Guidance to Planning Grant States to Apply to Participate in the Section 223 CCBHC Demonstration Program

Introduction

Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014 (P.L. 113-93)[1] authorized the Certified Community Behavioral Health Clinic (CCBHC) demonstration to allow states to test a new strategy for delivering and reimbursing a comprehensive array of services provided in community behavioral health clinics. The demonstration aims to improve the availability, quality, and outcomes of outpatient services provided in these clinics. It also requires states to reimburse CCBHC providers using a Medicaid prospective payment system (PPS) methodology intended to cover the full cost of providing CCBHC services to Medicaid beneficiaries. In 2016, the U.S. Department of Health and Human Services (HHS) selected eight states to participate in the demonstration (Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania) and expanded the demonstration to two new states (Kentucky and Michigan) through the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136) in August 2020. Though there have been several extensions to what was an originally a two-year demonstration program, the most recent expansion under the Bipartisan Safer Communities Act of 2022 (P.L. 117-259) authorized an additional one-year planning grant phase and the addition of up to 10 additional states to participate in the CCBHC Demonstration beginning as early as July 1, 2024, and every two years thereafter.

The CCBHC Planning Grants awarded by SAMHSA in March 2023[2] are designed to support states through the 1-year statutory planning phase of the CCBHC Demonstration and prepare them and their clinics to participate in Demonstration program. As a planning grant recipient, CCBHC planning grant states are expected to submit an application to formally apply to participate in the four-year Demonstration. Up to ten states will be selected to participate in the Demonstration based on the quality of the applications and geographic distribution, per the statute. All states that received a CCBHC Planning Grant, either in 2016 or 2023, are eligible to apply to participate in the four-year Demonstration.

Applications will be reviewed by a panel of federal subject matter experts. Based on that review, recommendations for selection will be made to federal officials of the Assistant Secretary for Planning and Evaluation (ASPE), the Centers for Medicare & Medicaid Services (CMS), and the Substance Abuse and Mental Health Services Administration (SAMHSA) for final selection no later than June 17, 2024. This document outlines the key application materials that must be

[1] H.R. 4302, 113th Congress. Protecting Access to Medicare Act of 2014. PL No 113-92; April 2, 2014. https://www.congress.gov/bill/113th-congress/house-bill/4302

[2] On March 16, 2023, the U.S. Department of Health and Human Services (HHS), through the Substance Abuse and Mental Health Services Administration (SAMHSA), awarded 15 states each with $1 million, one-year CCBHC planning grants. The 15 states selected were Alabama, Delaware, Georgia, Iowa, Kansas, Maine, Mississippi, Montana, North Carolina, New Hampshire, New Mexico, Ohio, Rhode Island, Vermont, and West Virginia.

submitted and clarifies the evaluation criteria that will be used to select states to participate in the demonstration.

PAMA (P.L. 113-93, 42 U.S.C. 1396a, note), at subsection 223 (d)(4)(A) under which the program is authorized, is explicit that preference must be given to selecting demonstration programs where participating CCBHCs will achieve at least one of the following:

- Provide the most complete scope of services as described in the Criteria to individuals eligible for medical assistance under the state Medicaid program; OR
- Improve availability of, access to, and participation in, services described in subsection Criteria to individuals eligible for medical assistance under the state Medicaid program; OR
- Improve availability of, access to, and participation in assisted outpatient mental health treatment in the state; OR
- Demonstrate the potential to expand available mental health services in a demonstration area and increase the quality of such services without increasing net federal spending.

This guidance is provided to clarify the criteria that federal subject matter experts will use to assess which states are most likely to achieve at least one of the above goal(s) during the demonstration program. Other criteria will be considered such as each state's readiness to participate in the program in terms of meeting the expectations of the planning grant, the state's compliance with the updated CCBHC Criteria[3] and conformance of the state's PPS to the updated PPS Guidance[4].

Planning Grant States must submit applications to participate in the demonstration no later than March 20, 2024, 11:59PM EST. Applications must be submitted by email to CCBHC@samhsa.hhs.gov. States selected to participate in the demonstration program will be announced in June 2024.

[3] The updated criteria, released in March 2023, are available at https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf.
[4] The updated PPS guidance, anticipated to be released by December 31, 2023, will be available at https://www.medicaid.gov/medicaid/financial-management/section-223-demonstration-program-improve-community-mental-health-services/index.html

Components of the Application to Participate in the Section 223 Demonstration Program

Applications to participate in the demonstration program will be assessed on the completeness of the application and the score applied by an objective review of applications. There are three parts to this application: Required Attachments, Program Narrative, and Prospective Payment System Methodology Description. The components are described in greater detail below along with the points assigned for each section in parentheses. The total possible score is 100 for the complete application.

Part 1: Required Attachments

You must include all of the following attachments. Attachment 1 will be scored as described under Part 2, item B.

Attachment 1.	Complete the *Certified Community Behavioral Health Clinic (CCBHC) Criteria Compliance Checklist 2023* according to the guidance included in this application guidance. This single checklist will identify the readiness of the proposed CCBHCs in your state to be compliant with the updated CCBHC Certification Criteria by the proposed start date of your demonstration program. Include the completed checklist as Attachment 1.
Attachment 2	Include a signed statement that verifies that all CCBHCs proposed to be a part of the state's demonstration program will be compliant with the CCBHC Certification Criteria by the proposed start date of the state demonstration program and that, as a part of this, all participating CCBHCs will participate in SAMHSA's treatment locator. The applicant must document that they have provisionally certified at least two CCBHCs in diverse geographic areas including rural and underserved areas. These provisionally certified CCBHCs must substantially meet the criteria and be ready to fully meet the certification criteria by the proposed date of state entry into the demonstration.
Attachment 3.	Include a statement that describes the target Medicaid population(s) to be served under the demonstration program.
Attachment 4.	Include a list of proposed certified community behavioral health clinics including any designated collaborating organizations (DCOs) proposed to work with each CCBHC and what portions of the nine required services they would be providing.
Attachment 5.	Include a signed statement that verifies that the state has agreed to pay for CCBHC services at a rate established under the prospective payment system.

Attachment 6. Include a description of the scope of services required by the state in compliance with CCBHC Criteria, Scope of Services, provided by/through CCHBCs in your state, available under the state Medicaid program, and that will be paid for under one of the selected PPS methodologies tested in the demonstration program. This is meant to be a verification of the scope of services that the state has required in order to comply with the CCBHC Criteria, including any additional services required through state discretion and evidence-based practices.

Attachment 7. Include the SAMHSA Budget Justification form from your state's original application for a Planning Grant for CCBHCs and modify it to project the amount of unexpended funds, if any, and how they will be used after March 30, 2024.

Part 2: Program Narrative

In the Program Narrative, you will describe your state's readiness to participate in the demonstration program and project the impact of participation. The Program Narrative will be scored up to a total of 80 points and may not exceed 30 pages. Each of the sections will be scored as listed below. More detailed guidance is provided in the next section.

A. Solicitation of input by stakeholders in developing CCBHCs (10 points)
B. State Capacity to Support CCBHC and Certification of clinics as CCBHC (30 points)
C. Development of enhanced data collection and reporting capacity (10 points)
D. Participation in the national evaluation (15 points)
E. Projection of the impact of the state's participation in the Demonstration program (15 points)

Part 3: Prospective Payment System Methodology Description

Please complete Part 3 Prospective Payment System Methodology Description, the form that is attached later in this guidance. Part 3 will be scored up to a total of 20 points. Using this form, you will describe the following:

1. CCBHC PPS Rate-Setting Methodology Options
2. Payment to CCBHCs that are FQHCs, Clinics, or Tribal Facilities
3. Cost Reporting and Documentation Requirements
4. Managed Care Considerations
5. CCBHC Claims and Service Level Encounter Detail
6. Funding Questions

Part 2: Program Narrative

In the Program Narrative, you will describe your state's readiness to participate in the demonstration program and project the impact of participation. This part will be scored up to a total of 80 points and may not exceed 30 pages.

A. (10 points – approximately 3 pages) Solicitation of input by stakeholders with respect to the development of such a demonstration program from consumers, family members, providers, tribes, and other key stakeholders. Please provide the following:

- A description of the steering committee or use of an existing committee, council, or process composed of relevant state agencies, providers, service recipients, and other key stakeholders to guide and provide input throughout the grant period.
- A description of the outreach, recruitment, and engagement of the population of focus including adults with serious mental illness and children with serious emotional disturbances and their families, and those with long term serious substance use disorders, as well as others with mental illness and substance use disorders in the solicitation of input.
- A description of the coordination with other local, state, and federal agencies and tribes to ensure that services are accessible and available.

B. (30 points – approximately 11 pages) State capacity to support CCBHCs and certification of CCBHCs for purposes of participating in a demonstration program, using the updated CCBHC criteria. Reviewers will examine the state's submission of the *CCBHC Criteria Compliance Checklist 2023* attachment (https://www.samhsa.gov/sites/default/files/ccbhc-compliance-checklist.pdf). This compliance checklist includes the updated criteria required for the CCBHCs and their Designated Collaborating Organizations (DCOs) which together form the CCBHC. For each of the criteria on the checklist, please indicate the number of clinics in your state that fall within each of the following categories:

1. Ready to implement
    - The CCHBC fully satisfies all elements under this Program Requirement Criteria.
2. Mostly ready to implement
    - The CCBHC satisfies almost all elements under this Program Requirement Criteria although some minor adjustments are currently in process to fully satisfy. The CCBHC has a plan to come into compliance within the required timeframe.

3. Ready to implement with remediation

    - The CCBHC satisfies some elements but must make significant improvements in other elements to fully satisfy this Program Requirement Criteria. The CCBHC is responsive to implementing the needed changes and has begun to do so. The CCBHC has a plan to come into compliance within the required timeframe.

4. Unready to implement

    - The CCBHC has not demonstrated capacity to meet the elements under this Program Requirement Criteria and will be unable to come into compliance within the required timeframe.

In addition, please provide the following:

- A description of the state's current readiness and history implementing the CCBHC program, including any current CCHBC Expansion grants in the state as well as the efforts to support the CCBHC Demonstration program; CCBHC initiatives under Medicaid state plan or waiver; any support of CCBHCs through other funding sources managed by the State; and the State's capacity and infrastructure established to support the CCHBC Demonstration program in areas such as certification, technical assistance, data systems, and payment.
- A description of the selection processes and review procedures that you used to select and certify clinics as CCBHCs that demonstrates attention to quality of care, access and availability of services.
- A description of the diversity of CCBHCs including geographic area, population density, underserved areas or other data. Cite documentation, including medically underserved area (MUA) designations, that at least one CCBHC is located in a rural and/or underserved area. Include a description of how the state and CCBHCs will address disparities, including systematic processes that have been established to ensure under-served/historically marginalized populations, including Black, Latino, Hispanic, and Indigenous and Native American persons, Asian Americans and Pacific Islanders, and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversity affected by persistent poverty or inequity, have access to high-quality healthcare.
- A description of how the state has worked with selected CCBHCs to improve the delivery of high-quality behavioral healthcare, such as support for evidence-based practices, workforce development, development of interdepartmental partnerships, recovery-oriented and trauma-informed models of care, and other related areas as well as a description of plans to continue support CCBHCs in these areas as a part of the demonstration program.

- A description of how CCBHCs will be working with other community organizations, including the 988 Suicide & Crisis Lifeline, and state mental health and substance use crisis response systems.
- A description of how the CCBHC needs assessments have been used to identify behavioral health needs and resources in the service areas of included CCBHCs across the lifespan, to include the impact the CCBHC needs assessment will have on staffing, language and culture, services, locations, service hours, and evidence-based practices, while identifying and addressing barriers and increasing access to healthcare.
- A description and justification of the evidence-based practices[5] that the state has required
- For each proposed CCBHC, provide the definition of the CCBHC service area using recognized geographic boundaries, such as municipal or county borders, zip codes, or census tracts.
- A description of the guidance to CCBHCs regarding the CCBHCs organization governance that ensures meaningful input by consumers, persons in recovery, and family members.
- A description of any other areas that the state is exercising their discretion to place additional requirements that go beyond the minimum expectations set in the CCBHC criteria, using the State Discretion Guidance.
- A description of the planned process for bringing additional CCBHCs into the State CCBHC Demonstration program over time, if the state is planning to add additional CCBHCs over the course of the 4-year demonstration program (note: states may describe a process without identifying specific CCBHCs).

C. (10 points – approximately 4 pages) Development of enhanced data collection and reporting capacity. Please provide the following:

- A description of the ways in which the state and CCBHCs have developed or enhanced data collection and reporting capacity in support of meeting PPS requirements, quality reporting requirements, and demonstration evaluation reporting requirements listed under Criteria Program Requirement 5: Quality and Other Reporting in the Criteria.
- A description of the designed or modified and implemented data collection and reporting systems-including but not limited to registries or electronic health record functionality that report on access, quality, scope of services, and costs and reimbursement for behavioral health services. A description of how the state assisted CCBHCs with preparing to use data to inform and support continuous quality improvement processes within CCBHCs, including fidelity to evidence-based practices, and person-centered, and recovery-oriented care during

[5] For more information about evidence-based practices for mental and substance use conditions, please visit the SAMHSA Evidence-Based Practices Resource Center: https://www.samhsa.gov/resource-search/ebp

demonstration. A description of how the state plans or has developed processes by which it can provide timely input to CCBHCs on interim results of stated-collected quality measures.

- A description of how the state will work with CCBHCs to ensure that the CCBHCs are billing for CCBHC services correctly using the federal CCBHC, or state developed demonstration billing codes, in a way that results in proper payment of the PPS and captures service level detail of CCBHC services delivered under the claim.
- A description of the format of all data described in this section and when and how evaluators will be able to access this data.

D. (15 points – approximately 6 pages) Participation in the national evaluation of the Demonstration Program. Please provide the following:

- A description of the capacity and willingness to assist HHS to access data related to the cost, quality, and scope of services provided by CCBHCs and the impact of the demonstration programs on the federal and state costs for a full range of mental health and substance abuse services (including inpatient, emergency, and ambulatory services paid for through sources other than the demonstration program funding).
- A summary of discussions with the federal evaluation planning team regarding the selection of an appropriate comparison group for an assessment of access, quality, and scope of services available to Medicaid enrollees served by CCBHCs.
- The status of requests or planned requests for an Institutional Review Board's approval to collect and report on process and outcome data (as applicable and necessary).

E. (15 points – approximately 6 pages) Project the impact of the state's participation in the Demonstration program. Please project the impact of CCBHCs in your state to achieve at least one of the goals listed below during the four-year demonstration program. Use the following guidance to develop your narrative.

- Select one or more goals from the four listed below to project the impact of CCBHCs in your state. Explain the process by which you selected the goal(s) and why it is important to your state and CCBHC communities. Include a description of the impact from established State CCBHC efforts, if applicable.
- List specific measures, selected from CCBHC Criteria: Appendix B, that will show the impact on the population served by CCBHCs over the four-year demonstration program period.[6] Explain how these measures are related to the goal(s) selected.
- Provide baseline data on selected measures from the planning grant period.

[6] CCBHC Criteria - Appendix B: https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

- Describe your plan for data collection, documentation, tracking of outcomes, and analysis to measure progress in achieving the outcome.
- Using the selected measures, project the impact on the target population from baseline to the completion of the demonstration program and justify your projections. Include any data that was collected based on State CCBHC efforts already implemented on the target population, if applicable.

  Goal 1. Provide the most complete scope of services required in the CCBHC Criteria to individuals who are eligible for medical assistance under the state Medicaid program.

  Goal 2. Improve availability of, access to, and participation in, services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program.

  Goal 3. Improve availability of, access to, and participation in assisted outpatient mental health treatment in the state.

  Goal 4. Demonstrate the potential to expand available mental health services in a demonstration area and increase quality of such services without increasing net federal spending.

A: The Iowa Department of Health and Human Services (Iowa HHS), in the development of its Certified Community Behavioral Health Clinic (CCBHC) demonstration program, sought regular and ongoing feedback from behavioral health (BH) system stakeholders. Iowa HHS premised its stakeholder input efforts on bidirectional and iterative feedback, where Iowa HHS informed BH system stakeholders about the CCBHC initiative so that they were empowered to make recommendations that informed our CCBHC planning work. Our stakeholder process harnessed collaboration and collective decision-making to ensure the CCBHC demonstration reflects a broad perspective that emphasizes our populations of focus (POF), including individuals with serious mental illness (SMI), substance use disorders (SUD), serious emotional disturbance (SED), historically underserved populations (including, black, indigenous, and other people of color [BIPOC], Native American and tribal populations, and individuals identifying as LGBTQIA+, pregnant and parenting persons, and Veterans.

Iowa HHS' CCBHC Demonstration Planning was Bolstered by Iowa's BH System Alignment Work. Effective July 1, 2023, Iowa state agencies overseeing Aging and Disability, Mental Health (MH), Substance Use and Addiction, Community Access, Family Well-Being and Protection, and Public Health are now aligned in a single state agency: Iowa HHS. This system alignment ensures that the CCBHC initiative is built on the foundation of a single agency responsible for Iowans' holistic health and well-being. Iowa HHS is currently undertaking additional efforts to centralize BH authority in Iowa, including a central point of funding and authority to align incentives and improve access and outcomes at the local level for Iowans with BH needs. Iowa HHS' leadership is committed to maximizing this alignment as evidenced by our CCBHC demonstration planning work, which has benefited from this unified structure by leveraging shared, integrated decision-making that contemplates the needs of all Iowans with mild, moderate, and severe MH and SUD needs.

Iowa HHS' CCBHC Stakeholder Engagement and Planning Committees were broadly inclusive and were empaneled with diverse and representative membership. Each had a mission and charter that defined objectives, authority, and processes regarding CCBHC demonstration planning activities. Upon receipt of its CCBHC Planning Grant from the Substance Abuse and Mental Health Administration (SAMHSA) in March 2023, Iowa HHS convened the **Iowa HHS CCBHC Steering Committee (Steering Committee)** comprised of Iowa HHS leadership, including representatives from Medicaid, Provider Licensure and Accreditation, BH divisional leads who oversee MH, Substance Use Prevention, Treatment and Recovery (SUPTR), and crisis services (including 988). Their mission is to provide overall guidance and leadership to Iowa's CCBHC demonstration program planning and to ensure the transformational opportunity presented by maximizing the CCBHC rollout on behalf of Iowans with BH needs. The Steering Committee is responsible for integrating its CCBHC planning work into the broader Iowa BH system alignment efforts to improve access and outcomes for all Iowans, including:

- The development and implementation of provider certification, including standards, selection criteria, oversight and auditing mechanisms, and State-specific program requirements.
- Cost reporting and Prospective Payment System (PPS) rate-setting activities, billing, and technical guidance associated managed care policies, and contractual requirements.
- The development of outcomes, reporting expectations, and statewide goals.

The **HHS CCBHC Leadership Committee** is the Steering Committee's executive sponsor and conduit to elected leadership. Figure 1 includes Leadership and Steering Committee members.

Figure 1. Iowa CCBHC HHS CCBHC Leadership and Steering Committee Members

Iowa HHS CCBHC Steering Committee	
Theresa Armstrong, Director, Operations and Compliance, Behavioral Health Division	Rebecca Curtiss, Deputy Director of Operations, Iowa Medicaid
DeAnn Decker, Director, Service, Planning and Performance, Behavioral Health Division	Jenny Erdman, Bureau Chief, Quality and Innovation and Medicaid Policy
Laura Larkin*, CCBHC Project Director, Behavioral Health Division	Hannah Olson, BH & SUD Policy Specialist, Medicaid
Clay Gemmill*, CCBHC Certification Specialist, Behavioral Health Division	Julie Maas, Suicide Prevention and 988 Director, Behavioral Health Division
Wendy DePhillips*, CCBHC Project Coordinator, Behavioral Health Division	Michele Tilotta, Provider Accreditation Specialist, Behavioral Health Division
Natalie Sipes, Program Manager, Office of the Chief Information Officer	Jerilyn Oshel, Director of Operations, Behavioral Health Division
Justin Edwards, SUPTRS Block Grant Manager, Behavioral Health Division	Emily Eppens, Behavioral Health Communications Manager
Jennifer Robertson-Hill, Director of Prevention, Treatment and Recovery Services, Behavioral Health Division	Gloria Symons, Program Planner, Behavioral Health Division (CCBHC Contract Manager)
Kevin Gabbert, Opioid Initiatives Director, Behavioral Health Division	
**Indicates staff dedicated to HHS' CCBHC demonstration program planning activities*	
Iowa HHS CCBHC Leadership Committee	
Kelly Garcia, Iowa Department of HHS Director	
Elizabeth Matney, HHS Deputy Director and Director, Iowa Medicaid and Division of Administration	
Marissa Eyanson, Behavioral Health Director	
Robert Kruse, MD, MPH, FAAFP, State Medical Director	

The Steering Committee, as part of its CCBHC demonstration planning responsibilities, convened the **Iowa CCBHC Stakeholder Committee (Stakeholder Committee)** in May 2023. The Stakeholder Committee's mission is to ensure the CCBHC initiative is informed by a representative and diverse group of stakeholders who have meaningful and routine input into the design of Iowa's CCBHC initiative. Stakeholders include Iowans with lived experience of the BH system and family members of Iowans with lived experience, community-based BH providers (including CCBHC expansion grantees), representatives from the BH and 988 crisis system, local BH authorities (Mental Health and Disability Services [MHDS] regions), peer-based workforce, consumer advocates, tribal representation, and law enforcement. There are 23 committee members, a third of whom have identified themselves as individuals or family members of persons with lived experience. The CCBHC Stakeholder Committee has met regularly throughout Iowa HHS' CCBHC planning efforts and was tasked with:

- identifying existing gaps in care that should be prioritized through the CCBHC initiative.
- identifying provider training and technical assistance needs.
- participating in a series of regional community forums for interested stakeholders to ensure community input into the CCBHC initiative.
- developing the CCBHC Listserv to ensure broad stakeholder coverage; and
- helping to establish the CCBHC initiative goals as detailed below.

Stakeholder Committee members (listed in Figure 2) discussed CCBHC requirements, certification processes, infrastructure needs, quality strategies, and payment models for developing and refining Iowa's CCBHC demonstration program. The Stakeholder Committee was also instrumental in identifying opportunities for broader CCBHC education opportunities across the state.

In collaboration with Iowa HHS, they participated in several committee and board meetings to elicit additional feedback, including State town halls, Medicaid Iowa HHS Council sessions, Children's Behavioral Health State Board meetings, and the Mental Health Planning Council.

Figure 2. Iowa CCBHC Stakeholder Committee Members

CCBHC Stakeholder Committee Member	Stakeholder Type
Andrew Allen, Youth Shelter Services (YSS)	BH Provider
Emily Blomme, Foundation 2 Crisis Services	988/Crisis Provider
Samantha Cannon, Iowa Primary Care Association	Advocate
Leslie Carpenter, Iowa Mental Health Advocacy	Advocate, Family Member*
Rod Courtney, Community Resources United to Spread Hope (CRUSH) of Iowa Recovery Community Center	Advocate, Family Member*
Mae Hingtgen, MHDS of East Central Region	Local BH Authority
Peggy Huppert, NAMI Iowa	Advocate*
Todd Jacobus, Iowa Department of Veterans Affairs	Veterans Services*
Chad Jensen, New Opportunities	BH Provider
Kathy Johnson, Abbe Center	BH Provider, CCBHC Expansion Grantee
Reed Kious, Marion County Sheriff's Office	Law Enforcement
Devon McClurken, Iowa Office of Recovery Services	Advocate, LGBTQIA+ Provider*
Sarah Nelson, CommUnity Crisis Services	988/Crisis Provider
Mary O'Neil, Heartland Family Service	BH Provider, CCBHC Expansion Grantee
Rudy Papkee, Meskawki Tribal Health Clinic *(invited)*	Tribal Services*
Jen Pearson, UCS Healthcare	BH, LGBTQIA+ Medical Provider*
Rebecca Peterson, Lantis Enterprises	BH, Pregnant/Parenting Provider*
Christine Ross, Iowa HHS Bureau of Refugee Services	Refugee Services*
Laura Semprini	Person with Lived Experience*
Cynthia Steidl-Bishop, Eyerly Ball	BH Provider, CCBHC Expansion Grantee
Lauren Vorwald	Person with Lived Experience*
Rich Whitaker, Vera French Mental Health Center	BH Provider
Cindy West	Person with Lived Experience*
**Indicates representative of demonstration program's population of focus*	

Outreach, Recruitment, and Engagement with the POF has been a priority for Iowa HHS. Iowa HHS invested significant effort in implementing a comprehensive outreach, recruitment, and engagement approach with our POF. Iowa HHS leveraged our partnerships with community- based organizations (CBOs), MH agencies, SUD treatment agencies, schools, peer support specialists, individuals with lived experiences, and advocates to maximize outreach efficacy. In partnership with the Stakeholder Committee, Iowa HHS organized twelve CCBHC focus groups that offered communities information about the

Figure 3. Role of Focus Group Participants	
Persons with lived experience	15%
Family member of person with lived experience	14%
Community member	25%
BH Provider	49%
Advocate	15%
Tribal member	1%
Other stakeholder	36%

CCBHC initiative, gathered stakeholder input, and addressed questions and concerns. Ten focus groups were hybrid (in-person with a virtual option), and two were virtual.

