Oklahoma Certified Community Behavioral Health Clinics

CCBHC

Provider Manual 2023

This manual is intended as a reference document for Oklahoma Department of Mental Health and Substance Abuse certified providers with contracts for CCBHC Services. It contains requirements for provision, reimbursement and reporting of CCBHC services, and is intended to complement existing policy. Although every effort is made to keep this Manual up-to-date, the information provided is subject to change.

SERVICE QUESTIONS- WHO TO CONTACT

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OKLAHOMA
Mental Health &
Substance Abuse

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Background

On April 1, 2014 the Protecting Access to Medicare Act of 2014 (H.R. 4302) was enacted, laying the groundwork for the establishment of Certified Community Behavioral Health Clinics or CCBHCs. CCBHCs are a comprehensive community behavioral health provider that provides an opportunity to improve the behavioral health system by increasing access to high quality, integrated care. Section 223 of the law authorized the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS) under the United States Department of Health and Human Services to develop certification criteria for CCBHCs, provide guidance to states on developing a prospective payment system (PPS) to reimburse CCBHC, administer one year planning grants to states interested in developing a proposal for the two year program demonstration, and report findings and recommendations to Congress on CCBHC.

In October of 2015 the State of Oklahoma was awarded a one year planning grant from SAMHSA and CMS to develop a proposal and program demonstration for the provision of CCBHC. Under the planning grant the State was charged with collaborating with key stakeholders, certifying at least two clinics as CCBHC per SAMHSA's guidelines, assisting clinics with meeting certification standards through training and technical assistance, developing a PPS methodology, and collecting and reporting data in preparation to participate in the national evaluation.

The State of Oklahoma was successful in the planning grant period. Oklahoma submitted a proposal and was awarded a two-year demonstration grant starting in 2016. Oklahoma began CCBHC with three providers as part of the demonstration. As the end of the demonstration drew near, Oklahoma was able to obtain a State Plan Amendment (SPA) through CMS in 2019 to continue to support CCBHC services in the state.

CCBHC represent an opportunity for states to improve the behavioral health of their citizens by: providing community-based mental and substance use disorder services; advancing integration of behavioral health with physical health care; assimilating and utilizing evidence based practices on a more consistent basis; and promoting improved access to high quality care. Care coordination is the linchpin holding these aspects of CCBHC care together and ensuring CCBHC care is, indeed, an improvement over existing services.

CCBHCs must provide a broad array of services and care coordination across settings and providers on a full spectrum of health, including acute, chronic, and behavioral health needs. The CCBHC model of care requires integrating mental health, substance use disorder, and physical health services at one location.

NOTE: Oklahoma is concurrently running both SAMHSA Demonstration CCBHCs and State Plan Amendment (SPA) CCBHCs. This document reflects the standards and general programmatic structure of both CCBHC programs. There are some differences in reporting/ billing. Please refer to separate appendix at end of document based on your program.

Values and Core Principles

To ensure enhancement of current behavioral health system, CCBHCs must adhere to the following values and core principles of services.

• Coordination and Collaboration: Care Coordination activities should be the foundation of CCBHC, along with efforts to foster individual responsibility for health awareness. These characteristics should guide all aspects of treatment and rehabilitation to support effective partnerships with the individual, family and other key natural supports and outside service providers. Services should be integrated – addressing both physical and behavioral health needs of individuals.

• Accessible and Available: Services should be flexible and mobile, and adapt to the specific and changing needs of each individual. CCBHCs should use non-four walls service delivery model, along with therapeutic methods and recovery approaches which best suit each individual's needs.

• Evidenced Based: Services should utilize evidence-based practices where appropriate and provide or enable continuing education activities to promote uptake of these practices.

• Person Centered Care: Person-centered care involves the individual seeking services to the maximum extent possible, reflecting the individual's goals and emphasizing shared decision making approaches that empowers, provide choice, and minimize stigma. Services should be self-directed, include family members and other key natural supports, emphasize wellness and attention to the person's overall wellbeing, and promote full community inclusion.

• Family Driven Care: Services that are family-focused emphasizes the important role of family in the service planning and delivery process for children. Family driven care promotes the wellbeing and developmental needs of the child, and supports relationships among the child, family and service providers.

• Recovery Oriented: Recovery oriented services should incorporate "a process of change through which individuals improve their lives and wellness, live a self-directed life, and strive to reach their full potential". Guiding principles of recovery include; hope, person-driven, many pathways, holistic, peer support, relational, culture, addresses trauma, strengths/ responsibility, respect (Substance Abuse and Mental Health Services Administration [2012]).

• Trauma Informed: Trauma informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches. Trauma informed services and programs are more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives (SAMHSA 2014).

• Data Driven: Providers should use data to determine outcomes, monitor performance, and promote health and wellbeing. Performance metrics should reflect a broad range of health and recovery indicators beyond those related to acute care.

Purpose

The purpose of Oklahoma CCBHCs is to:
1) provide access to integrated services for all individuals regardless of pay source or ability to pay;

2) provide a full array of mental health and substance use disorder services available in every certified location, and provide, or coordinate with, primary care services;

3) provide quality driven services as demonstrated through data reports and outcomes reports generated by the OD□MHSAS or its contractor; and

4) provide enhanced integration and coordination of mental health, primary, and substance use disorder services and supports for persons across the lifespan. Services and supports will be delivered utilizing an interdisciplinary, team-based approach.

Access and Availability of Services

Per the criteria established by SAMHSA, CCBHCs shall offer services in a manner accessible and available to individuals in their community. All Oklahoma CCBHCs must complete a needs assessment at CCBHC implementation, then at minimum, every 3 years. The purpose of a needs assessment is to ensure that the behavioral health treatment needs in the community are identified and integrated into CCBHCs strategic planning, and will ensure that their program designs and services are well suited to the populations they serve. The assessment provides information about cultural, linguistic, resources, treatment and staffing needs of the areas to be served by the CCBHC. It also addresses potential barriers to care including transportation, income, and cultural factors. Findings from the needs assessment are intended to provide information relevant to CCBHC staffing requirements, services and cost reports. Important considerations for accessible and available care includes:

Service times and settings that are convenient to the community served: Services that meet the needs of the community should be reasonably accessible. CCBHCs shall utilize the community needs assessment to ensure service settings and hours are appropriate.

Where the service recipient lives: CCBHCs should consider acceptable travel times from the individual's home when ensuring accessibility of services. The facility will ensure no individual is denied behavioral healthcare services because of place of residence or homelessness or lack of a permanent address. Facility will have protocol's addressing the needs of clients who do not live within the facility's service area. At a minimum, facility is responsible for providing crisis response, evaluation, and stabilization services regardless of the client's place of residence and shall have policies and procedures for addressing the management of the client's ongoing treatment needs.

Prompt intake and engagement in services: CCBHCs will follow the prompt screening, assessment, and, diagnosis timeframes as outlined in this manual.

Access to adequate care, regardless of residency or ability to pay: CCBHC program guidelines requires that no individual will be denied behavioral health care services-including but not limited to crisis management services-because of their inability to pay for such services. Any fees or payments required by the clinic for such services will be reduced or waived to ensure appropriate accessibility and availability. Moreover, CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence. CCBHCs must have protocols in place to address the needs of individuals who do not live close to a CCBHC. The Facility will have a published sliding fee discount schedule(s) that includes all services offered.

Comprehensive Care planning and service provision: CCBHCs should exercise person-centered care whenever possible to ensure accessibility and availability of services. Care planning and service provision should reflect an individual's goals and emphasize self-direction and choice.

Access to adequate crisis services: Because the emergency department (ED) is often a source of crisis care, CCBHCs must have clearly established relationships with local EDs to facilitate care coordination, discharge and follow-up, as well as relationships with other sources of crisis care.

Availability of community-based services and telehealth: Service provision should meet the needs of the community being served. Community-based peer, recovery, and clinical supports-as well as the use of telehealth/ telemedicine shall be used to increase accessibility and availability of services. To the extent allowed by state and federal regulations, facility will make services available via telemedicine in order to ensure clients have access to all required services. To the extent possible, the facility should make reasonable efforts to provide transportation or transportation vouchers for clients to access services provided or arranged for by the facility.

Outreach

Outreach in CCBHC:

⇒ The CCBHC must have staff dedicated to outreach and engagement, who do not carry a caseload. Facility records will identify which staff members are responsible for specific elements of outreach and engagement

⇒ A CCBHC must conduct outreach activities to engage those clients who are difficult to find and engage, with an emphasis on the special population list also known as the "Most in Need" list that is determined and supplied to the CCBHC by the ODMHSAS.

⇒ A CCBHC must have dedicated staff to work with The ODMHSAS on Care Coordination efforts for vulnerable populations.

⇒ For those who are homeless, there should be at least two contact phone numbers for persons of the client's choice who know how to reach the client in the client's record, and/or a location most likely to find the client, and/ or a location to find a person of the client's choice likely to know where the client is located.

⇒ The CCBHC must have policies and procedures to describe how outreach and engagement activities will occur to assist clients and families to access benefits and formal or informal services to address behavioral health conditions and needs.

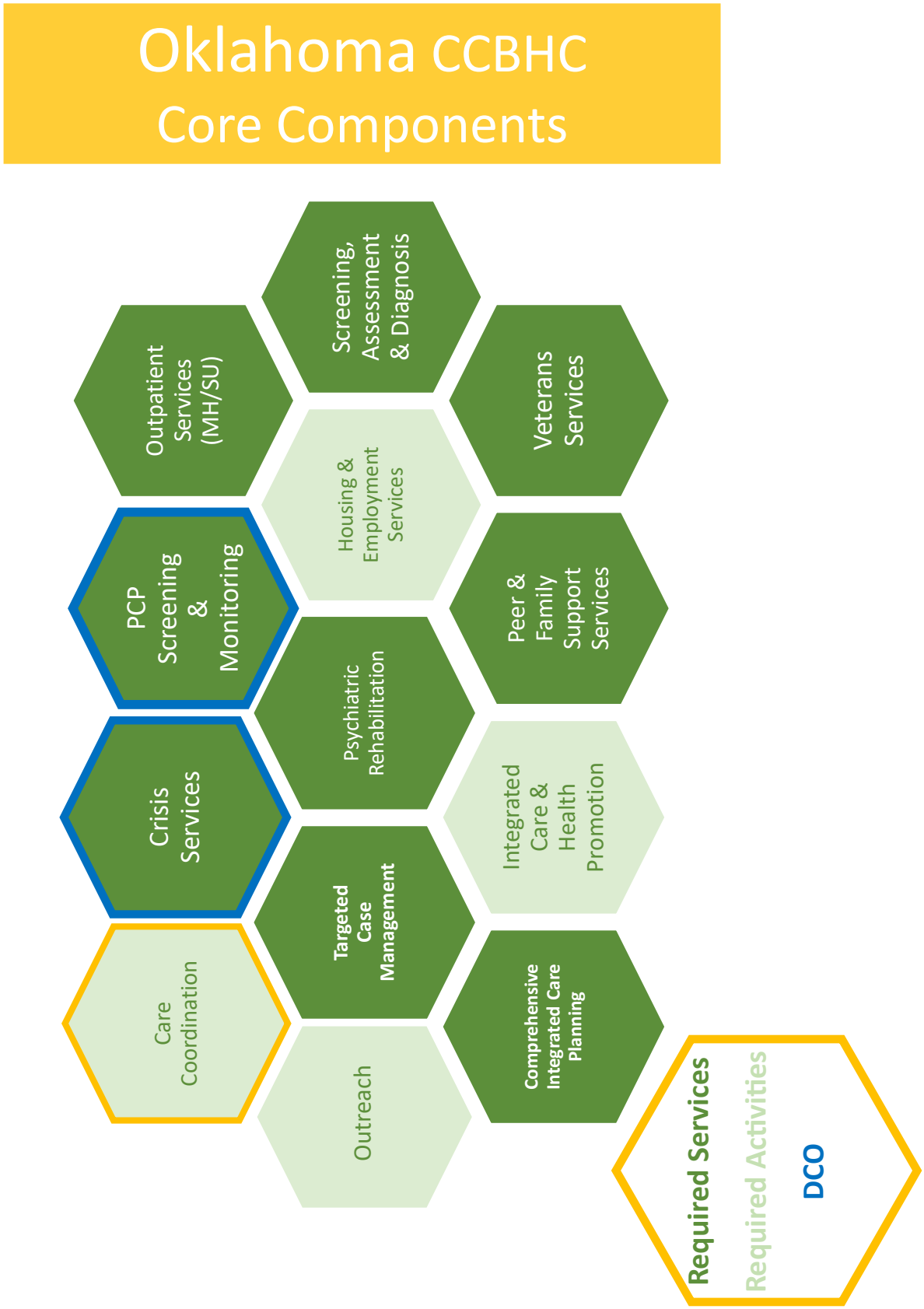
Onboarding

Transforming a community mental health center into a Certified Community Behavioral Health Clinic (CCBHC) will require intensive commitment, flexibility, and teamwork. The leadership team must be working very closely together, and will also need to ensure input from persons served and all staff.

Oklahoma's Community Mental Health Centers are already held to high standards by the ODMHSAS, and already meet many of the CCBHC criteria. However, there are important structures that must change and services that must expand. Below is a list of milestones your agency will need to achieve during your development year. You will need to ensure that you are:

- Integrating all of your programs and staff. Staff will begin working in integrated teams; implementing principles of Team Based Care across agency.
- Serving entire lifespan, including children zero to five. This will require adding specialized staff and providing evidence-based training.
- Ensure integrated health and care coordination for all persons served, and utilizing risk stratification to ensure appropriate care for those at greatest risk for adverse health outcomes.
- Develop a representative board Including clients, persons in recovery, and family members beginning with the needs assessment forward.
- Changing care planning procedures to ensure integration of all outpatient mental health, substance use disorder services, and primary care services. This includes: 1) perform an initial evaluation and care plan within 10 days of first contact to meet presenting needs and other immediate or urgent needs; 2) within 30 days, conduct mental health assessments, 3) within 60 days, develop a Comprehensive Care Plan; 4) update the Comprehensive Care Plan (CCP) as needed, with a 3-month review to determine if any changes are needed, and conduct a CCP update at every 6 months.
- Compiling and reporting cost report data to develop clinic specific rate.
- Collecting, analyzing and reporting data measures, including CCBHC quality measures.

In order to be eligible for payment, CCBHCs must have an approved provider agreement on file with the OHCA. Through this agreement, the CCBHC assures that OHCA's requirements are met and assures compliance with all applicable federal and State Medicaid law, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, the Code of Federal regulations, and the Oklahoma State Medicaid Plan. These agreements are renewed annually with each provider.


Oklahoma CCBHC
Core Components
Screening, Assessment & Diagnosis
Outpatient Services (MH/SU)
Veterans Services
Housing & Employment Services
PCP Screening & Monitoring
Peer & Family Support Services
Psychiatric Rehabilitation
Crisis Services
Integrated Care & Health Promotion
Targeted Case Management
Care Coordination
Comprehensive Integrated Care Planning
Outreach
Required Services
Required Activities
DCO

Oklahoma CCBHCs will follow SAMHSA's initial guidance on CCBHC scope of service. SAMHSA differentiates between "services' and "activities".

Oklahoma CCBHC Required Services include: crisis services, screening/assessment/diagnosis, care planning, outpatient mental health/substance use services, targeted case management, psychiatric rehabilitation services, peer/family support services and veteran's services. CCBHC Required Services trigger a PPS rate.

Oklahoma CCBHC Activities are activities that have the purpose of coordinating and managing the care and services furnished to each client, including both behavioral and physical healthcare, regardless of whether the care and services are provided directly by the CCBHC or through referral or other affiliation with care providers and facilities outside the CCBHC. CCBHC Activities are required and tracked for data and outcomes, however CCBHC Activities alone do not trigger a PPS rate.

Oklahoma CCBHC Required Activities include: care coordination, outreach/engagement, housing and vocational services, primary care screening, health promotion and other integrated care activities.

A Designated Collaborating Organization (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. 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. The CCBHC maintains clinical responsibility for the services provided for CCBHC clients by the DCO. To the extent that services are required that cannot be provided by either the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for care coordination including services to which it refers clients. Payment for those referred services is not through the PPS but is made through traditional mechanisms within Medicaid.

CCBHC Core Components; Integrated Care

CCBHCs are required to offer a full array of services to treat and support the client base of the community they serve. CCBHCs are expected to build upon the foundation of Health Homes within the Community Mental Health Center model to promote enhanced integration and coordination of behavioral health, primary care, acute care, and long-term services and supports for persons across the lifespan with chronic illness, including adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).

