Services Individualized Plan of Service Requirements Guidance

Identify what data will be collected to assess whether the restriction is having an impact on the area of concern.

Conduct regular reviews to determine whether the restriction is having the desired impact of increasing the individual's health or safety. If the restriction is not effective it should be removed.

Identify how data related to efficacy of the intervention will be gathered and how this will be documented.

All evidence documentation must be available in the individuals record for review upon request.

Include established time limits for periodic review of the modification. *Plan must include information regarding how the restriction can be phased out over time. This includes specifically what data will be gathered and reviewed to assess ongoing need, the efficacy of the intervention and the timelines for reduction/elimination of restrictions.*

Plan will include the supportive interventions that will be available to the person to build upon skills and reduce or eliminate the need for restriction.

Review must occur no less than quarterly with documentation that supports the review occurred and the outcome of the review. This documentation must be kept in the individual's record and be easily accessed by CMHSP staff upon request.
Review will address whether current restrictions have been effective in addressing the need and if so, how restrictions can be lessened to increase freedoms.
In the event that the restriction has not been effective in reducing the need the review will consider whether another approach is warranted and will justify why the restriction should be kept in place, and what will be different between time of current review and the next review.

Evidence of these elements will be documented in the individual's record and available upon request. Plan will be updated to reflect any changes.

Include informed consent of the individual *Consistent with CMS's expectations that all individuals be assumed competent to join in the Person-Centered Planning process the IPOS with restrictions must be signed by the person receiving services regardless of guardianship status.*

CMS provides the following guidance: A person-centered approach to informed choice is to always presume competence.

Include assurances that the modifications will cause no harm to the individual. *Assure that inquiry has been made about any known medical, psychological, or other factors that the individual has, which might put him/her at high risk of death, injury, or trauma if subjected to intrusive or restrictive techniques. Document that this consideration occurred.*

Home and Community Based Services Individualized Plan of Service Requirements Guidance

What if there are restrictions in the setting that are not for the benefit of the participant and a workaround has been developed, how do you document this? *Identify in the individual's IPOS that a restriction is present in the setting that is not for the benefit of the person.*

Identity agreements around how the person will be able to access whatever item or activity is restricted.

Note the person should be able to access the item or activity seamlessly. For example, the requirement to ask to staff to open a door or retrieve a particular item does not allow seamless access as it requires a staff member to provide the person with something and can involve refusal or waiting.

Resources
Michigan Medicaid Provider Manual HCBS Chapter
- MedicaidProviderManual.pdf (state.mi.us)

Centers for Medicare and Medicaid
- Home and Community Based Services | CMS

MDHHS HCBS Behavioral Health Webpage
- MDHHS Behavioral Health HCBS Waivers (michigan.gov)

Conclusions and Recommendations

The Home and Community Based Services Individualized Plan of Service Requirements Guidance document states, "This document does not address the requirements regarding Behavior Treatment Plans (BTP) or the policies of MDHHS related to those plans. The existence of a BTP *has no bearing* on the requirement that any and all restrictions must be identified in the person's Individual Plan of Service (IPOS) consistent with the requirements outlined in the Medicaid Provider Manual (MPM). This current MDHHS position, while justified in the HCBS chapter, does not account for the strength of the BTP process, and thus, should consider intertwining BTP and HCBS IPOS requirements in a more thoughtful and planned way.

- MDHHS HCBS team should recognize that the BTP is a part of the IPOS.
- MDHHS internal teams for BTP and HCBS should meet to discuss system needs and overlaps and revise guidance.
- Revise BTP Guidelines to require and ensure that instances of not requiring a BTP should be clearly defined and linked to the HCBS IPOS requirement.
- Expand options to meet BTP and HCBS requirements without sacrificing efficiency.

in the goals section of treatment plan that BTP does not contain any intrusive or restrictive interventions.

****Intrusive Strategies: None Proposed
****Restrictive Strategies: None Proposed

identify that BTP does contain any intrusive and/or restrictive interventions.

****Intrusive Strategies: Community supervision
****Restrictive Strategies: None Proposed

In treatment plan goals include the intrusive/restrictive interventions as they are noted in the BTP.