The in-person focus groups were held in communities with broad geographic (rural, suburban, and urban) representation. Focus groups were observed by Iowa's CCBHC Planning Grant contracted evaluator, the University of Northern Iowa Center for Social & Behavioral Research (CSBR). CSBR developed a demographic profile of focus group attendees to ensure feedback gathered was from a representative sample of the POF (illustrated in Figure 3). Approximately one-third of focus group participants identified as a person with lived experience or a family member of a person with lived experience. The focus group identified opportunities where the CCBHC initiative could support improved access to BH services, particularly for specific groups, including the LGBTQ+ community, older adults, rural residents, individuals diagnosed with severe MH conditions, and individuals with intellectual disabilities. Focus group participants highlighted concerns about service access, waiting periods, and the role of health-related social needs (i.e., housing insecurity and transportation challenges) in compounding difficulties for individuals with BH needs.

Iowa HHS Coordinated with other Local, State, and Federal Agencies and Tribes. Due to the holistic and integrated nature of Iowa HHS, our core CCBHC planning team encompassed agencies responsible for Aging and Disability, Mental Health, Substance Use and Addiction, Community Access, Family Well-Being and Protection, and Public Health. Importantly, Iowa's Medicaid fiscal leadership was at the forefront of these planning efforts from the outset to ensure an aligned and fiscally prudent approach to our demonstration planning activities, including rate-setting activities and collaboration with Iowa's Medicaid Managed Care partners: Iowa Total Care, Molina Healthcare of Iowa, and Wellpoint Iowa, Inc.

Iowa HHS prioritized including critical interagency government partners connected to our POF, particularly The Iowa Department of Veterans Affairs and the Iowa Bureau of Refugee Services (BRS). The *Bureau Chief/Director* for BRS and Iowa's Refugee Health Coordinator regularly participated in CCBHC Stakeholder meetings and contributed on behalf of refugee BH needs in Iowa. Iowa HHS also included the Executive Director of the Iowa Department of Veterans Affairs and Commandant of the Iowa Veterans Home as partners in our CCBHC Stakeholder Committee. Iowa HHS made significant efforts to outreach to tribal representatives in Iowa, particularly the Meskwaki Nation, who expressed interest in participating in our CCBHC stakeholder efforts. We will continue to deepen these partnerships throughout the demonstration period.

Iowa's MHDS regional representatives have also been instrumental voices at the local governmental level to inform our CCBHC demonstration planning efforts, particularly with respect to our BH crisis system and 988 integration efforts.

Our CCBHC Project Director, Laura Larkin, has maintained regular contact with SAMHSA throughout the planning grant period to advise and seek feedback on Iowa HHS's CCBHC planning activities. Iowa HHS has also participated in SAMHSA's technical assistance sessions.

B: Provided as Attachment 1, Iowa HHS has completed the *CCBHC Criteria Checklist,* which captures the readiness of the proposed CCBHCs in Iowa that are compliant with updated CCBHC Certification Criteria, for Iowa's CCBHC Demonstration Year 1 (DY1) starting July 1,

2024. In summary, nine provider organizations have been provisionally certified by Iowa HHS as a CCBHC for the Iowa CCBHC Demonstration in DY1:

Figure 4. CCBHC Readiness Category for Eligible Clinics

Readiness Category	Number of Clinics
Ready To Implement	1
Mostly Ready to Implement	6
Ready to Implement with Remediation	2
Unready to Implement	1 (will work toward participation in DY2 – 7/1/25)

Iowa's Commitment to CCBHC Implementation and Readiness. Iowa HHS' path to successfully implementing the CCBHC demonstration is marked by a strategic and intentional progression in expanding access to community based BH services throughout the State. In 2016, Iowa HHS was awarded a CCBHC planning grant as part of SAMHA's original CCBHC demonstration opportunity for States. Iowa HHS' initial planning grant enabled technical assistance and training, emphasizing Evidence-Based Practice (EBPs), which yielded important improvements and capacity development in our community based BH care system. Since 2016, Iowa has continued its efforts to support the CCBHC initiative, particularly through our 15 CCBHC expansion grantees who have successfully applied to SAMHSA since 2018. These grantees have laid important groundwork for Iowa's demonstration planning efforts and adherence to SAMHSA's certification criteria. Iowa HHS has allocated Mental Health Block Grant funds to Community Mental Health Centers to support emerging CCBHCs in Iowa by providing them with technical assistance and facilitating their use of the statewide learning management system for CCBHC training and technical assistance. This funding initiative provides CCBHC expansion grantees with resources to enhance their operational capabilities and support the integration of their work into Iowa's broader BH system of care. In 2020, Iowa also convened a CCBHC Community of Practice with the state's CCBHC Expansion grantees to identify the specific needs of CCBHCs in Iowa, assess their progress in developing capacity under the expansion grant opportunity, and identify opportunities to leverage their grant-funded work on behalf of Iowans. Iowa HHS' ongoing commitment to the CCBHC model and readiness to participate in the demonstration resulted in being awarded a second CCBHC planning grant in 2023.

CCBHC Technical Assistance and Provider Capacity Development. Following the 2023 planning grant award, Iowa HHS strategized its CCBHC demonstration planning activities to deliver targeted technical assistance and capacity development to equip providers with the tools necessary to meet the CCBHC requirements and enable participation in the demonstration.

Iowa HHS kicked this activity off by conducting a baseline provider CCBHC readiness assessment. This survey enabled providers to formally assess their readiness against SAMHSA's updated CCBHC Certification Criteria and also gave providers a vehicle to express their initial interest in participating in Iowa's CCBHC demonstration. 22 provider organizations completed the assessment, covering all geographic areas and BH outpatient services types in Iowa. Based on the

assessment findings, Iowa HHS developed a technical assistance curriculum for prospective CCBHC providers and their intended Designated Collaborative Organizations (DCOs).

Figure 5. Initial CCBHC Readiness Assessment Results

CCBHC Criteria Domain	Level of Initial Readiness
Care Management, Wraparound, and Outreach	92%
Training and EBPs	91%
Quality and Compliance	89%
Treatment and Service Planning	89%
Community Needs	87%
Health Information Technology and Exchange	85%
Culturally and Linguistically Appropriate Services	84%
Staffing	81%
DCOs	81%
Consumer and Family Voice (Governance)	80%
Required Services and Access Standards	79%
Primary Care Screening	77%
Veteran Services	77%

An array of live and recorded webinar sessions for on-demand reference covered a comprehensive set of topics critical to the demonstration's success, including a deep dive into CCBHC certification criteria and requirements, including: CLAS Standards and the facets of Culturally Responsive Care, processes for developing a compliant Community Needs Assessments and staffing plan, and best practices for addressing the needs of Iowa's POF, including specific sessions on BH needs of veterans, older adults, pregnant and parenting persons, and children. Additionally, training sessions were held on Iowa-specific CCBHC expectations, cost reporting, and rate-setting activities, and best practices for providing integrated MH/SUD care and crisis services.

Once Iowa HHS identified its initial cohort of providers eligible for CCBHC certification (the process for identifying this initial cohort is detailed further below), one-on-one technical assistance was provided. Each initially selected provider received consultative support to enhance their capacity related to specific demonstration implementation activities, including processes for partnering with DCOs, data collection and quality reporting capabilities, staffing considerations, cost report development, crisis service planning, and governance structures (including the establishment of Consumer Advisory Boards).

Iowa's Process for Certifying CCBHCs for Participation in its Demonstration. Using input from our stakeholder engagement efforts and provider capacity development activities, Iowa HHS developed a competitive CCBHC application process and rigorous review procedure to identify an initial cohort of eligible providers, ensuring a focus on compliance with all 113 federal CCBHC standards and State-specific requirements. The CCBHC Request for Proposal (RFP) process was designed to be inclusive, allowing qualified provider applicants from any county to apply, provided they met specific eligibility criteria and thresholds. These criteria included current accreditation and licensure as an MH and SUD provider, nonprofit status, and at least two years of experience as an accredited or licensed BH provider in Iowa. Tribal health organizations, clinics, or health centers were also eligible applicants.

Applicants were required to demonstrate sufficient service capacity by proposing a service area with at least three counties and a minimum of 12,000 Medicaid enrollees. Preference was given to applicants proposing to serve high-need counties. To identify high-need counties, Iowa HHS formulated risk score criteria incorporating a composite score assessing Medicaid enrollment volume, drug overdose death rate, suicide death rate, and whether the county is rural based on the U.S. Office of Management and Budget's Metropolitan County definition. Counties in the top 20%

based on this composite risk score were classified as high risk. Bidders were also required to demonstrate proven community partnerships with key stakeholders in their proposed service areas, as evidenced by letters of support. The RFP required respondents to share demographic information on the site for which they were seeking CCBHC certification, including the current scope of MH and SUD services and supports for adults and children and their experience serving individuals included in Iowa HHS' POF.

Organizations were also required to provide in their RFP response their current (1) EBPs, including their training and fidelity monitoring plan; (2) continuous quality improvement processes and strategies for using data to improve program outcomes; (3) system for data collection and reporting, including Electronic Health Record (EHR) functionality and experience sharing data with the Iowa Behavioral Health Reporting System (IBHRS) – the statewide BH data collection system identified for Iowa HHS' CCBHC demonstration reporting and evaluation activities; (4) experience with cost reporting and other relevant fiscal and accounting practices that support revenue and expense forecasting; and (5) process for engaging their governance and individuals with lived experience in their CCBHC certification planning activities. Each RFP respondent also submitted a CCBHC implementation plan outlining how they would meet certification criteria with a corresponding timeline and their historic MH and SUD service volumes, broken down by age. The RFP was released in September 2023. Ten successful bidders progressed to Iowa HHS' CCBHC certification process, which entailed several additional deliverables: (1) completion of a compliant CCBHC CNA for the proposed service area; (2) submission of a CCBHC cost report; (3) participation in Iowa HHS-mandated technical assistance; (4) participation in a mandatory Iowa HHS site- visit; (5) a completed criteria assessment facilitated by an independent national accrediting organization; and (6) successful transmission of sample data to IBHRS.

All CCBHC certification steps are required to be complete by June 1, 2024, to achieve full certification for participation in the demonstration for DY1. Providers who have successfully completed steps 1-4 and demonstrated substantial compliance with the CCBHC criteria have been provisionally certified as a CCBHC for this application. Step 5 will be completed prior to full certification and step 6 will be required prior to measurement year 1. Each CCBHC certification step is detailed and defined in Figure 6. Provisionally certified CCBHCs are required to address any remediation plan identified by Iowa HHS before achieving full CCBHC certification for DY1 (July 1, 2024). Any provider that fails to complete all required certification activities to Iowa HHS' satisfaction will participate in the Demonstration no earlier than DY2 (July 1, 2025). Iowa HHS has committed to additional TA and capacity development to support providers who fail to meet all certification criteria by DY1 to support their participation in DY2.

Leveraging Independent Accrediting Organizations in CCBHC Certification Process

A defining feature of Iowa HHS' strategy for CCBHC certification was its collaboration with national, independent accrediting organizations, including the Commission on Accreditation of Rehabilitation Facilities (CARF), Social Current (formerly Council on Accreditation), and the Joint Commission. These collaborations were initiated to support thorough CCBHC criteria compliance assessments for the selected CCBHC Demonstration Providers. Iowa HHS outreached and met with each accrediting organization during the summer of 2023 to identify an approach and

process to connect the initial cohort of providers with an accreditor to conduct a rigorous compliance review to ensure they are fully compliant with all CCBHC criteria.

This component of our certification process ensures adherence to the high standards necessary for CCBHCs and exemplifies Iowa HHS' unwavering dedication to setting a precedent of excellence in its CCBHC implementation work.

This initiative is not just about meeting present requirements; it is about laying the groundwork for a sustainable model. Iowa HHS' investment in a comprehensive CCBHC certification process underscores a commitment to creating a resilient, quality-centered BH system prepared to meet evolving needs and maintain the highest levels of care for years to come.

Figure 6. Iowa HHS CCBHC Certification Requirements

Certification Element	Description
Community Needs Assessment (CNA)	Selected applicants were required to submit a CNA that was used to inform its CCBHC service plan and delivery, outreach and engagement strategies, staffing, and interventions, including EBPs. The CNA must identify the need for CCBHC services, provide quantitative and qualitative justification for the need, and recommended actions to address the need. Required components included: service area description, population description, MH and SUD prevalence data, social determinants of health and economic factors, service needs and gaps, stakeholder and partner input, description of plans to update the CNA every 3-years, and alignment with the CCBHC staffing plan and accessibility standards. CNAs were reviewed for compliance and if not complete, CCBHCs were directed to revise CNAs prior to being provisionally certified for the CCBHC demonstration.
Cost Report Submission	Selected applications were required to submit a PPS-1 cost report, detailing their current and anticipated costs for delivering CCBHC services and their project number of total visits. In addition to submitting the standard CMS' cost report schedule, providers were required to submit supporting documentation outlining cost report assumptions, including staffing and anticipated capacity. Providers were also required to share their anticipated costs related to mobile crisis services to support Iowa's consideration of PPS-3 in the future.
Participation in HHS-mandated TA	CCBHC applicants were required to participate in CCBHC technical assistance sessions plus one-to-one assistance sessions. All of our selected CCBHCs demonstrated their commitment to excellence by attending all mandated technical assistance training sessions, with only one organization missing the initial state orientation session as they onboarded to the program.
Site Audits	The Iowa HHS site audit protocol included a review of policies regarding triage, crisis stabilization, mobile crisis and other crisis services, outreach and engagement, specialty populations, and quality improvement. The site audit protocol also included discussion of CCBHC requirements including crisis services, service integration, the CCBHC's CNA and approach to CLAS standards, and the board composition and vehicle for including persons with lived experience in organizational decision making. Iowa HHS also conducted a physical walk-through of the CCBHC clinic space to review the clinic environment, signage, Americans Disability Act compliance, and accessibility.
CCBHC Criteria Assessment by National Accrediting Body	Iowa was the first state to reach out to independent, national accrediting bodies to collaborate on conducting a CCBHC criteria assessment as part of its CCBHC certification approach. CARF, Social Current and the Joint Commission all agreed to partner with Iowa HHS and support this CCBHC criteria assessment for selected applicants. Any provider that fails the national accreditor Criteria Assessment would have 30 days to implement a corrective action plan to reach compliance. One provider in Iowa has completed this assessment successfully. Additional providers who have been provisionally certified are scheduled for their criteria assessment reviews between April and June of 2024.

Data submission to IBHRS	Providers will need to demonstrate the ability to upload required client data to the Iowa Behavioral Health Reporting System (IBHRS) via XML format. Iowa's technological enhancements to the IBHRS system will significantly broaden its capacity to capture and monitor various demographic variables for clients, encompassing factors such as race, ethnicity, gender, marital status, insurance status, and employment status. IBHRS will incorporate comprehensive BH information, including diagnoses, assessment details, substance use patterns (including age at onset and frequency), and all necessary data for calculating clinic-collected measures. Iowa will access Medicaid claims, identifying services provided, costs, reimbursements, and more via the Medicaid Management Information System (MMIS). CCBHC providers must submit claims using the T1040 code and designate the CCBHC provider type for both threshold and shadow claims.

Ensuring Diversity of CCBHCs in Iowa. Iowa's selection of CCBHCs for its demonstration program is set to extend essential services across a significant portion of the state, encompassing 63 of the 99 counties. This expansive reach includes 55 of Iowa's 80 rural counties, ensuring that rural areas receive much-needed BH access improvements. Of these counties, 48 are recognized by the Health Resources and Services Administration (HRSA) as of January 2024 as whole-county MH professional shortage areas (HPSAs), with an additional five counties having partial HPSA designations. Notably, CCBHCs will provide services to 12 of the 20 counties identified as high need by Iowa HHS, addressing urgent needs in locations with acute BH-related challenges. This strategic alignment of CCBHC locations with high-need areas underscores Iowa's commitment to addressing disparities in access to quality MH care, particularly in underserved and rural communities.

Abbe Center for Community Mental Health is poised to serve a six-county region in eastern Iowa with a collective population of 455,864, including four rural counties. Within this service area, 72,863 individuals are enrolled in Medicaid. One of these counties is designated as a whole-county MH professional shortage area, while two others are recognized as partial shortage areas. Additionally, Iowa HHS has identified two counties within Abbe Center's service area as high need.

North Central Iowa Mental Health Center (Berryhill Center) will serve a four-county region in north central Iowa with a collective population of 69,009, all of which are rural. Within this service area, 15,593 individuals are enrolled in Medicaid. All counties hold the designation of a whole-county MH professional shortage area. Additionally, Iowa HHS has identified three counties within the service area as high-need.

Eyerly-Ball Community Mental Health Services will serve a four-county region in central Iowa with a collective population of 658,952, including one rural county. Within this service area, 119,283 individuals are enrolled in Medicaid. Two counties hold the designation as a whole-county MH professional shortage area, while one other is recognized as a partial shortage area. Additionally, Iowa HHS has identified one of the counties within the service area as high need.

Heartland Family Service will serve a nine-county region in southwestern Iowa with a collective population of 185,561, of which eight are rural. Within this service area, 40,885 individuals are enrolled in Medicaid. Six counties are designated as a whole-county MH professional shortage area, while one other is recognized as a partial shortage area. Additionally, Iowa HHS has identified two counties within the service area as high need.

Pathways Behavioral Services will serve a six-county region in northeastern Iowa with a collective population of 213,570, five of which are rural. Within this service area, 42,023 individuals are enrolled in Medicaid. All counties hold the designation of a whole-county MH professional shortage area. Additionally, Iowa HHS has identified one county within the service area as high need.

Plains Area Mental Health Center will serve an eight-county region in northwestern Iowa with a collective population of 117,475, all of which are rural. Within this service area, 24,816 individuals are enrolled in Medicaid. All counties hold the designation of a whole-county MH professional shortage area. None of the counties within their proposed service area are high need.

Prairie Ridge Integrated Behavioral Healthcare will serve a thirteen-county region in north-central Iowa with a collective population of 225,230, all of which are rural. Within this service area, 45,996 individuals are enrolled in Medicaid. Ten counties hold the designation of a whole-county MH professional shortage area. Two of the counties within their proposed service area are high need.

Robert Young Center will serve a five-county region in eastern Iowa with a collective population of 298,851, four of which are rural. Within this service area, 62,074 individuals are enrolled in Medicaid. Three counties hold the designation as a whole-county MH professional shortage area, while one other is recognized as a partial shortage area. Additionally, Iowa HHS has identified one county within the service area as high need.

Northwest Iowa Mental Health Center (Seasons Center) will serve an eight-county region in northwestern Iowa with a collective population of 118,737, in which all counties are rural. Within this service area, there are 21,529 individuals enrolled in Medicaid. All counties hold the designation as a whole-county MH professional shortage area. Iowa HHS has identified none of the counties within the service area as high need.

Ensuring Certified CCBHCs Address Disparities Faced by Under-Served/Historically Marginalized Populations. Iowa HHS is committed to ensuring access to culturally competent CCBHC services for members of historically underserved and marginalized groups, as well as members of groups experiencing poor BH outcomes, including our POF. Iowa HHS' certification approach has emphasized the importance of integrated BH care for all populations, including individuals with complex diagnoses. Iowa HHS, consistent with the disparity impact statement submitted to SAMHSA, plans to meet the following CLAS standards through its CCBHC planning activities in preparation for our demonstration:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

CCBHCs, in their contract with Iowa HHS and as a condition of participation in the demonstration, are responsible for serving the needs of the whole of their service area, with the expectation that they develop culturally responsive and congruent services. Iowa HHS will monitor this by reviewing CNAs, staffing plans, demographic data collected by CCBHCs, and outcome measures stratified by race and ethnicity. As part of its review, Iowa HHS assessed to what degree the provisionally certified CCBHCs solicited diverse and representative stakeholder feedback from BH stakeholders in their service area as part of the development of their CNA. As part of its certification process, Iowa HHS reviewed and provided feedback on CCBHC CNAs to ensure that their service area needs assessment reflected diverse populations and the related staffing plan reflected the findings included in the CNA.

Provisionally certified CCBHCs in their CNAs and related staffing plans have identified strategies to ensure diverse recruitment activities, including hiring fluent, culturally responsive, and congruent staff aligned to the needs of the population, including bilingual staff in Spanish, Swahili, Marshallese, Kirundi, and other languages spoken by individuals they serve. Where they are unable to hire bilingual staff directly, CCBHCs have identified investing in technological resources including: (1) real time translation software to limit reliance on the use of translation services and (2) software that will translate forms and documents in clients preferred language. Certified CCBHCs are also broadening CLAS and DEI training requirements for all staff, with focused trainings on strategies to engage the POF.

CCBHCs are also required to enhance their outreach, engagement, care management, treatment, and peer support services. To support CCBHCs efforts in serving under-served and historically marginalized populations, Iowa HHS has deployed technical assistance to support provider compliance with cultural and linguistic competence requirements under the CCBHC demonstration, aligned with Iowa HHS' commitment to CLAS standards. This technical assistance will continue during the demonstration period.

Iowa HHS will also ensure that the IBHRS data reporting system gathers and provides reports on key demographics, allowing evaluation of the CCBHC's effectiveness in providing services to the statewide POF and populations specific to their service area. This will be an ongoing activity throughout the demonstration period.

Supporting CCBHCs to Provide High-Quality BH Services, including EBPs and Workforce. Iowa HHS has actively collaborated with providers to fortify the delivery of BH within the CCBHC framework under the demonstration. This preparation was initiated with our statewide readiness survey, which was used to inform the development of a technical assistance and capacity development plan. TA delivered by Iowa HHS included targeted trainings on the topics described in Figure 7. Iowa HHS identified faculty who are national subject matter experts in CCBHC fidelity and implementation, licensed BH clinicians trained in serving diverse BH needs and populations, and experts in equitable, community engagement strategies.

Figure 7. Technical Assistance and Capacity Development Topics

TA Topic	Topic Description
Federal Expectations and CCBHC Goals	Detailed insights into federal CCBHC objectives, operational strategies, and lessons learned from existing CCBHC programs.
Culturally Responsive Care and CLAS Standards	Advanced concepts in cultural competency, the National CLAS Standards, and strategies for promoting BH equity.
Community Needs Assessments	Guidance on conducting comprehensive assessments, leveraging data to understand community needs, and storytelling for organizational missions.
Specialty Population Services	Focused strategies for serving veterans, tribal populations, children and families, and older adults within the CCBHC paradigm.
State Expectations for CCBHCs	An overview of Iowa-specific requirements and certification processes for CCBHCs across all operational domains.
Cost Reporting and Financial Management	Sessions on PPS requirements, cost report components, visit projections, and quality bonus metrics, complemented by individualized technical assistance.
Integrated MH/SUD Care and Crisis Services	Coverage of required services, best practices, and innovative models for crisis and integrated care.
Collaboration with Designated Organizations	In-depth examination of DCO requirements, partnership models, contracting, oversight, and care coordination expectations.
Data Management and Reporting	Two-part sessions addressing data collection, required measures, reporting, and partner collaboration utilizing IBHRS.
Consumer Advisory Board and Governance	Strategies to foster meaningful participation of individuals and families with lived experience in CCBHC planning.

Iowa HHS also provided 1:1 consultative support for each selected CCBHC bidder, ensuring provisionally certified CCBHCs developed sound staffing plans, compliant workflows, enhanced crisis services, and collaborative partnerships, including with DCOs.

Iowa HHS will provide sustained support to certified and prospective CCBHCs throughout the Demonstration period. To ensure adherence to CCBHC criteria and facilitate quality improvement activities, biannual site visits to certified CCBHCs will be conducted. Iowa HHS will also provide ongoing technical assistance, with a strong emphasis on capacity building for CCBHCs. This will include training in data management, clinical best practices, and administrative efficiency. Additionally, Iowa HHS plans to foster Learning Collaboratives that have emerged from technical assistance efforts. These collaboratives will provide a forum for CCBHCs to exchange knowledge, experiences, and strategies for enhancement. Capacity-building initiatives will also encompass leadership development, workforce training, and the integration of technology to improve service delivery. Certified CCBHCs will also be required to maintain national CCBHC certification. A comprehensive information dissemination strategy ensures CCBHCs access the latest resources, guidelines, and updates relevant to their operations. Through these activities, Iowa HHS aims to bolster the overall efficacy and sustainability of CCBHCs within the state's BH system, ensuring they are well-equipped to meet the evolving needs of their communities.

Collaborating with Community Organizations, Including the State's Crisis Response System. Iowa's CCBHCs are mandated to establish concrete partnerships with specific key community partners to ensure a robust, community-integrated approach to service delivery. These partners are integral to the CCBHC model, and their collaboration is vital for comprehensive care. Key partners include the local Mental Health and Disability Services (MHDS) regions, Integrated Provider Networks (IPNs) that are responsible for coordinating local substance use and addiction treatment services, crisis service providers, Crisis Access Centers and Crisis Stabilization

Providers, 988 call centers, hospitals offering inpatient psychiatric services for adults and children, and residential SUD services for both adults and children.

To implement the CCBHC model, the Contractor must establish a Community Partnership with Opioid Treatment Programs (OTPs) in the service area, ensuring access to Medication-Assisted Treatment (MAT) for Methadone. This partnership is crucial to meeting outpatient MH and SUD service comprehensive needs. Additionally, Contractors must work with DCOs to facilitate other MAT services, ensuring a complete scope of services is maintained per the CCBHC requirements.