The CCBHC directly provides outpatient mental health and substance use disorder services that are evidence-based or best practices, consistent with the needs of individual clients as identified in their individual care plan. In the event specialized services outside the expertise of the CCBHC are required for purposes of outpatient mental health 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.

Care is delivered using an integrated team that will comprehensively address mental health needs, substance use disorder treatment needs and physical health needs; with a goal to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and emergency room visits, promote the use of Health Information Technology (HIT), and avoid unnecessary care.

Care Coordination is the cornerstone of behavioral healthcare integration. It involves actively bringing together various providers and information systems to coordinate health services, client needs and information to improve outcomes.

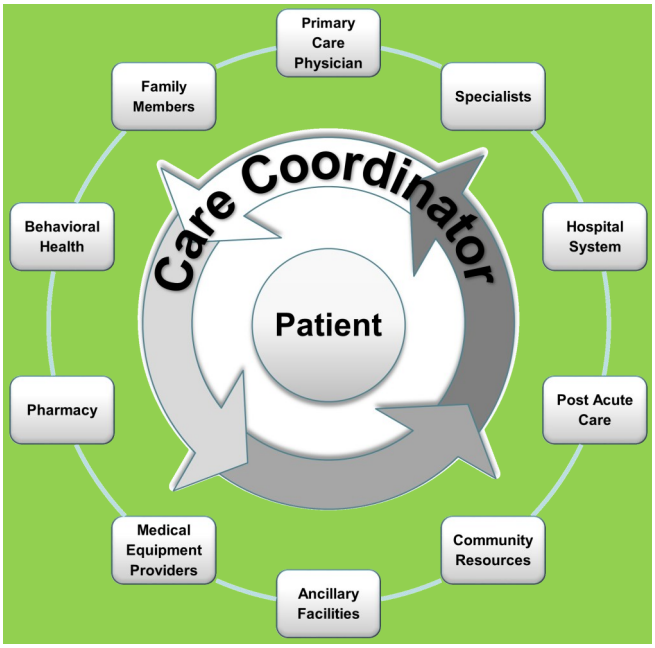
It is the CCBHCs responsibility, as the primary provider of care to ensure the needs of the client are being addressed in a coordinated fashion. The CCBHC is responsible for care coordination with any other provider or facility providing any of the required CCBHC services. See Appendix B for sample Care Coordination Letters.

Examples of coordination of care include:

- Ensuring that every enrollee is aligned with a PCP through which care is coordinated.
- Partnerships or Formal Agreements with treating providers or service agencies.
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional. This care coordination involves not only referral but follow up after referral to ensure that services were obtained, to gather the outcome of those services, and to identify next steps needed.
- Researching issues to provide education and address questions from patient, family, guardian, and/or caregiver.
- Reviewing HIE, Population Health Management and other information sources, such as dashboards and registries. to improve health outcomes at the individual level.
- Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, labs, home health agencies, etc.) utilized by the client.
- Monitoring and follow-up activities with treatment or service providers for the purposes of monitoring client attendance of scheduled physician, medication, therapy, rehabilitation, or other supportive service.
- Development of Clinical Pathways.
- Transitional Care including transitions from inpatient, residential or crisis centers, as well as transitions between levels of care within the agency and/or transitions from different age groups. The CCBHC will provide care coordination while the client is hospitalized as soon as it becomes known. A team member will go to the hospital setting to engage the client in person and/or will connect through tele-health as a face to face meeting. Reasonable attempts to fulfill this important in-person contact will be documented.
- Structured staffings including but not limited to; team huddles, team meetings, and case conferences.
- Participation in high need staffings as organized by ODMHSAS Care Coordination Team, for MIN clients, partner state agency referrals and hospital discharges.

Care coordination in crisis, will be carried out in keeping with the client's preferences and needs for care, to the extent possible and in accordance with the client's expressed preferences, with the client's family/caregiver and other supports identified by the client. The facility will work with the client in developing a **crisis plan** with each client, such as a **Psychiatric Advanced Directive** or **Wellness Recovery Action Plan**.

These plans should be available in the charts for review.



CCBHC Core Components; Care Coordination

Care coordination activities are the foundation of the CCBHC program, and should guide all aspects of treatment to support effective partnerships among the individual, family and other key natural supports and services providers. CCBHC care coordination is a provider practice that facilitates transition of care in and out of CCBHC services. CCBHC care coordination facilitates integrated care by intentionally organizing client care services, information, needs and preferences across all appropriate care settings.

CCBHCs are required to maintain formal relationships with the following care settings for care coordination purposes:

- Federally Qualified Health Centers and/or Rural Health Clinics;
- Inpatient psychiatric facilities, substance use outpatient and residential programs;
- Other community supports such as:
- Schools, child welfare,
- Juvenile and criminal justice systems and facilities,
- Indian Health Services,
- Child placing agencies/therapeutic foster care services, and
- Other social and human services;
- Veteran's Affairs
- Inpatient acute care hospitals and hospital outpatient clinics;
- Health Management Programs (HMP) and Health Access Networks (HAN).

Policy Guidance: Coordination with Certified Community Behavioral Health Clinics (CCBHCs), Adults ages 18 and over

Effective Date:

September 1, 2021

EXTERNAL PROVIDER TYPES AFFECTED

ADvantage Home and Community Based Services (HCBS) Waivers Case Management

Developmental Disabilities Services Division, Targeted Case Management (DDSD-TCM) Individually contracted LBHPs/ Psychologists

Outpatient Behavioral Health (OPBH) Agencies

Drug and Specialty Court OP Agency

BACKGROUND`

Certified Community Behavioral Health Clinics (CCBHCs) are required to provide a broad array of services directly. They may also provide services through referral or formal relationships with other providers, in order to meet the needs of the population served. This integrated clinic and service delivery model uses a monthly prospective payment system (PPS) reimbursement structure. Originally a federal demonstration project from 2017-2019 (extended by law to September 2023) this new service delivery model aims to integrate mental health and substance use disorder service provision; coordinate care across settings and providers to ensure seamless transitions for individuals across the full spectrum of health and social services; increase consistent use of evidence-based practices; and increase access to high-quality care. In a nutshell, CCBHCs provide outreach, increase access, improve services, improve and expand crisis response services, and serve as a 'one-stop shop' to those who are currently underserved.

In addition, Oklahoma was able to obtain a State Plan Amendment (SPA) through CMS in 2019 to continue to expand CCBHC services in the state. This policy guidance will apply to State Plan CCBHCs as well.

PURPOSE

The purpose of this guidance is to define the CCBHCs care coordination activities for:

1. Adults referred to them by external providers listed above that are already receiving a service from another mental health and/or substance use disorder provider; or
2. Adults that are currently being served at the CCBHC when it is discovered they are also receiving services with an external service provider.

POLICY/PROCESS

The current CCBHCs will provide a primary care coordinator (CC) to work with the adult in the CCBHC. This CCBHC CC function will be performed by the CCBHC's integrated team lead (job titles may vary between agencies). The CCBHC CC will be working closely with the adult to coordinate care across settings as well as with providers to ensure seamless transitions for individuals across the full spectrum of health and social services. The goal of CCBHC CC is to increase consistent use of evidence-based practices and improve access to integrated high-quality care. The CCBHC CC does not replace the ADvantage or DDSD case manager but is seen as someone the Advantage or DDSD case manager will collaborate with to best serve the adult. CCBHC CCs who are made aware that they are working with an adult who is eligible for Advantage CM or DDSD TCM or who has an existing clinical provider, will be required to reach out to the assigned ADvantage or DDSD case manager and/or clinical provider as appropriate. During this initial contact, the CCBHC CC and external providers will discuss the following:

- How to contact each other with adult related updates
- Share information related to the adult's care plan
- Discuss what the preferred method of communication will be between the external providers and the CCBHC CC.

AGREEMENTS

CCBHCs and external providers are to work cooperatively and collaboratively. As a participant in the Demonstration or in the approved state plan, CCBHCs are required to provide care coordination and to establish agreements with a variety of community or regional services, supports, and providers. (See Demonstration criteria 3.c.3 and ODMHSAS rules in OAC 450:17-5-183). A care coordination agreement describes the parties' mutual expectations and responsibilities related to care coordination in enough detail so that it leaves no question about the need for services from each provider, (or it is the adult/caregiver's choice) in order to avoid duplication. The agreement must be completed and signed by all within 60 days.

The communication between coordinators will include conversations on how to best support the adult for the best outcomes possible.

EXAMPLES OF NEEDED CONTACTS

- Adult starts with a CCBHC
- Referral for new service provider
- Change in living situation/address
- Change in symptoms, decompensation requiring additional intervention
- Hospital admission/discharge
- Emergency Department (ED) admission/discharge
- Detoxification services admission/discharge
- Detoxification step-down services admission/discharge
- Residential treatment admission/discharge
- Home and Community Based Service (HCBS) referral/intake

Notes:

- CCHBC adult may also be receiving TCM. These services may be delivered by the CCBHC provider (BH-TCM), or different providers (ADvantage, DDSD). Regardless of the provider of these services, the CCBHC CC **will remain the primary contact.**
- Proper release of information should be on file.
- CCBHC CCs are to include external providers as part of a adult's care team on the adult's care plan/service agreement and document all contacts with the external providers in the adult's record.

CONSIDERATIONS FOR A CCBHC DELIVERY SYSTEM: AVOIDING DUPLICATION AND PAYMENT

All OPBH services must be provided following established medical necessity criteria (MNC). Medicaid recipients are allowed free choice of providers as indicated in §1902(a)(23) of the Social Security Act. As such, they can receive health services at their choice of CCBHC or non-CCBHC. Duplication of services is prohibited. The use of care coordination and TCM should minimize duplication.

PROVTYPE	COLLABORATION ACROSS PROVIDERS
CCBHCs	When a CCBHC is working with an **established/existing** adult who is also eligible for ADvantage CM or DDSD-TCM (who meet CCBHC eligibility criteria), the CCBHC ensures that case management activities are coordinated through initiation of a care coordination (CC) agreement to avoid unnecessary duplication. Providers should have the adult/caregiver sign the agreement and insert the information in the individual's record. The CCBHC will bill the monthly bundle rate, when a trigger service is provided, and shadow report the appropriate case management code.
ADvantage CM	If a **non-established/new** adult is referred from the ADvantage nurse, the member must have a preliminary screening and risk assessment to determine acuity of needs. The CCBHC and Waiver both offer a package of services. The CCBHC model is generally better suited for those with higher behavioral health needs, while the ADvantage Waiver is better suited for those individuals with higher physical health needs. The CCBHC will initiate a CC agreement that describes the role of each case manager in enough detail so that it leaves no question for the need for dual case management. For example, the ADvantage nurse may assume primary responsibility for physical health care coordination while the CCBHC role is for behavioral health coordination. This must be documented in the CC agreement and also added to the waiver plan of care. This differentiation is vital since both providers may service report and use the same billing code T1016, which may appear to be concurrent billing of the same service.
DDSD-TCM	If a **non-established/new** adult is referred from DDSD, the adult must have a preliminary screening and risk assessment. If it is determined that the adult has a co-morbid behavioral health/IDD condition, the adult would then be eligible for the behavioral health services that are provided. IDD services are not part of the CCBHC certified services and are not to be included in the PPS. The CCBHC will initiate a CC agreement with the HCBS waiver case manager. The need for dual case management and services must be documented in the CC agreement and also added to the waiver plan of care(see OAC 317:30-5-1011(1)(B)).

Independent LBHPs/ Psychologists	When an independently contracted LBHP/psychologist requests an authorization for an assessment for a medical operation or testing and the adult is **also an established/existing CCBHC adult,** a CC agreement initiated by the CCBHC is required. The agreement describes each parties' mutual expectations, including the need for services from each provider (e.g., specialty service, testing, and adult/caregiver's choice). *The CC agreement must be signed by the adult/ caregiver and a copy documented in the adult's record.*
OPBH Agency	When an OPBH Agency requests a Level 1/2/3/4 authorization for treatment or testing for an **established/existing CCBHC adult** that has been receiving services from the CCBHC within the last six (6) months, a CC agreement or Letter of Collaboration (LOC) initiated by the CCBHC is required. The agreement/LOC describes each parties' mutual expectations, including the need for services from each provider (e.g., specialty service, testing, and adult/caregiver's choice*). The CC agreement must be signed by the adult/caregiver, and a copy documented in the adult/ caregiver's record*.
Drug and Specialty Court Provider	In addition to the psychiatric assessment, if a **non-established/new adult** is referred from a drug and specialty court provider for medication clinic only the CCBHC will initiate a CC agreement.

Notes*:*

*Per Demonstration criteria 4. d.1and 4.e.1 and ODMHSAS rules in OAC 450:17-5-178 and 450:17-5-180, the CCBHC directly provides assessment, diagnosis and treatment planning.

PROVIDER RESOURCES

CCBHC Federal Demonstration Criteria

CCBHC Federal Demonstration Guidance– When is a Person a CCBHC consumer?

CCBHC Manual

Prior Authorization Manual

LEGAL REFERENCES

Medicaid Rules OAC 317:30-5-241(d) (Medical Necessity and Prior Authorization) Medicaid Rules OAC 317:30-5-241.1(2) (Assessments)

Medicaid Rules OAC 317:30-5-241.1(3) (Service Plans)

Medicaid Rules OAC 317:30-5-241.6 (BH-TCM)

Medicaid Rules OAC 317:30-5-266(2) (CCBHCs)

Medicaid Rules OAC 317:30-5-281(b) (LBHP)

Medicaid Rules OAC 317:30-5-1011(1)(B)) (DDSD-TCM)

Medicaid Rules OAC **317:35-17-14** (ADvantage Case Management)

ODMHSAS Rules OAC 450:17-5-178 (CCBHC Assessment Dx)

ODMHSAS Rules OAC 450:17-5-183 (CCBHC Care Coordination)

ODMHSAS Rules OAC 450:17-5-186 (CCBHC Case Management)

OKLAHOMA Mental Health & Substance Abuse

Policy Guidance: Coordination with Certified Community Behavioral Health Clinics (CCBHCs), Children and Youth, 0-17

Effective Date:

September 1, 2021

EXTERNAL PROVIDER TYPES AFFECTED

Qualified Schools; School-based Case Management (SB-CM)

Early Intervention Targeted Case Management (EI-TCM; SoonerStart)

Child Welfare Targeted Case Management (CW-TCM)

Developmental Disabilities Services Division, Targeted Case Management (DDSD-TCM)

Office of Juvenile Affairs, Targeted Case Management (OJA-TCM)

Individually contracted LBHPs/Psychologists

Outpatient Behavioral Health (OPBH) Agencies

BACKGROUND`

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In addition, Oklahoma was able to obtain a State Plan Amendment (SPA) through CMS in 2019 to continue to expand CCBHC services in the state. This policy guidance will apply to State Plan CCBHCs as well.

PURPOSE

The purpose of this guidance is to define the CCBHCs care coordination activities for:

1. Children referred to them by external providers listed above that are already receiving a service from another mental health and/or substance use disorder provider; or
2. Children that are currently being served at the CCBHC when it is discovered they are also receiving services with an external service provider.

POLICY/PROCESS

The current CCBHCs will provide a primary care coordinator (CC) to work with the child/youth in the CCBHC. This CCBHC CC function will be performed by the CCBHC's integrated team lead (job titles may vary between agencies). The CCBHC CC will be working closely with the child/youth to coordinate care across settings as well as with providers to ensure seamless transitions for individuals across the full spectrum of health and social services. The goal of the CCBHC CC is to increase consistent use of evidence-based practices and improve access to integrated high-quality care. The CCBHC CC does not replace the CW or OJA case manager but is seen as someone the CW or OJA case manager will collaborate with to best serve the child/youth. CCBHC CCs who are made aware that they are working with a child/youth who is eligible for CW-TCM or OJA TCM or who has an existing clinical provider, will be required to reach out to the assigned CW or OJA case manager and/or clinical provider as appropriate. During this initial contact, the CCBHC CC and external providers will discuss the following:

- How to contact each other with child/youth related updates
- Share information related to the child/youth's care plan
- Discuss what the preferred method of communication will be between the external providers and the CCBHC CC.