****Intrusive Strategies: Community supervision
****Restrictive Strategies: Locked food access

Last Revision Date: November 10, 2021

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION

PERSON-CENTERED PLANNING PRACTICE GUIDELINE

"Person-centered planning" means 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 honors the individual's preferences, choices, and abilities." **MHC 330.1700(g)**

I. What is the Purpose of the Community Mental Health System?

The purpose of the community mental health system is to support adults and children with intellectual and developmental disabilities (DD), adults with serious mental illness and co-occurring disorders (including co-occurring substance abuse disorders), and children with serious emotional disturbance (SED) to live successfully in their communities – achieving community inclusion and participation, independence, and productivity. Person-centered planning (PCP) enables individuals to identify and achieve their personal goals. As described below, PCP for minors (family-driven and youth-guided practice) involves the whole family.

PCP is a way for individuals to plan their life in their community, set the goals that they want to achieve, and develop a plan for how to accomplish those goals. PCP is required by state law, (the Michigan Mental Health Code (MMHC)), and federal law, (the Home and Community Based Services (HCBS) Final Rule and the Medicaid Managed Care Rules), as the way that individuals receiving services and supports from the community mental health system plan how those supports are going to enable them to achieve their life goals. The process is used to plan the life that the individual aspires to have considering various options – taking the individual's goals, hopes, strengths, and preferences and weaving them into plans for the future. Through PCP, an individual is engaged in decision making, problem solving, monitoring progress, and making needed adjustments to goals and supports and services provided in a timely manner. PCP is a process that involves support and input from those individuals who care about the individual doing the planning. The PCP process is used any time an individual's goals, desires, circumstances, choices, or needs change. While PCP is the required planning approach for mental health and intellectual and DD services provided by the CMHSP system, PCP can include planning for other public supports and privately funded services chosen by the individual.

The Home and Community Based Services (HCBS) Final Rule requires that Medicaid-funded services and supports be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving such services and supports. 42 CFR 441.700 et. seq. The HCBS Final Rule also requires that PCP be used to identify and reflect choice of services and supports funded by the community mental health system.

Through the PCP process, an individual and those he/she has selected to support him/her:

a. Focus on the individual's life goals, interests, desires, choices, strengths, and abilities as the foundation for the PCP process.

b. Identify outcomes based on the individual's life goals, interests, strengths, abilities, desires, and choices.

c. Make plans for the individual to achieve identified outcomes.

d. Determine the services and supports the individual needs to work toward or achieve outcomes including, but not limited to, those services and supports available through the community mental health system.

e. After the PCP process, develop an Individual Plan of Services (IPOS) that directs the provision of supports and services to be provided through the Community Mental Health Services Program (CMHSP).

PCP focuses on the individual's goals while still meeting his/her basic needs (food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation as identified in the Code). As appropriate for the individual, the PCP process may address recovery, self-determination, positive behavior supports, treatment of substance abuse or other co-occurring disorders, and transition planning as described in the relevant Michigan Department of Health and Human Services (MDHHS) policies and initiatives.

PCP focuses on services and supports needed (including medically necessary services and supports funded by the CMHSP) for the individual to work toward and achieve his/her personal goals.

For minor children, the concept of PCP is incorporated into a family-driven, youth-guided approach. See the MDHHS Family-Driven and Youth-Guided Policy and Practice Guideline. The needs of the child are interwoven with the needs of the family; and therefore, supports and services impact the entire family. As the child ages, services and supports should become more youth-guided especially during transition into adulthood. When the individual reaches adulthood, his/her needs and goals become primary.

There are a few circumstances where the involvement of a minor's family may not be appropriate:

a. The minor is 14 years of age or older and has requested services without the knowledge or consent of parents, a guardian, or an individual in loco parentis within the restrictions stated in the MMHC.

b. The minor is emancipated.

c. The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the minor or substantial disruption of the planning process. Justification of the exclusion of parents shall be documented in the clinical record.

II. How is PCP Defined in Law?

PCP, as defined by the MMHC, "'Person-centered planning' means 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 individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires." MHC 330.1700(g).