To fortify these collaborations, provider organizations aiming for state CCBHC certification have reported establishing 28 new care coordination agreements, 17 new DCO agreements, and 31 additional informal partnerships, enhancing the support network and ensuring comprehensive crisis services in alignment with federal and state standards.

Regarding crisis services, Iowa HHS mandates that CCBHCs comply with the timeliness and accessibility standards as stipulated by SAMHSA in the CCBHC Criteria. However, Iowa HHS intends to leverage the CCBHC demonstration to progress towards full adherence with the requirements of Section 9813 of the American Rescue Plan Act (ARPA), ensuring that mobile crisis responses meet designated timeframes appropriate to their geographic areas and that non-mobile crisis services are in line with these critical accessibility standards. To illustrate the scale of collaboration and integration, 36 counties will utilize a DCO in conjunction with the state-sanctioned mobile crisis provider to deliver mobile crisis services. In 28 counties, CCBHCs themselves function as the mobile crisis provider and in 14 additional counties will function as the DCO for the designated CCBHC. The remaining 21 counties will be served through DCO agreements with state-sanctioned crisis providers. Consequently, 63 out of 99 counties in Iowa will benefit from mobile crisis coverage facilitated by CCBHCs—a significant stride toward service standardization and quality monitoring statewide.

CCBHCs are required to demonstrate coordination with 988 (including state crisis lines) through formal agreements. Iowa's call center structure is described in Figure 8.

Figure 7. Iowa's Crisis Continuum Integrated into its CCBHC Demonstration

Call Center	Description
988	Iowa has two 988 Centers that provide statewide coverage for 988 calls, chats, and texts. On December 1, 2022, the 988 centers started Mobile Response Warm Handoffs for individuals accessing crisis care through 988 who need and consent to mobile response per Iowa HHS's guidelines. Iowa HHS is partnering with the Iowa 911 program administrator to lead a 988/911 coordination effort with the 988 Centers and interested Public Safety Answering Points (PSAPs). The 911/988 coordination effort includes developing guidelines for determining when to transfer callers from 911 to 988 and transfer protocols.
Your Life Iowa	CCBHCs also partner with Your Life Iowa (YLI), which provides high quality 24/7/365 information, referral and crisis services via phone, text and chat for gambling, MH, substance use, suicide, and related concerns. YLI has a formal agreement to transfer calls to and from the Agency-funded statewide warmline to best meet the identified needs of the individual contacting the warm line or YLI. One of the 988 Centers is the Iowa HHS contracted YLI provider.

Using CCBHC CNAs to Identify BH Needs and Resources in Iowa. CCBHC CNAs are instrumental in identifying BH needs and resources. They allow CCBHCs and Iowa HHS

alike to identify gaps and strengths in services across the lifespan and different age groups. This information directly informed CCBHC decision making about **service offerings, staffing, language and culture considerations, hours of operation, geographical locations, and the incorporation of EBPs**. Iowa HHS reviewed each CCBHCs CNA to ensure it systematically addressed barriers (e.g., transportation, stigma, awareness), fostered collaborations and partnerships to enhance the overall continuum of care, and leveraged identified resources to enhance the accessibility and quality of BH services for Iowa's diverse populations through its demonstration participation.

Figure 8 details the CCBHC's CNAs, which identify BH needs and resources in their respective service areas across the lifespan, including the CCBHCs staffing, services, locations, service hours, and EBPs while identifying and addressing barriers. CCBHCs were instructed to conduct additional research to include additional information in their CNAs to sufficiently address underserved populations, their culture, and commonly spoken languages (in addition to English) in their respective service areas.

Figure 8. Iowa CCBHC CNA Findings

CCBHC	CNA Findings for Service Needs and Gaps
Abbe Center	Findings include a high prevalence of SMI, SUD, and COD, alongside elevated rates of excessive drinking and substance use, particularly alcohol and amphetamines. Moreover, Benton, Linn, and Iowa Counties experience elevated suicide rates, requiring enhanced crisis outreach efforts. Substance use and overdose concerns are notable, particularly in Linn and Johnson Counties. They will double SUD counseling capacity and introduce a peer recovery coach. High poverty rates, food insecurity, and transportation barriers, especially in Johnson County, are significant obstacles to accessing care. Cultural and linguistic needs are also identified, emphasizing the importance cultural competence staff training and community collaborations to address language barriers. Service expansion efforts for children and families include filling service gaps and addressing accessibility and workforce challenges. Recommendations include increasing staff, enhancing crisis outreach, expanding SUD counseling, addressing socioeconomic challenges, improving cultural competence training, and advocating for improved accessibility and transportation options.
Berryhill Center	The community served by Berryhill faces a multitude of mental and physical health challenges, compounded by access barriers and the aftermath of the COVID-19 pandemic. MH statistics reveal a significant burden, with shortages of psychiatrists exacerbating the challenge, particularly in a designated Health Professional Shortage Area (HPSA) like the service area. The pandemic has further strained MH, with a notable rise in anxiety and depressive disorders among adults. Berryhill's CNA underscores MH and SUD as primary concerns, emphasizing the urgent need for comprehensive intervention. Access to care is hindered by various barriers, including a shortage of primary care providers and financial costs, exacerbated by economic challenges in the community. Berryhill prioritizes linguistic competence through interpreter services and adherence to non-discrimination policies, ensuring equitable access to care for all consumers regardless of language or background. Special attention is directed toward vulnerable populations, such as veterans, pregnant and parenting women with SUD concerns, youth with depression and SUD, and disparities among various racial and ethnic backgrounds.
Eyerly Ball CMHS	MH and SUD were identified as prevalent needs across the service area, with wait times being a prominent barrier cited by respondents. Gaps in MH services persist, particularly in rural areas and a need for specialty care, primary care, and dental care. SU, although not highly identified in surveys, remains a concern across Iowa, prompting the utilization of data tracking tools to address this issue effectively. Diverse needs noted include a focus on older adults and veteran populations in Boone and Warren Counties, elevated depression

	rates in Polk and Warren Counties, and significant poverty levels in Story County. Transportation barriers and wait times also emerged as challenges. Spanish and Asian/Pacific Islander residents also need translation resources for essential documents. Agency challenges include staffing shortages, fine-tuning partnerships, and addressing knowledge gaps in marketing. They also identified a need to enhance representative feedback for future assessments.
Heartland Family Service (HFS)	HFS acknowledges various barriers for underserved populations in their service area. With a notable Spanish-speaking demographic, they actively recruit Spanish-speaking staff and ensures access to interpretation services, adhering to CLAS standards. Notably, veterans are recognized as an underserved population, prompting care coordination agreements with the VA and the establishment of a veterans' group. LGBTQIA+ individuals are also prioritized, with efforts to create inclusive and affirming care environments, particularly crucial in rural areas where MH stigma is pronounced. County-specific needs highlight MH and SUD as prevalent concerns, necessitating targeted interventions and community outreach to address gaps in services and awareness. Mills County emphasizes a need for better awareness and outreach, particularly in crisis care. Montgomery County ranks lowest in health metrics, with elevated rates of poor MH days and SUD. Pottawattamie County needs include crisis intervention, housing assistance, MH therapy, and SUD services. Shelby County stresses limited SUD support and need to improve access and eliminating service barriers.
Prairie Ridge	Although most of this service area is white, non-Hispanic, there is an identifiable proportion of the service area who is Hispanic, American Indian, African American or another culture. There is a recognized training gap for other cultures (in addition to Hispanic) in this service area, highlighting the need to identify trainers and engagement mechanisms for a more inclusive training protocol across all staff positions. While Prairie Ridge and the CCBHC program accommodate Spanish speakers, the reliance on interpretive services poses limitations, hindering optimal service accessibility. All but two counties in the area have an older population than the state average, leading to a common identification of needs related to aging and support for older adults. One county has a higher Native American population, and the community has recognized gaps in services for this group. Primary care access presents challenges, with practitioners often not accepting new patients, leading many to resort to urgent care or emergency departments. All counites are MH Health Professional Shortage areas, as per HRSA, with two counties lacking any therapists, necessitating travel or telehealth utilization. Telehealth accessibility underscores internet availability and equipment challenges for a significant portion of the population.
Pathways Behavioral Health	The need for comprehensive MH and SUD services is evident, with similar trends observed in all counties, highlighting a widespread demand for targeted interventions and resources to improve MH and combat SUD services. Black Hawk County presents alarming rates of depression, suicide, and SU, as evidenced by data from various sources. With 21 suicides reported in 2022, the county faces a significant challenge in addressing MH crises. SUD, particularly involving opioids and psychostimulants, remains a pressing issue, contributing to overdose deaths and ED visits. High levels of alcohol consumption, binge drinking, and heavy drinking further exacerbate health risks, including motor vehicle crash deaths. Additionally, tobacco use persists as a significant concern, especially among youth. Stakeholders and economic data point to transportation to services issues, particularly in rural areas. Grundy County identified gaps in “in-person” services and a desire for more extended evening hours. Childcare continues to be a concern for most of their service area.
Plains Area Mental Health	Potential barriers to care for Plains service area includes geographic limitations, workforce shortages affecting appointment availability, transportation challenges, and economic hardship, as reflected in rural poverty rates and job creation issues in Iowa. Additionally, there are cultural, linguistic, physical, and BH needs for non-English-speaking clients. Plains uses platforms like Jeenie, Spectra, and Cyracom to address the high demand for

	languages such as Spanish, Hmong, Lao, and Burmese. Their Culturally Competent Trauma Informed Care Committee focuses on improving interpretation services, particularly for Pohnpeian, and will expand its responsibilities to meet CAB requirements. Employee training on various cultures and quarterly data reviews ensure appropriate cultural responsiveness. Plains also plans to implement EBPs like SBIRT and FFT but may face challenges due to training availability.
Robert Young Center	In Eastern Iowa, around 128,000 adults are affected, with psychosis spectrum and mood disorders being common reasons for hospitalization. Moreover, children with SED face challenges, with up to 13% of all children and adolescents experiencing SED. Rates of SUD are also concerning, with 33.5% of adults with mental illness experiencing SUD. Among Iowa's youth, depression and SUD concerns are also prevalent, with rates of depression higher than the national average and significant co-occurrence between mental illness and SU. Veterans, especially those with combat experience, face higher rates of MH conditions, and justice-involved individuals often grapple with mental illness and SU, necessitating streamlined screening, assessment, and treatment to prevent recidivism. Opportunities include addressing access barriers such as inconvenient office hours, appointment availability, and transportation issues. Other identified needs encompass strategies for information sharing, effective care coordination, utilization, and cost data tracking, addressing critical workforce shortages through Peer Support, and strengthening partnerships with primary care providers to ensure integrated care. The assessment also emphasizes a need to address workforce challenges and promote comprehensive, integrated care coordination.
Seasons Center for Behavioral Health	Notable concerns include high rates of uninsured adults and children, a significant elderly population with MH needs, challenges in BH service accessibility, and disparities in service delivery between rural and urban areas. All counties are MH Health Professional Shortage Areas. The Hispanic/ Latino population is the second largest after the white population and has seen growth over the past five years, necessitating strategies such as translation services, multilingual signage and providers, and cultural sensitivity training for staff to reduce disparities. Key recommendations include expanding CCBHC services as a model of care, fostering local partnerships, ongoing education, utilizing new funding for program enhancement, and advocating for the continued use of telehealth.

In addition to using CCBCH CNA findings to identify BH needs and resources, Iowa HHS also incorporated participant feedback about their experiences with community BH services. In July 2023, Iowa HHS facilitated 12 focus groups that provided insights into community-specific challenges. Complementing these discussions, a thorough data analysis was conducted to delineate and identify high-need counties statewide. These insights shaped the Iowa HHS CCBHC RFP criteria and directives. The table below shows a thematic analysis identifying key emerging themes across all focus groups and corresponding CCBCH program features.

Figure 9. Focus Group Findings and Responsive CCBHC Demonstration Program Features

Findings Theme	Description	Responsive Iowa CCBHC Demonstration Program Features
Access	Attendees emphasized stigma remains a notable obstacle to accessing BH services. They suggested a pressing need for increased public awareness and enhanced BH literacy. Transportation barriers were also discussed, especially in rural locations, with attendees offering potential solutions such as broadening geographical access points.	CCBHC programs will be expected to outreach to their service areas using inclusive methods that are tailored to the variety of population groups in their area.

Care Coordination	Data-sharing issues were discussed, such as confidentiality barriers and inefficient information-sharing mechanisms. Participants said excessive documentation requirements detracted from important time providing patient care and that strengthening collaboration with emergency departments was essential to seamless care transitions, especially post-discharge. They also emphasized improving collaboration with Veterans Affairs to address the unique needs of veterans and the need to expand peer support services.	The CCBHC demonstration will leverage a shared BH reporting platform that will enable Iowa HHS and participants to monitor performance against outcome targets and benchmarks.
Child and Family Services	Several focus groups underscored a significant shortage of services tailored for children and their families, exacerbated by funding constraints, therapist scarcity, and a lack of specialized services. Participants also said that ensuring quality care remains consistent as individuals age requires a smoother transition from youth to adult services. Collaboration between CCBHCs and schools for consistent childcare was highlighted.	CCBHCs are required to implement at least one of the following child-focused EBPs: • Functional Family Therapy • Multidimensional Family Therapy • Multisystemic Therapy
Workforce	Discussion about workforce shortages, particularly in rural areas, emphasized the need to attract and retain BH professionals. Factors cited include work environments, non-competitive salaries, provider work-life imbalances, administrative burdens, and cumbersome Medicaid reimbursement structures.	Enhanced CCBHC investments will be targeted to workforce needs and any earned incentives (i.e., Quality Bonus Payments) will be reinvested in CCBHC programs.
Telehealth Services	Telehealth's potential to expand accessibility, particularly in rural areas, was acknowledged; however, issues like unreliable internet connectivity in rural areas and technological barriers for older adults and young children were a concern. Participants strongly preferred in-person or hybrid models (combining in-person and telehealth).	CCBHCs use telehealth to supplement in-person services and to address workforce and individual transportation challenges especially in rural areas.
Crisis Services	Inconsistent availability and use of mobile crisis services were highlighted, citing geographic and transportation barriers. Other issues included crisis response delays, bed shortages, and post-crisis continuity of care. Participants called for increased public awareness, targeted first responders training and promoting the 988 Lifeline for timely crisis interventions.	CCBHCs will implement crisis services compliant with CCBHC criteria and integrate mobile crisis services into their overall crisis continuum to improve awareness and access to crisis services.
Additional Topics	Fragmented MH and SUD services were widely discussed. Participants called for enhanced service integration and approaches, expressed concerns about present catchment areas (need refinements to cater to communities), and bridging service gaps for marginalized populations.	Iowa's CCBHC procurement allowed providers to define their catchment areas based on local needs while prioritizing serving rural and high needs areas.

EBPs Included in Iowa's CCBHC Demonstration. EBPs are defined in Iowa Administrative Code 441.25.1 as interventions rigorously tested that yield consistent, replicable results, are proven safe, beneficial, and effective, and have established standards. Iowa HHS requires five EBPs that CCBHCs must implement based on stakeholder input, CNAs, a focus on high-risk individuals, and an emphasis on children who need cross-sector collaboration. CCBHCs must directly provide or partner to provide the EBPs listed in Figure 10, as informed by their CNAs, to address the unique needs of the individuals in their service areas.

Figure 10. Selected Demonstration EBPs and Rationale

Required Evidence-Based Practice	Rationale
Assertive Community Treatment (ACT) is defined in Iowa Administrative Code 441.25.1 as a program of comprehensive outpatient services provided in the community and directed toward the amelioration of symptoms and the rehabilitation of behavioral, functional, and social deficits of individuals with severe and persistent mental illness and individuals with complex symptomology who require multiple MH and supportive services to live in the community.	Reduces incidence of hospitalization and emergency department interventions.
Motivational Interviewing (MI) is person-centered counseling that addresses the common problem of ambivalence about change.	Addresses attitudes to advance changes benefiting a client's MH.
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a for children and adolescents with SED who are impacted by trauma and their parents or caregivers.	Provides early intervention important for children who suffer trauma.
Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a quick and comprehensive, integrated, public health approach for early intervention and treatment services for persons with or at-risk for SUD.	Assesses the severity of substance uses, increase SUD awareness, and motivate behavioral changes.
Plus One of the Following	
Functional Family Therapy (FFT**)** is an intervention for youth and families. This strength-focused counseling model is primarily for at-risk youth referred by the juvenile justice, MH, school, or child welfare systems. Services are short-term and conducted in clinics, homes, schools, child welfare facilities, probation and parole systems, and MH facilities.	Brief and time-limited therapy that reduces negative and increases positive behaviors in teens and improves family relationships.
Multidimensional Family Therapy (MDFT) is a manualized, family-centered treatment and substance misuse prevention program for youths with SUD and problem behaviors (such as aggression, truancy, and other mental comorbidities).	Addresses and reduces youth behavioral challenges, such as cannabis use and juvenile offending (Liddle et al., 2001).
Multisystemic Family Therapy (MST) is an intensive treatment for diagnosed BH disorders and environmental systems (family, school, peer groups, culture, neighborhood, community) that contribute to or influence involvement, or potential involvement in the juvenile justice system.	Targets all the important systems for young people to bring about lasting change with skills and knowledge needed to make healthy decisions

CCBHC Service Area Descriptions. Defining Iowa's CCBHC service area is critical in strategically delivering and tailoring services to meet the specific needs of our POF. The service area footprint for our proposed CCBHCs allows us to allocate resources efficiently, respond to community needs, and ensure our services are accessible and tailored to the unique characteristics of the defined area. This service area delineation enhances and helps facilitate effective collaboration with local stakeholders and ensures a focused and impactful approach to meeting the BH needs of our communities.

Iowa HHS initially proposed nine catchment areas designed based on population size, MH and SUD acuity, and other needs data collected through statewide monitoring activities. However, the Stakeholder Committee and public members expressed concerns about Iowa HHS' framework and how it corresponded to patient access patterns and how BH services were delivered. Stakeholders expressed concerns about a single CCBHC provider's accessibility and capacity to meet the needs of residents in certain regions. Iowa HHS then reviewed the proposed catchment areas to determine whether the geographical boundaries needed revision. Based on this feedback, Iowa HHS allowed CCBHC bidders to define and propose their service areas based on minimum numbers of counties, Medicaid enrollees, and high need areas. Iowa HHS selection criteria only

permits one CCBHC in a given county to ensure each certified CCBHC has sufficient critical mass regarding workforce, population size, and partnerships to ensure effectiveness in meeting all required criteria and fidelity to the CCBHC service model, while also maintaining important accountability for its service area and the population they serve under the demonstration. The provisionally certified CCBHC service areas are detailed in Figure 11.

Figure 11. CCBHC Service Areas

CCBHC	Counties (High Need Counties in **bold**)	Medicaid Enrollees
Abbe Center	Eastern Iowa: Benton, **Delaware**, Iowa, **Johnson**, Jones, and Linn	72,863
Berryhill Center	North Central Iowa: **Calhoun, Hamilton,** Humboldt, and **Webster**	15,593
Eyerly Ball CMHS	Central Iowa: Boone, Story, **Polk**, and Warren	119,283
Heartland Family Service	Southwest Iowa: Cass, Fremont, Harrison, Mills, Monona, Montgomery, Page, **Pottawattamie**, and **Shelby**	40,885
Pathways Behavioral Services	Northeast Iowa: Black Hawk, Bremer, Buchanan, Butler, Chickasaw, and **Grundy**	42,023
Plains Area	Northwest Iowa: Cherokee, Buena Vista, Carroll, Crawford, Ida, Plymouth, Pocahontas, and Sac	24,816
Prairie Ridge	North Central Iowa: **Cerro Gordo**, Floyd, **Franklin,** Hardin, Hancock, Kossuth, Marshall, Mitchell, Poweshiek, Tama, Winnebago, Wright, and Worth	45,996
Robert Young Center	Eastern Iowa MHDS: Cedar, **Clinton**, Jackson, Muscatine, and Scott	62,074
Seasons Center	Northwest Iowa: Clay, Dickinson, Emmet, Lyon, Osceola, O'Brien, Palo Alto, and Sioux	21,529

CCBHC Governance Requirements. Consistent with federal Criteria 1.3.11 and CCBHC Criteria 6.B, Iowa HHS requires each CCBHC to incorporate meaningful participation in planning and oversight from individuals with lived experience of MH or SUD and their families, including youth. Their participation is designed to ensure their perspectives are integrated into decision-making on all aspects of CCBHC implementation. Iowa HHS offered CCBHCs the following two options to fulfill these governance requirements. Two provisionally certified CCBHCs have elected to use Option 1 and seven have elected to use Option 2 (see below) to meet this governance requirement.

- **Option 1:** At least 51 percent of the CCBHC Governing Board is comprised of individuals with lived experience of mental illness or SUD and their families. To do so, CCBHCs must consider the governing board's culture, size and composition, fundraising expectations, and changes needed to be accessible and meaningful for people with lived experience, if any.

- **Option 2:** Other means are established to demonstrate meaningful participation in board governance involving people with lived experience, such as a Consumer Advisory Board (CAB) or Consumer Advisory Committee (CAC) that reports to the board.
    - Members can establish cultural norms and expectations with CCBHC staff guidance.
    - Support the development of systems knowledge needed to provide substantive input.
    - Provide mentorship and enhancement/development of leadership skills.

To further our commitment to fostering inclusive and consumer-centered BH services, we facilitated technical assistance for all selected CCBHC providers, which described best practices

for how to establish governance structures that prioritize and ensure meaningful input from consumers, persons in recovery, and family members. Subject matter experts focused on best practices for advisory boards to ensure successful compliance with Iowa CCBHC Demonstration Program governance requirements, including:

- Creating a CAB that reflects the diverse voices of those with lived experiences, ensuring representation across various demographics and service types.
- Establishing transparent communication channels, regular feedback mechanisms, and accessible meeting formats to facilitate active participation.
- Governing Board language authorizing the CAB and their formal roles.
- Training programs on cultural competency and the unique challenges individuals face in recovery to enhance the understanding of governance members.
- Continuous evaluation and improvement of governance structures to foster an environment that values and integrates the meaningful contributions of consumers, persons in recovery, and family members in shaping BH services.

If **Option 2** is chosen, the governing board must:

- Establish protocols for incorporating input received.
- Provide meeting minutes or summaries to the CAB.
- Offer members the opportunity to regularly address and share recommendations with the governing board directly and formally document them in the minutes.
- Develop an annual summary of recommendations and post them on the CCBHC website.
- Offer the staff support.

Additional State Demonstration Requirements. Figure 12 describes additional Iowa HHS CCHBC certification requirements that exceed the minimum expectations set in the federal CCBHC criteria using the State Discretion Guidance. Additional requirements were informed by stakeholder feedback, opportunities to align our CCBHC demonstration with other State systems work we are pursuing in the BH continuum, and further alignment with existing licensure and accreditation expectations for BH providers in Iowa. Iowa HHS believes these requirements enhance the CCBHC model and will improve the CCBHC's demonstration's ability to advance the set goals and outcomes we have defined for our POF.

Figure 12. Iowa-Specific CCBHC Demonstration Requirements

CRITERIA	SAMHSA REQUIREMENT	IOWA REQUIREMENT
2	**AVAILABILITY AND ACCESS OF SERVICES**	
2	Iowa HHS has set network adequacy expectations for CCBHCs with respect to their selected service area. CCBHCs shall provide or coordinate provision of all nine required CCBHC core services ensuring that all services are accessible within 60 minutes or 60 miles (whichever is less) of a client's home address. Psychosocial Rehabilitation Access Standard: If a client's scheduled appointment time for psychosocial rehabilitation is longer than 3 hours on any given day, the access standard is 60 minutes or 60 miles in urban areas and 90 minutes or 90 miles in rural areas.	

2A	**General Requirements and Access and Availability**	
2.a.2	Informed by the CNA, the CCBHC ensures that services are provided during times that facilitate accessibility and meet the needs of the population served by the CCBHC, including some evening and weekend hours.	In addition to the SAMHSA CNA requirements, CCBHCs must provide a summary of the BH strengths and needs of their proposed service area. The summary shall include for the CCBHC's proposed service area: 1) demographic composition of the service area 2) summary of Iowa HHS' population of focus living in the area, including individuals with SMI, Individuals with SED, Individuals with SUD, Pregnant and parenting women, Veterans, Youth with depression and SUD concerns, BIPOC and other underrepresented populations
2.a.5	CCBHC uses telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies, to the extent possible, in alignment with the preferences of the person receiving services to support access to all required services.	Telehealth access alone does not satisfy the CCBHC network adequacy requirement; however, telehealth can be offered when clinically appropriate as a choice in addition to accessible in-person services.
3	**CARE COORDINATION**	
3.C	**Care Coordination Partnerships**	
3.c.3	CCBHCs are required by statute to develop partnerships with the following organizations that operate within the service area: • Schools • Child welfare agencies • Juvenile and criminal justice agencies and facilities • Indian Health Service youth regional treatment centers • State licensed, nationally accredited child placing agencies for therapeutic foster care • Other social and human services	The CCBHC shall engage and partner with BH stakeholders in its service area consistent with SAMHSA's Published CCBHC Certification Criteria, and key Iowa BH system partners, including but not limited to: 1) IPN providers, 2) CMHCs, 3) Access Centers, 4) MHDS Regions, 5) Crisis Service Providers, 6) Integrated Health Homes, 7) Federally Qualified Health Centers, 8) Inpatient psychiatric care providers, and 9) Residential SUD treatment providers
4	**SCOPE OF SERVICES**	
4.C	**Crisis Behavioral Health Services**	
4.c.1	The CCBHC shall provide crisis services directly or through a DCO agreement with existing state-sanctioned, certified, or licensed system or network for the provision of crisis BH services. Iowa HHS recognizes that state-sanctioned crisis systems may operate under different standards than those identified in these criteria. If a CCBHC would like to have a DCO relationship with a state-sanctioned crisis system that operates under less stringent standards, they must request approval from Iowa HHS to do so.	Mobile crisis services must comply with timeliness and accessibility rules established under Section 9813 of the American Rescue Plan Act of 2021 (ARPA), which requires an in-person, community-based response in accordance with the following standards: a. 1 hour in urban areas b. 2 hours in rural areas Any non-mobile crisis services offered directly by the CCBHC must meet the same accessibility standards as other CCBHC core services, as specified above.