AGREEMENTS

CCBHCs and external providers are to work cooperatively and collaboratively. As a participant in the Demonstration or in the approved state plan, CCBHCs are required to provide care coordination and to establish agreements with a variety of community or regional services, supports, and providers. (See Demonstration criteria 3.c.3 and ODMHSAS rules in OAC 450:17-5-183). A care coordination agreement describes the parties' mutual expectations and responsibilities related to care coordination in enough detail so that it leaves no question about the need for services from each provider, (or it is the child/youth's choice) in order to avoid duplication. The agreement must be completed and signed by all within 60 days.

The communication between coordinators will include conversations on how to best support the child/youth for the best outcomes possible.

EXAMPLES OF NEEDED CONTACTS

- ◊ Child/youth starts with a CCBHC
- ◊ Child/youth starts with a Child Welfare Targeted Case Manager (CW-TCM)
- ◊ Referral for new service provider
- ◊ Change in living situation/address
- ◊ Change in symptoms, decompensation requiring additional intervention
- ◊ Hospital admission/discharge
- ◊ Emergency Department (ED) admission/discharge
- ◊ Detoxification services admission/discharge
- ◊ Detoxification step-down services admission/discharge
- ◊ Residential treatment admission/discharge
- ◊ Home and Community Based Service (HCBS) referral/intake

Notes:

- CCHBC child/youth may also be receiving TCM. These services may be delivered by the CCBHC provider (BH-TCM), or different providers (CW, OJA, DDSD). Regardless of the provider of these services, the CCBHC CC **will remain the primary contact.**
- Proper release of information should be on file.
- CCBHC CCs are to include external providers as part of a child/youth's care team on the child/youth's care plan/service agreement and document all contacts with the external providers in the child/youth's record.

CONSIDERATIONS FOR A CCBHC DELIVERY SYSTEM: AVOIDING DUPLICATION AND PAYMENT

All OPBH services must be provided following established medical necessity criteria (MNC). Medicaid children/youth are allowed free choice of providers as indicated in §1902(a)(23) of the Social Security Act. As such, they can receive health services at their choice of CCBHC or non-CCBHC. Duplication of services is prohibited. The use of care coordination and TCM should minimize duplication.

PROVTYPE	COLLABORATION ACROSS PROVIDERS
CCBHCs	1) When a CCBHC is working with an **established/existing** child/youth who is also eligible for CW-TCM, OJA-TCM, DDSD-TCM (who meet CCBHC eligibility criteria), or EI-TCM, the CCBHC ensures that case management activities are coordinated through initiation of a care coordination agreement to avoid unnecessary duplication. Providers should have the parent/legal guardian sign the agreement and insert the information in the child/youth's record. The CCBHC will bill the monthly bundle rate, when a trigger service is provided.
	2) When a **non-established/new** child/youth has been screened and referred to the CCBHC from external providers (e.g., school settings designated for Behavior Intervention Supports in Schools (B.I.S.S.) and identified as needing intensive supports (e.g., BH-TCM, children's psychosocial rehab (PSR)*, Behavioral Health Aide (BHA), peer and family supports) a care coordination agreement will be initiated by the CCBHC. When it is the family/ caregiver's choice to retain an existing therapist, this should be noted on the care coordination agreement/integrated care plan. Providers should have the parent/legal guardian sign the agreement and insert the information in the child/youth's record. The CCBHC will bill the monthly bundle rate, when a trigger service is provided.
	3) When a **non-established/new** child 0-3 who is eligible for CW-TCM and/or EI-TCM and is referred to the CCBHC for Infant and Early Childhood Mental Health (IECMH) services, the CCBHC initiates a CC agreement. The agreement should differentiate services between the CCBHC and involved child serving systems (including SDE, OSDH, local schools) to ensure non-duplication of services. Therapeutic interventions must meet medical necessity criteria for children ages 0-36 months, Children's PSR is not reimbursable, (Refer to PA manual). The CCBHC will bill the monthly bundle rate, when a trigger service is provided.

Qualified Schools SB-CM	When a qualified school refers a child, appropriate staff must collaborate with CCBHC for referred services (see OAC 317:30-5-1031(a)(2)). The CCBHC CC will initiate the care coordination agreement. The agreement should differentiate services to avoid duplication.
EI-TCM	When SoonerStart refers a child to a CCBHC for behavioral health services, the Resource Coordinator (RC) must collaborate with the CCBHC (see OAC 317:30-5-621(2)(B)). The CCBHC CC will initiate the care coordination agreement. The agreement should differentiate services to avoid duplication(refer to section 2502 of SoonerStart Operations Manual for role of RC). Service should be added to the Individual Family Service Plan (IFSP).
CW-TCM	When a child is referred to a CCBHC, Child Welfare staff must collaborate with the CCBHC CC (see OAC 317:30-5-991(2)(B)). The CCBHC will initiate the care coordination agreement. The agreement should differentiate services to prevent duplication.
DDSD-TCM	If a **non-established/new** child/youth is referred from DDSD, the child must have a preliminary screening and risk assessment. If it is determined that the child has a co-morbid behavioral health/IDD condition, the child would then be eligible for the behavioral health services that are provided. IDD services are not part of the CCBHC certified services and are not to be included in the PPS. The CCBHC will initiate a CC agreement with the HCBS waiver case manager. The need for dual case management and services must be documented in the CC agreement and also added to the waiver plan of care (see OAC 317:30-5-1011(1)(B)).
OJA-TCM	When a child is referred to a CCBHC, OJA staff must collaborate with the CCBHC see OAC 317:30-5-971.1(b)). The CCBHC CC will initiate the care coordination agreement. The agreement should differentiate services to prevent duplication.
Independent LBHPs/ Psychologists	When an independently contracted LBHP/Psychologist requests an authorization for treatment or testing, services for an **established/existing CCBHC child/youth** that has been receiving services from the CCBHC within the last six (6) months a CC agreement initiated by the CCBHC is required. The agreement describes each parties' mutual expectations, including the need for services from each provider (e.g., specialty service, testing, and child/parent's choice). *The CC agreement must be signed by the parent/ legal guardian and a copy documented in the child/ youth's record.*
OPBH Agency	When an OPBH Agency requests a Level 1/2/3/4 authorization for treatment or testing for an **established/existing CCBHC child/youth** that has been receiving services from the CCBHC within the last six (6) months a CC agreement or Letter of Collaboration (LOC) initiated by the CCBHC is required. The agreement/LOC describes each parties' mutual expectations, including the need for services from each provider (e.g., specialty service, testing, and child/parent's choice*). The CC must be signed by the parent/legal guardian, and a copy documented in the child/youth's record*.

Notes*:*

* Per OAC 317:30-5-266(6)(A), eligibility requirements and billing limits found in OAC 317:30-5-241.3 (5)(D)(ii) do not apply.

**Per Demonstration criteria 4. d.1and 4.e.1 and ODMHSAS rules in OAC 450:17-5-178 and 450:17-5-180, the CCBHC directly provides Assessment, diagnosis and treatment planning.

PROVIDER RESOURCES

CCBHC Federal Demonstration Criteria

CCBHC Federal Demonstration Guidance– When is a Person a CCBHC consumer?

CCBHC Manual

Prior Authorization Manual

LEGAL REFERENCES

Medicaid Rules OAC 317:30-5-241(d) (Medical Necessity and Prior Authorization) Medicaid Rules OAC 317:30-5-241.1(2) (Assessments)

Medicaid Rules OAC 317:30-5-241.1(3) (Service Plans)

Medicaid Rules OAC 317:30-5-241.6 (BH-TCM)

Medicaid Rules OAC 317:30-5-266(2) (CCBHCs)

Medicaid Rules OAC 317:30-5-281 (LBHP)

Medicaid Rules OAC 317:30-5-621(2)(B) (EI-TCM)

Medicaid Rules OAC 317:30-5-971.1(b)) (OJA-TCM)

Medicaid Rules OAC 317:30-5-991(2)(B) (CW-TCM)

Medicaid Rules OAC 317:30-5-1011(1)(B)) (DDSD-TCM)

Medicaid Rules OAC 317:30-5-1031(2) (SB-CM)

ODMHSAS Rules OAC 450:17-5-178 (CCBHC Assessment Dx)

ODMHSAS Rules OAC 450:17-5-183 (CCBHC Care Coordination)

ODMHSAS Rules OAC 450:17-5-186 (CCBHC Case Management)

An ideal behavioral health crisis system has **coordination** of:

- Comprehensive array of service capacities
- A continuum of service components
- Robust inter-disciplinary staffing to meet the needs of all segments of the population

CCBHC Core Components; Crisis Services

Crisis Services: It is the responsibility of the CCBHC to ensure adequate crisis services are available and accessible 24 hours a day, 365 days a year and delivered within one hour from the time services are requested. If the CCBHC does not directly provide all necessary crisis services, the facility shall make crisis management services available through clearly defined arrangements, for behavioral health emergencies during hours when the facility is closed.

Facility will directly make available, the following co-occurring capable services:

* 24-hour mobile crisis teams;
* Emergency crisis intervention services; and
* crisis stabilization.

Facility will make available, either directly or through an agreement, or through a qualified DCO, the following co-occurring capable services:

* Facility-based Crisis Stabilization;
* Urgent Recovery Center; and
* Outpatient SUD Withdrawal Management.

Crisis services must include suicide crisis response and services capable of addressing crises related to substance use disorder and intoxication, including ambulatory and medical withdrawal management.

Facility will have an established protocol specifying the role of law enforcement during the provision of crisis services.

State sanctioned crisis system: If the CCBHC does not have a 24/7 walk-in crisis clinic or psychiatric urgent care they must have an agreement in place with a state-sanctioned alternative. A state-sanctioned alternative is a Community-based Structured Crisis Center (CBSCC) with a psychiatric urgent care unit as certified by ODMHSAS.

Prevention	Post Crisis Care	Crisis Response
• Early engagement in care • Crisis prevention planning • Outreach & support outside the clinic	• Discharge planning • Enhance discharge support • Enhance coordination post elevated level of care	• 24/7 Mobile crisis teams • Crisis stabilization • Suicide prevention/Zero Suicide Protocols • Coordination with law enforcement • Coordination with hospitals

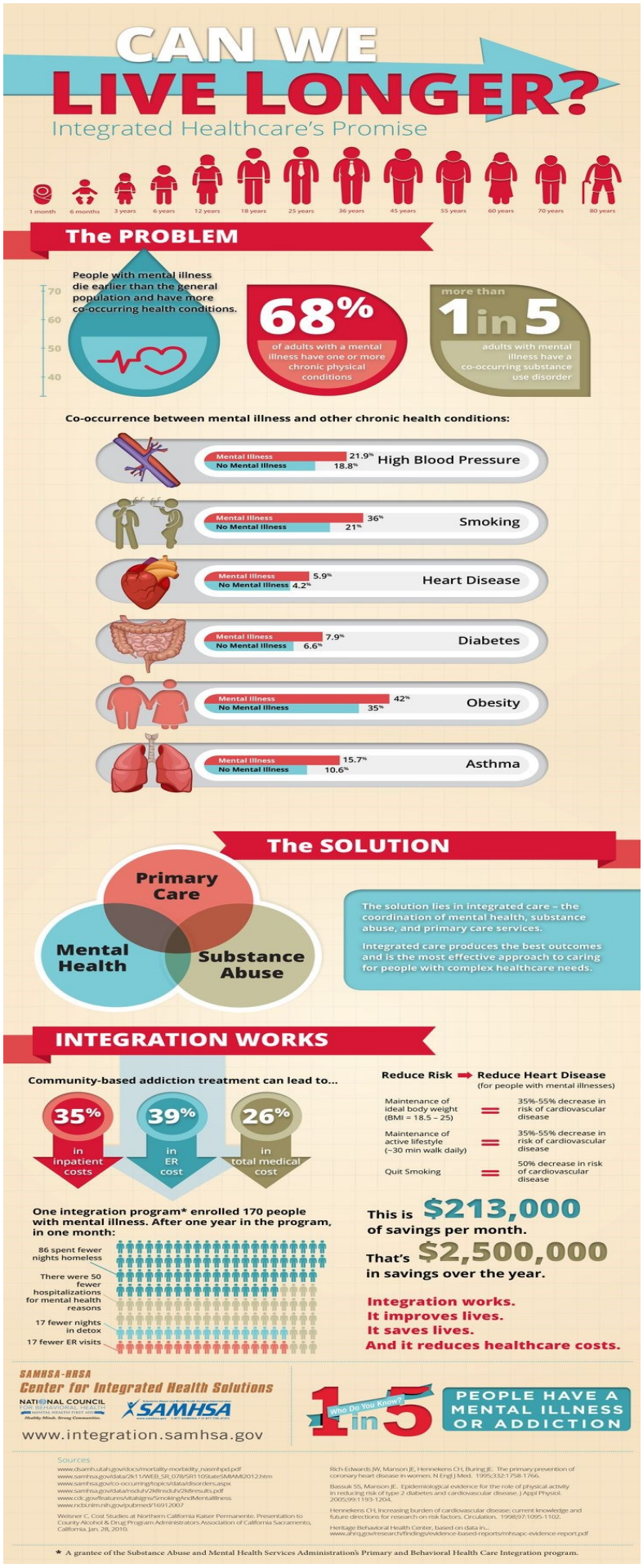
CCBHC Core Components; Outpatient Clinic Primary Care, Screening and Monitoring

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.

Required primary care screening and monitoring of key health indicators and health risk provided by the facility shall include but not be limited to the following, as applicable:

1. Adult Body Mass Index (BMI) Screening and Follow-Up;
2. Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents;
3. Weight assessment and counseling for nutrition and physical activity for children/adolescents;
4. Blood Pressure;
5. Tobacco use: Screening and cessation intervention;
6. Screening for clinical depression and follow-up plan;
7. Unhealthy alcohol use;
8. Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications;
9. Diabetes care for people with serious mental illness;
10. Metabolic monitoring for children and adolescents on antipsychotics;
11. Cardiovascular health screening for people with schizophrenia;
12. Adherence to mood stabilizers for individuals with Bipolar I Disorder;
13. Adherence to antipsychotic medications for individuals with Schizophrenia; and
14. Antidepressant medication management.

The CCBHC will ensure 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.


CAN WE
LIVE LONGER?
Integrated Healthcare's Promise
1 month
6 months
3 years
6 years
12 years
18 years
25 years
36 years
45 years
55 years
60 years
70 years
80 years
The PROBLEM
People with mental illness die earlier than the general population and have more co-occurring health conditions.
70
60
50
40
68%
of adults with a mental illness have one or more chronic physical conditions
more than
1 in 5
adults with mental illness have a co-occurring substance use disorder
Co-occurrence between mental illness and other chronic health conditions:
Mental Illness 21.9%
No Mental Illness 18.8%
High Blood Pressure
Mental Illness 36%
No Mental Illness 21%
Smoking
Mental Illness 5.9%
No Mental Illness 4.2%
Heart Disease
Mental Illness 7.9%
No Mental Illness 6.6%
Diabetes
Mental Illness 42%
No Mental Illness 35%
Obesity
Mental Illness 15.7%
No Mental Illness 10.6%
Asthma
The SOLUTION
Primary Care
Mental Health
Substance Abuse
The solution lies in integrated care – the coordination of mental health, substance abuse, and primary care services.
Integrated care produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs.
INTEGRATION WORKS
Community-based addiction treatment can lead to...
35% in inpatient costs
39% in ER cost
26% in total medical cost
Reduce Risk → Reduce Heart Disease
(for people with mental illnesses)
Maintenance of ideal body weight (BMI = 18.5 – 25) = 35%-55% decrease in risk of cardiovascular disease
Maintenance of active lifestyle (~30 min walk daily) = 35%-55% decrease in risk of cardiovascular disease
Quit Smoking = 50% decrease in risk of cardiovascular disease
One integration program* enrolled 170 people with mental illness. After one year in the program, in one month:
86 spent fewer nights homeless
There were 50 fewer hospitalizations for mental health reasons
17 fewer nights in detox
17 fewer ER visits
This is $213,000 of savings per month.
That's $2,500,000 in savings over the year.
Integration works.
It improves lives.
It saves lives.
And it reduces healthcare costs.
SAMHSA-HRSA
Center for Integrated Health Solutions
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
SAMHSA
www.integration.samhsa.gov
Who Do You Know?
1 in 5
PEOPLE HAVE A MENTAL ILLNESS OR ADDICTION
Sources
www.dsamh.utah.gov/docs/mortality-morbidity_nasmhpd.pdf
www.samhsa.gov/data/2k11/WEB_SR_078/SR110State/SAMA2012.htm
www.samhsa.gov/co-occurring/topics/data/disorders.aspx
www.samhsa.gov/data/msduh/2kRnsduh/2kRresults.pdf
www.cdc.gov/features/vitalsigns/Smoking/AndMentalIllness
www.ncbi.nlm.nih.gov/pubmed/16912007
Weisner C. Cost Studies at Northern California Kaiser Permanente. Presentation to County Alcohol & Drug Program Administrators Association of California Sacramento, California. Jan. 28, 2010.
Rich-Edwards JW, Manson JE, Hennekens CH, Buring JE. The primary prevention of coronary heart disease in women. N Engl J Med. 1995;332:1758-1766.
Bassuk SS, Manson JE. Epidemiological evidence for the role of physical activity in reducing risk of type 2 diabetes and cardiovascular disease. J Appl Physiol. 2005;99:1193-1204.
Hennekens CH. Increasing burden of cardiovascular disease: current knowledge and future directions for research on risk factors. Circulation. 1998;97:1095-1102.
Heritage Behavioral Health Center, based on data in... www.ahrq.gov/research/findings/evidence-based-reports/mhsapc-evidence-report.pdf
★ A grantee of the Substance Abuse and Mental Health Services Administration's Primary and Behavioral Health Care Integration program.