The MMHC also requires use of PCP for development of an IPOS:

> "(1) The responsible mental health agency for each recipient shall ensure that a PCP process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan." MCL 330.1712.

The HCBS Final Rule does not define PCP but does require that the process be used to plan for Medicaid-funded services and supports. 42 CFR 441.725. The HCBS Final Rule also sets forth the requirements for using the process. These requirements are included in the PCP Values and Principles that Guide the PCP Process and the Essential Elements of the PCP Process below.

III. What are the Values and Principles that Guide the PCP Process?

PCP is an individualized process designed to respond to the unique needs and desires of every individual. The following values and principles guide the PCP process whenever it is used.

a. Every individual is presumed competent to direct the planning process, achieve his/her goals and outcomes, and build a meaningful life in the community. PCP should not be constrained by any preconceived limits on the individual's ability to make choices.

b. Every individual has strengths, can express preferences, and can make choices. The PCP approach identifies the individual's strengths, goals, choices, medical and support needs, and desired outcomes. In order to be strength-based, the positive attributes of the individual are documented and used as the foundation for building the individual's goals and plans for community life as well as strategies or interventions used to support the individual's success.

c. The individual's choices and preferences are honored. Choices may include the family and friends involved in his/her life and PCP process, housing, employment, culture, social activities, recreation, vocational training, relationships, friendships, and transportation. Individual choice must be used to develop goals and to meet the individual's needs and preferences for supports and services and how they are provided. Therefore, it is important that the individual has the ability to communicate with those involved in the individual's life and care.

d. The individual's choices are implemented unless there is a documented health and safety reason that they cannot be implemented. In that situation, the PCP process should include strategies to support the individual to implement his/her choices or preferences over time.

e. Every individual contributes to his/her community and has the right to choose how supports and services enable him/her to meaningfully participate and contribute to his/her community.

f. Through the PCP process, an individual maximizes independence, creates connections, and works towards achieving his/her chosen outcomes.

g. An individual's cultural background is recognized and valued in the PCP process. Cultural background may include language preference, religion, values, beliefs, customs, dietary choices, and other things chosen by the individual. Linguistic needs, including American Sign Language (ASL) interpretation, text messaging, video phone access, assistive technology and Computer Assisted Realtime Translation (CART), are also recognized, valued, and accommodated.

IV. What are the Essential Elements of the PCP Process?

The following elements are essential to the successful use of the PCP process with an individual and those invited by the individual to participate.

a. **Person-Directed.** The individual directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.

b. **Person-Centered.** The planning process focuses on the individual, not the system or the individual's family, guardian, or friends. The individual's goals, interests, desires, and choices are identified with a positive view of the future and plans for a meaningful life in the community. The planning process is used whenever there are changes to the individual's needs or choices, rather than viewed as an annual event.

c. **Outcome-Based.** The individual identifies outcomes to achieve in pursuing his/her goals. The way that progress is measured toward achievement of outcomes is identified.

d. **Information, Support, and Accommodations.** As needed, the individual receives complete and unbiased information on services and supports available, community resources, and options for providers, which are documented in the IPOS. Support and accommodations to assist the individual to participate in the process are provided. The individual is offered information on the full range of services available in an easy-to-understand format.

e. **Independent Facilitation.** Every individual has the information and support to choose an independent facilitator to assist him/her in the planning process.

f. **Pre-Planning.** The purpose of pre-planning is for the individual to gather the information and resources necessary for effective PCP and set the agenda for the PCP process. Every individual must use pre-planning to ensure successful PCP. Pre-planning, individualized for the individual's needs, is used anytime the PCP process is used.

The following items are addressed through pre-planning with sufficient time to take all needed actions (e.g. invite desired participants):

1. When and where the meeting will be held.

2. Who will be invited, including whether the individual has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support. Identify any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and plan for how to deal with them as to what will be discussed and not discussed.