		The CCBHC shall leverage existing State Sanctioned Crisis Provider as a DCO where the existing State Sanctioned Crisis Provider is compliant with Section 9813 of the ARPA. If the State Sanctioned Crisis Provider is not compliant, the Contractor must directly or through a DCO provide a comprehensive, compliant array of Crisis Services in accordance with Section 9813 and CCBHC Certification Criteria.
4.F	**Outpatient Mental Health and Substance Use Services**	
	Based upon the CNA findings as required in program requirement 1, certifying states must establish a minimum set of required EBPs. EBPs states might consider are: Motivational Interviewing; CBT; DBT; Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP); Seeking Safety; ACT; Forensic Assertive Community Treatment (FACT); Long-acting injectable medications to treat mental and SUD; Multi-Systemic Therapy; Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Cognitive Behavioral Therapy for psychosis (CBTp); High-Fidelity Wraparound; Parent Management Training; Effective but underutilized medications such as clozapine and FDA-approved medications for SUD including smoking cessation.	CCBHCs shall implement and maintain ongoing compliance and fidelity to EBPs that address the unique needs of the individuals in their service area (as informed by their CNA). The CCBHC shall directly provide or partner to provide the following EBPs in their service area: 1) Assertive Community Treatment (ACT) 2) Multi-Dimensional Family Therapy and/or Functional Family Therapy and/or Multi-Systemic Therapy; and 3) Motivational Interviewing; and 4) TF-CBT 5) Screening, Brief Intervention, & Referral to Treatment (SBIRT)
5	**QUALITY AND OTHER REPORTING**	
5.A	**Data Collection, Reporting, and Tracking**	
5.a.1	The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including, but not limited to, data capturing: (1) characteristics of people receiving services; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) outcomes of people receiving services.	CCBHCs are required to demonstrate ability to upload required client data to IBHRS and accurate, up-to-date claims data to the Medicaid system
6	**ORGANIZATIONAL AUTHORITY, GOVERNANCE, AND ACCREDITATION**	
6.A	**General Requirements of Organizational Authority and Finances**	
6.c.1	The CCBHC enrolled as a Medicaid provider and licensed, certified, or accredited provider of both MH and SUD services including developmentally appropriate services to children, youth, and their families, unless there is a state or federal administrative, statutory, or regulatory framework that substantially prevents the CCBHC organization provider type from obtaining the necessary licensure, certification, or accreditation to provide these services. The CCBHC will adhere to any applicable state accreditation, certification, and/or licensing requirements.	CCBHCs shall participate in all required certification activities, including but not limited to: 1) CCBHC Criteria Assessment by a National Accrediting Body 2) Cost Report and Supporting Material Submission to Support PPS Rate Development 3) Submission of any requested documents or materials 4) Agency-mandated technical assistance 5) Participation in on-site and virtual visits conducted by Agency reviewers/auditors

Process for Adding Additional CCBHCs and Achieving Statewide CCBHC Coverage. Iowa HHS is committed to statewide CCBHC coverage over the course of our demonstration

authority from SAMHSA and CMS. We believe every Iowan should have access to high-quality, accessible BH care in fidelity with the CCBHC program model. As such, we have crafted a process for growing CCBHC capacity in the state. The initial CCBHC RFP was designed to promote collaboration among existing providers and encourage the inclusion of rural and high-needs counties in CCBHC service areas. The RFP was strategically designed to select the cohort of providers most prepared for the CCBHC certification process and capable of participating in DY1. Providers who did not achieve provisional certification for DY1 are set to receive continued TA to guide them toward full certification in the program's second year, beginning July 1, 2025.

To accommodate the expansion of CCBHCs, the state has outlined a clear pathway: Providers are to apply to the state for certification, with the process tailored to address specific needs and service gaps and adhere to updated certification criteria. As we work to continue centralizing how BH services are organized throughout our State, CCBHC is a core component in our statewide strategy to improve access, accountability, and outcomes.

In pursuit of streamlining and enhancing the certification process, Iowa plans to amend its regulations to integrate the CCBHC accreditation process directly into state rules. The certification process will follow the same process completed by the provisionally certified CCBHCs included in this application:

(1) completion of a compliant CCBHC CNA for the proposed service area;
(2) submission of a CCBHC cost report;
(3) participation in Iowa HHS-mandated technical assistance;
(4) participation in a mandatory Iowa HHS site- visit;
(5) successful transmission of sample data to IBHRS;
(6) a completed criteria assessment facilitated by an independent national accrediting organization.

Our focus in DY2, will be identifying and developing capacity amongst BH providers serving counties not already served by CCBHC certified and approved in DY1. This approach underscores Iowa's commitment to a dynamic and responsive CCBHC program that scales according to evolving community needs across all parts of Iowa.

C: Iowa HHS has undertaken deliberate actions to enhance and strengthen its analytic infrastructure to elevate data collection and reporting capacities for the CCBHCs reporting of clinic-collected measures to the state and Iowa's direct reporting obligation to SAMHSA. This comprehensive approach is designed to meet payment and PPS requirements, quality reporting prerequisites, and the specific essential reporting criteria for the demonstration program. The foundation of this initiative lies in establishing standardized data elements and definitions to ensure a consistent understanding and interpretation of data. This facilitates accurate reporting and alignment with PPS and quality reporting requirements.

In Iowa, our state's infrastructure for collecting and reporting BH claims and data is robust, leveraging two key databases: the Medication Management Information System (MMIS) and IBHRS. Through the MMIS, Iowa gains comprehensive access to Medicaid claims, encompassing all services provided by each CCBHC. This access offers detailed insights into CCBHC encounters, providing essential information such as provider identification, client demographics, service date, payment rates, and more. It serves as a vital resource for tracking and analyzing the delivery of BH services across the state. All CCBHCs are required to utilize the primary HCPCS

Code T1040 using the CCBHC Provider Type. This code is utilized on claims containing both threshold and shadow service codes for all Medicaid-reimbursable services provided to clients on the day of service. Reimbursements under the PPS are seamlessly integrated into the standard MMIS claims adjudication process. As such, all threshold claims, shadow claims, provider information, and client data are securely stored and managed within the Iowa HHS Data Warehouse. This centralized repository facilitates efficient data management and analysis, contributing to informed decision-making and improved service delivery within Iowa's BH landscape.

To enhance this data collection process's efficiency, Iowa supports CCBHCs as they integrate and modify existing systems, prioritizing XML data transfer to IBHRS. This automation expedites information gathering and reduces potential errors, meeting PPS requirements and aligning with the demonstration evaluation reporting criteria. CCBHCs must receive health information from DCOs, care coordination, and other providers outside the clinic setting to provide requested metrics. This includes services provided related to health, recovery and home and community-based services that may come from a wide range of providers within the CCBHC's network. Iowa HHS is supporting CCBHCs with data collection guidance through technical assistance and ongoing support to ensure CCBHCs are equipped and prepared to provide client-level files to calculate system-wide outcomes and support the national evaluation.

The integration with IBHRS serves as a crucial conduit for obtaining provider data, as CCBHCs submit relevant data through standardized formats and protocols. This ensures consistency and accuracy, meeting PPS requirements and enhancing overall reporting efficiency.

In addition to IBHRS, the state recognizes the value of Medicaid data and other sources in enriching the reporting landscape. Iowa's meticulous data synthesis process involves aggregating, standardizing, and validating data from IBHRS, MMIS, and other sources. This ensures the creation of a cohesive and accurate dataset that aligns with diverse reporting requirements under Criteria Program Requirement 5.

Supporting CCBHCs in Data Collection Activities. Iowa HHS has taken a comprehensive approach to designing, modifying, and implementing data collection systems, leveraging electronic health record (EHR) functionality. The EHRs of each CCBHC was evaluated during the onsite certification reviews to determine the ability of the clinic to comply with the RFP requirement of XML data upload. Although these systems require modifications to configure the additional data elements necessary to produce the clinic-reported measures and create the automated workflows to generate the XML file for upload, these clinics will meet the mandates of the CCBHC demonstration. The clinics will undertake the required modifications internally or with the support of the EHR vendor.

The IBHRS system will be enhanced to serve as the primary analytic infrastructure for clinic-collected measures for Iowa's CCBHC demonstration program. These enhancements include developing unique codes and specifications to identify unique CCBHCs and assess performance across measures, ensuring proper stratification of performance measures by CCBHC, race/ethnicity, payer, and other meaningful elements. A collaborative data governance and technical support team has been established to support the state in facilitating the necessary changes to the data infrastructure, including IBHRS, MMIS, the Iowa HHS Data Warehouse, and other related data systems.

Iowa HHS leverages the IBHRS system, a robust statewide secure technology infrastructure, to support CCBHC performance measurement and evaluation. IBHRS will collect, aggregate, analyze, and monitor data prospectively and retrospectively to support data analysis, population health management, and continuous quality improvement (CQI) efforts. Data from IBHRS will be used to analyze clinic performance, understand risk, evaluate adherence, uncover gaps in care, identify substandard care, assess over- and underutilization patterns, and monitor vulnerable populations, co-occurring conditions, and other indicators influencing health outcomes or contributing to increasing costs. To achieve this, CCBHCs must support data sharing using XML/data file upload processes to IBHRS. Iowa HHS has expanded the IBHRS analytic infrastructure to accommodate data from all CCBHC individual-level data necessary to calculate performance on all measures required for reporting, demographic data to assess disparities, and additional data elements such as care coordination data.

The IBHRS and the MMIS systems play pivotal roles in this data collection ecosystem. IBHRS is a central platform that standardizes data formats and transmission protocols for seamless integration. CCBHCs submit relevant information through IBHRS, ensuring a cohesive and standardized dataset. MMIS capabilities are harnessed to integrate Medicaid data, enriching the reporting landscape and providing a more comprehensive view of fee for service and MCO encounter claims housed in the Iowa HHS Data Warehouse.

In preparation for data reporting for the CCBHC Demonstration program, Iowa HHS will support CCBHC clinics in submitting baseline data for the five clinic-reported measures. This baseline data period is scheduled to commence in July 2024 to allow for a trial run of data collection from CCBHCs and test the XML/data sharing functionality with the IBHRS data system. The state is prepared to support CCBHCs in troubleshooting issues, supporting the development of rigorous clinic data validation processes, and guiding quality improvement for clinics to be prepared for the demonstration program. This process will allow Iowa HHS to identify potential problem areas and find solutions to impact data integrity, timely reporting, and ensuring adherence to the technical specifications for measure calculation.

TA is a cornerstone of the state's strategy to assist CCBHCs in effectively utilizing data for CQI processes. Iowa offers tailored TA, guiding data collection, reporting, continuous performance monitoring, and interpreting and utilizing data to enhance service quality. This comprehensive support extends to tracking process measures for fidelity to evidence-based practices, person-centered care, and recovery-oriented approaches. Workshops, training sessions, and one-on-one consultations are available to ensure that CCBHCs are well-prepared to leverage data for ongoing improvement initiatives.

Iowa HHS has created an approach to embed CCBHC performance management into a quality framework to support population health goals. This work aims to align coordinated quality management and performance improvement between the state and CCBHC clinics. To ensure ongoing efforts to support aligned quality improvement work, Iowa HHS will provide performance feedback to CCBHCs on state-collected quality measures at least quarterly. This involves a structured feedback mechanism where CCBHCs receive periodic updates on their performance based on the collected data. The state has established clear communication channels, facilitating a responsive and iterative feedback loop. This ensures that CCBHCs can promptly identify areas of success and opportunities for improvement, fostering a culture of continuous improvement.

Ensuring Appropriate CCBHC Billing. Collection and reporting capacity enhancements to support the PPS reporting requirements build on Iowa's existing processes. The state will establish clear communication channels and support mechanisms to guide CCBHCs in correctly using billing codes. This includes providing comprehensive documentation and training resources that elucidate the intricacies of federal or state-specific billing codes. Workshops, webinars, and direct consultations are integral to this educational initiative, aiming to empower CCBHCs with the knowledge and skills necessary for precise billing.

To align billing practices with service-level details, Iowa has fostered a collaborative approach where CCBHC EHR systems will be configured to automatically capture and document the relevant service details, according to threshold and allowed services that crosswalk to the nine core services under the federal CCBHC program model. This integrated approach streamlines the billing process and ensures that each claim accurately reflects the scope and nature of the services provided by CCBHCs. CCBHCs must submit a valid CCBHC encounter code as defined in the CCBHC Demonstration Handbook with a corresponding T1040 service encounter code to receive appropriate payment. CCBHCs must bill for these services under a new CCBHC Provider Type, NPI, and taxonomy code to distinguish CCBHC services from other services provided under the existing Iowa State Medicaid Plan that are distinct from those services defined in the state's CCBHC program manual.

Furthermore, the state is instituting ongoing monitoring and auditing processes to ensure compliance with billing code usage and the accuracy of service-level details. Regular audits will be conducted to review billing practices, offering feedback and corrective guidance where necessary. This proactive approach safeguards against billing errors and promotes transparency and accountability in the billing process.

Data Format and Access for Evaluation. Clinic and state-generated quality indicators will be submitted to SAMHSA and the national evaluators in the format specified by the Demonstration Templates as provided. SAMHSA and the national evaluators will also have ongoing access to the Quality Dashboard once developed. Client-level data will flow from the CCBHCs to the State, where identifying information will be removed, and an 'alternative' client identifier will be used to link client records. The evaluator can be furnished with a comprehensive data file, facilitating regular monitoring and in-depth analysis. Moreover, the system supports providing historical data files in finalized and automated formats upon request. The State-level data is maintained in a structured query language (SQL), feeding into a suite of monthly and quarterly reports and visually intuitive dashboards. Flexibility is embedded in the data submission process, allowing for various formats, such as comma-separated values, pipe-delimited, flat files, and more, based on the evaluators' preferences. Iowa HHS is committed to collaboration by accommodating diverse data-sharing methods per evaluators' preferences. The agency's proactive approach ensures timely and accurate delivery of requested data in the correct format, aligning with the needs of federal partners, universities, research organizations, and other state agencies.

D: Iowa is exceptionally well-prepared to actively engage in the national evaluation of the CCBHC demonstration program, as our current data processes, coupled with the numerous enhancements, meet the data collection and reporting requirements in the CCBHC demonstration. Iowa HHS has a robust capacity to engage with SAMHSA and CMS in the comprehensive assessment of the cost, quality, and scope of services delivered by certified CCBHCs. Leveraging

our extensive experience in the MH and SUD sector, we stand ready to collaborate with the federal agencies to evaluate the impact of the demonstration program on both federal and state costs associated with a full spectrum of services. Iowa HHS has participated in multiple cross-site evaluations and is willing to provide the necessary data timely and in any requested format.

Iowa HHS has a long and successful history of collecting and reporting quality data particularly regarding national performance measures, such as the CMS Adult and Child Core Measures. This established proficiency in data collection and reporting mechanisms provides a solid foundation for our efforts. Our commitment extends beyond the financial dimensions of the assessment. We are eager to contribute insights into the qualitative aspects of MH and SUD services, emphasizing the importance of service excellence, accessibility, and effectiveness. By actively participating in the national evaluation, we aim to provide valuable perspectives on the intricate interplay between programmatic interventions and service outcomes.

In addition to our analytical capabilities, we are willing to facilitate a deeper understanding of the broader healthcare landscape by considering services paid for through sources other than the demonstration program funding. This includes but is not limited to, inpatient, emergency, and ambulatory services. Our comprehensive approach will ensure that the evaluation encompasses a holistic understanding of the MH and SUD service ecosystem, considering the multifaceted funding sources contributing to the overall support system.

As stakeholders deeply invested in the well-being of our state residents, we see this as an opportunity to contribute not only to the success of the Demonstration Program but also to the broader national effort to enhance MH and SUD services. We are eager to actively engage, collaborate, and share our insights to support Iowa HHS in its national evaluation endeavors, fostering a collective commitment to advancing the state of MH care in Iowa.

Discussions with Federal Evaluation Planning Team. Iowa HHS is developing a comprehensive approach to selecting an optimal comparison group for the CCBHC demonstration project. The objective is to ensure the comparison group would be as similar as possible concerning other factors that could influence or confound outcomes being studied, and information collection could be as accurate and comparable as possible for both groups to avoid unintended biasing associations. Our preferred methodology is to use clients served at Community Mental Health Centers (CMHCs) who are not participating in the CCBHC demonstration project to allow assessment of changes that could be attributed to the CCBHC program implementation. The proposed design adopts an experimental framework, employing a “difference-in-difference” methodology that compares outcome differences for Iowa CCBHC clients before and after CCBHC implementation against clients served in comparable BH organizations that did not transition to CCBHC status.

To mitigate potential bias, propensity score matching will be employed, aligning the characteristics of service users across study periods with the distribution of CCBHC and non-CCBHC service users. This approach ensures consistency over time within groups, bolstering the reliability of the "difference-in-difference" comparisons. The methodology for comparison group analyses will ensure that the following information can be assessed for Iowa CCBHCs, including disparity analysis using race/ethnicity and geographic indicators:

1. Increased access to BH services for Iowans in their service area
2. Increased access to physical/primary care for Iowans

3. Improved health outcomes for Iowans as measured by the MHSIP survey
4. Reduction in cost of care

By employing this robust methodology, we aim to provide a thorough and nuanced understanding of the CCBHC program's impact on diverse facets of BH services in Iowa, ensuring a comprehensive and unbiased assessment of outcomes.

Institutional Review Board (IRB) Request. We do not anticipating needing IRB approval for Iowa HHS to collect and report on process and outcome data for the CCBHC project; therefore, as proposed, IRB approval would not apply to the CCBHC demonstration project. If data collection or sharing requirements change during the demonstration program, CCBHC program staff will coordinate an additional IRB review of updates.

E: Projecting the Impact of the State's Participation in the Demonstration. Iowa has chosen Goal 2 to project the impact of CCBHCs. Our state has chosen to center its efforts on improving the availability of, access to, and participation in services for individuals eligible for medical assistance under the State Medicaid program (Goal 2). This selection aligns with our commitment to addressing healthcare disparities, particularly for vulnerable populations, and fortifying community-based MH care.

The decision to prioritize Goal 2 was informed by an assessment of the healthcare landscape in our state and was driven by stakeholder feedback gathered through public stakeholder engagement meetings and focus groups. Recognizing the disproportionate impact of BH disparities on Medicaid enrollees, we aim to bridge gaps in access to essential MH and SUD services. This goal is strategically aligned with our commitment to inclusivity, addressing the specific needs of a demographic that often faces barriers to quality mental healthcare.

Goal 2: Iowa HHS has been working diligently to cultivate a comprehensive community BH center model deeply rooted in evidence-based practices and innovative, evidence-informed practices. This is accomplished through thorough contracting, a robust certification and contract monitoring process, and an interactive continuous quality improvement process with CCBHCs based on consistent data monitoring. Iowa is committed to undertaking targeted efforts to ensure clients are accessing services easily, being provided with the services that meet their needs, and ensuring all of their MH, physical health, and SUD needs are integrated. Those with SMI, SUD, and SED must receive intensive care coordination and access peer support.

Adults with SMI and children with SED remain a priority population. Iowa saw an increase in adults reporting unmet needs from 18.2% in 2020 to 25.5% in 2022[i].

From the work undertaken in the CCBHC planning year, Iowa is committed to and poised to accomplish this goal. We are confident that with enhanced standards, increased workforce, and the new payment methodology of the CCBHC demonstration, Iowa will achieve improved availability, accessibility, and participation in services to meet the needs of Iowans.

Proposed CCBHC Measures to show Impact: Goal 2.

Primary Measures – Appendix B

1. Time to Services
2. Patient Experience of Care Survey

Additional Measures for Evaluating Impact and Effectiveness

1. Increase the number of clients served - *demonstrate the improved availability to persons who may not have been able to access services in the past.*
2. Increase the number of clients engaging in treatment as defined by a 3rd and 4th service within 30 days of the 2nd service - *measure improved participation in services.*
3. Increase the number of veterans and military personnel served.
4. Increase the number of BIPOC clients served.
5. Increase the number of LGBT community served - *address underserved populations identified through the needs assessments.*

Data Collection, Documentation, Tracking of Outcomes, and Analysis. Data will come from two sources, MMIS and IBHRS. The proposed measures will be compiled from claims and will incorporate a more robust analysis of impact through the inclusion of additional process measures to understand drivers of performance. To enhance transparency and facilitate CQI processes, clear definitions of both the numerator and denominator for each measure will be communicated to the CCBHCs. This dissemination of information ensures that sites understand the calculation of each measure, empowering them to internally monitor their progress.

The Iowa HHS staff will compile measures quarterly, and comprehensive reports will be made accessible to CCBHCs through internal dashboards. Access will be limited to each CCBHC's data, allowing drill-down capabilities to satellite locations and individual client information. The presentation of results will include trend lines, commencing with baseline figures, providing a visual representation of performance over successive quarters. Employing predictive analysis techniques, such as multiple regression, will enable the establishment of relationships among three or more variables. This approach allows for the creation of combinations that further define these relationships.

For example, if veteran outcomes appear lower than those of non-veterans, models can be employed to investigate whether this discrepancy applies universally to all veterans or specific subgroups, such as American Indian veterans. Additionally, data analysis by CCBHC will be conducted to identify and isolate any program-specific or contextual effects. This comprehensive approach ensures a nuanced understanding of performance metrics and supports informed decision-making within the CCBHCs.

Projection of Impact. To address variations in baseline numbers among the nine CCBHCs, the impacts are expressed as percentage increases relative to each CCBHC's baseline measure. Collaborating with the federal project officer, a comprehensive review of these measures will be conducted after the initial year to assess whether adjustments are warranted.

Measure
Goal 2: I-Serv
1. Increase the number of clients served - *demonstrate the improved availability to persons who may not have been able to access services in the past.* 2. Increase the number of clients engaging in treatment as defined by a 3rd and 4th service within 30 days of the 2nd service - *measure improved participation in services.* 3. Increase the number of veterans and military personnel served. 4. Increase the number of BIPOC clients served. 5. Increase the number of LGBT community served

[i] https://psychu.org/wp-content/uploads/2021/01/Trends-In-Behavioral-Health-A-Reference-Guide-2021_09082021-2.pdf

Part 3: Prospective Payment System Methodology Description

Using the following format, describe the state's prospective payment system (PPS) methodology. This part of the Guidance will be scored up to a total of 20 points and your response may not exceed 30 pages. Each section of this part of the application corresponds to the same section of the CCBHC PPS Guidance. Sections 1-5 of this form pertain to fee for service prospective payment; managed care payment is addressed in section 6.

Section 1: Introduction

Section 223 of the PAMA, requires payment using a PPS for CCBHC services provided by qualifying clinics and related satellite sites established prior to April 1, 2014. The Centers for Medicare & Medicaid Services (CMS) offers a state the option of using one of four (4) PPS payment methodologies. States may select from among the daily Certified Clinic PPS rate (CC PPS-1), the monthly Certified Clinic PPS rate (CC PPS-2), the daily Certified Clinic PPS rate that includes special crisis services (CC PPS-3), and the monthly Certified Clinic PPS rate that includes special crisis services (CC PPS-4). The rate selected by the state must be used demonstration-wide for payments that are either fee for service (FFS) or made through managed care payment systems. CMS updated the PPS Technical Guidance in 2023 which outlines details specific to the available PPS options currently available under the CCBHC demonstration.

Section 2: CCHBC PPS Rate-Setting Methodology Options

CMS offers a state the option of the CC PPS-1, CC PPS-2, CC PPS-3, or CC PPS-4 methodology for use demonstration-wide. The state chooses the following methodology (select one):

- (●) Certified Clinic PPS-1 Methodology (CC PPS-1) (Continue to Section 2.1)
- ( ) Certified Clinic PPS-2 Methodology (CC PPS-2) (Continue to Section 2.2)
- ( ) Certified Clinic PPS-3 Methodology (CC PPS-3) (Continue to Section 2.3)
- ( ) Certified Clinic PPS-4 Methodology (CC PPS-4) (Continue to Section 2.4)

Section 2.1: Certified Clinic PPS-1 Methodology (CC PPS-1)

The CC PPS-1 methodology is implemented as a fixed daily rate that reflects the expected cost of all CCBHC services provided on any given day to a Medicaid beneficiary. This is a cost based, per clinic rate that applies uniformly to all services rendered by a CCBHC and qualified satellite facilities established prior to April 1, 2014. The state has the option of offering Quality Bonus Payments (QBPs) that are to be paid in addition to the PPS rate to any certified clinic that achieves on state established thresholds for payment in accordance with Section 3: Quality Bonus Payments (QBPs) of the updated PPS Guidance.