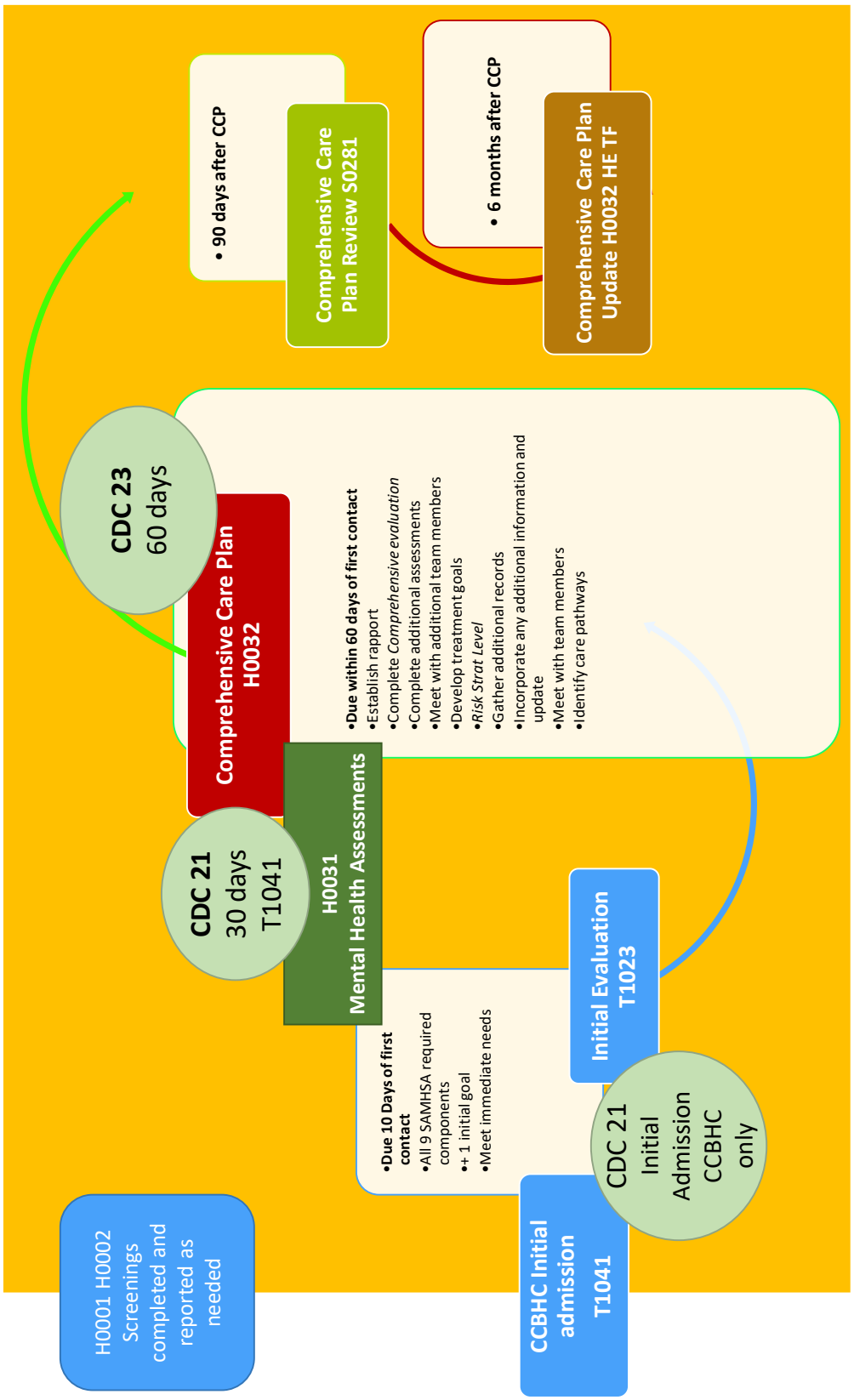
CCBHC Core Components; Comprehensive Integrated Care planning

The CCBHC directly provides person-centered and family driven care planning or similar processes, including but not limited to risk assessment and crisis 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 client, the adult client's family to the extent the client so wishes, or family/caregivers of youth and children, and is coordinated with staff or programs necessary to carry out the plan.

The plan shall clearly address clients' needs, strengths, abilities, physical and behavioral health goals, client preferences, and the overall health and wellness needs of the client.

- The plan is comprehensive, addressing all services required, with provision for monitoring of progress toward goals.
- The plan must be documented and completed within sixty (60) working days of admission to the CCBHC.
- The CCBHC must provide for each client and primary caregiver(s), as applicable, education and training consistent with the client and caregiver responsibilities as identified in the active care plan and relative to their participation in implementing the plan of care.


H0001 H0002 Screenings completed and reported as needed
CCBHC Initial admission T1041
CDC 21 Initial Admission CCBHC only
Initial Evaluation T1023
•Due 10 Days of first contact
•All 9 SAMHSA required components
•+ 1 initial goal
•Meet immediate needs
H0031 Mental Health Assessments
CDC 21 30 days T1041
Comprehensive Care Plan H0032
•Due within 60 days of first contact
•Establish rapport
•Complete *Comprehensive evaluation*
•Complete additional assessments
•Meet with additional team members
•Develop treatment goals
•*Risk Strat Level*
•Gather additional records
•Incorporate any additional information and update
•Meet with team members
•Identify care pathways
CDC 23 60 days
Comprehensive Care Plan Update H0032 HE TF
• 6 months after CCP
Comprehensive Care Plan Review S0281
• 90 days after CCP

CCBHC Core Components; Initial Evaluation

Initial Evaluation, Assessment and Diagnosis: The CCBHC will directly provide assessment and diagnosis, including risk assessment, for behavioral health conditions. The CCBHC must determine the extent to which each client's needs and preferences can be adequately addressed within the array of required services.

Preliminary screening and risk assessment

At first contact (maybe telephonic) for new clients requesting or being referred for behavioral health services, a Preliminary screening and risk assessment will be used to determine the client's acuity of needs. The facility shall use best practice screening tools, including Zero Suicide protocols as needed.

1. If the screening identifies an emergency/crisis need, the facility will take appropriate action immediately, including any necessary subsequent outpatient follow-up.
2. 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. An urgent need is one that if not addressed immediately could result in the person becoming a danger to self or others, or could cause a health risk.
3. If screening identifies unsafe substance use including problematic alcohol or other substance use, the facility will conduct a brief intervention and the client is provided or referred for and successfully linked with a full assessment and treatment, if applicable.
4. If the screening identifies routine needs, services will be provided and the initial evaluation completed within 10 business days.

Initial Evaluation T1023
Within 10 days first contact

The initial evaluation (including what was gathered as part of the preliminary screening and risk assessment) include at a minimum:
(1) preliminary diagnoses;
(2) source of referral;
(3) reason for seeking care, as stated by the client or other individuals who are significantly involved;
(4) identification of the client'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 client may be taking;
(6) an assessment of whether the client is a risk to self or to others, including suicide risk factors;
(7) an assessment of whether the client 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:
(10) At least1 immediate treatment goal.

Staff Requirement: Staff requirements are based on what is required to administer the specific screening tool(s) used. The following are eligible to provide this service, as allowed by the screening tool(s) used: BHA, or FSP, or PRSS, or BHCM I, or BHCM II (Certification issued July 1, 2013 or after), or CADC, or LBHP or Licensure Candidate. Urgent Recovery Center: LPN and RN can do health screenings.

Mental Health Psychosocial Assessment (H0031)

A Mental Health Psychosocial Assessment must be completed after Initial Evaluation and before Comprehensive Care Plan (CCP) to inform the development of the CCP.

A Mental Health Psychosocial Assessment is a face-to-face formal evaluation to establish problem identification, clinical diagnosis, or diagnostic impression. An evaluation shall include an interview with the client (and family, if deemed appropriate); may also include psychological testing, scaling of the severity of each problem identified for treatment; and /or pertinent collaborative information. This includes independent evaluations performed for children. The evaluation will determine an appropriate course of assistance which will be reflected in the service plan.

Licensed Behavioral Health Professional (LBHP) or Licensure Candidate, acting within his/her scope of practice requirements, must complete the Mental Health Psychosocial Assessment, in accordance with the standard in OAC 450:17-3-21.

Comprehensive Care Plan (H0032)

The CCBHC must complete the Comprehensive Care Plan (CCP) within 60 calendar days of the first contact. Until the CCP is completed, services shall be provided to meet initial needs as determined by Initial Evaluation.

The Comprehensive Care Plan must address all services necessary to assist the client in meeting his or her physical and behavioral health goals, and include the following:

- Client diagnoses and medications relative to behavioral and physical health conditions assessed by and addressed in terms of direct services provided and/or conditions for which the individual is referred and linked elsewhere for treatment;
- Client integrated care service needs, relative to behavioral and physical health conditions assessed by and addressed in terms of direct services provided and/or conditions for which the individual is referred and linked elsewhere for treatment;
- One to three treatment goals for the upcoming six (6) months, including preventive, primary care, and wellness services;
- Interventions, including identification of and follow up with necessary medical providers, and identification of any specific care pathways for chronic conditions; and
- The interdisciplinary treatment team's documentation of the client's or representative's and/or primary caregiver's (if any) understanding, involvement, agreement with the integrated care plan; and
- The client's advance wishes related to treatment and crisis management, and if the client does not wish to share their preferences, that decision is documented.

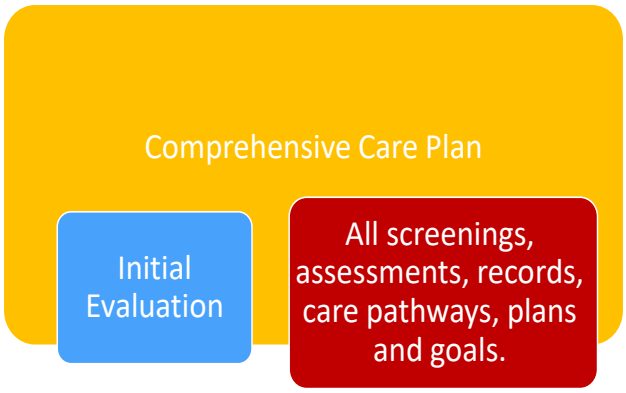
Comprehensive Care Plan H0032

45-60 Days

The ***process*** of developing a written plan based on the assessments (conducted by LBHP or Licensure Candidate) that identify the clinical needs/problems necessitating treatment. This process includes establishing goals and objectives; planning appropriate interventions; identifying treatment modalities, responsible staff, and discharge criteria. Client involvement must be clearly documented, if the client is 14 years of age or older. If the client is under 18 years of age, the parent or guardian must also be involved; as allowed by law.

This plan is the culmination of all plans with any updates or addendums. The Comprehensive Care Plan includes:

1) Initial Evaluation +
2) Any updates or addendums from:
    1) Additional records received
    2) Treatment team meetings
    3) Additional assessments, as needed
    4) Identified Care Pathways.



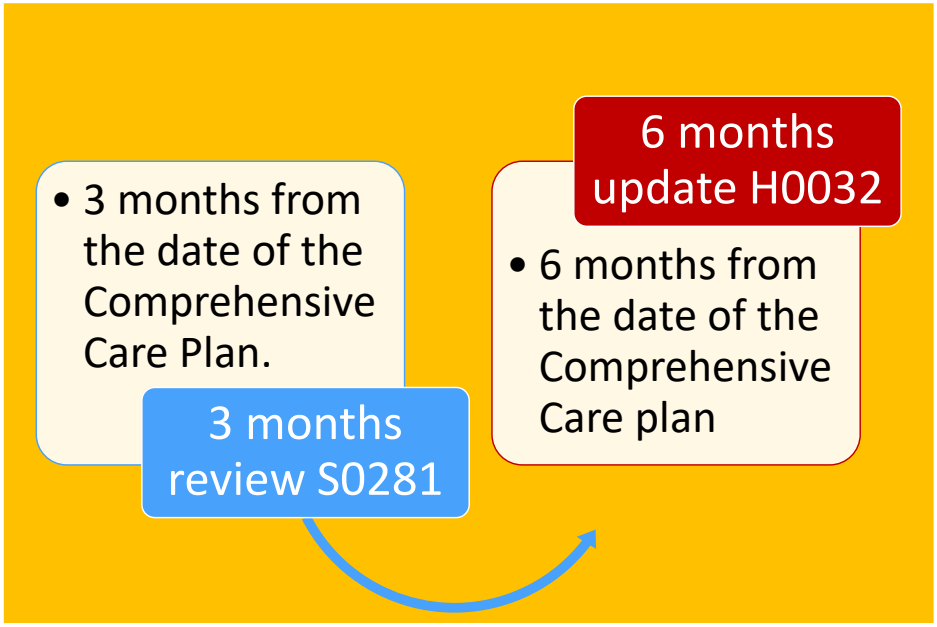
Comprehensive Care Plan Update (H0032)

The Comprehensive Care Plan must be updated at a minimum every 6 months.

Comprehensive Care Plan Review (S0281)

A Comprehensive Care Plan Review can occur anytime as needed, but must be completed within 3 months of the CCP and the CCP update(s) to determine any changes necessary to the CCP. A Comprehensive Care Plan Review can be as simple as a review with client or family and documented with a note in the client's record. If changes or updates are identified they are added to the CCP at the next CCP update. Anyone on the interdisciplinary team can complete the Comprehensive Care Plan Review with client or family.

Examples of items documented in a Comprehensive Care Plan Review could be addition of new treatment team member, completion of a previously identified goal, or identification of a new goal.



CCBHC Core Components; Team Based Care

CCBHC services shall incorporate principals of Team Based Care, ensuring that the needed and preferred services of clients are addressed and provided by appropriate staff as identified.

Team Based Care

At least two health providers who work collaboratively with patients and their caregivers – to the extent preferred by patient—to accomplish shared goals and achieve coordinated, high quality care.