3. The specific PCP format or tool chosen by the individual to be used for PCP.

4. What accommodations the individual may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).

5. Who will facilitate the meeting.

6. Who will take notes about what is discussed at the meeting.

g. **Wellness and Well-Being**. Issues of wellness, well-being, health, and primary care coordination support needed for the individual to live the way he/she wants to live are discussed and plans to address them are developed. individuals are allowed the dignity of risk to make health choices just like anyone else in the community (such as, but not limited to, smoking, drinking soda pop, and eating candy or other sweets). If the individual chooses, issues of wellness and well-being can be addressed outside of the PCP meeting.

   PCP highlights personal responsibility, including taking appropriate risks. The plan must identify risks and risk factors and measures in place to minimize them, while considering the individual's right to assume some degree of personal risk. The plan must assure the health and safety of the individual. When necessary, an emergency and/or back-up plan must be documented and encompass a range of circumstances (e.g. weather, housing, support staff).

h. **Participation of Allies**. Through the pre-planning process, the individual selects allies (friends, family members, and others) to support him/her through the PCP process. Pre-planning and planning help the individual explore who is currently in his/her life and what needs to be done to cultivate and strengthen desired relationships.

V. What is Independent Facilitation?

An Independent Facilitator is an individual who facilitates the PCP process in collaboration with the individual. In Michigan, individuals receiving support through the community mental health system have a right to choose an independent or external facilitator for their PCP process. The terms independent and external mean that the facilitator is independent of or external to the community mental health system. It means that the individual has no financial interest in the outcome of the supports and services outlined in the person-centered plan. Using an independent facilitator is valuable in many different circumstances, not just situations involving disagreement or conflict.

The PIHP and/or the CMHSP must contract with a sufficient number of independent facilitators to ensure availability and choice of independent facilitators to meet their needs. The independent facilitator is chosen by the individual and serves as the individual's guide (and for some individuals, assisting and representing their voice) throughout the process, making sure that his/her hopes, interests, desires, preferences, and concerns are heard and addressed. The independent facilitator must not have any other role within the PIHP and/or the CMHSP. The role of the independent facilitator is to:

a. Personally know or get to know the individual who is the focus of the planning, including what he/she likes and dislikes, personal preferences, goals, methods of communication, and who supports and/or is important to the individual.

b. Help the individual with all pre-planning activities and assist in inviting participants chosen by the individual to the meeting(s).

c. Assist the individual to choose planning tool(s) to use in the PCP process.

d. Facilitate the PCP meeting(s) or support the individual to facilitate his/her own PCP meeting(s).

e. Provide needed information and support to ensure that the individual directs the process.

f. Make sure the individual is heard and understood.

g. Keep the focus on the individual.

h. Keep all planning participants on track.

i. Develop an IPOS in partnership with the individual that expresses the individual's goals, is written in plain language understandable by the individual, and provides for services and supports to help the individual achieve their goals.

The Medicaid Provider Manual (MPM) permits independent facilitation to be provided to Medicaid beneficiaries as one aspect of the coverage called "Treatment Planning" (MPM MH&SAA Chapter, Section 3.25.) If the independent facilitator is paid for the provision of these activities, the PIHP and/or the CMHSP may report the service under the code H0032.

An individual may use anyone he/she chooses to help or assist in the PCP, including facilitation of the meeting. If the individual does not meet the requirements of an Independent Facilitator, he/she cannot be paid, and responsibility for the Independent Facilitator duties described above falls to the Supports Coordinator/Case Manager. An individual may choose to facilitate his/her own planning process with the assistance of an Independent Facilitator.

VI. How is PCP used to Write and Change the IPOS?

The MMHC establishes the right for all individuals to develop an IPOS through the PCP process. The PCP process must be used at any time the individual wants or needs to use the process but must be used at least annually to review the IPOS. The agenda for each PCP meeting should be set by the individual through the pre-planning process, not by the agency or by the fields or categories in a form or an electronic medical record

Assessments may be used to inform the PCP process but is not a substitute for the process. Functional assessments must be undertaken using a person-centered approach. The functional assessment and the PCP process together should be used as a basis for identifying goals, risks, and needs; authorizing services; utilization management; and review. No assessment scale or tool should be utilized to set a dollar figure or budget that limits the PCP process.