Section 2.1.a Components of the CC PPS 1 Rate Methodology

Demonstration Year One (DYl) Rate Data

In the box below explain the source(s) of cost and visit data used to determine the DYl rate. Detail any estimates that the state used to determine allowable cost and the appropriate number of daily visits to include in the rate calculation. If more space is needed, please attach and identify the page that pertains to this section.

Cost and visit data used to determine Demonstration Year 1 (DY1) rates came directly from data supplied in provider cost reports. The Iowa Department of Health and Human Services (HHS) used the cost report template provided by The Centers for Medicaid and Medicare Services (CMS). The HHS Provider Cost Audit team performed a review of each cost report that involved checking data against audited financial reports, claims history, and other requested data from providers. Providers also shared supplemental data that were used to inform their assumptions regarding anticipated costs, related staffing, and projected daily visits. Additional supplemental data were requested to understand detailed assumptions related to crisis services, to enable consideration of PPS-3 in future Demonstration Years. Rates were then properly adjusted to reflect the application of the Medicare Economic Index, at which point they were approved as preliminary rates for DY1.

Annual PPS-1 Rate Updates

The CC PPS-1 rates will be updated between DYs with mandatory rebasing by using (select one):

- (●) The Medicare Economic Index (MEI)
- ( ) Rebasing CC PPS-1 rate

Interim Payment Methodology for Rebasing

When rebasing PPS rates for an upcoming DY, the PPS rate for the upcoming DY is calculated by rebasing the prior DY's PPS rate so the rate calculated for the upcoming DY reflects the prior DY's cost experience. As the cost and visit data for the prior DY data will not be available to the state in time to analyze and rebase the rate prior to the start of the upcoming DY, the state will need to pay an interim PPS rate until the PPS rate(s) are finalized for that DY. In the box below, please provide an explanation of the interim payment methodology[7] that your state will use specifying what interim rate the state will pay providers, when the final PPS rate would be calculated for that DY, and how the state intends to reconcile claims for that DY to ensure that all CCBHC service encounters provided in that DY are paid that DY's rebased PPS rate. If the state intends to have a different interim payment methodology for the optional annual and mandatory rebasing timeframes (DY3 and every three years thereafter), please include a description of both methodologies below. If more space is needed, please attach and identify the page that pertains to this section.

[7] An interim rate is requested as it is likely that the current DY data will not be available to the state in time to analyze and rebase the rate for the upcoming DY.

Iowa HHS will use the Medicare Economic Index (MEI) to rebase the CC PPS-1 rates at the end of each DY. The rates for DY1 have been set according to the methodology described above and will be applicable as the interim rate for DY2 until DY1 rates have been rebased using the MEI. Any claims paid at the interim rate level while rebasing occurs will be reconciled and updated to the final approved rate once finalized in accordance with our timeframe for rate setting across Medicaid programs and services.

If Section 2.1 is completed, skip Sections 2.2, 2.3, and 2.4 and continue to Section 3.1.

Section 2.2: Certified Clinic PPS-2 Methodology (CC PPS-2)

The CC PPS-2 methodology is implemented as a fixed monthly rate that reflects the expected cost of all CCBHC visits provided within any given month to a Medicaid beneficiary. This is a cost-based, per clinic rate that applies uniformly regardless of the number of services rendered within the month by a CCBHC and qualified satellite facilities established prior to April 1, 2014. Under this methodology, separate rates are developed for both the base population and if elected to implement by the state, clinic users with certain conditions, or special populations (SP). In addition, the CC PPS-2 methodology includes outlier payments that are required to be paid for costs exceeding state- defined thresholds and the implementation of QBPs in accordance with Section 3: Quality Bonus Payments of the PPS guidance.

Section 2.2a Components of the CC PPS 2 Rate Methodology

DYl Rate Data

In the box below explain the source(s) of cost and visit data used to determine the DYl rate. Detail any estimates that the state used to determine allowable cost and the appropriate number of monthly visits to include in the rate calculation. If more space is needed, please attach and identify the page that pertains to this section.

Not Applicable

Annual PPS-2 Rate Updates

The DYl CC PPS-2 rate(s) will be updated between DYs with mandatory rebasing by using (select one):

- ○ The Medicare Economic Index (MEI)
- ○ Rebasing CC PPS-2 rate

Interim Payment Methodology for Rebasing

When rebasing PPS rates for an upcoming DY, the PPS rate for the upcoming DY is calculated by rebasing the prior DY's monthly PPS rate so the rate calculated for the upcoming DY reflects the prior DY's cost experience. As the cost and visit data for the prior DY data will not be available to the state in time to analyze and rebase the rate prior to the start of the upcoming DY, the state will need to pay an interim PPS rate until the PPS rate(s) are finalized for that DY. In the box below, please provide an explanation of the interim payment methodology[8] that your state will use specifying what interim rate the state will pay providers, when the final PPS rate would be calculated for that DY, and how the state intends to reconcile claims for that DY to ensure that all CCBHC service encounters provided in that DY are paid that DY's rebased PPS rate. If the state intends to have a different methodology interim payment methodology for the optional annual and mandatory rebasing timeframes (DY3 and every three years thereafter), please include a description of both methodologies below. If more space is needed, please attach and identify the page that pertains to this section.

Not Applicable

PPS-2 Identification of Populations with Certain Conditions, or Special Populations (SP)

Under the PPS-2 Methodology states have the option to develop a monthly PPS rate for populations with certain conditions, or Special Populations (SP). The state chooses to (select one):

- ○ Implement SPs and develop monthly SP PPS Rate(s) as part of the PPS-2 Methodology
- ○ Not implement SPs, therefore no monthly SP PPS Rate(s) will be developed as part of the PPS-2 Methodology (Continue to Section 2.2a, PPS-2 Outlier Payments)

[8] An interim rate is requested as it is likely that current DY data will not be available to the state in time to analyze and rebase the rate for the upcoming DY payment.

In the box below, identify populations with certain conditions for which separate PPS rates will be determined by the state and explain the criteria used to identify them. If more space is needed, please attach and identify the page that pertains to this section. Note: the populations listed below should match those shown on the sample cost report submitted by the state.

Not Applicable

PPS-2 Outlier Payments

Outlier payments are reimbursements to clinics in addition to PPS rates for participant costs that exceed a state-defined threshold to ensure that clinics are able to meet the costs of serving their users.

In the box below provide a description of the outlier payment methodology including an explanation of the threshold for making payment and how much of total allowable cost is set aside for outlier payment; how often outlier payment is calculated; and, how often certified clinics receive outlier payment. If more space is needed, please attach and identify the page that pertains to this section.

Not Applicable

If Section 2.2 is completed, skip Sections 2.1, 2.3, and 2.4 and continue to Section 3.2.

Section 2.3: Certified Clinic PPS-3 (CC PPS-3)

The CC PPS-3 methodology is implemented as a fixed daily rate that reflects the expected cost of all CCBHC services provided on any given day to a Medicaid beneficiary. This is a cost based, per clinic rate that applies uniformly to all services rendered by a CCBHC and qualified satellite facilities established prior to April 1, 2014. Under this methodology, separate rates are developed for both the base population and for at least one of the categories of special crisis services (SCS). In addition, under this methodology the state has the option of offering Quality Bonus Payments (QBPs) that are to be paid in addition to the PPS rate to any certified clinic that achieves on state established thresholds for payment in accordance with Section 3: Quality Bonus Payments (QBPs) of the updated PPS Guidance.

Section 2.3.a Components of the CC PPS-3 Rate Methodology

Demonstration Year One (DYl) Rate Data

In the box below explain the source(s) of cost and visit data used to determine the DYl rate. Detail any estimates that the state used to determine allowable cost and the appropriate number of daily visits to include in the rate calculation. If more space is needed, please attach and identify the page that pertains to this section.

Not Applicable

Annual PPS-3 Rate Updates

The DYl CC PPS-3 rates will be updated between DYs with mandatory rebasing by using (select one):

- ○ The Medicare Economic Index (MEI)
- ○ Rebasing CC PPS-3 rates

Interim Payment Methodology for Rebasing

When rebasing PPS-3 rates for an upcoming DY, the PPS rate for the upcoming DY is calculated by rebasing the prior DY's PPS rate so the rate calculated for the upcoming DY reflects the prior DY's cost experience. As the cost and visit data for the prior DY data will not be available to the state in time to analyze and rebase the rate prior to the start of the upcoming DY, the state will need to pay an interim PPS rate until the PPS rate(s) are finalized for that DY. In the box below, please provide an explanation of the interim payment methodology9 that your state will use specifying what interim rate the state will pay providers, when the final PPS rate would be calculated for that DY, and how the state intends to reconcile claims for that DY to ensure that all CCBHC service encounters provided in that DY are paid that DY's rebased PPS rate. If the state intends to have a different methodology interim payment methodology for the optional annual and mandatory rebasing timeframes (DY3 and every three years thereafter), please include a description of both methodologies below. If more space is needed, please attach and identify the page that pertains to this section.

Not Applicable

PPS-3 Special Crisis Services (SCS) Rates

Under the PPS-3 Methodology states are required to develop a daily PPS rate for at least one of the three categories of Special Crisis Services (SCS). The state chooses to implement the following SCS categories (select ***at least*** one):

- ☐ 9813 CCBHC mobile crisis services
- ☐ Other CCBHC Mobile Crisis services (non- 9813 Mobile Crisis Services)
- ☐ Crisis stabilization services occurring at the CCBHC

[9] An interim rate is requested as it is likely that the current DY data will not be available to the state in time to analyze and rebase the rate for the upcoming DY payment.

In the box below, please describe what demonstration services the CCBHC will provide under each category of SCS service the state intends to implement. If more space is needed, please attach and identify the page that pertains to this section. Note: the categories listed below should match those shown on the sample cost report submitted by the state.

Not Applicable

If Section 2.3 is completed, skip Sections 2.1, 2.2, and 2.4 and continue to Section 3.1.

Section 2.4: Certified Clinic PPS Alternative (CC PPS-4)

The CC PPS-4 methodology is implemented as a fixed monthly rate that reflects the expected cost of all CCBHC visits provided within any given month to a Medicaid beneficiary. This is a cost-based, per clinic rate that applies uniformly regardless of the number of services rendered within the month by a CCBHC and qualified satellite facilities established prior to April 1, 2014. Under this methodology, separate rates must be developed for both the base population and at least one of the categories of special crisis services (SCS). Additionally, states have the option to elect separate rates developed for clinic users with certain conditions, or special populations (SP). In addition, the CC PPS-4 methodology requires outlier payments that are paid for costs exceeding state- defined thresholds and the implementation of QBPs in accordance with Section 3: Quality Bonus Payments of the PPS guidance.

Section 2.4.a Components of the CC PPS-4 Rate Methodology

DY1 Rate Data

In the box below explain the source(s) of cost and visit data used to determine the DY1 rate. Detail any estimates that the state used to determine allowable cost and the appropriate number of monthly visits to include in the rate calculation. If more space is needed, please attach and identify the page that pertains to this section.

Not Applicable

Annual PPS-4 Rate Updates

The DYl CC PPS-4 rates will be updated between DYs with mandatory rebasing by using (select one):

- ○ The Medicare Economic Index (MEI)
- ○ Rebasing CC PPS-4 rates

Interim Payment Methodology for Rebasing

When rebasing PPS-4 rates for an upcoming DY, the PPS rate for the upcoming DY is calculated by rebasing the prior DY's PPS rate so the rate calculated for the upcoming DY reflects the prior DY's cost experience. As the cost and visit data for the prior DY data will not be available to the state in time to analyze and rebase the rate prior to the start of the upcoming DY, the state will need to pay an interim PPS rate until the PPS rate(s) are finalized for that DY. In the box below, please provide an explanation of the interim payment methodology[10] that your state will use specifying what interim rate the state will pay providers, when the final PPS rate would be calculated for that DY, and how the state intends to reconcile claims for that DY to ensure that all CCBHC service encounters provided in that DY are paid that DY's rebased PPS rate. If the state intends to have a different methodology interim payment methodology for the optional annual and mandatory rebasing timeframes (DY3 and every three years thereafter), please include a description of both methodologies below. If more space is needed, please attach and identify the page that pertains to this section.

Not Applicable

PPS-4 Identification of Populations with Certain Conditions, or Special Populations (SP)

Under the PPS-4 Methodology states have the option to develop a monthly PPS rate for populations with certain conditions, or Special Populations (SP). The state chooses to (select one):

- ○ Implement SPs and develop monthly SP PPS Rate(s) as part of the PPS-4 Methodology
- ○ Not implement SPs, therefore no monthly SP PPS Rate(s) will be developed as part of the PPS-4 Methodology (Continue to Section 2.4a, PPS-4 Special Crisis Services)

[10] An interim rate is requested as it is likely that current DY data will not be available to the state in time to analyze and rebase the rate for the upcoming DY payment.

In the box below, identify populations with certain conditions for which separate PPS rates will be determined by the state and explain the criteria used to identify them. If more space is needed, please attach and identify the page that pertains to this section. Note: the populations listed below should match those shown on the sample cost report submitted by the state.

Not Applicable

PPS-4 Special Crisis Services (SCS) Rates

Under the PPS-4 Methodology states are required to develop a monthly PPS rate for at least one of the three categories of Special Crisis Services (SCS). The state chooses to implement PPS rates for the following SCS categories (select ***at least*** one):

☐ 9813 CCBHC mobile crisis services

☐ Other CCBHC Mobile Crisis services (non- 9813 Mobile Crisis Services)

☐ Crisis stabilization services occurring at the CCBHC

In the box below, please describe what services the CCBHC will provide under each category of SCS service the state intends to implement. If more space is needed, please attach and identify the page that pertains to this section. Note: the categories listed below should match those shown on the sample cost report submitted by the state.

Not Applicable

PPS-4 Outlier Payments

Outlier payments are reimbursements to clinics in addition to PPS rates for participant costs that exceed a state-defined threshold to ensure that clinics are able to meet the costs of serving their users.

In the box below provide a description of the outlier payment methodology including an explanation of the threshold for making payment and how much of total allowable cost is set aside for outlier payment; how often outlier payment is calculated; and, how often certified clinics receive outlier payment. If more space is needed, please attach and identify the page that pertains to this section.

Not Applicable

If Section 2.3 is completed, skip Sections 2.1, 2.2, and 2.3 and continue to Section 3.2.

Section 3: Quality Bonus Payments (QBPs)

Section 3.1: Optional QBPs (CC PPS-1 and CC PPS-3)

When using the CC PPS-1 or CC PPS-3 methodology, a state may elect to offer a QBP to any CCBHC that has achieved on the state-defined threshold for a measure in accordance with Section 3: Quality Bonus Payments, of the PPS guidance. No incentive payment shall be made solely on the basis of reporting on measures and shall only be paid for CCBHC performance improvement at or above the measure threshold. The state can make a QBP for optional QBP quality measures provided in the PPS Guidance and may propose its own additional QBP quality measures. Any additional state-proposed measure must be approved by CMS.

The state chooses to (select one):

- ○ Not offer QBP(s) (Continue to Section 4)
- ◉ Offer OBP(s)

In the box below provide a list of the quality measures that will be used in addition to the required QBP measures listed in Section 3 of the PPS guidance. Please note any measure that is state-defined and provide a full description of the measure. If additional space is needed, please attach and identify the page that pertains to this section.

Iowa HHS intends to use the required QBP measures listed below. No additional measures will be utilized.

Time to Services (I-SERV)
Depression Remission at Six Months
Follow-Up After Mental Health Hospitalization (6-17)
Follow-Up After Mental Health Hospitalization (18-65)
Initiation and Engagement of Substance Use Disorder Treatment
Comprehensive Diabetes Care: Hemoglobin A1c Control for Patients with Diabetes
Plan All-Cause Readmission

In the box below describe the QBP methodology, specifying (1) the state-developed thresholds that trigger payment, (2) the methodology for calculating the payment, (3) the amount that will be paid for each measure, and (4) how often the payment is made to CCBHCs. Also provide an annual estimate of the amount of QBP payment by demonstration year (DY) for all clinics expected to be certified, including an estimate of the percentage of QBP payment to be made through the PPS rate. If additional space is needed, please attach and identify the page that pertains to this section.

Please see attached page titled "Iowa HHS CCBHC QBP Methodology."

In the box below, please specify how the state-developed thresholds were developed in such a way where QBPs made to providers are reflective of performance improvement, the provision of a higher quality of care, improvement of beneficiary health, or a reduction in health disparities. Please also explain how state needs assessments, priorities, and goals were used to determine the thresholds for the QBP quality measures. If additional space is needed, please attach and identify the page that pertains to this section.

In Iowa, the development of Quality Bonus Payment (QBP) thresholds for CCBHCs was meticulously aligned with our commitment to driving performance improvement, enhancing care quality, improving beneficiary health, and reducing health disparities. Grounded in collaborative engagement and data-driven decision-making, our approach was shaped by the firsthand insights of CCBHCs themselves, reflecting the unique challenges and priorities of Iowa's behavioral health landscape.

Our quality improvement initiatives were informed by needs assessments conducted directly by CCBHC sites themselves, reflecting the firsthand insights of those on the frontlines of care provision. Through structured dialogues, stakeholder consultations, and data analysis, we identified priorities for enhancing behavioral health services in Iowa. This collaborative process ensured that our QBP thresholds were firmly grounded in the realities and priorities of Iowa's behavioral health landscape. CCBHCs, intimately familiar with the unique challenges their communities faced, were able to identify gaps in service delivery, geographic disparities, and other barriers hindering timely access to care.

Drawing upon the findings of CCBHC-led needs assessments, we engaged in a rigorous process of synthesizing and prioritizing identified needs and challenges. Through data analysis, stakeholder consultations, and consensus-building exercises, we distilled key themes and priorities that resonated across diverse communities and populations served by CCBHCs. These priorities served as the foundation for our quality measurement framework, guiding the selection of performance metrics and the establishment of QBP thresholds.

Access to care emerged as a critical priority, with a particular emphasis on timely access. Leveraging insights from needs assessments and stakeholder engagements, we prioritized the development of a QBP approach aimed at prioritizing access to care, specifically, the Time to Services measure. Given the importance in promoting access, we allocated $500,000 of the available $1,000,000 QBP fund specifically to reward performance on this measure. By tracking and analyzing the duration between initial contact and first scheduled appointment, we stand to gain valuable insights into the efficiency of appointment scheduling processes and the overall accessibility of behavioral health services.

Our approach to QBP thresholds prioritizes continuous quality improvement, fostering a culture of data-driven feedback and collaboration among CCBHCs. Through continuous monitoring, evaluation, and refinement of performance metrics, CCBHCs will be empowered to pinpoint areas for improvement and enact focused interventions to catalyze positive change. This iterative process ensures that our QBP thresholds remain dynamic and responsive to evolving needs and priorities within Iowa's behavioral health system.

While CCBHCs took the lead in conducting needs assessments and identifying local priorities, our efforts remained closely aligned with the broader goals and objectives outlined in Iowa's healthcare transformation initiatives and strategic plans. We ensured that our quality measurement framework complemented statewide efforts to improve access to care, enhance care coordination, promote evidence-based practices, and address health disparities. Our collaborative approach, grounded in data-driven decision-making and continuous quality improvement, ensured that our QBP thresholds were effectively aligned with the goals of Iowa's healthcare transformation efforts, with a specific allocation of resources to address the critical priority of promoting access through the Time to Services measure.

Section 3.2: Required QBPs (CC PPS-2 and CC PPS-4)

Under the CC PPS 2 and CC PPS-4 methodologies, a state must offer a QBP to any CCBHC that has achieved the state-defined threshold for a measure in accordance with Section 3: Quality Bonus Payments, of the PPS Guidance. No incentive payment shall be made solely on the basis of reporting on measures and shall only be paid for CCBHC performance at or above the measure threshold. The state can make a QBP for optional QBP quality measures provided in the PPS guidance and may propose its own additional QBP quality measures. Any additional state-proposed measures must be approved by CMS.

In the box below provide a list of the quality measures that will be used in addition to the required QBP measures listed in Section 3 of the PPS guidance. Please note any measure that is state-defined and provide a full description of the measure. If additional space is needed, please attach and identify the page that pertains to this section.

Not Applicable

In the box below describe the QBP methodology, specifying (1) the state-developed thresholds that trigger payment, (2) the methodology for calculating the payment, (3) the amount that will be paid for each measure, and (4) how often the payment is made to CCBHCs. Also provide an annual estimate of the amount of QBP payment by demonstration year (DY) for all clinics expected to be certified, including an estimate of the percentage of QBP payment to be made through the PPS rate. If additional space is needed, please attach and identify the page that pertains to this section.

Not Applicable

In the box below, please specify how the state-developed thresholds were developed in such a way where QBPs made to providers are reflective of performance improvement, the provision of a higher quality of care, improvement of beneficiary health, or a reduction in health disparities. Please also explain how state needs assessments, priorities, and goals were used to determine the thresholds for the QBP quality measures. If additional space is needed, please attach and identify the page that pertains to this section.

Not Applicable

Section 4: Payment to CCBHCs that are FQHCs, Clinics, or Tribal Facilities

In some instances, a CCBHC may already participate in the Medicaid program as a Federally Qualified Health Center (FQHC), clinic services provider or Indian Health Service (IHS) facility that receives payment authorized through the Medicaid state plan. In these instances, the state should refer to the PPS guidance for how these Medicaid providers would be paid when a clinic user receives a service authorized under both the state plan and this demonstration.

☑ The state will require each certified clinic on its CCBHC cost report to report whether it is dually certified as a FQHC, clinic services provider or IHS facility.

Section 5: Cost Reporting and Documentation Requirements

In order to determine CCBHC PPS rates, states must identify allowable costs necessary to support the provision of services.

Section 5.1: Treatment of Select Costs

CMS provides additional guidance for the state regarding how to treat select costs, including uncompensated care, telehealth, and interpretation or translation service costs.

☑ The state excludes the cost of uncompensated care from its calculation of the CCBHC PPS rate(s).

Section 5.2: Cost Report Elements and Data Essentials

Cost Reporting

◉ The state will use the CMS CCBHC cost report and has attached a sample completed CCBHC Cost Report form plus an explanatory narrative that demonstrates the rate for DY1.

○ The state will use its own cost report and has attached a sample completed CCBHC Cost Report form plus an explanatory narrative that demonstrates the rate for DY1 and the cost report instructions.

The attached state-developed cost report template includes following key elements as specified in section 4.2 of the PPS guidance:

☐ Provider Information

☐ Direct and Indirect Cost-Identification

☐ Direct and Overhead Cost-Allocations

☐ Number of Visits

☐ Rate Calculations

Section 6: Managed Care Considerations

The statute requires payment of PPS and allows payment to be made through FFS and/or through managed care delivery systems for demonstration services. If the state chooses to include CCBHC service coverage in their managed care contracts, CCBHCs must still receive the full PPS payment.

Section 6.1: Managed Care Capitation CCBHC PPS Rate Methodology

☑ Please check the box if at least some, if not all of the CCBHC services under the demonstration will be delivered through managed care.

☑ Please check the box to confirm that the PPS methodology selected in Section 2 will apply to CCBHC demonstration services delivered in both managed care and FFS.

☐ Please check the box if none of the CCBHC services under the demonstration will be delivered through managed care. (Continue to Section 7)

Section 6.2: Building CCBHC PPS Rates into Managed Care Capitation

CMS offers states the option of using either of the following methodologies for incorporating the CCBHC rate into the managed care payment methodology (select one):

◉ Fully incorporate the PPS payment into the managed care capitation rate and require the managed care plans to pay the full PPS.

Explain how the state will provide adequate oversight to ensure CCBHCs receive the actual PPS rates, including provisions for special populations and outlier payments, as applicable (PPS-2 and PPS-4). If additional space is needed, please attach and identify the page that pertains to this section.

Iowa HHS will fully incorporate the PPS payment in the managed care capitation rate and require the medicaid managed care plans in Iowa to pay the full PPS to certified CCBHCs in the demonstration program. We will use the same approach for management and oversight of these payments as we have used for Federally Qualified Health Centers (FQHC) in Iowa. Under this approach, managed care plans will be contractually required to enter into contracts for service provision with CCBHCs and required to provide payment that is not less than the level and amount of payment which the managed care plan would make for the services if the services were furnished by a Provider that is not an CCBHC. The Contractor is then required by the State to add the required amount to the contracted payment rate consistent with the amount specified for the CCBHC wrap around payment that would equal what was owed under the PPS rate setting methodology. In addition to these contractual requirements for managed care plans serving Medicaid that detail payment expectations, HHS conducts regular payment oversight audits to ensure payments made to FQHCs, and in this case CCBHCs, are whole and complete based on the capitation rates and required wrap around payment corresponding with the published clinic-specific rates, as developed by Iowa HHS actuaries. Any plan found not in compliance with this requirement can be placed under a Corrective Action Plan and failure to address audit findings can result in punitive action, up to and including contract termination.