5 Components of effective Interdisciplinary teams

1. Clear roles,
2. mutual trust,
3. effective communication,
4. measurable processes and
5. outcomes.

7 Core Components of Team Based Care

1. Team Roles
2. Team caseloads and ratios
3. Team meetings
4. Risk stratification
5. Care pathways
6. Quality measures
7. Health information technology

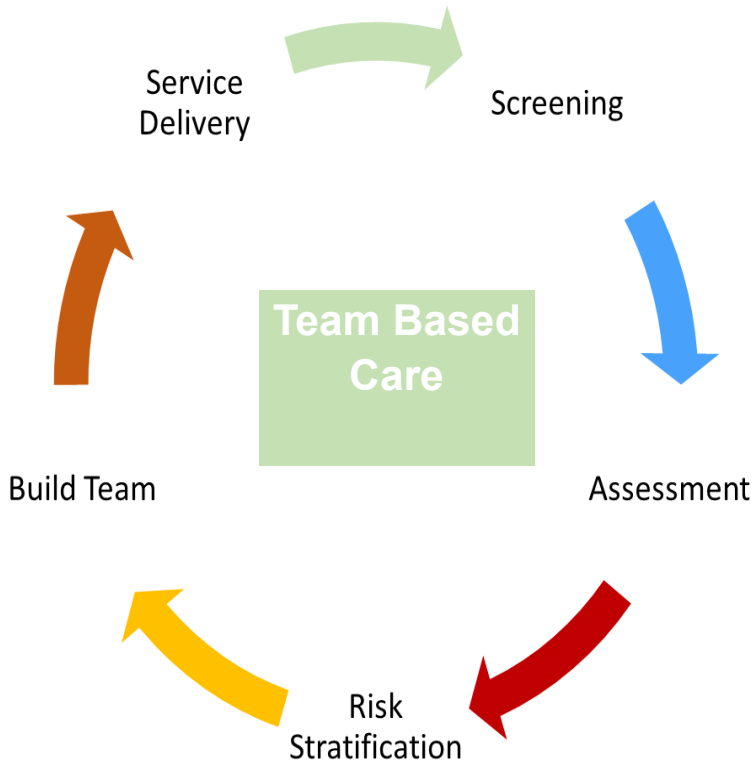
Benefits of a Team

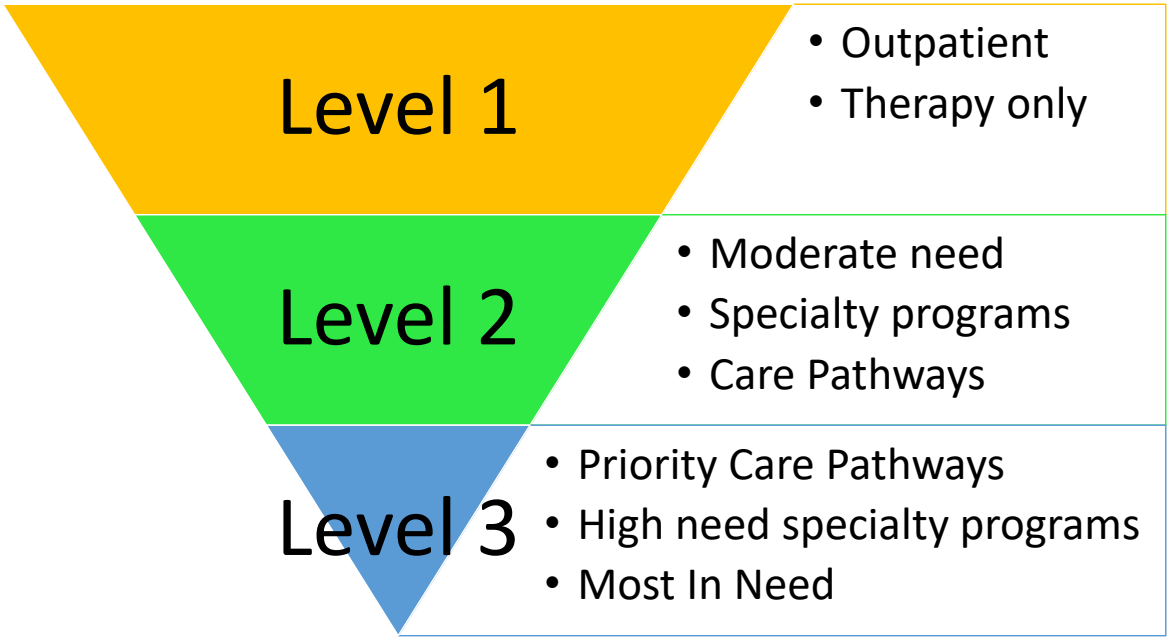
- Effective chronic illness models generally rely on multidisciplinary teams.
- Successful teams can provide critical elements of care that doctors do not have the time or training to do.
- Participation of medical specialists in consultative and educational roles contribute to better outcomes.

Wagner, E.H. (2000). The role of patient care teams in chronic disease management.

The treatment team includes the client, the family/caregiver of child clients, the adult clients family to the extent the client does not object, and any other person the client chooses. Each CCBHC location shall maintain a core staff comprised of employed and, as needed, contracted staff, as appropriate to the needs of clients as stated in the client's individual care plan and shall, at a minimum, include the following positions:

- Licensed Psychiatric;
- Licensed Nurse Care Manager (RN or LPN);
- Consulting Primary Care Physician, Advance Practice Registered Nurse, or Physician Assistant;
- Licensed Behavioral Health Professional or Licensure Candidate;
- Certified Behavioral Health Case Manager I or II;
- Certified Peer Support Specialist;
- Family Support Provider for child clients;
- Behavioral Health Aide for child clients; and
- Wellness Coach.



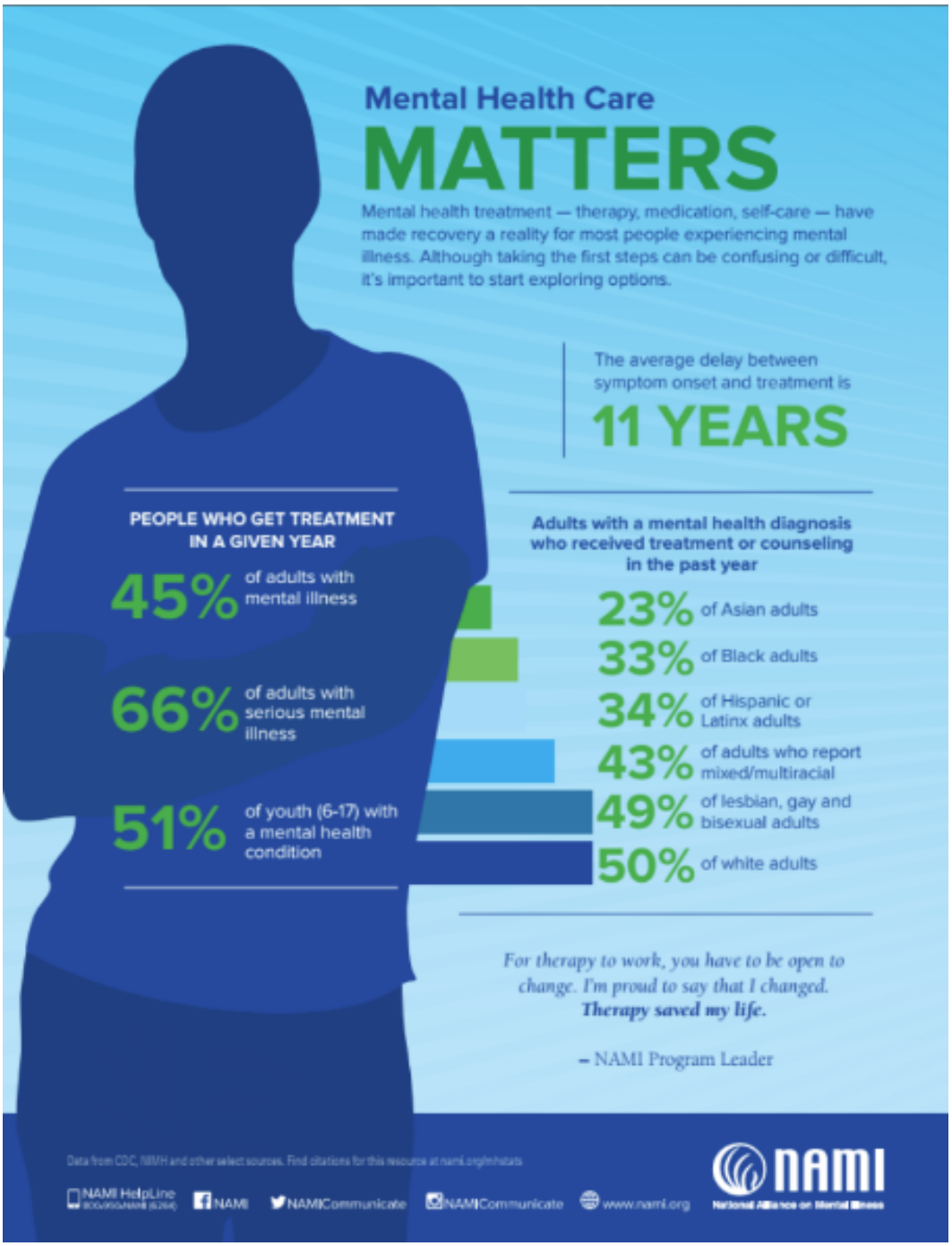


Risk Stratification is extremely important in the CCBHC population, as most all clients trigger the same rate. Not all clients will require the same intensity of services. Appropriate screening, assessment and stratification is imperative. CCBHCs are encouraged to research, and implement risk stratification tools with guidance from The ODMHSAS.

Risk Stratification is defined as a ongoing process of assigning all clients in a practice a particular risk status – risk status is based on data reflecting vital health indicators, lifestyle and medical history of adult or child populations. Stratifying risk helps to :

- Address specific population management challenges
- Match risk with levels of care
- Individualize care plans to lower risk and improve function
- Align the practice with value-based care approaches

Reference: https://www.health.state.mn.us/facilities/hchomes/collaborative/documents/ld2019w2.pdf


Mental Health Care
MATTERS
Mental health treatment — therapy, medication, self-care — have made recovery a reality for most people experiencing mental illness. Although taking the first steps can be confusing or difficult, it's important to start exploring options.
The average delay between symptom onset and treatment is
11 YEARS
PEOPLE WHO GET TREATMENT IN A GIVEN YEAR
45% of adults with mental illness
66% of adults with serious mental illness
51% of youth (6-17) with a mental health condition
Adults with a mental health diagnosis who received treatment or counseling in the past year
23% of Asian adults
33% of Black adults
34% of Hispanic or Latinx adults
43% of adults who report mixed/multiracial
49% of lesbian, gay and bisexual adults
50% of white adults
For therapy to work, you have to be open to change. I'm proud to say that I changed. Therapy saved my life.
– NAMI Program Leader
Data from CDC, NIMH and other select sources. Find citations for this resource at nami.org/mhstats
NAMI HelpLine
NAMI
NAMICommunicate
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National Alliance on Mental Illness

Outpatient mental health and substance use services are designed to treat an individual's mental health and/or substance use disorder in a manner consistent with the individual's phase of life and development. The provision of outpatient mental health and substance use services is informed and determined by screening, assessment, and diagnosis process as well as the person-centered, comprehensive, integrated care planning process.

Outpatient services shall incorporate evidenced-based or best practices and maintain consistency with the needs and preference of the individuals, children/youth and family/caregivers. Outpatient mental health and substance use services must be directly provided by the CCBHC. In the event specialized services outside the expertise of the CCBHC are required for treatment, the CCBHC makes them available through referral or other formal arrangement with other providers as needed. All services must be medically necessary but fee for services limits and documentation requirements so not apply in CCBH

Therapy Services

The CCBHC is responsible for high quality, evidenced based, targeted therapeutic interventions.

Targeted Case Management

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. 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.

Peer & Family Support Services

The CCBHC is responsible for peer services including Peer Recovery Support Specialists. This service provides the training and support necessary to ensure active participation of the family or client in the care planning process and with the ongoing implementation, support, and reinforcement of skills learned throughout the treatment process.

The CCBHC is responsible for family support services. Training may be provided to family members to increase their ability to provide a safe and supportive environment in the home and community. This may involve assisting the client or family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management; assistance in understanding crisis plans and plan of care process; training on medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures, and regulations that impact those with mental illness while living in the community.

Intensive Support for Members of the Armed Forces

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.

Psychiatric Rehabilitation Services

The CCBHC is responsible for evidence-based and other psychiatric rehabilitation services. Psychiatric rehabilitation services that might be considered include: medication education; self-management; training in personal care skills; individual and family/caregiver psycho-education; community integration services; Illness Management & Recovery and financial management. Psychiatric rehabilitation services should be curriculum based and documented as such in the

Health promotion

The CCBHC is responsible to provide health promotion services to insure continued integrated care for clients. Health Promotion is the process of enabling clients to increase control over, and to improve, their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions. Health promotion consists of providing health education specific to the client's chronic condition. Examples of health promotion include:

· Development of wellness self-management plan
· Facilitation of the self-management plan
· Facilitation of chronic disease specific interventions
· Implementation of care pathways.

Health promotion interventions should be physical health, chronic disease specific interventions facilitated by trained Wellness Coach or Nurse Care Manager. Wellness Coaches can provide many wellness interventions and groups. Evidence based practices and standardized curriculum should be utilized and documented accordingly.

Per SAMHSA guidelines states must establish a minimum set of Evidenced Based Practices, EBPs, to be used in every CCBHC within the state. Some communities may require EBPs that have been adapted to best meet the populations that CCBHCs serve.

It is the expectation that Oklahoma CCBHCs will utilize and provide Evidenced Based Practices to the highest standard of care. All requirements set forth by ODMHSAS program staff, ODMHSAS program requirements, contracts, statements of work, and fidelity to the models should be adhered to.

The following practices were selected as minimum standards; however, a CCBHC may choose to employ additional EBPs as indicated by needs assessment and the population being served.

CCBHC Core Components; Evidenced Based Practices

Required Evidenced Based Practices	Recommended Evidenced Based Practices
• Motivational Interviewing	◊ Program of Assertive Community Treatment (PACT)
• Cognitive Behavioral Therapy (CBT)	◊ Wellness Recovery Action Plan
• CBT for Suicide Prevention	◊ Recovery Oriented Cognitive Therapy
• Trauma Focused CBT	◊ Critical Time Intervention
• Collaborative Assessment and Management of Suicidality (CAMS)	◊ Matrix Model
• Medication Assisted Treatment	◊ Dialectical Behavioral Therapy (DBT)
• Wraparound	◊ Motivational Enhancement Therapy
• Seeking Safety	◊ First Episode early intervention for psychosis
• Peer Recovery Support Specialists (PRSS)	◊ Strengthening Families
• Individual Placement and Supports (IPS	◊ Celebrating Families
• Housing First	◊ Transition to Independence Process (TIP)
• Enhanced Illness Management and Recovery (eIMR)	◊ Circle of Security
•	◊ Child Parent Psychotherapy (CPP)
•	◊ Parent Child Interaction (PCIT)
•	◊ Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
•	◊ Attachment Biobehavioral Catch-up (ABC)
•	◊ Program to Encourage Active Rewarding Lives (PEARLs)

Quality Measures

The CCBHC Quality Measures are requirements placed on CCBHCs as part of the Demonstration Program, the state plan amendment (SPA), and the CCBHC expansion grants to improve community mental health services, found in Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA). Data and quality measure reporting have multiple objectives. Collection and reporting of this information offer providers, states, and other stakeholders a better method for assessing the manner in which care is accessed and provided. The information can be used for internal quality improvement (QI) processes to determine the degree of progress achieved or to determine where new or additional improvement is needed. The data can be used for accountability, and may be used to evaluate programs, such as the national evaluation of the CCBHC Demonstration Program. In general, the data collected will help states and the federal government to have a better understanding of the quality of health care that clients at CCBHCs receive. Measures are collected at the facility and state-level and reported annually.

Information about the Demonstration quality measures, including the two-volume technical specification manual and reporting template can be found at https://www.samhsa.gov/section-223/quality-measures. Questions and clarification about specific quality measures can be found at https://www.samhsa.gov/sites/default/files/questions-clarifications-about-specific-qms.pdf.

Oklahoma received permission from SAMHSA and CMS to make modifications to some measures under the SPA. The measure specifications and modifications are as follows.

FACILITY-LEVEL MEASURES:	Time to Initial Evaluation (I-EVAL)
	Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow Up (BMI-SF)
	Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH)
	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)
	Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)
STATE-LEVEL MEASURES	Follow-up After Emergency Department Visit for Mental Illness (FUM)
	Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)
	Plan All-Cause Readmissions Rate (PCR-BH)
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)
	Follow-Up After Hospitalization for Mental Illness (FUH-BH)
	Follow-Up After Crisis Center Episodes for Mental Illness (FUH-CC)
	Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-BH)
	Antidepressant Medication Management (AMM-BH)
	Initiation and Engagement in Treatment (IET-BH)
	Psychiatric Hospitalizations
	Emergency Department Admissions

FACILITY-LEVEL MEASURES:

Time to Initial Evaluation (I-EVAL)

DESCRIPTION: The number of clients in the eligible population who received an initial evaluation within 10 business days of the first contact with the provider entity during the measurement year.

Metric #1: The percentage of new clients with initial evaluation provided within 10 business days of first contact.

Metric #2: The mean number of days until initial evaluation for new clients.

MEASUREMENT PERIOD: The measurement period for the denominator is the state fiscal year excluding the last 30 days of the measurement year and using the 6 months preceding the measurement year to ensure individuals were not seen in the previous six months. The measurement period for the numerator is the measurement year.

GUIDANCE FOR REPORTING:

- This is a two-part measure and requires two different calculations.
- This metric is stratified by age (12–17 years, 18 years and older) and by race (American Indian, Asian, Black, White, Native Hawaiian or Pacific Islander, multi-racial).