While the Code requires that PCP be used to develop an IPOS for approved community mental health services and supports, the purpose of the PCP process is for the individual to identify life goals and decide what medically necessary services and supports need to be in place for the individual to have, work toward, or achieve those life goals. The individual or representative chooses what services and supports are needed. Depending on the individual, community mental health services and supports may play a small or large role in supporting him/her in having the life he/she wants. When an individual is in a crisis, that situation should be stabilized before the PCP process is used to plan the life that he/she desires to have.

individuals are often at different points in the process of achieving his/her life goals. The PCP process should be individualized to meet every individual's needs of the individual for whom planning is done, i.e. meeting an individual where he/she is. Some individuals may be just beginning to define the life he/she wants and initially the PCP process may be lengthy as the individual's goals, hopes, strengths, and preferences are defined and documented and a plan for achieving them is developed. Once an IPOS is developed, subsequent use of the PCP process, discussions, meetings, and reviews will work from the existing IPOS to amend or update it as circumstances and preferences change. The extent to which an IPOS is updated will be determined by the needs and desires of the individual. If and/or when necessary, the IPOS can be completely redeveloped. The emphasis in using PCP should be on meeting the needs of the individual as they arise. An IPOS must be prepared in person-first singular language and be understandable by the individual with a minimum of clinical jargon or language. The individual must agree to the IPOS in writing. The IPOS must include all the components described below:

a. A description of the individual's strengths, abilities, plans, hopes, interests, preferences, and natural supports.

b. The goals and outcomes identified by the individual and how progress toward achieving those outcomes will be measured.

c. The services and supports needed by the individual to work toward or achieve his/ her outcomes, including those available through the CMHSP and other publicly funded programs (such as Home Help, Michigan Rehabilitation Services (MRS), community resources, and natural supports.)

d. The setting in which the individual lives was chosen by himself/herself and what alternative living settings were considered by him/her. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving services and supports from the community mental health system. The PIHP and/or the CMHSP is responsible for ensuring it meets these requirements of the HCBS Final Rule.

e. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

f. Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports.

g. Documentation of any restriction or modification of additional conditions must meet the standards.

h. The services which the individual chooses to obtain through arrangements that support self-determination.

i. The estimated/prospective cost of services and supports authorized by the community mental health system pursuant to the Technical Requirement for Explanation of Benefits.

j. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and the providers in implementing the IPOS.

k. The individual or entity responsible for monitoring the plan.

l. The signatures of the individual and/or representative, the case manager or the support coordinator, and the support broker/agent (if one is involved).

m. The plan for sharing the IPOS with family, friends, and/or caregivers with the permission of the individual.

n. A timeline for review.

o. Any other documentation required by Section R 330.7199 Written Plan of Services of the Michigan Administrative Code.

Once an individual has developed an IPOS through the PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of his/her needs, changes in his/her condition as determined through the PCP process, or changes in his/her personal preferences for support).

The individual and the case manager or the supports coordinator should work on and review the IPOS on a routine basis as part of regular conversations. An individual or his/her guardian or authorized representative may request and review the IPOS at any time. A formal review of the IPOS with the individual and his/her guardian or authorized representative, if any, shall occur not less than annually. Reviews will work from the existing IPOS to review progress on goals, assess personal satisfaction, and to amend or update the IPOS as circumstances, needs, preferences, or goals change, or to develop a completely new plan, if the individual desires to do so. The review of the IPOS, at least annually, is done through the PCP process.

The PCP process often results in personal goals that are not necessarily supported by the CMHSP services and supports. Therefore, the PCP process must not be limited by program specific functional assessments. The IPOS must describe the services and supports that will be necessary and specify what the HCBS Final Rule is to be provided through various resources, including natural supports, to meet the goals in the PCP. The specific individual or individuals and/or provider agency, or other entity providing services and supports, must be documented. Non-paid supports, chosen by the individual and agreed to by the unpaid provider, needed to achieve the goals, must be documented. With the permission of the individual, the IPOS should be discussed with family, friends, and/or caregivers chosen by the individual so that they fully understand it and their role(s).