OR

○ Require the managed care plans to pay a rate to the CCBHCs that other providers would receive for similar services, then use a state supplemental payment (wraparound) to ensure payment to CCBHCs is equal to the PPS.

Explain how the state will provide adequate oversight related to reconciling managed care payments with full PPS rates, including provisions for special populations and outlier payments. If additional space is needed, please attach and identify the page that pertains to this section.

Not Applicable

Explain the frequency and timing of the wraparound payment used by the state:

Not Applicable

Section 6.3: Managed Care Delivery System Operational Considerations

Strategies for avoiding duplication of payments: There is significant variation of how services are delivered through Medicaid managed care. Several states contract with PIHPs and PAHPs that specialize in behavioral health services. Medicaid enrollees may be members of a PIHP or PAHP and MCO at the same time. As such, a CCBHC may not be aware which managed care plan is responsible for payment of behavioral health services. Please indicate the contractual arrangement(s) that will be delivering services under the demonstration:

- (●) CCBHC demonstration services will be delivered by multiple managed care plans (MCOs, PIHPs, PAHPs).

  OR:

- ( ) The state will require all CCBHC services to be delivered under the contract for one managed care plan.

Describe which managed care plans will be responsible for providing CCBHC services and what services provided in other managed care plans may duplicate the CCBHC services.

Iowa HHS contracts with three managed care entities to provide and manage Medicaid benefits for eligible Iowans: Iowa Total Care (Centene), Molina Healthcare of Iowa, and Wellpoint Iowa, Inc. (formerly Amerigroup Iowa, Inc.). Each managed care entity is responsible for providing and managing all medical and behavioral health benefits for their enrollees as detailed in our State Plan Amendment (SPA), block grants, and waiver authorities, inclusive of all services required under the CCBHC demonstration program. Each managed care entity will be responsible for covering CCBHC services for the eligible beneficiaries enrolled in their respective plan. There is no expectation of overlap or duplication of CCBHC services in the managed care system. Each managed care entity would remit payment to the appropriate CCBHC following the methodology described in Section 6.2 based on the provision of threshold and/or allowable CCBHC services to eligible Iowans enrolled in their respective managed care plan on the date when CCBHC services were rendered.

Explain the methodology for removing services that duplicate CCBHC demonstration services from the managed care plans not responsible for the CCBHC services, how managed care capitation rates will be changed, the timing/process for determining that the new managed care rates will be actuarially sound, and how the state will ensure no duplication of expenses. If additional space is needed, please attach and identify the page that pertains to this section.

As described above, HHS does not anticipate the need to remove duplicate services provided under the CCBHC demonstration, as we are planning for managed care plans to be responsible for the totality of the CCBHC services for eligible Medicaid beneficiaries enrolled under their respective plans. However, HHS is conducting a thorough review of services that already exist in Iowa's Medicaid program under existing authorities to ensure there is no duplication or overlap of services that are provided to eligible individuals (i.e., Integrated Health Home Services, B2 waiver services, etc.) This analysis has begun and is supported by our Medicaid actuarial team and will be complete by the start of DY1 and is being conducted in collaboration with our provider audit and actuarial teams.

Capitation rates are typically developed three to four months prior to the annual contract period. For example, the capitation rates effective for a state fiscal year (SFY) beginning July 1st and effective through June 30th of the following year are developed between January – April prior to the July 1st date.

Additionally, where necessary, annual capitation rates may be amended to reflect program changes that were not anticipated or known during the period the capitation rates were being developed. In these circumstances, our Medicaid actuarial team will assess the impact of the program change(s) is analyzed, and the capitation rates are modified. In the case of the implementation of the CCBHC demonstration, the capitation rate development adjustment will include evaluating historical utilization of Medicaid state plan services to develop the impact of implementing CCBHC Prospective Payment Systems (PPS-1) rate methodology as well as estimates for additional service utilization, if necessary, anticipated because of the implementation of CCBHC providers.

If a state chooses not to include all demonstration services under one contractor, define the delineation of services between contractors. If this delineation will require a change to managed care capitation rates, explain how rates will be affected, the timing and process for determining that the new managed care rates will be actuarially sound, and how the state will ensure non-duplication of payments. If additional space is needed, please attach and identify the page that pertains to this section.

HHS will require each of its three Medicaid Managed Care plans listed in Section 6.3 to provide all CCBHC services, according to the scope of services contemplated in their current contractual agreement with HHS. As described above, our actuaries will assess capitation rates and will adjust them to incorporate the costs associated with the CC PPS-1 rates and managed care plans will be expected to reimburse CCBHCs consistent with current requirements applicable to FQHC reimbursement. Specific CCBHC services will not be delineated or distributed between contractors. Contractors will be responsible for providing the full range of required CCBHC services to beneficiaries who are enrolled in their respective plan and receive threshold and/or allowable CCBHC services on a given day. The contractor will then be responsible for reimbursing the CCBHC according to their published clinic-specific CC PPS-1 rate.

Section 6.4: Data Reporting and Managed Care Contract Requirements

Describe the data reporting polices and processes, including specific data deliverables to be reported by each entity, collection of data, timing of reporting, and contract language for data reporting. If additional space is needed, please attach and identify the page that pertains to this section.

Performance monitoring and data analysis are critical components in assessing how well Iowa's managed care entities are maintaining and improving the quality of care delivered to Medicaid beneficiaries. Managed care entities are required to submit to HHS a range of data which will be leveraged under the CCBHC demonstration, including encounter data; data on the basis of which HHS certifies the actuarial soundness of capitation rates; data on the basis of which HHS determines compliance with medical loss ratio requirements; data on the basis of which HHS determines the plan has made adequate provision against the risk of insolvency; documentation that assures that Contractor has complied with HHS requirements for availability and accessibility of services, including the adequacy of its provider network; information on ownership and control; and the annual report of overpayment recoveries. In addition the data and documentation specified, Managed Care entities are also required to submit and furnish any other data, documentation, or information related to their performance as required by HHS. Managed Care plans are required to comply with all reporting requirements submit requested data completely and accurate within requested time frames and in the format identified by HHS. Managed care plans are also required to develop and submit member service reports that capture the completion of initial health risk scoring, completion of comprehensive health risk assessment, care plan development, member helpline performance, member enrollment, member grievances, member hearing and appeals, and consumer assessment of healthcare providers and systems (CAHPS). Managed care plans are also required to develop and submit quality management reports that identify program and clinical improvements, including HEDIS reports that must be completed annually and submitted along with the same audited data provided to NCQA. HHS uses these data to establish baseline performance targets for all HEDIS measures. On a quarterly basis, managed care plans must develop a behavioral health clinic report and baselines rates for behavioral health indicators. These specifically will be leveraged as part of our data collection and quality improvement objectives under the CCBHC demonstration. These quarterly reports include: follow-up after inpatient hospitalization for mental illnesses, readmission rates for psychiatric hospitalizations, anti-depression medication management, follow-up care for children prescribed attention deficit hyperactivity disorder medication, diabetes screening for people with schizophrenia or bipolar disorder who are using anti-psychotic medication; adherence to anti-psychotic medications; number and percentage of members receiving mental health services, number and percent of members receiving substance use disorder services, report that identifies foster children by a common identifier, their age, diagnosis, and prescribed medications; and a report that identifies foster children by a common identifier who are on two or more prescribed psychotropic medications, psychotropic prescriptions, and diagnoses to support prescribing pattern. (A full copy of contract language regarding data reporting is attached as an additional page and titled "Managed Care Data Reporting Requirements.")

Explain how the state will ensure access to CCBHC services from Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), or Prepaid Ambulatory Health Plans (PAHP), particularly how it will address out-of-network access to CCBHCs. Please also indicate if the state plans to develop quantitative networks adequacy standards specific to CCBHCs (note: this is recommended but not required). If additional space is needed, please attach and identify the page that pertains to this section.

All CCBHCs certified for DY1 currently participate as in-network providers with our three managed care plans in Iowa. HHS will continue to have the expectation that any certified CCBHCs participate contractually in Medicaid managed care plan networks to ensure access to CCBHC services. HHS plans to include CCBHC services in its existing quantitative network adequacy requirements for Behavioral Health Access Standards for managed care plans, including Time and Distance requirements for Behavioral Health outpatient services and Appointment Time requirements. The CCBHC standard for access will be used where it is more stringent than the current network adequacy requirements, (A full copy of contract language regarding data reporting is attached as an additional page and titled "Behavioral Health Network Adequacy Requirements.")

Section 6.5: Identification of Expenditures Eligible for Enhanced Federal Matching Percentage (FMAP)

Describe the process whereby the state will ensure proper claiming of enhanced FMAP for CCBHC services by identifying the portion of the capitation payment(s) applicable to the services/populations that are eligible for the enhanced match. States should reference the SMD-23-0005 guidance CMS issued in August 2023 on Medicaid managed care claiming methodologies. If additional space is needed, please attach and identify the page that pertains to this section.

HHS will follow CMS guidance (SMD-23-005 guidance) to ensure proper claiming of enhanced federal matching percentage (FMAP). HHS will identify eligible CCBHC costs on a service basis by identifying eligible expense paid for CCBHC encounters via managed care and fee-for-service Medicaid. Our actuary will identify these services by utilizing the HCPCS code T1040 and eligible and threshold service codes billed for eligible Iowans enrolled in Medicaid. We will then attribute those populations on a Per Member Per Month (PMPM) basis to claim the appropriate FMAP level based on their service provision within the CCBHC demonstration program. HHS will claim this using the CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.

Section 7: Identifying CCBHC Claims and Service Level Encounter Detail

States participating in the CCBHC demonstration must have a mechanism for identifying claims attributable to the CCBHC demonstration as well as service level detail of the CCBHC services provided during the encounter. The CMS Alpha Numeric Healthcare Common Procedure Coding System (HCPCS) File & Code Sets contain dedicated 223 demonstration encounter "T" billing codes that are for CCBHCs to bill solely for demonstration encounters and a Q2 billing code modifier that can be used for billing service-level data associated with each demonstration encounter.

The State will use one of the following mechanisms to identify claims attributable to the CCBHC demonstration (select one):

- (●) T1040 Medicaid certified community behavioral health clinic services, per diem demonstration billing code
- ( ) T1041 Medicaid certified community behavioral health clinic services, per month demonstration billing code
- ( ) Another state-developed mechanism for identifying CCBHC claims, as described below.

Not Applicable

The State will use one of the following mechanisms to identify the service level detail associated with each demonstration encounter (select one):

- (●) Q2 Demonstration procedure/service modifier
- ( ) Another state-developed mechanism for identifying service level detail associated with each demonstration encounter, as described in detail below.

Not Applicable

Section 8: Funding Questions: Section 223 Behavioral Health Demonstration

The questions below should be answered relative to all payments made to CCBHCs reimbursed pursuant to Section 223 of P.L. 113-93 Protecting Access to Medicare Act of 2014[3] and the methodology described in the state's application to participate in the demonstration program.

CMS requests the following information about the source(s) of the non-federal share of payment made for demonstration services.

1. Section 1902(a)(2) stipulates that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

    a. Describe how the non-federal share of each type of Medicaid payment (e.g., basic PPS rate, outlier payment and quality bonus payments) is funded.

The non-federal (state) share of each type of Medicaid payment (PPS-1 rate and quality bonus payments) will be funded from an appropriation from the legislature to the Iowa HHS, the state Medicaid agency.

    b. Describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through an IGT. In this case, please also identify the agency to which the funds are appropriated.

The state share will be funded from appropriations from the Legislature to the Medicaid agency (Iowa HHS) only. Funding will not be provided through IGTs, provider taxes or any other mechanism.

c. If any of the non-federal share of payment is being provided using IGTs, fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

Not Applicable

d. For any payment funded by IGTs, please provide the following information:

i. A complete list of the names of entities transferring funds;
ii. The operational nature of the entity (state, county, city, other);
iii. The total amounts transferred o by each entity;
iv. Clarify whether the transferring entity has general taxing authority: and,
v. Whether the transferring entity received appropriations (identify level of appropriations)

Not Applicable

2. Do CCBHC providers receive and retain the total Medicaid expenditures claimed by the state for demonstration services (includes PPS and quality bonus payments) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization?

   If providers are required to return any portion of payments, provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, who they return the funds to (state, local governmental entity, or any other intermediary organization), the amount or percentage of payments that are returned, and the disposition and use of the funds once they are returned (e.g., general fund, medical services account, etc.).

CCBHC providers will retain the total Medicaid expenditures claimed by the state for demonstration services. No portion of the payments will be returned to the state, local governmental entity, or any other intermediary organization.

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Certified Community Behavioral Health Clinic (CCBHC) Explanatory Narrative

Providers were required to submit CCBHC cost reports based on their fiscal year end. The fiscal year ends ranged from 12/31/2022 through 12/31/2023. One provider used their 12/31/2022 fiscal year to ensure accuracy of the financial and statistical data. The following process steps were developed to ensure the following:

- The Centers for Medicare and Medicaid Services (CMS) cost report template was used and applicable schedules were completed.
- The provider was able to isolate and identify reported CCBHC costs separate from non-CCBHC costs and allocation methodology was supported by documentation.
- CCBHC cost and visits reconciled to supporting documentation.
- CCBHC cost was only reported for sites that existed prior to April 1, 2014.
- The reported visits were for threshold CCBHC services, only for one visit per day per patient, and for all patients regardless of payor.
- Anticipated cost rationale was included and supported by documentation.
- Reported indirect cost was based on the provider's federal indirect cost rate (FIR). If the provider had no FIR and either the federal minimum rate or percentage of direct cost was used, accuracy was verified. No provider used their own allocation methodology.
- Non-allowable cost per 2 C.F.R. Part 200 were excluded from CCBHC costs.
- Revenues reduced CCBHC costs as applicable.
- Medicare Economic Index (MEI) percentage was applied from the mid-point of the cost report period to mid-point of the rate period.

The submitted cost reports were not audited, instead the process steps were completed at the desk level through provider inquiry and documentation submission.

666 Walnut Street, Ste. 2400 | Des Moines, IA 50309
PH 515.256.4610 | PH 866.863.8610 | FX 515.725.1353
www.myersandstauffer.com

Iowa HHS CCBHC QBP Methodology

Iowa intends to provide a QBP for CCBHCs meeting the seven identified comparative measures. The CCBHC must achieve or exceed the threshold set for each measure to be eligible for a quality bonus payment. CCBHC QBP performance will be evaluated and awarded at the CCBHC site level. Per recent federal guidance, CCBHCs' will be awarded funding for measures which the CCBHC attains or exceeds the state established performance targets. QBP will be awarded only for achieving the quality targets and no payment will be made for reporting of quality measures. In order to earn the QBP, the CCBHC must achieve the performance target to enter the QBP measure-specific pool. This Iowa-developed approach is a performance-driven tiered methodology which is a fixed amount per measure with a higher share of the QBP going to the CCBHC with the best performance. The Iowa-developed performance driven tiered structure is designed to incentivize continuous improvement while rewarding exceptional performance appropriately. The calculation process involves assessing CCBHCs' performance levels against established thresholds and categorizing them into different tiers based on their achievements. Higher-performing CCBHCs, those surpassing predetermined benchmarks by significant margins, are placed in top tiers and receive larger bonus payments relative to their performance. Conversely, CCBHCs performing at lower levels are placed in lower tiers, with correspondingly smaller bonus payments. This methodology ensures that rewards are commensurate with performance levels, motivating CCBHCs to strive for excellence and contribute to the overall enhancement of behavioral health services in Iowa.

Iowa has allocated $1,000,000 to fund the QBP pool. The Time to Service (I-SERV) measure is of high priority to the state to ensure access to behavioral health care is timely for those seeking services. Therefore, $500,000 will be specifically dedicated to meeting the I-SERV measure targets. The remaining dollars for QBP measures will be allocated across the remaining measures with 10% for Depression Remission at Six Months and 8% allocated across the remaining measures For any dollars that are left remaining will be added to a redistribution pool to fund CCBHC TA, capacity building, and additional state support efforts to promote quality performance improvement. All CCBHCs will be informed of their incentive payment award by the fourth quarter of the year following the Measurement Period.

Measure	Threshold	Amount of QBP Pool	% of QBP
Time to Service - Initial Evaluation*	1 day	$500,000	50%
Time to Service - Initial Clinical Service*	10 days		
Time to Service - Crisis Service*	1 hour		
Depression Remission at Six Months	8.20%	$100,000	10%
Follow-Up After Mental Health Hospitalization (Adult)	41.20%	$80,000	8%
Follow-Up After Mental Health Hospitalization (Child)	54.50%	$80,000	8%
Initiation and Engagement of Substance Use Disorder Treatment	39.20%	$80,000	8%
Comprehensive Diabetes Care: Hemoglobin A1c Control for Patients with Diabetes	6.80%	$80,000	8%
Plan All Cause Readmission	7.40%	$80,000	8%

Note: Time to Service require CCBHCs to meet 2 of 3 of the submeasures to qualify for the bonus payment.

Managed Care Data Reporting Requirements

Contractor shall maintain records regarding third party liability collections and report these collections to the Agency in the timeframe and format determined by the Agency. The Contractor shall retain all third party liability collections made on behalf of its members; the Contractor shall not collect more than it has paid out for any claims with a liable third party. The Contractor shall provide to the Agency or its designee information on members who have newly discovered health insurance, in the timeframe and manner required by the Agency. The Contractor shall provide members and providers instructions on how to update TPL information on file and shall provide mechanisms for reporting updates and changes.

Reports include, but are not limited to:

1. Monthly amounts billed and collected, current and year-to-date.
2. Recoveries and unrecoverable amounts by carrier, type of coverage, and reason (quarterly).
3. TPL activity reports (quarterly).
4. Internal reports used to investigate possible third-party liability when paid claims contain a TPL amount and no resource information is on file.
5. Monthly quality assurance sample to the Department verifying the accuracy of the TPL updated applied during the previous month.
6. Monthly pay-and-chase carrier bills.

13.6.4 *Reserved*

13.6.5 *Health Insurance Premium Payment Program*

The Contractor shall identify members with third party coverage who may be appropriate for enrollment in the Health Insurance Premium Payment (HIPP) program. The Contractor shall report members identified as potentially eligible for HIPP to the Agency in the timeframe and manner to be determined by the Agency. The Agency maintains full and final authority for determining if an individual is eligible for HIPP.

13.7 Health Information Technology

The use of Health Information Technology (HIT) has the potential to improve quality and efficiency of health care delivery. Sharing of health care data can reduce medical errors, increase efficiency, decrease duplication and reduce fraud and abuse. HIT initiatives are an important part in improving public health research data quality to aid in evidenced-based decisions, membership health management and improve compliance and oversight. The Contractor shall obtain Agency approval of HIT initiatives and interfaces with IHIN. The Contractor shall leverage IHIN fully once it becomes fully operational. The Agency reserves the right to require the Contractor to establish additional HIT initiatives in the future.

14 Performance Targets and Reporting Requirements

14.1 General

Performance monitoring and data analysis are critical components in assessing how well the Contractor is maintaining and improving the quality of care delivered to members. The Agency will use various performance targets, industry standards, national benchmarks and program-specific standards in

monitoring the Contractor's performance and outcomes. The Agency reserves the right to publish Contractor performance. Failure to meet performance targets shall subject the Contractor to the corrective actions as outlined in Exhibit E. Refer to Exhibit F for information on the pay-for-performance program.

[31]The Contractor shall comply with the following data, information and documentation requirements in accordance with 42 C.F.R. § 438.604:

(a) *Specified data, information, and documentation.* Contractor shall submit to the Agency the following data:

(1) Encounter data in the form and manner described in 42 C.F.R. § 438.818.

(2) Data on the basis of which the Agency certifies the actuarial soundness of capitation rates to the Contractor under 42 C.F.R. § 438.4, including base data described in 42 C.F.R. § 438.5(c) that is generated by the Contractor.

(3) Data on the basis of which the Agency determines the compliance of the Contractor with the medical loss ratio requirement described in 42 C.F.R. § 438.8.

(4) Data on the basis of which the Agency determines that the Contractor has made adequate provision against the risk of insolvency as required under 42 C.F.R. § 438.116.

(5) Documentation described in 42 C.F.R. § 438.207(b) on which the Agency bases its certification that the Contractor has complied with the Agency's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 C.F.R. § 438.206.

(6) Information on ownership and control described in 42 C.F.R. § 455.104 from Contractor, and subcontractors as governed by 42 C.F.R. § 438.230.

(7) The annual report of overpayment recoveries as required in 42 C.F.R. § 438.608(d)(3).

(b) *Additional data, documentation, or information.* In addition to the data, documentation, or information specified in paragraph (a) of this section, Contractor must submit any other data, documentation, or information relating to the performance of the entity's obligations under 42 C.F.R. part 438 required by the Agency or the Secretary.

14.1.1 *Reporting Requirements*

The Contractor shall comply with all reporting requirements and shall submit the requested data completely and accurately within the requested timeframes and in the format identified by the Agency. The Agency reserves the right to require the Contractor to work with and submit data to third-party data warehouses or analytic vendors. The Contractor shall have policies, procedures

and mechanisms in place to ensure that the financial and non-financial performance data submitted to the Agency is accurate. The Contractor shall comply with the following certification requirements in accordance with 42 C.F.R. §438.606:

(a) *Source of certification.* For the data, documentation, or information specified in 42 C.F.R. § 438.604, Contractor shall certify the data, documentation or information the Contractor submits to the Agency by either the Contractor's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

(b) *Content of certification.* The certification provided by the individual in paragraph (a) of this section must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 C.F.R. § 438.604 is accurate, complete, and truthful.

(c) Timing of certification. Contractor shall submit the certification concurrently with the submission of the data, documentation, or information required in 42 C.F.R. § 438.604(a) and (b).

14.1.2 *Audit Rights and Remedies*

The Agency reserves the right to audit the Contractor's self-reported data at any time. The Agency may require corrective action or other remedies as specified in Exhibit E for Contractor non-compliance with these and other subsequent reporting requirements and performance standards.

14.1.3 *Meeting with the Agency*

The Agency may schedule meetings or conference calls with the Contractor upon receiving the performance data. Meetings or conference calls will be scheduled on days and times that are mutually agreed upon to by the Agency and the Contractor. [32]When the Agency identifies potential performance issues, the Contractor shall formally respond in writing to these issues within the timeframe required by the Agency. If the Contractor fails to provide a formal, written response to the feedback or fails to respond within the timeframe established by the Agency, the Agency may consider the Contractor noncompliant in its performance reporting and may implement corrective actions.

14.1.4 *Implementation Reporting*

The Agency reserves the right to require more frequent reporting at the beginning of the Contract to: (i) monitor program implementation; (ii) permit adequate oversight and correction of problems as necessary; and (iii) ensure satisfactory levels of member and provider services.

14.1.5 *Other Reporting and Changes*

The Agency will provide at least thirty (30) calendar days' notice to the Contractor before changing or adding any reporting requirements for reports that are anticipated as routine or are intended to be included in the reporting manual. The Agency will provide reasonable notice in advance but may request ad hoc reports at any time. The Reporting Manual, which shall be provided following the Contract award date, will detail reporting requirements and the full list of required reports.

14.2 Financial Reports and Performance Targets

Financial reports assist the Agency in monitoring the Contractor's financial trends to assess its stability and its ability to offer health care services to its members. The financial reports include but are not limited to the reports described in Section 14.2.1 through Section 14.2.7.

14.2.1 *Third Party Liability Collections*

The Contractor shall report all third party liability collections to the Agency in the timeframe and format determined by the Agency.

14.2.2 *Iowa Insurance Division Reporting*

The Contractor shall comply with all reporting requirements at Iowa Admin. Code r. 191-40.14(514B) and copy the Agency on all required filings with the Iowa Insurance Division.

14.2.3 *Annual Independent Audit*

The Contractor shall complete an annual independent audit as described in Section 2.3.5.

14.2.4 *Physician Incentive Plan Disclosure*

The Contractor shall submit information on physician incentive plans, in the manner prescribed by the Agency, with sufficient detail to permit the Agency to determine compliance with 42 C.F.R. § 422.208 and 42 C.F.R. § 422.210.

14.2.5 *Insurance Premium Notice*

The Contractor shall submit certificates of insurance for required insurance no less than thirty (30) calendar days after the policy renewal effective date.

14.2.6 *Reinsurance*

The Contractor shall provide to the Agency all contracts of reinsurance or a summary of the plan of self-insurance which meet the requirements as set forth in Section 2.3.2. As applicable, the Contractor shall report to the Agency, in the manner dictated by the Agency, all health care claims costs paid by the Contractor's commercial reinsurer due to meeting the reinsurance attachment point.

14.2.7 *Medical Loss Ratio*

The Contractor shall maintain, at minimum, a medical loss ratio as set forth in Attachment 2.7.[33]

14.3 Member Services Reports and Performance Targets

Member services reports identify the methods the Contractor uses to communicate to members about health care and program services and monitor member satisfaction. Examples of member services reports to be submitted by the Contractor, in accordance with the terms of the Reporting Manual, include but are not limited to the reports described in Sections 14.3.1 through Section 14.3.10.