FACILITY-LEVEL MEASURES:

Time to Initial Evaluation (I-EVAL)

Example of how measures will be reported:

Measure	Numerator	Denominator	Rate
Age 12-17 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Total (all Age Groups)			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

TERM	DEFINITION
Business Days	Monday through Friday, excluding state and federal holidays (regardless of days of operation)
Initial Evaluation	For a CCBHC, the initial evaluation is due within 10 business days of first contact for those who present with "routine" non-emergency or non-urgent needs. That standard is used in this specification.
New Client	An individual not seen at the clinic in the past 6 months
Age	Report two age stratifications and a total rate: • 12–17 years as of the end of the measurement year • 18 years and older as of the end of the measurement year • Total (both age groups)

MEDICAL RECORD METRIC SPECIFICATION #1
Percentage of new clients with initial evaluation provided within 10 business days of first contact

Denominator
The number of clients in the eligible population

Numerator
The number of clients in the eligible population who received an initial evaluation within 10 business days of the first contact with the provider entity during the measurement year

MEDICAL RECORD METRIC SPECIFICATION #2
The mean number of days until initial evaluation for new clients

Denominator
The number of clients in the eligible population

Numerator
The total number of days between first contact and initial evaluation for all members of the eligible population seen at the eligible population at the provider entity during the measurement year

Note: The measurement period for the numerator is the measurement year. Anyone who received an initial evaluation after the last day of the measurement year are treated as having been evaluated 31 days after initial contact.

Reporting Code:
ODMHSAS has now created an Initial Evaluation service (T1023). The initial evaluation (including what was gathered as part of the preliminary screening and risk assessment) include at a minimum: (1) preliminary diagnoses; (2) source of referral; (3) reason for seeking care, as stated by the client or other individuals who are significantly involved; (4) identification of the client'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 client may be taking; (6) an assessment of whether the client is a risk to self or to others, including suicide risk factors; (7) an assessment of whether the client 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.

ADDITIONAL INFORMATION FROM SAMHSA:

Please define first contact. First contact means the first time that the person (or family or guardian if the person is a child or has a guardian) contacts the BHC to obtain services, but also applies to a person if they have not received services by the BHC during the previous six months. First contact usually will be a call from a potential client looking for an appointment or a walk-in looking for an appointment. A first contact also could be a crisis service provided by the BHC. The certification criteria (2.b.1) require that, at first contact, there be a preliminary screening and risk assessment to ascertain acuity of needs. Depending on the results, the first service and initial evaluation is required within 10 business days if needs are routine. If needs are urgent, the initial evaluation and service must be within one business day. If the needs constitute an emergency, "appropriate action must be taken at once." An initial evaluation, as defined in 4.d.3, should be incorporated into the emergency evaluation process conducted by the CCBHC.

Can a PCP referral be considered the first point of contact? No, it must be a contact by the person who is seeking services or by their family or guardian if they are a child or have a guardian. The first point of contact is the person seeking services so their acuity of needs can be determined using the preliminary screening and risk assessment that is supposed to occur at first contact.

If a program has open access where clients can come in whenever they want during certain hours, but they call first to determine what open access hours are, is the call first contact? No, a call to determine when open access hours are held is not first contact unless that call is accompanied by the preliminary screening and risk assessment and collection of basic data about the person, including insurance information. In, general, however, if a person calls just to find out what hours you are open, that is not an initial contact. That is an attempt to find out when they can come in and have an initial contact.

If a person contacts a clinic more than once to initiate services, does the first or last contact count as initiation or does each contact count separately? Only one contact in a six-month period will count (six months to determine if they are a new client). The first contact seeking services is initiation and the time to initial evaluation counts from that point.

Are business or calendar days used to calculate the first metric (the percent receiving an initial evaluation within 10 days)? Only standard business days count. The measure captures those evaluated within 10 business days. For the first metric, if the initial contact was Friday and the evaluation was performed on Saturday, it would be 1 day as it was completed by Monday (the next business day).

Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow Up (BMI-SF)

DESCRIPTION: Percentage of clients, aged 18 years and older, who have two BMI measurements documented AND, for BMIs outside of normal parameters, a follow-up plan is documented during the encounter, in the measurement year.

Normal Parameters:
- Age 65 years and older BMI > 23 and < 30 kg/m2
- Age 18 - 64 years BMI > 18.5 and < 25 kg/m2

MEASUREMENT PERIOD: The measurement period for the numerator and denominator is the state fiscal year. For individuals with enrollment in the CCBHC with less than 12 months but more than six months, only one BMI documentation and follow-up plan, if needed, is required. For individuals with less than six months of CCBHC enrollment, BMI documentation and follow-up plan, if needed, is not required but encouraged.

GUIDANCE FOR REPORTING:

This metric is stratified by race (American Indian, Asian, Black, White, Native Hawaiian or Pacific Islander, multi-racial).

Measure	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

TERM	DEFINITION
Body Mass Index (BMI)	BMI is a number calculated using the Quetelet index—weight divided by height squared (W/H2)—and is commonly used to classify weight categories. BMI can be calculated using: Metric Units: BMI = Weight (kg) / (Height [m] x Height [m]) **OR** English Units: BMI = (Weight [lbs] x 703) / (Height [in] × Height [in])
Follow-Up Plan	Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up plan may include, but is not limited to: • Documentation of education • Referral (for example a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professions, or surgeon) • Pharmacological interventions • Dietary supplements • Exercise counseling • Nutrition counseling
Not eligible for BMI Calculation or Follow Up Plan	A client is not eligible if one or more of the following reasons are documented: • Client is receiving palliative care • Client is pregnant • Client 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 • Client is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the client's health status

Denominator:

The number of admitted clients 18 years and older

Numerator:

The number of admitted clients 18 years and older with two documented BMI scores AND follow-up if needed in the measurement year

Numerator Instructions:

Height and Weight: An eligible professional or their staff is required to measure both height and weight. Self-reported values cannot be used. *During the COVID pandemic, self-reported weight and height may be used to calculate BMI.

Follow-Up Plan: If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter. The documented follow-up plan must be based on the most recent documented BMI, outside of normal parameters, example: "Client referred to nutrition counseling for BMI above normal parameters."

Exclusions:

A client is not eligible for BMI calculation or development of a follow-up plan if one or more of the following reasons are documented:

- Client is receiving palliative care
- Client is pregnant
- Client 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
- Client is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the client's health status

Reporting codes:

Performance Met:

BMI is documented within normal parameters and no follow-up plan is required (G8420)

BMI is documented above normal parameters and a follow-up plan is documented (G8417)

BMI is documented below normal parameters and a follow-up plan is documented (G8418)

BMI not documented, with documentation the client is not eligible for BMI calculation (G8422)

Performance Not Met:

BMI is not documented and no reason given (G8421)

BMI documented outside normal parameters, no follow-up plan documented, no reason is given (G8419).

**Do not use the value set of CPT or HCPCS codes included in the CCBHC Manual Final Spec. Include any admitted client during the measurement year (MY).*

***For CCBHCs which were certified for less than 12 months but more than six months in the measurement year, only one documented BMI score AND follow-up if needed will be expected. For CCBHCs which were certified for less than six months in the measurement year, report the measure but results will not be counted against the CCBHC.*

Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH)

DESCRIPTION: The percentage of admitted children, aged 3 to 17, which have two body mass index (BMI) percentiles during the measurement year.

Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than the absolute BMI value.

MEASUREMENT PERIOD: The measurement period for the numerator and denominator is the state fiscal year. For youth with enrollment in the CCBHC with less than 12 months but more than six months, only one BMI percentile documentation is required. For youth with less than six months of CCBHC enrollment, BMI percentile documentation is not required but encouraged.

GUIDANCE FOR REPORTING:

This measure is stratified by age (3-11 years, 12-17 years) and a total. This metric is also stratified by race (American Indian, Asian, Black, White, Native Hawaiian or Pacific Islander, multi-racial).

Measure	Numerator	Denominator	Rate
Age 3-11 years			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Age 12-17 years			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Total (all Age Groups)			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

The height, weight, and BMI percentile must be from the same data source.

If the caregiver or youth refuse to provide weight and height, a value 0 can be reported to indicate the exclusion of the youth from the measure.

**The child does not have to be seen by a PCP or OB/GYN to be counted in the measure. Include any admitted child during the MY.*

***Do not use the value set of CPT or HCPCS codes included in the CCBHC Manual Final Spec. Include any admitted client during the measurement year (MY).*

****For CCBHCs which were certified for less than 12 months but more than six months in the measurement year, only one documented BMI percentile will be expected. For CCBHCs which were certified for less than six months in the measurement year, report the measure but results will not be counted against the CCBHC.*

ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Clients aged 3–17 years as of the end of the measurement year. Report two age stratifications and a total: • 3 to 11 • 12 to 17 • Total The total is the sum of the age stratifications.

Denominator:

The number of admitted clients 3 – 17 years of age, at the end of the measurement year

Numerator:

The number of admitted clients 3 – 17 years of age at the end of the measurement year that have two BMI percentiles documented during the measurement year

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

DESCRIPTION: The percentage of admitted clients, aged 18 years and older, with two tobacco screenings documented AND who received cessation counseling intervention if identified as a tobacco user during the measurement year.

DEFINITIONS

TERM	DEFINITION
Tobacco Cessation Intervention	May includes brief counseling (3 minutes or less) and/or pharmacotherapy
Tobacco Use	Includes use of any type of tobacco

Denominator:

The number of admitted clients 18 years and older

Numerator:

The number of admitted clients 18 years and older that have two tobacco screenings was done AND follow-ups if needed is documented during the measurement year

Reporting Guidance:

This metric is stratified by race (American Indian, Asian, Black, White, Native Hawaiian or Pacific Islander, multi-racial).

Measure	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

Measurement Period: The measurement period for the numerator and denominator is the state fiscal year. For individuals with enrollment in the CCBHC with less than 12 months but more than six months, only one tobacco screening is required. For individuals with less than six months of CCBHC enrollment, tobacco screening is not required but encouraged.

Reporting codes:

Performance Met:

Patient screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (4004F)

Current tobacco non-user (1036F), or Documentation of medical reason(s) for not screening for tobacco use (4004F 1P); Performance Not Met: 4004F 8P.

**Do not use the value set of CPT or HCPCS codes included in the CCBHC Manual Final Spec. Include any admitted client during the measurement year (MY).*

***For CCBHCs which were certified for less than 12 months but more than six months in the measurement year, only one documented tobacco screenings AND cessation counseling intervention if identified as a tobacco will be expected. For CCBHCs which were certified for less than six months in the measurement year, report the measure but results will not be counted against the CCBHC.*

Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)

DESCRIPTION: The percentage of admitted clients, ages 18 years and older, who have two alcohol screenings during the measurement year AND received brief counseling if identified as an unhealthy alcohol user.

TERM	DEFINITION
Screening	A validated screening questionnaire for **unhealthy** alcohol use.
Brief Counseling	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.
Provider Entity	The provider entity that is being measured (i.e., BHC)
Systematic Screening Method	For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include: • AUDIT Screening Instrument (score ≥ 8) • AUDIT-C Screening Instrument (score ≥4 for men; score ≥3 for women) • Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response ≥2)

Denominator:

The number of admitted clients 18 years and older

Numerator:

The number of admitted clients 18 years and older that have two alcohol screenings in the measurement year AND received brief counseling if identified as an unhealthy alcohol user. For individuals with enrollment in the CCBHC with less than 12 months but more than six months, only one unhealthy alcohol screening and brief counseling, if needed, is required. For individuals with less than six months of CCBHC enrollment, an unhealthy alcohol screening is not required but encouraged.

Reporting Guidance:

This metric is stratified by race (American Indian, Asian, Black, White, Native Hawaiian or Pacific Islander, multi-racial).

Measure	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

Measurement Period: The measurement period for the denominator is the state fiscal year. The measurement period for the numerator is the measurement year and 30 days prior to the measurement year.

Reporting codes:

Performance Met:

Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling (G9621)

Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method (G9622)

Performance Not Met:

Patient not screened for unhealthy alcohol screening using a systematic screening method OR patient did not receive brief counseling, reason not given (G9624)

Medical Performance Exclusion:

Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy, other medical reasons) (G9623)

**Do not use the value set of CPT or HCPCS codes included in the CCBHC Manual Final Spec. Include any admitted client during the measurement year (MY).*

***For CCBHCs which were certified for less than 12 months but more than six months in the measurement year, only one documented unhealthy alcohol screening AND brief intervention if identified as an unhealthy alcohol user will be expected. For CCBHCs which were certified for less than six months in the measurement year, report the measure but results will not be counted against the CCBHC.*

The suicide risk assessment measures have been replaced with state-level measures of follow-up after inpatient and crisis center stays.

STATE-LEVEL MEASURES:

Follow-up After Emergency Department Visit for Mental Illness (FUM): The percentage of emergency department (ED) visits for clients 6 years of age and older with a primary diagnosis of mental illness, who had an outpatient visit, an intensive outpatient encounter or a partial hospitalization for mental illness. Two rates are reported:

1. The percentage of ED visits for which the client received follow-up within 30 days of the ED visit.
2. The percentage of ED visits for which the client received follow-up within 7 days of the ED visit

Note: This measure only includes clients with Medicaid as their pay source due to non-Medicaid clients not having ED claims.

Measure – 7 Day Follow UP	Numerator	Denominator	Rate
Age 6-17 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – 30 Day Follow UP	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA):

The percentage of emergency department (ED) visits for clients 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:

1. The percentage of ED visits for which the client received follow-up within 30 days of the ED visit.
2. The percentage of ED visits for which the client received follow-up within 7 days of the ED visit.

Note: This measure only includes clients with Medicaid as their pay source due to non-Medicaid clients not having ED claims.

Measure – 7 Day Follow UP	Numerator	Denominator	Rate
Age 13-17 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – 30 Day Follow UP	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

Plan All-Cause Readmissions Rate (PCR-BH): For clients 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:

1. Count of Index Hospital Stays (IHS) (denominator)
2. Count of 30-Day Readmissions (numerator)

Readmission Rate
Note: This measure only includes clients with Medicaid as their pay source due to non-Medicaid clients not having inpatient claims at non-DMHSAS facilities.

Measure – 7 Day Follow UP	Numerator	Denominator	Rate
Age 18-64 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – 30 Day Follow UP	Numerator	Denominator	Rate
Age 65+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD): The percentage of clients 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.

Measure	Numerator	Denominator	Rate
Age 18-64 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH): Percentage of clients ages 19 to 64 during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent
of their treatment period.

Measure	Numerator	Denominator	Rate
Age 19-64 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

Quality Measures; State Level

Follow-Up After Hospitalization for Mental Illness (FUH-BH): Percentage of discharges for individuals ages 6 and over who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit with a CCBHC staff. Three rates are reported:

Percentage of discharges for which clients received follow-up within 30 days of discharge
Percentage of discharges for which clients received follow-up within 7 days of discharge
Percentage of discharges for which the client received follow-up within 48 hours of discharge

Note: This measure only includes clients with Medicaid as their pay source due to non-Medicaid clients not having inpatient claims at non-DMHSAS facilities.

Quality Measures; State Level

Measure – 30 Day Follow Up	Numerator	Denominator	Rate
Age 6-17 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – 7 Day Follow Up	Numerator	Denominator	Rate
Age 6-17 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – 48 Hour Follow Up	Numerator	Denominator	Rate
Age 6-17 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – 30 Day Follow Up	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – 7 Day Follow Up	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – 48 Hour Follow Up	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

Follow-Up After Crisis Center Episodes for Mental Illness (FUH-CC):

The percentage of discharges for individuals 18 years and older who were admitted to a crisis center and who had an outpatient visit with a CCBHC staff. Three rates are reported:

1. Percentage of discharges for which the client received follow-up within 30 days of discharge
2. Percentage of discharges for which the client received follow-up within 7 days of discharge
3. Percentage of discharges for which the client received follow-up within 48 hours of discharge

Measure – 30 Day Follow Up	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – 7 Day Follow Up	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – 48 Hour Follow Up	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-BH)

: 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 ages 6 to 12 as of the IPSD with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Measure – Initiation Phase	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – Continuation & Maintenance Phase	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

Antidepressant Medication Management (AMM-BH): The percentage of clients 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 clients who remained on an antidepressant medication for at least 84 days (12 weeks)

2. Effective Continuation Phase Treatment. Percentage of clients who remained on an antidepressant medication for at least 180 days (6 months)

Measure – Acute Phase	Numerator	Denominator	Rate
Age 18-64 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – Acute Phase	Numerator	Denominator	Rate
Age 65+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – Continuation & Maintenance Phase	Numerator	Denominator	Rate
Age 18-64 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – Continuation & Maintenance Phase	Numerator	Denominator	Rate
Age 65+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

Initiation and Engagement in Treatment (IET-BH): Percentage of clients age 6 and older (on the start date of service) who received at least two services within fourteen days (initiation) and at least four services within 45 days of the start date of an outpatient episode (engagement).