The individual must be provided with a written copy of his/her IPOS within **15 business days** of conclusion of the PCP process. This timeframe gives the case manager and the supports coordinator sufficient time to complete the documentation described above.

VII. How Must Restriction on an Individual's Rights and Freedoms be Documented in the IPOS?

Any effort to restrict the certain rights and freedoms listed in the HCBS Final Rule must be justified by a specific and individualized assessed health or safety need and must be addressed through the PCP process and documented in the IPOS.

The rights and freedoms listed in the HCBS Final Rule are:

a. A lease or residency agreement with comparable responsibilities and protection from eviction that tenants have under Michigan landlord/tenant law.

b. Sleeping or living units lockable by the individual with only appropriate staff having keys.

c. Individuals sharing units have a choice of roommate in that setting.

d. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

e. Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.

f. Individuals can have visitors of their choosing at any time.

The following requirements must be documented in the IPOS when a specific health or safety need warrants such a restriction:

1. The specific and individualized assessed health or safety need.
2. The positive interventions and supports used prior to any modifications or additions to the IPOS regarding health or safety needs.
3. Documentation of less intrusive methods of meeting the needs that have been tried but were not successful.
4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need.
5. A regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Informed consent of the individual to the proposed modification.
8. An assurance that the modification itself will not cause harm to the individual.

VIII. What do the PIHPS, the CMHSPS and Other Organizations Need to do to Ensure Successful Use of the PCP Process?

Successful implementation of the PCP process requires that agency policy, mission/vision statements, and procedures incorporate PCP standards. A process for monitoring PCP should be implemented by both the PIHPs and the CMHSPs, along with the monitoring process through the MDHHS site review.

The following elements are essential for organizations responsible implementing the PCP process:

a. **Person-Centered Culture**. The organization provides leadership, policy direction, and activities for implementing PCP at all levels of the organization. Organizational language, values, allocation of resources, and behavior reflect a person-centered orientation.

b. **Individual Awareness and Knowledge.** The organization provides easily understood information, support, and when necessary, training to individuals using services and supports, and those who assist them, so that they understand their right to and the benefits of PCP, know the essential elements of PCP, the benefits of this approach, and the support available to help them succeed (including, but not limited to, pre-planning and independent facilitation).

c. **Conflict of Interest.** The organization ensures that the conflict of interest requirements of the HCBS Final Rule are met and the individual responsible for the PCP process is separate from the eligibility determination, assessment, and service provision responsibilities.

d. **Training.** All Staff receive competency-based training in PCP so that they have consistent understanding of the process. Staff who are directly involved in IPOS services or supports implementation are provided with specific training.

e. **Roles and Responsibilities.** As an individualized process, PCP allows every individual to identify and work with chosen allies and other supports. Roles and responsibilities for facilitation, pre-planning, and developing the IPOS are identified; and the IPOS describes who is responsible for implementing and monitoring each component of the IPOS.

f. **System-wide Monitoring.** The Quality Assurance/Quality Management (QA/QM) System includes a systemic approach for measuring the effectiveness of PCP and identifying barriers to successful use of the PCP process. The best practices for supporting individuals through PCP are identified and implemented (what is working and what is not working in supporting individuals). Organizational expectations and standards are in place to assure that the individual directs the PCP process and ensures that PCP is consistently followed.

IX. What Dispute Resolution Options are Available?

Individuals who have a dispute about the PCP process or the IPOS that results from the process have the rights to appeals, grievances, and recipient rights as set forth in detail in the Appeal and Grievance Resolution Processes Technical Requirement. As described in this Technical Requirement, some of the dispute resolution options are limited to Medicaid beneficiaries and limited in the scope of the grievance (such as a denial, reduction, suspension, or termination of services). When an individual is receiving services and no agreement on IPOS can be made through the PCP process during the annual review, services shall continue until a notice of a denial, reduction, suspension, or termination is given, in which case the rights and procedures for appeals and grievances take over. Other options are available to all recipients of community mental health services and supports.

Supports Coordinators, Case Managers, and Customer Services at the PIHPs and/or the CMHSPs must be prepared to help people understand and negotiate the dispute resolution processes.