14.3.1 *Completion of Initial Health Risk Screening*

As described in Section 9.1.1, the Contractor shall complete an initial health risk screening no later than ninety (90) calendar days after member enrollment with the Contractor. Each quarter, at least seventy percent (70%) of the Contractor's new members, who have been assigned to the Contractor for a continuous period of at least ninety (90) days, shall complete an initial health risk screening within ninety (90) days. For any member who does not obtain an initial health risk screening, the Contractor shall document at least three (3) attempts to conduct the screening.

14.3.2 *Completion of Comprehensive Health Risk Assessment*

As described in Section 9.1.2, the Contractor shall complete a comprehensive health risk assessment, in the timeframe mutually determined by the Agency.

14.3.3 *Care Plan Development*

Ninety-eight percent (98%) of members identified by the Contractor through the comprehensive health risk assessment as having a potential special healthcare care need shall have a care plan developed. Ninety-eight percent (98%) of care plans shall be updated, at minimum, annually.

14.3.4 *Member Helpline Performance Report*

The Contractor shall demonstrate the following: maintain a service level of 99% of calls answered by an individual or an electronic device without receiving a busy signal, and 80% of all calls will be answered in 30 seconds or less. The average speed for answering calls will be 30 seconds or less.[34]

14.3.5 *Member Enrollment*

The Contractor shall report total member enrollment count for the reporting period.

14.3.6 *Member Grievances Report*

The Contractor shall resolve one hundred percent (100%) of grievances within thirty (30) calendar days of receipt, or within seventy-two (72) hours of receipt for expedited grievances. The Contractor shall maintain and report to the Agency a member grievance log, which shall include the current status of all grievances.

14.3.7 *Member Hearing and Appeals Report*

The Contractor shall resolve one hundred percent (100%) of appeals within thirty (30) calendar days of receipt, or within 72 hours of receipt for expedited appeals. Further, one hundred percent (100%) of appeals shall be acknowledged within three (3) business days. The Contractor shall maintain and report to the Agency a member appeal log, which shall include the current status of all appeals.

14.3.8 *Summary of Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

The Contractor shall annually provide to the Agency the survey results from its independent CAHPS survey.

14.3.9 *Member Website Utilization Report*

The Contractor shall have the capability to track and report to the Agency member website utilization data, including EOB and quality information hits.

14.3.10 *Member PCP Assignment Report*

The Contractor shall report: (i) total member enrollment count for those members under a Value Based Purchasing arrangement for the reporting period; (ii) the total member disenrollment count for those members disenrolled from a Value Based Purchasing arrangement for the reporting period; and (iii) a separate, detail report showing each member assignment to their PCP, including, but not limited to the individual PCP (name, NPI), physical location, affiliated organizational NPI(s), organizational name and organizational tax ID. This report will be in the format and frequency determined by the Department.

14.4 Provider Network Reports and Performance Targets

Provider network reports assist the Agency in monitoring the Contractor's provider services, network composition and geo-access ratios in order to assess member access, network capacity and provider relations. The Contractor shall identify current enrollment, gaps in network services and the corrective actions that the Contractor is taking to resolve any potential problems relating to network access and capacity. The provider network reports and performance targets include but are not limited to the reports described in Section 14.4.1 through Section 14.4.5.

14.4.1 *Network Geographic Access Reports for Providers*

The Contractor shall demonstrate access within the requirements set forth in Exhibit B or additional network adequacy standards developed by the Agency. the Agency reserves the right to request more frequent Network Geographic Access Assessment reporting at the beginning of the Contract, until the Contractor demonstrates that the network access standards have been met.

14.4.2 *Twenty four (24) Hour Availability Audit*

One hundred percent (100%) of Contractor's network primary care providers shall be available to member's twenty-four (24) hours-a-day, seven (7) days-a-week, and the Contractor shall implement corrective actions for network providers identified through the audit as failing to meet this standard.

14.4.3 *Provider Credentialing Report*

The Provider Credentialing Report details the timeliness and effectiveness of the Contractor provider credentialing processes. Credentialing of all providers applying for network provider status shall be completed as follows: (i) eighty-five percent (85%) within thirty (30) calendar days; and (ii) ninety-eight percent (98%) within forty-five (45) calendar days. The start time begins when the Contractor has received all necessary credentialing materials from the provider. Completion time ends when written communication is mailed or faxed to the provider notifying them of the Contractor's decision.

14.4.4 *Subcontractor Compliance Summary Report*

The Contractor shall conduct quarterly formal reviews of all subcontractors and provide summary reports to the Agency, in the prescribed format, of all key findings and any applicable corrective action plans implemented.

14.4.5 *Provider Helpline Performance Report*

99% of calls will be answered by an individual or an electronic device without receiving a busy signal. 80% of all calls will be answered in 30 seconds or less. The average speed for answering calls will be 30 seconds or less.

14.5 Quality Management Reports & Performance Targets

Quality management reports document the methods and processes the Contractor uses to identify program and clinical improvements that enhance the appropriate access, level of care, quality and utilization of program services by its members and providers. These reports assist the Agency in monitoring the Contractor's quality management and improvement activities. The quality management reports include but are not limited to the reports described in Section 14.5.1 through Section 14.5.5.

14.5.1 *Quality Management and Improvement Program Work Plan*

In the Work Plan required by 2.13, the Contractor shall develop a work plan for the Quality Management and Improvement Program to identify the goals the Contractor has set to address its strategy for

improving the delivery of health care benefits and services to its members (QMIP Plan). In the QMIP Plan, the Contractor shall identify the steps to be taken and include a timeline with target dates. The plan shall be submitted prospectively for each year, with quarterly updates and a final evaluation of the prior year. As a part of this work plan, the Contractor shall include its proposal to align with the SIM project, including specific detail for the value based purchasing requirements described in section 6.1.2. The Contractor shall incorporated use of the Value Index Score (VIS) in the QMIP plan.

14.5.2 *Quality Management Committee Meeting Minutes*

The Contractor shall report Quality Management Committee meeting minutes, document the actions of the Contractor's Quality Management Committee, and shall be provided in the reporting cycle following the meeting.

14.5.3 *Care Coordination Report*

The Contractor shall submit the Care Coordination Report to summarize all members engaged in care coordination programs developed by the Contractor, in accordance with Section 9, including summary information on active participation, number of contacts, disenrollment and outcomes.

14.5.4 *HEDIS Report*

The Contractor shall conduct an annual HEDIS audit survey and submit the compliance auditor's final audit report along with the same audited data provided to NCQA. The Agency will establish baseline performance targets for all HEDIS measures.

14.5.5 *Quarterly Health Outcomes and Clinical Reports*

The Agency intends to establish quarterly clinical reports and baseline rates to monitor healthcare services utilization and quality outcomes. Priority areas for monitoring which the Contractor shall report on include, but are not limited to:

14.5.5.1 Behavioral Health. (i) Follow-up after inpatient hospitalization for mental illness; (ii) readmission rates for psychiatric hospitalizations; (iii) anti-depression medication management; (iv) follow-up care for children prescribed attention deficit hyperactivity disorder (ADHD) medication; (v) diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication; (vi) adherence to antipsychotic medications; (vii) number and percentage of members receiving mental health services; and (viii) number and percent of members receiving substance use disorder services; (ix) report that identifies foster children by a common identifier, their age, diagnosis, prescribed medications; and (x) a report that identifies foster children by a common identifier who are on two (2) or more prescribed psychotropic medications, psychotropic prescriptions, and diagnoses to support prescribing pattern.

14.5.5.2 Children's Health. (i) EPSDT screening rate; (ii) well-child visits; (iii) adolescent well-care visits; (iv) childhood immunization status; (v) adolescent immunization status; (vi) developmental screening for children age 0-3; and (vii) report that identifies foster children that receive EPSDT screenings.

14.5.5.3 Prenatal and Birth Outcomes. (i) Number of infants born between thirty-four (34) and

Behavioral Health Network Adequacy Requirements

6.3 Requirements by Provider Type

6.3.1 *Primary Care Providers*

The specific primary care provider (PCP) designation is required for those members under a value based purchasing arrangement described in section 6.1.2. If using a PCP model, in any Work Plan required by Section 2.13, the Contractor shall describe the types of physician's eligible to serve as a PCP, any panel size limits or requirements, and proposed policies and procedures to link members to PCPs.

Contractor shall demonstrate compliance with 42 C.F.R. § 438.208.

6.3.2 *Physician Extenders*

In accordance with 42 C.F.R. § 441.22, State Medicaid programs are required to make nurse practitioner services available to Medicaid enrollees. The Contractor shall ensure this requirement is met for enrollees through the provider network.

6.3.3 *Behavioral Health Providers*

The Contractor shall develop a network of appropriately credentialed behavioral health providers to assure the availability of services for both adults and children and to meet the general access requirements described in Exhibit B.

6.3.4 *Essential Hospital Services*

The Contractor shall demonstrate sufficient access to essential hospital services to serve the expected enrollment and to meet, at minimum, the access and availability requirements set forth in Exhibit B.

6.3.5 *Physician Specialists*

The Contractor shall establish and maintain a network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical and behavioral health needs of its members without excessive travel requirements. This means that, at a minimum: (i) the Contractor has signed provider agreements with providers of the specialty types listed in Exhibit B who accept new Medicaid enrollees and are available on at least a referral basis; and (ii) the Contractor is in compliance with the access and availability requirements set forth in Exhibit B.

6.3.6 *Health Homes*

The Contractor shall develop a network of Integrated Health Homes and Health Homes. The Contractor shall develop strategies to encourage additional participation, particularly in areas of the State where participation has been low. In developing the Integrated Health Homes and Health Homes networks, the Contractor shall ensure all providers meet the minimum requirements for participation as

CMS-10398 (#45)
OMB Control # 0938-1148

Attachment #1
Iowa Health and Human Services Certified Community Behavioral Health Clinic (CCBHC)
Criteria Compliance Checklist
Updated July 2023

Table of Contents

List of Acronyms

CCBHC: Certified Community Behavioral Health Clinic
CEO: Chief operating officer
CQI: Continuous Quality Improvement
DCO: Designated collaborating organizations
ED: Emergency department
HHS: Health and Human Services
HIPAA: Health Insurance Portability & Accountability Act
LEP: Limited English proficiency
SUD: Substance use disorder
VHA: Veterans Health Administration

Instructions

For each of the criteria on the checklist, please indicate the number of CCBHCs in your state that fall within each of the following categories:

1. Ready to implement
    - The CCHBC fully satisfies all elements under this Program Requirement Criteria.
2. Mostly ready to implement
    - The CCBHC satisfies almost all elements under this Program Requirement Criteria although some minor adjustments are currently in process to fully satisfy. The CCBHC has a plan to come into compliance within the required timeframe.
3. Ready to implement with remediation
    - The CCBHC satisfies some elements but must make significant improvements in other elements to fully satisfy this Program Requirement Criteria. The CCBHC is responsive to implementing the needed changes and has begun to do so. The CCBHC has a plan to come into compliance within the required timeframe.
4. Unready to implement
    - The CCBHC has not demonstrated capacity to meet the elements under this Program Requirement Criteria and will be unable to come into compliance within the required timeframe.

CCBHC Criteria Compliance Checklist 2023

This compliance checklist identifies the criteria required for a Certified Community Behavioral Health Clinic (CCBHC).

Program Requirement 1: Staffing

Criteria 1.A: General Staffing Requirements

1.a.1 Needs Assessment and Staffing Plan

Readiness Level				
Criteria 1.a.1	1	2	3	4
# of Clinics	4	4	1	0

The CCBHC has completed a community needs assessment. The community needs assessment includes the following components:

- A description of the physical boundaries and size of the service area, including identification of sites where services are delivered by the CCBHC, including through DCOs
- Information about the prevalence of mental health and substance use conditions and related needs in the service area, such as rates of suicide and overdose
- Economic factors and social determinants of health affecting the population's access to health services, such as percentage of the population with incomes below the poverty level, access to transportation, nutrition, and stable housing
- Cultures and languages of the populations residing in the service area
- The identification of the underserved population(s) within the service area
- A description of how the staffing plan does and/or will address findings
- Plans to update the community needs assessment every 3 years
- Input with regard to:
  - Cultural, linguistic, physical health, and behavioral health treatment needs
  - Evidence-based practices and behavioral health crisis services
  - Access and availability of CCBHC services including days, times, and locations, and telehealth options
  - Potential barriers to care such as geographic barriers, transportation challenges, economic hardship, lack of culturally responsive services, and workforce shortages
- Input gathered from the following entities in the service area:
  - People with lived experience of mental and substance use conditions and individuals who have received/are receiving services from the clinic conducting the needs assessment
  - Health centers (including FQHCs)

- Local health departments (Note: these departments also develop community needs assessments that may be helpful)
- Inpatient psychiatric facilities, inpatient acute care hospitals, and hospital outpatient clinics
- One or more Department of Veterans Affairs facilities
- Representatives from local K-12 school systems
- Other community partners

- Input should also come from other community partners who work with people receiving services from the CCBHC and populations that historically are not engaging with health services, such as:

- Organizations operated by people with lived experience of mental health and substance use conditions
- Residential programs
- Juvenile justice agencies and facilities
- Criminal justice agencies and facilities
- Indian Health Service or other tribal programs such as Indian Health Service youth regional treatment centers as applicable
- Child welfare agencies and state licensed and nationally accredited child placing agencies for therapeutic foster care service
- Crisis response partners such as hospital emergency departments, crisis stabilization settings, crisis call centers and warmlines
- Specialty providers of medications for treatment of opioid and alcohol use disorders
- Peer-run and operated service providers
- Homeless shelters
- Housing agencies
- Employment services systems
- Services for older adults, such as Area Agencies on Aging
- Aging and Disability Resource Centers
- Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs)

- Additional state required community needs assessment requirements if any have been established by the state.

- The CCBHC has completed a staffing plan that reflects the findings of the needs assessment.

- (Recertification) The needs assessment and staffing plan updated in the past 3 years or less.

1.a.2 Staff

Readiness Level				
Criteria 1.a.2	1	2	3	4
# of Clinics	3	5	1	0

The CCBHC staff (both clinical and non-clinical) is appropriate in size and composition, and provides services appropriate for the population served.

Staffing satisfies the requirements of criteria 4.K for services to veterans.

1.a.3 Management Staffing

Readiness Level				
Criteria 1.a.3	1	2	3	4
# of Clinics	9	0	0	0

CCBHC management staffing is adequate for the needs of CCBHC, as determined by the needs assessment and staffing plan.

The Chief Executive Officer (CEO) or equivalent of the CCBHC maintains a fully staffed management team appropriate for the needs and size of the clinic, as determined by the current needs assessment and staffing plan.

The management team includes a CEO or equivalent/Project Director and a psychiatrist as Medical Director.

- For a CCBHC without a psychiatrist, provisions are made for psychiatric consultation and a medically trained behavioral health provider with appropriate education and licensure to independently prescribe as the Medical Director.

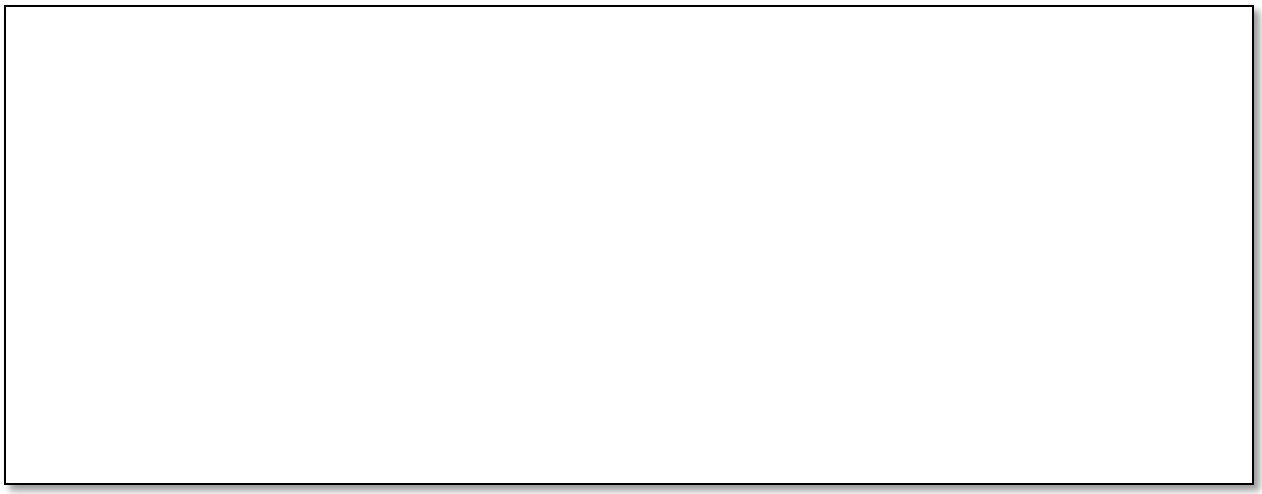
The Medical Director provides guidance regarding behavioral health clinical service delivery, ensures the quality of the medical component of care, and provides guidance to foster the integration and coordination of behavioral health and primary care.

- If the CCBHC is unable to hire a psychiatrist and hires another prescriber instead psychiatric consultation is obtained regarding behavioral health clinical service delivery, quality of the medical component of care, and integration and coordination of behavioral health and primary care.

1.a.4 Liability/Malpractice Insurance

Readiness Level				
Criteria 1.a.4	1	2	3	4
# of Clinics	9	0	0	0

The CCBHC maintains adequate liability/malpractice insurance.



Criteria 1.B: Licensure and Credentialing of Providers

1.b.1 Appropriate Licensure and Credentialing

Readiness Level				
Criteria 1.b.1	1	2	3	4
# of Clinics	9	0	0	0

CCBHC practitioners providing direct services furnish them within their scope of practice in accordance with all applicable federal, state, and local laws and regulations, including Medicaid billing regulations or policies.

Appropriate supervision is provided for CCBHC providers that are working towards licensure.

1.b.2 Required Staffing

Readiness Level				
Criteria 1.b.2	1	2	3	4
# of Clinics	6	3	0	0

The CCBHC staffing plan meets requirements of the state behavioral health authority and any accreditation or other standards required by the state.

The staffing plan is informed by the community needs assessment and is appropriate to the needs of people receiving CCBHC service.

The staffing plan includes clinical, peer, and other staff and core staff comprised of employed and as needed, contracted staff. Staffing is appropriate to the needs of people receiving services at the CCBHC, reflected in individual treatment plans, and as required to meet program requirements of these criteria.

The CCBHC has a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other FDA-approved medications used to treat opioid, alcohol, and tobacco use disorders.

If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder directly, it refers to an opioid treatment program (if any exist in the CCBHC service area) and provides care coordination to ensure access to methadone.

The CCBHC has staff, either employed or under contract, who are licensed or certified substance use treatment counselors or specialists.

The Medical Director has experience in the assessment and diagnosis of SUD, substance intoxication and withdrawal; pharmacological management of intoxication, withdrawal, and SUDs; ambulatory withdrawal management; outpatient addiction treatment; toxicology testing; and pharmacodynamics of commonly used substances.

- If the Medical Director is not experienced with the treatment of substance use disorders, the CCBHC has experienced addiction medicine physicians or specialists on

staff, or arrangements that ensure access to consultation on addiction medicine for the Medical Director and clinical staff.

The CCBHC has credentialed substance use treatment specialists either employed or under contract.

The CCBHC has staff with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance and adults with serious mental illness.

The CCBHC supplements its core staff as necessary in order to adhere to program requirements 3 and 4 and individual treatment plans, through arrangements with, and referrals to, other providers.

The CCBHC has staff disciplines as required (if any) by the certifying state.

Criteria 1.C: Cultural Competence and Other Training

1.c.1 Training Plans

Readiness Level				
Criteria 1.c.1	1	2	3	4
# of Clinics	9	0	0	0

The CCBHC has a training plan for all employees and contract staff who have direct contact with people receiving services or their families.

The training plan satisfies and includes requirements of the state behavioral health authority and any accreditation standards on training required by the state.

At staff orientation and at reasonable intervals, the CCBHC provides training on:

- Evidence-based practice
- Cultural competency
- Person-centered and family-centered, recovery-oriented planning and services
- Trauma-informed care
- The clinic's policy and a continuity plan for operations/disasters
- The clinic's policy and procedures for integration and coordination with primary care integrated care of mental health and substance use disorders

At orientation and annually thereafter, the CCBHC provides training on:

- Risk assessment
- Suicide and overdose prevention and response
- The roles of families and peer staff

Trainings are aligned with the National Standards for Culturally and Linguistically Appropriate Services to advance health equity, improve quality of services, and eliminate disparities.

Trainings include information related to military culture, to the extent active-duty military or veterans are being served.

1.c.2 - 1.c.4 Skills and Competence

Readiness Level				
Criteria 1.c.2-4	1	2	3	4
# of Clinics	9	0	0	0

The CCBHC regularly assesses and has written policies and procedures that describe the methods used for assessing skills and competencies of providers and keeps track of training provided for each employee.

The CCBHC maintains documentation of completion of training and demonstration of competencies within staff personnel records.

Individuals providing training to CCBHC staff have the qualifications to do so as evidenced by their education, training, and experience.

Criteria 1.D: Linguistic Competence

1.d.1 - 1.d.4 Meaningful Access

Readiness Level				
Criteria 1.d.1-4	1	2	3	4
# of Clinics	9	0	0	0

The CCBHC takes reasonable steps to provide meaningful access to people with Limited English Proficiency (LEP) or with language-based disabilities.

Interpretation/translation service(s) are readily available, appropriate and timely for the size/needs of the LEP CCBHC consumer population (e.g., bilingual providers, onsite interpreters, language video or telephone line). To the extent interpreters are used, such translation service providers are trained to function in a medical and, preferably, a behavioral health setting.

CCBHC auxiliary aids and services are available, ADA compliant, and responsive to the needs of people with physical, cognitive, and/or developmental disabilities (e.g., sign language interpreters, teletype [TTY] lines) receiving services.

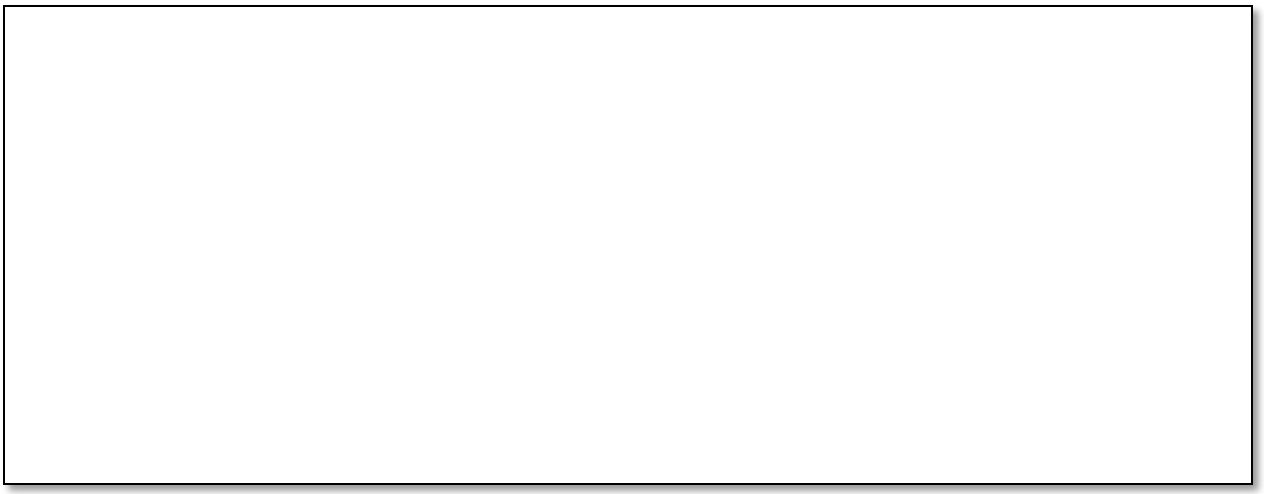
Documents or messages vital to the ability of a person receiving services to access CCBHC services (e.g., registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available online and in paper format, in languages commonly spoken within the community served, taking account of literacy levels and the need for alternative formats, and provided in a timely manner at intake and throughout the time a person is served by the CCBHC.

The community needs assessment has informed which languages require language assistance.

1.d.5 Meaningful Access and Privacy

Readiness Level				
Criteria 1.d.5	1	2	3	4
# of Clinics	9	0	0	0

CCBHC policies have explicit provisions for ensuring that all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider, including but not limited to the requirements of the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records), patient privacy requirements specific to care for minors, and other state and federal laws.



Program Requirement 2: Availability and Accessibility of Services

Criteria 2.A: General Requirements of Access and Availability

2.a.1 - 2.a.8 Access and Availability

Readiness Level				
Criteria 2.a.1-8	1	2	3	4
# of Clinics	6	3	0	0

The CCBHC provides a safe, functional, clean, sanitary, and welcoming environment for people receiving services and staff.

The CCBHC provides services during times that facilitate accessibility and meet the needs of the population served, including some evening and weekend hours as informed by the community needs assessment.

The CCBHC provides services at locations that are accessible to and meet the needs of the population to be served, such as community settings as informed by the community needs assessment.

The CCBHC provides transportation or transportation vouchers for people receiving services to the extent possible with relevant funding or programs in order to facilitate access to services in alignment with the person-centered and family-centered treatment plan.