The start date is the first service in an outpatient program, or, if a client starts in a crisis unit or inpatient, the date of the sublevel of care change (transaction type 40). For clients who receive services through a a preadmission (transaction type 21) the date of the first outpatient service is used as the start date. In order to ensure individuals have been in treatment for at least 45 days to achieve the measure, it is necessary to include individuals with an outpatient episode start date prior to the study period, that is, individuals with an outpatient start date 45 days before the start of the month and 45 days before the end of the month are included.

Exclusion: 1. Discharge codes within 45 days of admission include 63 (Moved), 68 (Death), 65 (Incarcerated), 64 (Transferred), 71 (Medical) OR discharge codes within 45 days of admission include 60/61 (Completed) 2. Data that is missing, invalid, or does not fit the criteria

Measure – Initiation	Numerator	Denominator	Rate
Age 6-17 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – Initiation	Numerator	Denominator	Rate
Age 18+			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – Engagement	Numerator	Denominator	Rate
Age 6-17 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure – Engagement	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

Psychiatric Hospitalizations

percent of total served,

mean days,

median days

UNDER CONSTRUCTION

Metric #1: The percentage of clients with psychiatric hospitalization.

Metric #2: The median number of days of all psychiatric hospitalization.

Measure: Percent of psychiatric hospitalizations	Numerator	Denominator	Rate
Age 6-17 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure: Percent of psychiatric hospitalizations	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure: Median number of days in psychiatric hospitalization	Numerator	Denominator	Rate
Age 6-17 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure: Median number of days in psychiatric hospitalization	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

For this measure, only Medicaid clients are included.

Emergency Department Admissions

percent of total served

UNDER CONSTRUCTION

Metric #1: The percentage of clients with psychiatric hospitalization.

Metric #2: The median number of days of all psychiatric hospitalization.

Measure: Percent of ED admissions	Numerator	Denominator	Rate
Age 6-17 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure: Percent of ED admissions	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure: Median number of days in ED	Numerator	Denominator	Rate
Age 6-17 years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			
Measure: Median number of days in ED	Numerator	Denominator	Rate
Age 18+ years Total			
American Indian			
Asian			
Black			
White			
Native Hawaiian or Pacific Islander			
Multi-racial			

Notes:

For measures requiring a mental health or substance abuse diagnosis, any of the diagnoses listed on the claim was used.

Age of the client at the beginning of the time period was used for the age variable.

For this measure, only Medicaid clients are included.

Health Information Technology

The use of health information technology (HIT) has been shown to improve the quality and effectiveness of health care; promote individual and public health, increase the accuracy of diagnoses, while reducing costs and medical errors. According to the Office of the National Coordinator for Health Information Technology, by strategically combining HIT tools and effective health communication processes, there is the potential to:

- Improve health care quality and safety;
- Increase the efficiency of health care and public health service delivery;
- Support care in the community and at home;
- Facilitate clinical and client decision-making; and
- Build health skills and knowledge.

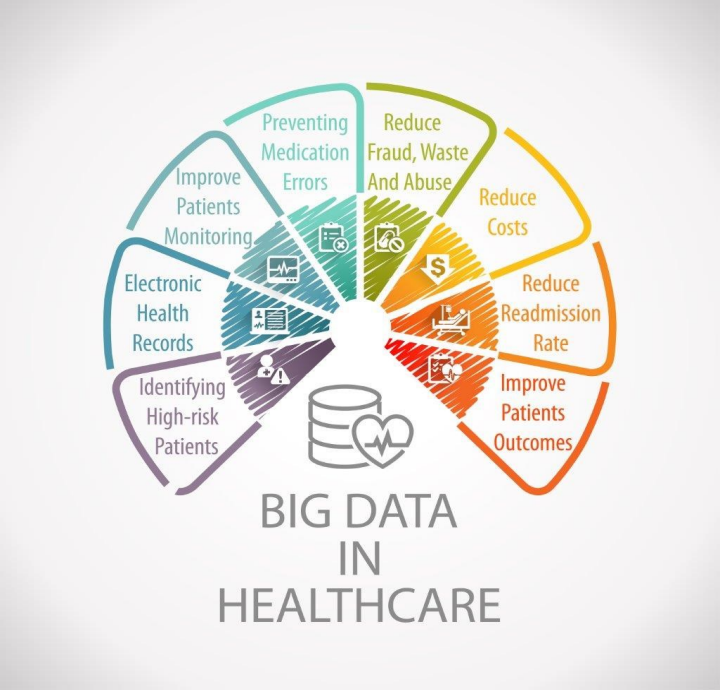
CCBHCs are required to incorporate HIT in their clinical processes to increase individual and population healthcare quality and improvement. Towards this end, CCBHCs are required to have a certified Electronic Health Record (EHR), utilize a Health Information Exchange (HIE), and utilize and contribute client information to a population performance management system.

Using software that has received **EHR** certification is important because it guarantees specific safeguards. It protects the confidentiality of patient information, makes sure the data is secure, provides a standard way of entering information so it can be shared between providers and ensures a consistent way of recording data for the CQMs.

An **HIE** is a vehicle for improving quality and safety of patient care by getting the right information to the right person at the right time. Data gained from an HIE has been shown to be effective in reducing medication and medical errors, increasing efficiency by eliminating unnecessary paperwork and tests, and providing caregivers with clinical decision support tools for more effective care and treatment.

A **population performance management system** allows providers to monitor performance on key metrics related to value-based care initiatives; identify high risk clients and understand the care gaps and utilization patterns of all clients to provide better care.

While these are the basic requirements, CCBHCs are encouraged to utilize a variety of HIT to improve population health outcomes and healthcare quality, and to achieve health equity for the people we serve.



Eligibility

All SoonerCare and DMHSAS clients are eligible to receive CCBHC services, except individuals residing in nursing facilities, Intermediate Care Facilities/Intellectual Developmental Disabilities, inmates of public correctional institutions and SoonerCare clients served by a PACE provider or receiving partial hospitalization.

Accessibility of Services

CCBHCs are designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals, especially individuals who have the most complex needs. Per SAMHSA, CCBHCs will offer service access regardless of ability to pay and place of residence, access to adequate crisis services, and client choice in treatment planning and services.

CCBHCs are expected to provide services to all individuals and accept all fund sources necessary to meet the needs of the individual presenting for services. All costs are incurred to operate a CCBHC are included in the rate calculation of the monthly bundled rates.

Special Eligibility Provisions For persons receiving External Case Management /Targeted Case Management (TCM)

- Advantage Waiver case management or enrolled in HMP

  ADvantage Waiver case management or services from the Health Management Program (HMP) may receive CCBHC core services following an initial evaluation and risk assessment. An agreement will be developed delineating the roles and responsibilities between the CCBHC and the external case manager for the physical, behavioral health and social service needs.

  Targeted Case Management - Clients receiving TCM services from external entities may receive CCBHC core services following an initial evaluation and risk assessment. An agreement will be developed delineating the roles and responsibilities for TCM, in order to avoid duplication.

- CW-TCM;
- OJA-TCM;
- IDD-TCM.

CCBHCs and external providers are to work cooperatively and collaboratively. As a participant in the Demonstration or in the approved state plan, CCBHCs are required to provide care coordination and to establish agreements with a variety of community or regional services, supports, and providers. See Care Coordination Policy Guidance for more information.

Types of CCBHC Clients

New Clients

"New" to CCBHC, means they have not been served by the clinic in the six months before the current service, and must receive the following to become a person receiving CCBHC services:

- Receive a non-crisis service at a CCBHC location.
- An initial evaluation and risk assessment must be completed at first contact
- and an Initial Evaluation must be completed within 10 days of first contact.

Non-Established Clients

Clients that:

- receive crisis services without a pre-admission within the last 60 days or a current outpatient admission at the CCBHC,
- are referred to the CCBHC directly from other outpatient behavioral health agencies for enhanced case management and pharmacologic management only, e.g., Drug Court and Specialty Courts clients being served at a different treatment facility.

Eligibility

Most In Need (MIN)

The ODMHSAS has identified individuals who are in need of intensive care and are not being served well in the community. Individuals. Most in Need consists of clients that have a large number of inpatient, crisis or substance abuse residential treatment days or episodes.

MIN includes adult clients 18 years and over and children/youth clients 6 and over who meet the following criteria:

1. have had two or more psychiatric inpatient episodes in the past 12 months; OR
2. have had three or more community based structured crisis episodes in the past 12 months; OR
3. had have 12 or more emergency department visits with a mental health or substance abuse diagnosis; OR
4. have had two or more substance abuse residential treatment episodes in the last 12 months (but will not be shown until admission due to confidentiality laws); OR
5. has been discharged from a psychiatric inpatient episode in the last 90 days.

CCBHC Payment

The State uses a Prospective Payment System (PPS) for services delivered by a CCBHC. PPS is a cost-based, per clinic monthly rate that applies uniformly to all CCBHC services rendered by a certified clinic.

Development of the CCBHC Rates

For CCBHCs participating in the Demonstration (Red Rock, North Care and Grand Lake), the State uses a Prospective Payment System (PPS) for services delivered by a CCBHC. PPS are cost-based, per clinic monthly rates that apply uniformly to all CCBHC services rendered by a certified clinic. For SFY20, Clinic rates were established based on allowable costs from the period April 1, 2018 to June 30, 2018 and applied to all qualifying sites of the certified clinic established prior to April 1, 2014.

For new CCBHCs that are certified by ODMHSAS after July 1, 2019, under the State Plan, the State will establish interim monthly bundled rates by reference to 90% of the average rates of existing urban and rural CCBHCs.

Provider specific monthly rates will be updated annually by the MEI to reflect changes due to inflation.

Cost Reporting and Rate Setting

The CCBHC payment methodologies are based on a cost report from each clinic, using federal cost reporting rules. The cost report includes allowable costs which are necessary costs to comply with CCBHC criteria. The report also includes numbers of qualifying visit months. ODMHSAS reviews all cost reports to determine individual rates for each CCBHC. Total approved costs for a year divided by total visit months to arrive at provider-specific rates per visit month. The rates represent an average cost per visit month for all clients receiving CCBHC services from a particular CCBHC. The rate includes the cost of providing services and activities listed in Appendix D, Demo/SPA CCBHC Codes FY2023.

Reimbursement varies based on levels of service intensity:

⇒ one standard monthly rate to reimburse the CCBHC for services and

⇒ two separate monthly special population rates for adults and children to reimburse CCBHCs for the higher costs associated with providing all services needed to meet the needs of clients who are “most in need” of intensive, integrated care.

Payment for CCBHC service is made when a CCBHC delivers at least one (1) CCBHC covered service, and when a valid individual procedure code is reported for the calendar month. Providers are required to use the T1041 code to report monthly encounters. Providers are also required to “shadow report” all services provided. These services will be paid at 0.00.

The methodology for establishing each facility's rates is found in the CCBHC Demonstration Guidance and in Attachment 4.19 B of the OHCA's State Plan, as amended effective October 1, 2022 and incorporated herein by reference.

Cost reports and supporting data must be filed annually using the CMS template and must be completed within 5

CCBHC Payment

Reimbursement for Standard Population

There is one standard population rate for both adults and children. For each individual served during the calendar month, the CCBHC can bill the procedure code T1041, and receive the standard population rate. The T1041 must be billed with a shadow reported covered service that triggers the monthly rate. CCBHCs should continue to report the correct contract source on the claims. Care coordination and other activities do not trigger a payment when billed alone in a calendar month.

*CCBHC clients can only receive one monthly payment per month. For a client that has been seen at two or more CCBHCs in one month, the first CCBHC to bill the T1041 will receive the monthly payment.

Billing Requirements for MIN (Special Populations)

CCBHCs are required to outreach to the individuals on the MIN list in their areas. Once these individuals are admitted to a CCBHC and receive intensive services, the CCBHC may bill an additional payment each month the client is served, which is the difference between the standard rate and the special population rate. The additional payment code is H0046 and does not need to be billed with an additional shadow reported service. For example, if the standard population rate is $500 and the special population rate is $750, the T1041 will pay $500 and the H0046 will pay $250, bringing the total monthly payment to the special population rate of $750.

Individuals meeting criteria 1 - 4 on the MIN list will remain on the list for 12 calendar months beginning the month of eligibility. For example, an individual who becomes eligible on April 15, will remain on the list until March 31st of the following year. In the event that a client is erroneously placed on the MIN list, e.g., an inpatient claim is voided, the individual will remain on the MIN list through the end of the month. Individuals meeting criterion 5, will remain on the list for 3 months, including the month they were discharged from their inpatient episode.

The MIN can be accessed through the PICIS website, under reports, under “Most in Need”. The MIN list is updated weekly. Because there is a lag in claims, individuals may not be placed on the list as soon as they become eligible. For example, a second inpatient episode may occur in March but the claims are not billed until June. Eligibility will be retroactive to inpatient discharge. Due to federal confidentiality laws, individuals on the MIN list due to substance abuse residential treatment episodes will not be displayed until the individual is admitted to the CCBHC. The facility may then bill the H0046 for intensive services for these individuals.

- If a CCBHC bills the H0046 for the additional payment and the individual is admitted to psychiatric inpatient facility during the same month, the additional payment will be recouped once the inpatient claim is received.
- If a CCBHC bills the H0046 for a client who is not on the most in need list for the date of service, payment will be recouped.

Claims for Established Clients

Claims should include detailed HCPC/CPT coding, including modifiers, in order to bill the monthly payment.

- CCBHCs will need to have a charge master in order to implement the cost to charge ratio as demonstrated in the CMS cost report. The charges would be equal for all clients regardless of payer.
- Claims should include reasonable and customary charges or actual cost as the billed amount, not fee schedule amount. This will help facilitate claims adjustments and a means to associate costs of special populations.
- Each external provider to which services are referred is the billing provider for the services that it furnishes.
- CCBHCs must shadow report all CCBHC services provided including all care coordination activities that support CCBHC services.
- For Child Most in Need Clients receiving Targeted Case Management at an external entity, CW-TCM; OJA-TCM, only report T1016 if you have an established agreement to prevent duplication, otherwise use special TCM reporting code, T2023.
- For Adult Most in Need clients receiving Advantage Waiver services, only report T1016 (TCM) if you have an established agreement, to avoid duplication, with the Advantage Waiver provider, otherwise report T1017.

CCBHC Payment

Fee for Service (FFS) Reimbursement

Established Clients - Payment may be made on a FFS basis for non-CCBHC services provided to established clients. Payment is made for crisis services for non-established clients in accordance with the Crisis Chart (see page#).

Payment may be separately made for Medicaid covered non-CCBHC services provided by the CCBHC on a FFS basis using the SoonerCare fee schedule:

- Physician primary care services
- Medications, including MAT
- Medicare eligible CPT codes

Non-Established Clients

Payments for services provided to non-established clients will be separately billable and no monthly payment will be made. Services must be billed under separate provider location codes.

CCBHC Crisis Services Billing Requirements

Billing Requirements CCBHC Crisis Services Effective 12/1/2022

Outpatient Crisis Service:

For an outpatient crisis service for a non-admitted individual that you have not done a transaction type 21 in the last 60 days, report H2011 without a CDC transaction type and bill fee-for-service.

For a non-admitted individual that you have done a transaction type 21 in the last 60 days, do a transaction type 21 and report H0007. It can be used to trigger the PPS payment. The H0007 procedure code will replace the H2011 crisis code for CCBHC clients.

Mobile Crisis Service:

For a mobile crisis service for a non-admitted individual that you have not done a transaction type 21 in the last 60 days, submit a transaction type 21 and a service focus 26. A prior authorization will be returned, and you will bill FFS.

For a mobile crisis service for a non-admitted individual that you have done a transaction type in the last 60 days, submit a transaction type 21 and a service focus 26. A quality initiative (QI) line will be returned, and the mobile crisis can be used to trigger the PPS payment.

Urgent Recovery Crisis (URC):

When an admitted client at your CCBHC goes to your URC, submit a transaction type 42 with a service focus of 32. A QI line will be returned and the URC stay can be used to trigger the monthly rate.

When a non-admitted client goes to the URC, submit a transaction type 27 with a service focus of 32. A PA will be returned and you can bill FFS, regardless of whether they are admitted at another CCBHC.

Billing Requirements CCBHC Crisis Services Effective 12/1/2022, continued

Crisis Center:

When an individual that is not admitted at your CCBHC or any other CCBHC, is admitted in your crisis center, submit a transaction type 23 with a level of care of SC and a PA will be returned. You will bill FFS for the crisis stay.

When your CCBHC client is admitted at your crisis center, submit a transaction type 40 and a level of care of SC. A QI line will be given and you can use the crisis stay to trigger the monthly rate.

When a Medicaid-eligible individual admitted at another CCBHC, is admitted in your crisis center, you will bill the other CCBHC for the crisis stay. When an DMHSAS only-eligible individual admitted at another CCBHC, is admitted in your crisis center, submit a transaction type 23 and a level of care of SC. You can bill the crisis stay as FFS.

In the event that you submit a preadmission (21) and the client is then admitted to a crisis center on the same day, contact the PICIS Helpdesk and ask that the 21 be removed. Once this is removed, you will be able to get DH509 PA and bill the crisis stay as FFS.

CCBHC CRISIS SERVICES Prior to December 1, 2022

	(1) Non-admitted client	(2) Client admitted at CCBHC where client is getting the crisis service	(3) Client admitted at CCBHC where client is getting the crisis service through DCO	(4) Admitted CCBHC client receiving crisis services at another CCBHC crisis center	(5) Admitted CCBHC client receiving crisis services at a non-CCBHC crisis center
Crisis Center (CBSCC)	FFS	No payment (qualifying triggering service must be billed to receive PPS)	No payment (qualifying triggering service must be billed to receive PPS)	Bill other CCBHC**	Bill other CCBHC**
URC	FFS	No payment (qualifying triggering service must be billed to receive PPS)	No payment (qualifying triggering service must be billed to receive PPS)	FFS	FFS
Mobile Crisis/ Crisis Intervention	PPS	PPS	PPS*	FFS	FFS

CCBHC Crisis Services Billing Requirements

CCBHC CRISIS SERVICES effective 12/1/2022

	(1) Non-admitted (have not received a PPS payment) client	(2) Client admitted at CCBHC where client is getting the crisis ser-	(3) Client admitted at CCBHC where client is getting the crisis service through	(4) Admitted CCBHC client receiving crisis services at another CCBHC crisis cen-	(5) Admitted CCBHC client receiving crisis services at a non-CCBHC crisis cen-
Crisis Center (CBSCC)	FFS	PPS	PPS*	Bill other CCBHC**	Bill other CCBHC**
URC	FFS	PPS	PPS*	FFS	FFS
Mobile Crisis/ Crisis Intervention	FFS	PPS	PPS*	FFS	FFS

1) A client not established at any CCBHC who comes to a CCBHC for crisis services as the first point of contact

2) A client established at a CCBHC who is receiving crisis services at the CCBHC where he/she is established

3) A client established at a CCBHC who is receiving crisis services at the CCBHC where he/she is established through the CCBHC's designated collaborating organization (DCO)

4) A client established at a CCBHC who is receiving crisis services at another CCBHC where he/she is NOT established

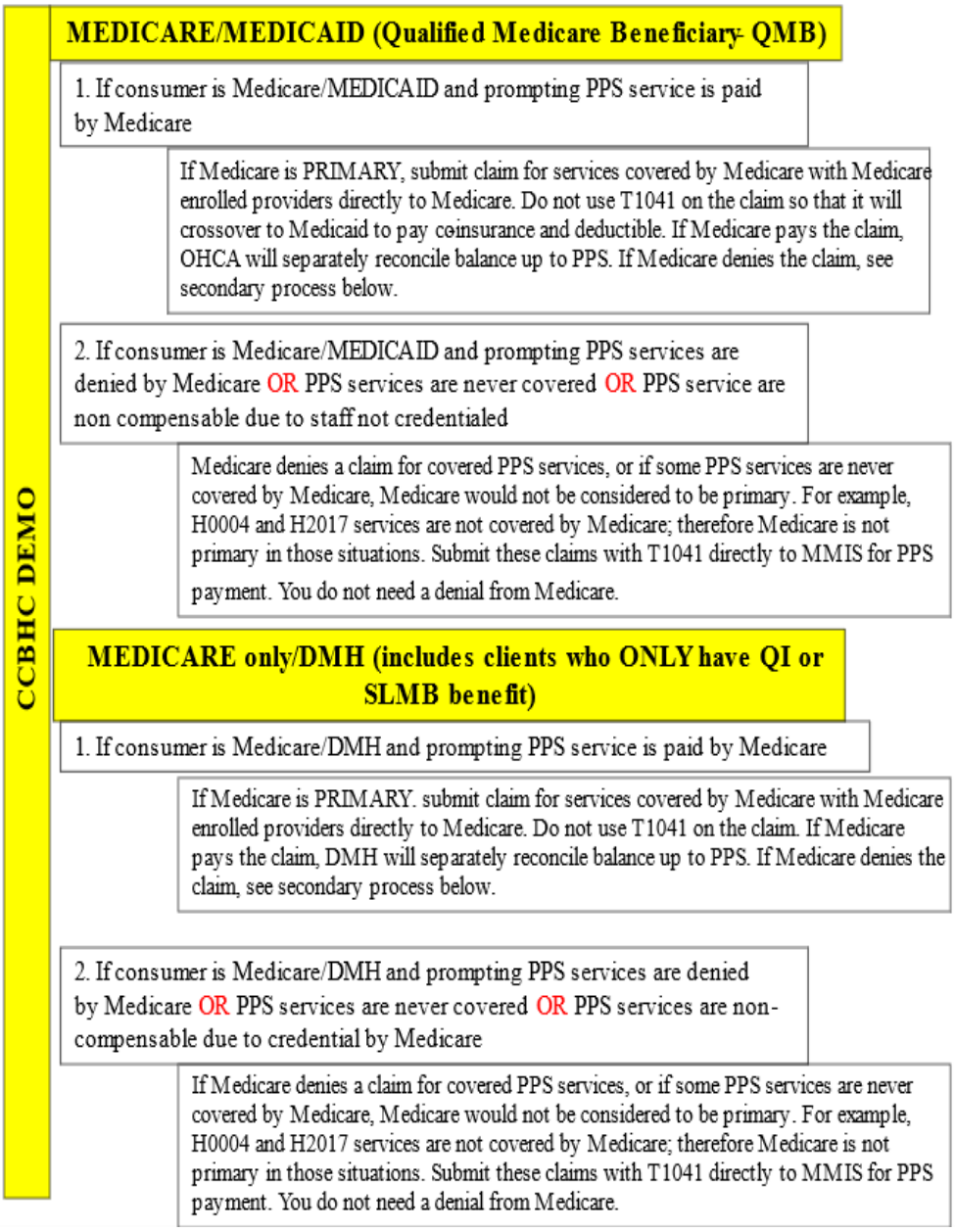
5) A client established at a CCBHC who is receiving crisis services at a non-CCBHC crisis facility (e.g., OCCIC)

*In these cases, the CCBHC is responsible to bill for the payment (PPS). The DCO should not bill OHCA/DMH for the services but may bill the CCBHC for the services provided.

**In order to get payment for services, the crisis provider/CBSCC must bill the CCBHC where the client is established if the client is a SoonerCare/Medicaid member. If the client is a DMH/indigent client, the crisis provider/CBSCC may bill fee -for-service for the crisis stay.

CCBHC Billing Guidance Dual Eligibles and Third Party Liability

CCBHCs are required to serve everyone, including persons with dual eligibility and third party liability. As Medicaid and OD-MHSAS are payors of last resort, services covered by other payors must be billed fee for service first. Please refer to the billing guidance below for additional information.



CCBHC DEMO

THIRD PARTY LIABILITY (TPL)/MEDICAID

1. If consumer is TPL/MEDICAID and prompting PPS service is paid by TPL

If consumer is Medicaid and Commercial is PRIMARY, submit claim with allowable codes directly to carrier. Follow normal TPL billing process. Do not use T1041 on the claim. Submit separate claim with T1041, less insurance payment if paid, using CCBHC location. OHCA will reconcile up to PPS.

2. If consumer is TPL/MEDICAID and prompting PPS services are denied OR PPS services are never covered OR PPS service are non -compensable due to credential by TPL

If consumer is Medicaid and Commercial is SECONDARY, PPS services are denied OR PPS services are never covered OR PPS service are noncompensable due to credentialed staff by TPL, submit claim directly to MMIS with T1041 and carrier denial if applicable.

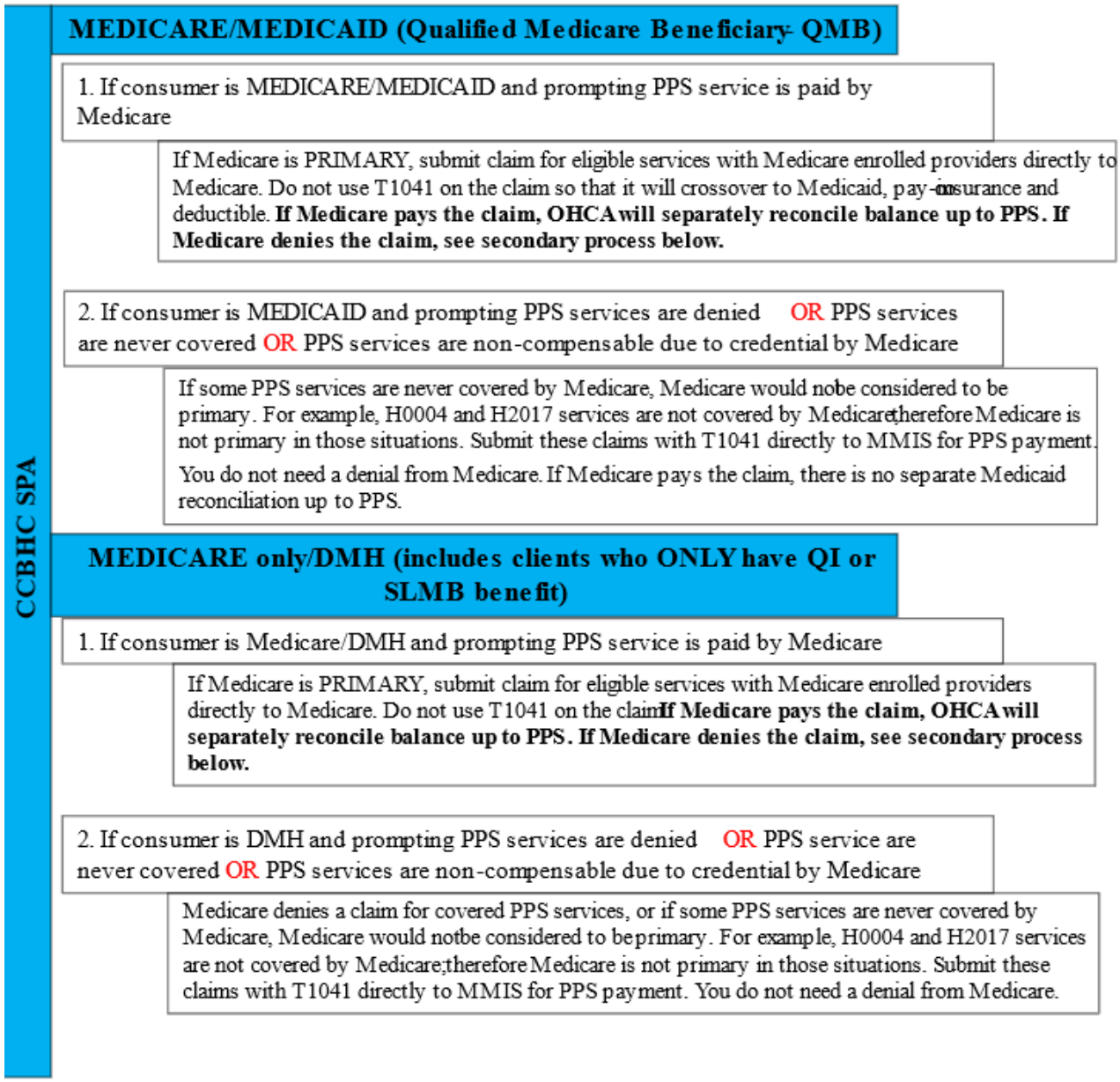
THIRD PARTY LIABILITY (TPL)/DMH

1. If consumer is TPL/DMH and prompting PPS service is paid by TPL

If consumer is not Medicaid, and is DMH eligible and Commercial is PRIMARY, submit claim with allowable codes directly to carrier. Follow normal TPL billing process. Do not use T1041 on the claim. Submit claim to MMIS less insurance payment. Payment will be made by DMH up to PPS subject to available funds.

2. If consumer is TPL/DMH and prompting PPS services are denied by TPL OR PPS services are never covered OR PPS services are non-compensable due to credential by TPL

If consumer is not Medicaid and is DMH eligible, and Commercial is SECONDARY, PPS services are denied OR PPS services are never covered OR PPS service are non compensable due to credential by TPL, submit claim directly to MMIS with T1041 and carrier denial if applicable.


CCBHC SPA
MEDICARE/MEDICAID (Qualified Medicare Beneficiary- QMB)
1. If consumer is MEDICARE/MEDICAID and prompting PPS service is paid by Medicare
If Medicare is PRIMARY, submit claim for eligible services with Medicare enrolled providers directly to Medicare. Do not use T1041 on the claim so that it will crossover to Medicaid, pay-in-insurance and deductible. If Medicare pays the claim, OHCA will separately reconcile balance up to PPS. If Medicare denies the claim, see secondary process below.
2. If consumer is MEDICAID and prompting PPS services are denied OR PPS services are never covered OR PPS services are non-compensable due to credential by Medicare
If some PPS services are never covered by Medicare, Medicare would nobe considered to be primary. For example, H0004 and H2017 services are not covered by Medicare;therefore Medicare is not primary in those situations. Submit these claims with T1041 directly to MMIS for PPS payment.
You do not need a denial from Medicare. If Medicare pays the claim, there is no separate Medicaid reconciliation up to PPS.
MEDICARE only/DMH (includes clients who ONLY have QI or SLMB benefit)
1. If consumer is Medicare/DMH and prompting PPS service is paid by Medicare
If Medicare is PRIMARY, submit claim for eligible services with Medicare enrolled providers directly to Medicare. Do not use T1041 on the claim If Medicare pays the claim, OHCA will separately reconcile balance up to PPS. If Medicare denies the claim, see secondary process below.
2. If consumer is DMH and prompting PPS services are denied OR PPS service are never covered OR PPS services are non-compensable due to credential by Medicare
Medicare denies a claim for covered PPS services, or if some PPS services are never covered by Medicare, Medicare would notbe considered to beprimary. For example, H0004 and H2017 services are not covered by Medicare;therefore Medicare is not primary in those situations. Submit these claims with T1041 directly to MMIS for PPS payment. You do not need a denial from Medicare.

CCBHC SPA

TPL/MEDICAID

1. If consumer is MEDICAID and prompting PPS service is paid by TPL

If consumer is Medicaid and Commercial is PRIMARY. submit claim with allowable codes directly to carrier. Follow normal TPL billing process, Do not use T1041 on the claim. Submit separate claim with T1041, less insurance payment if paid, using CCBHC location.

2. If consumer is MEDICAID and prompting PPS service is denied OR PPS service are never covered OR PPS service is non -compensable due to credential by TPL

If consumer is Medicaid and Commercial is SECONDARY, PPS services are denied OR PPS services are never covered OR PPS service are non-compensable due to credential by TPL, submit claim directly to MMIS with T1041 and carrier denial if applicable

TPL/DMH

1. If consumer is DMH and prompting PPS service is paid by TPL

If consumer is not Medicaid and is DMH eligible and Commercial is PRIMARY, submit claim with allowable codes directly to carrier. Follow normal TPL billing process. Do not use T1041 on the claim. Submit separate claim with T1041, less insurance payment if paid, using CCBHC location. Payment will be made by DMH up to PPS **subject to available funds.**

2. If consumer is DMH and prompting PPS service is denied OR PPS service are never covered OR PPS service is non -compensable due to credential by TPL

If consumer is not Medicaid and is DMH eligible, and Commercial is SECONDARY, PPS services are denied OR PPS services are never covered OR PPS service are non-compensable due to credential by TPL, submit claim directly to MMIS with T1041 and carrier denial if applicable.


OKLAHOMA
Mental Health &
Substance Abuse