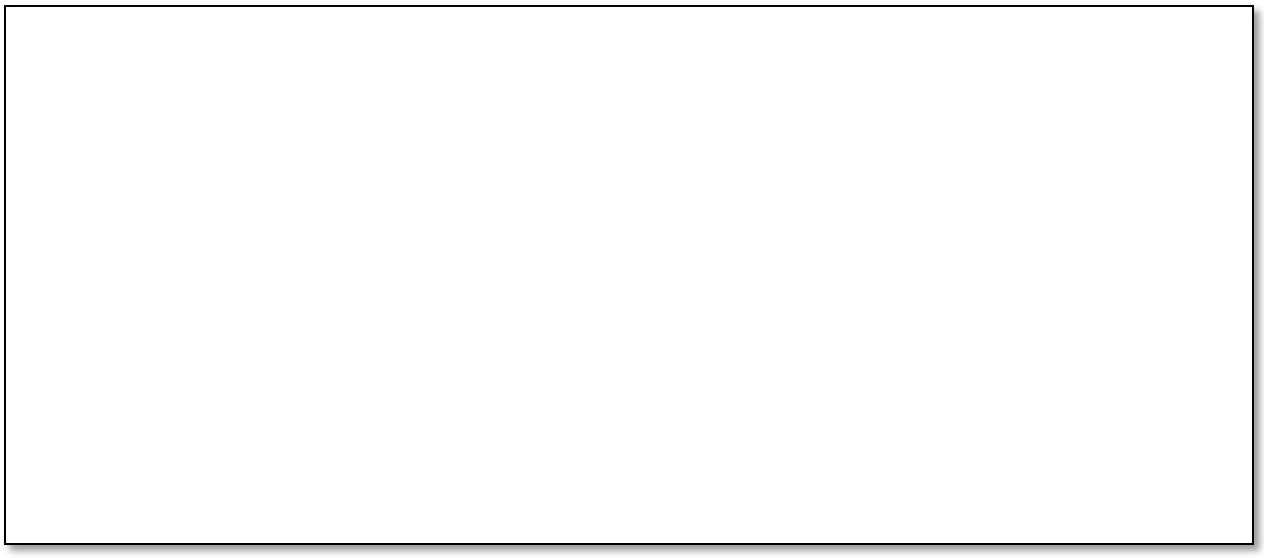
The CCBHC utilizes telehealth/telemedicine, video conferencing, digital therapeutics, remote patient monitoring, asynchronous interventions, and/or other technologies to the extent possible in alignment with the preferences of the person receiving services to support access to all required services.

The CCBHC conducts outreach, engagement, and retention activities to support inclusion and access for underserved individuals and populations as informed by the community needs assessment.

CCBHC services conform to state or county/municipal court standards for the provision of voluntary and court-ordered services.

The CCBHC has a continuity of operations/disaster plans in place that:

- Ensures the CCBHC is able to effectively notify staff, people receiving services, and healthcare and community partners when a disaster/emergency occurs or services are disrupted
- Identifies alternative locations and methods to sustain service delivery and access to behavioral health medications during emergencies and disasters
- Addresses health IT systems security/ransomware protection and backup and access to these IT systems, including health records, in case of disaster



Criteria 2.B: General Requirements for Timely Access to Services and Initial and Comprehensive Evaluation

2.b.1 Timing of Screening, Evaluation and Provision of Services to People Receiving Services New CCBHC

Readiness Level				
Criteria 2.b.1	1	2	3	4
# of Clinics	9	0	0	0

All new people requesting or referred for services receive, at the time of first contact, a preliminary triage (whether in-person, by telephone, or other remote communication) to determine acuity of needs.

- If the triage identifies an emergency/crisis need, appropriate action is taken immediately (see 4.c.1 for crisis response timelines and detail about required services), including plans to reduce or remove risk of harm and to facilitate any necessary subsequent outpatient follow-up.
- If triage identifies an urgent need, clinical services and initial evaluation are to be provided within one (1) business day of the time the request is made.
- If triage identifies routine needs, services are provided, including the initial evaluation completed within 10 business days.

For those presenting with emergency or urgent needs, if the initial evaluation is conducted telephonically, once the emergency is resolved, the person receiving services is seen in-person at the next subsequent encounter and the initial evaluation reviewed.

The preliminary triage and risk assessment is followed by: (1) an initial evaluation and (2) a comprehensive evaluation, with the components of each specified in program requirement 4.

All new people receiving services receive a comprehensive evaluation to be completed within 60 calendar days of the first request for services. If the state has established independent screening and assessment processes for certain child and youth populations or other populations, the CCBHC should establish partnerships to incorporate findings and avoid duplication of effort. This requirement does not preclude the initiation or completion of the comprehensive evaluation, or the provision of treatment during the 60-day period.

2.b.2 Updating Comprehensive Person-Centered and Family-Centered Diagnostic and Treatment Planning Evaluation

Readiness Level				
Criteria 2.b.2	1	2	3	4
# of Clinics	9	0	0	0

CCBHC treatment teams update the person-centered and family-centered diagnostic and treatment plan, in agreement with and endorsed by the person receiving services, when changes occur with the status of the person receiving services, based on responses to treatment, or when there are changes in treatment goals.

The treatment plan is reviewed and updated no less frequently than every 6 months unless the state, federal, or applicable accreditation standards are more stringent.

2.b.3 Timing of Services for Established People Who Are Receiving Services

Readiness Level				
Criteria 2.b.3	1	2	3	4
# of Clinics	9	0	0	0

Unless state, federal, or applicable accreditation standards are more stringent, appointments occur within 10 business days from when the request for appointment is made for all people who are already receiving services from the CCBHC and seeking routine outpatient clinical service.

If a person receiving services presents with an emergency/crisis need, the CCBHC takes appropriate and immediate action that is consistent with the needs of the person receiving services. This includes immediate crisis response.

If a person already receiving services presents with an urgent, non-emergency need, clinical services are generally provided within one business day of the request, or at a later time if that is the preference of the person receiving services.

Criteria 2.C: Access to Crisis Management Services

Readiness Level				
Criteria 2.C	1	2	3	4
# of Clinics	3	4	2	0

The CCBHC provides crisis management services in accordance with program requirement 4.c. that are available and accessible 24 hours a day, seven days a week.

The CCBHC has policies or procedures in place requiring communication to the public of the methods for providing a continuum of crisis prevention, response, and postvention services.

The CCBHC educates individuals served by the CCBHC about crisis planning; psychiatric advanced directives; how to access crisis services, including the 988 Suicide & Crisis Lifeline and other area hotlines and warmlines; and overdose prevention. This includes individuals with LEP or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels in accordance with program requirement 1.d).

Protocols established for CCBHC staff to address the needs of CCBHC people receiving services in psychiatric crisis who come to emergency departments.

Protocols with law enforcement are in place to reduce delays for initiating services during and following a behavioral health crisis.

The CCBHC has created, maintained, and followed crisis plans to prevent and de-escalate future crisis situations, in conjunction with the person receiving services following a psychiatric emergency or crisis.

Criteria 2.D: No Refusal of Services Due to Inability to Pay

Readiness Level				
Criteria 2.D	1	2	3	4
# of Clinics	6	3		

The CCBHC has policies that (1) services cannot be denied because of inability to pay and that (2) any fees or payments required by the clinic for such services are reduced or waived for those unable to pay.

The CCBHC has published sliding fee discount schedule(s) on the CCBHC website, posted in the CCBHC waiting room and that are readily accessible to people receiving services and their families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP, literacy barriers, or disabilities.

The fee schedule(s) conform to state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable. Absent applicable state or federal requirements, the schedule is based on locally prevailing rates or charges and includes reasonable costs of operation.

The CCBHC has written policies and procedures describing eligibility for and implementation of the sliding fee discount schedule and are applied equally to all individuals seeking services.

Criteria 2.E: Provision of Services Regardless of Residence

Readiness Level				
Criteria 2.E	1	2	3	4
# of Clinics	7	2	0	0

The CCBHC has a policy that services cannot be refused due to residence, homelessness, or lack of a permanent address.

The CCBHC has policies or protocols addressing services for those who do not live close to or within the CCBHC service area.

The CCBHC provides, at a minimum, crisis response, evaluation, and stabilization services in the CCBHC service area regardless of place of residence.

The CCBHC has protocols that address management of the individual's on-going treatment needs beyond crisis services. Protocols may provide for agreements with clinics in other localities, allowing the CCBHC to refer and track individuals seeking non-crisis services to the CCBHC or other clinics serving the individual's area of residence.

Program Requirement 3: Care Coordination

Criteria 3.A: General Requirements of Care Coordination

Readiness Level				
Criteria 3.A	1	2	3	4
# of Clinics	9	0	0	0

Care coordination is based on a person-centered and family-centered treatment plan aligned with the requirements of Section 2402(a) of the Affordable Care Act and aligned with state regulations and consistent with best practices.

The CCBHC coordinates care across the spectrum of health services, including access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person.

The CCBHC coordinates with other systems to meet the needs of the people they serve, including criminal and juvenile justice and child welfare.

The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA, 42 CFR Part 2, requirements specific to minors, and other privacy and confidentiality requirements of state or federal law addressing care coordination and in interactions with the DCOs.

The CCBHC obtains necessary consents for sharing information with community partners where information is not able to be shared under HIPAA and other federal and state laws and regulations.

- If the CCBHC is unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program requirement 3, such attempts are documented and revisited periodically.

Consistent with requirements of privacy, confidentiality, and the preferences and needs of people receiving services, the CCBHC assists people receiving services and the families of children and youth referred to external providers or resources in obtaining an appointment and tracking participation in services to ensure coordination and receipt of supports.

The CCBHC coordinates care in keeping with the preferences of the person receiving services and their care needs.

The CCBHC develops a crisis plan with each person receiving services. Crisis plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving services. Psychiatric Advance Directives are entered in the electronic health record of the person receiving services so that the information is available to providers in emergency care settings.

The CCBHC has procedures to coordinate care in collaboration with the family/caregiver of the person receiving services. The CCBHC develops a crisis plan with each person receiving services to identify the preferences of the person in the event of psychiatric or substance use crisis.

- At minimum, people receiving services should be counseled about the use of the National Suicide & Crisis Lifeline, local hotlines, warmlines, mobile crisis, and stabilization services should a crisis arise when providers are not in their office.

The CCBHC has procedures to coordinate care for medication reconciliation with other providers.

CCBHC agreements for care coordination do not limit the freedom of a person receiving services to choose their provider within the CCBHC, its DCOs, or any other provider.

The CCBHC assists people receiving services and families to access benefits, including Medicaid, and enroll in programs or supports that may be beneficial to them.

Criteria 3.B: Care Coordination and Other Health Information Systems

Readiness Level				
Criteria 3.B	1	2	3	4
# of Clinics	5	4	0	0

The CCBHC has a health information technology system in place that includes electronic health records.

The CCBHC uses its secure health IT system and related technology tools to conduct activities such as population health management, quality improvement, quality measurement and reporting, disparity reduction, outreach, and research.

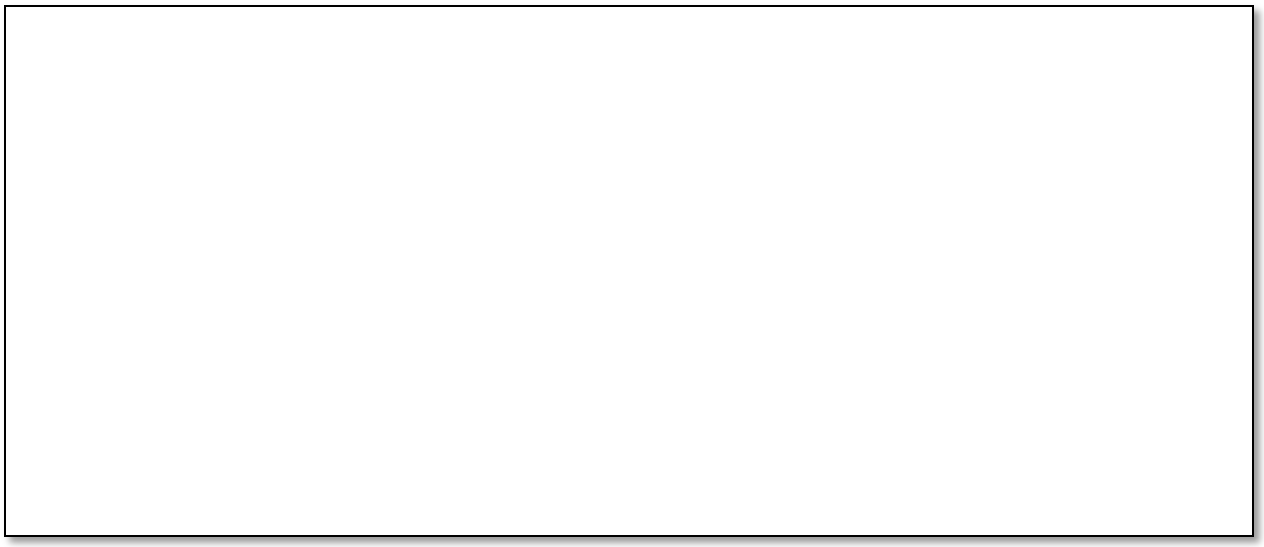
The CCBHC (*CCBHCs are not required to have all these capabilities in place when certified or when submitting their attestation*) uses technology that has been certified to current criteria under the ONC Health IT Certification Program for the following required core set of certified health IT capabilities that align with key clinical practice and care delivery requirements for CCBHCs:

- Capture health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status (as feasible)
- At a minimum, support care coordination by sending and receiving summary of care records
- Provide people receiving services with timely electronic access to view, download, or transmit their health information or to access their health information via an API using a personal health app of their choice
- Provide evidence-based clinical decision support
- Conduct electronic prescribing

The CCBHC works with DCOs to ensure all steps are taken, including obtaining consent from people receiving services, to comply with privacy and confidentiality requirements. These include, but are not limited to, those of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.

Within two years from CCBHC certification or submission of attestation the CCBHC produces a plan to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan includes:

- Information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care
- Integrating clinically relevant treatment records (evaluation planning, treatment, and care coordination) generated by the DCO for people receiving CCBHC services and incorporating them into the CCBHC health record
- All clinically relevant treatment records maintained by the CCBHC are available to DCOs within the confines of federal and/or state laws governing sharing of health records



Criteria 3.C: Care Coordination Agreements

Readiness Level				
Criteria 3.C	1	2	3	4
# of Clinics	8	1	0	0

The CCBHC has a partnership[1] establishing care coordination with Federally Qualified Health Centers and, where relevant, Rural Health Clinics, unless health care services are provided by the CCBHC.

For people receiving services who are served by other primary care providers, including but not limited to FQHC Look-Alikes and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination.

The CCBHC has partnerships[1] that establish care coordination expectations with programs that can provide inpatient psychiatric treatment, OTP services, medical withdrawal management facilities and ambulatory medical withdrawal management providers for substance use disorders, and residential substance use disorder treatment programs (if any exist within the CCBHC service area). These include tribally operated mental health and substance use services including crisis services that are in the service area. The CCBHC tracks when people receiving services are admitted to and discharged from these facilities (unless there is a formal transfer of care to a non-CCBC entity).

The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric programs, medically monitored withdrawal management services, and residential or inpatient facilities that serve children and youth such as Psychiatric Residential Treatment Facilities and other residential treatment facilities, to a safe community setting. This includes transfer of health records of services received (e.g., prescriptions), active follow-up after discharge, and, as appropriate, a plan for suicide prevention and safety, overdose prevention, and provision for peer services.

The CCBHC has partnerships[2] (with a variety of community or regional services, supports, and providers. CCBHCs are required to develop partnerships with the following organizations operating within the service area:

- Schools
- Child welfare agencies
- Juvenile and criminal justice agencies and facilities, including drug, mental health, veterans and other specialty courts

[1] These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC has developed written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.

[2] These partnerships should be supported by a formal, signed agreement detailing the roles of each party or unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.

- Indian Health Service youth regional treatment centers
- State licensed and nationally accredited child placing agencies for therapeutic foster care service
- The 988 Suicide & Crisis Lifeline call center serving the area in which the CCBHC is located
- Additional partners as required by certifying states
- CCBHCs may develop partnerships based on the population served, the needs and preferences of people receiving services, and/or needs identified in the community needs assessment (see 3.c.3 for examples)

The CCBHC has partnerships[1] in place with the nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department.

The CCBHC has care coordination partnerships[1] establishing expectations with inpatient acute-care hospitals in the area served by the CCBHC and their associated services/facilities including emergency departments, hospital outpatient clinics, urgent care centers, and residential crisis settings.

Care coordination partnerships with these entities include:

- Procedures and services, such as peer recovery specialist/coaches, to help individuals successfully transition from ED or hospital to CCBHC and community care to ensure continuity of services and to minimize the time between discharge and follow up
- Tracking when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged
- The transfer of health records of services received (e.g., prescriptions) and active follow-up after discharge
- For all people receiving CCBHC services being discharged from such facilities who are at risk for suicide or overdose, a requirement to coordinate consent and follow-up services with the person receiving services within 24 hours of discharge and that continues until the individual is linked to services or assessed to be no longer at risk
- The CCBHC requests that notification be provided through the Admission-Discharge-Transfer (ADT) system of relevant inpatient and outpatient facilities, for people receiving CCBHC services

The CCBHC makes and documents reasonable attempts to contact all people receiving CCBHC services who are discharged from these settings within 24 hours of discharge.

Criteria 3.D: Treatment Team, Treatment Planning, and Care Coordination Activities

Readiness Level				
Criteria 3.D	1	2	3	4
# of Clinics	9	0	0	0

CCBHC treatment teams include the person receiving CCBHC services, their family/caregivers to the extent the person receiving CCBHC services chooses, and any other people the person receiving CCBHC services desires to be involved in their care. All CCBHC treatment planning and care coordination are person-centered and family-centered and align with the requirements of Section 2402(a) of the Affordable Care Act.

All treatment planning and care coordination activities comply with HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.

The CCBHC designates interdisciplinary treatment teams that is responsible, with the person receiving services and their family/caregivers/legal guardians, to the extent the person receiving services desires their involvement for directing, coordinating, and managing care and services.

The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of people receiving services traditional approaches to care for people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups.

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

Program Requirement 4: Scope of Services

Criteria 4.A: General Service Provisions

Readiness Level				
Criteria 4.A	1	2	3	4
# of Clinics	7	2	0	0

Whether delivered directly or through a DCO agreement, the CCBHC is responsible for ensuring access to all care specified in the Protecting Access to Medicare Act. This includes the following required services: crisis services; screening, assessment, and diagnosis; person-centered and family-centered treatment planning; outpatient behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer and family supports; and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans.

The CCBHC organization directly delivers the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through DCOs.

All CCBHC services, if not available directly through the CCBHC, are provided through a DCO.

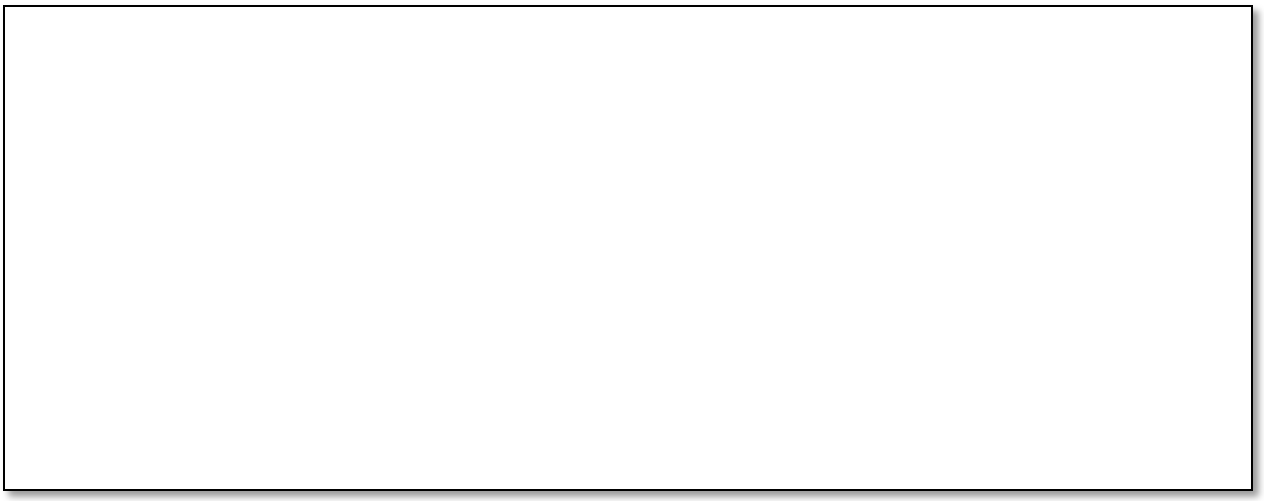
The CCBHC or DCO make outside referrals if a needed specialty service is unavailable through the CCBHC or DCO entities.

People receiving CCBHC services have freedom to choose providers within the CCBHC and its DCOs.

People receiving CCBHC services will be informed of and have access to CCBHC grievance procedures, including for CCBHC services provided by a DCO.

With regard to CCBHC or DCO services, the grievance process satisfies the minimum requirements of Medicaid and other grievance requirements such as those that may be mandated by relevant accrediting entities.

CCBHC services provided by DCOs meet the same quality standards as those required of the CCBHC.



Criteria 4.B: Person-Centered and Family-Centered Care

Readiness Level				
Criteria 4.B	1	2	3	4
# of Clinics	8	1	0	0

The CCBHC ensures all CCBHC services, including those supplied by its DCOs, are provided in a manner aligned with the requirements of Section 2402(a) of the Affordable Care Act. The CCBHC and its DCOs provide services that reflect person-centered and family-centered and recovery oriented, being respectful of the needs, preferences, and values of the person receiving CCBHC services, and ensuring both involvement of the person receiving CCBHC services and self-direction of services received.

The services that the CCBHC and its DCOs provide for children and adolescents are family-centered, youth-guided, and developmentally appropriate.

CCBHC services are responsive to the race, ethnicity, sexual orientation, and gender identity of the person receiving CCBHC services and are culturally and ethically appropriate, as indicated in the needs assessment, including services for people who are American Indian or Alaska Native.

Criteria 4.C: Crisis Behavioral Health Services

Readiness Level				
Criteria 4.C	1	2	3	4
# of Clinics	1	5	3	0

The CCBHC provides crisis services directly or through a DCO agreement with existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services as identified in these criteria.

- The CCBHC has received approval from HHS to have a DCO relationship with a state-sanctioned crisis system that operates under less stringent standards than those identified in these criteria.
- The certifying state has received approval from HHS to certify CCBHCs in its state that has or seeks to have a DCO relationship with a state-sanctioned crisis system with less stringent standards than those included in these criteria.

The CCBHC provides or coordinates with telephonic, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide.

Protocols have been established to track referrals made from the call center to the CCBHC or its DCO crisis care provider to ensure the timely delivery of mobile crisis team response, crisis stabilization, and post crisis follow-up care.

The CCBHC provides community-based behavioral health crisis intervention services using mobile crisis teams twenty-four hours per day, seven days per week to adults, children, youth, and families anywhere within the service area including at home, work, or anywhere else where the crisis is experienced.

Mobile crisis teams arrive in-person within one hour (2 hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed 3 hours. Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time. Technologies also may be used to provide crisis care to individuals when remote travel distances make the 2-hour response time unachievable

- The ability to provide an in-person response is available when it is necessary to assure safety.

The CCBHC provides crisis receiving/stabilization services that includes at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals.

Urgent care/walk-in services identify the individual’s immediate needs, de-escalate the crisis, and connect them to a safe and least-restrictive setting for ongoing care.

Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted.

Services are available to individuals of any level of acuity, whether individuals present on their own, with a concerned individual, such as a family member, or with a human service worker and/or law enforcement in accordance with state and local laws.

Crisis services include suicide prevention and intervention and services capable of addressing crises related to substance use including the risk of drug and alcohol related overdose and support following a non-fatal overdose after the individual is medically stable.

Overdose prevention activities include the availability of naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to their family members.

The CCBHC has an established protocol specifying the role of law enforcement during the provision of crisis services.

As a part of the requirement to provide training related to trauma-informed care, the CCBHC specifically focuses on the application of trauma-informed approaches during crises.

Criteria 4.D: Behavioral Health Screening, Assessment, and Diagnosis

Readiness Level				
Criteria 4.D	1	2	3	4
# of Clinics	9	0	0	0

The CCBHC directly, or through a DCO, provides screening, assessment, and diagnosis, including risk assessment for behavioral health conditions. In the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment, or diagnosis, the CCBHC refers the person to an appropriate provider.

Screening, assessment, and diagnosis are conducted in a timeframe responsive to the needs and preferences of the person receiving services and are of sufficient scope to assess the need for all services required to be provided by the CCBHC.

The CCBHC's initial evaluation of people receiving CCBHC services includes the following:

- Preliminary diagnoses
- Source of referral
- Reason for seeking care, as stated by the person receiving CCBHC services or other individuals who are significantly involved
- Identification of the immediate clinical care needs related to the diagnoses for mental and substance use disorders of the person receiving services
- A list of current prescriptions and over-the-counter medications, herbal remedies and dietary supplements and the indication for any medication
- A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful
- The use of any alcohol and/or other drugs the person receiving services may be taking
- An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors
- An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence
- An assessment of need for medical care (with referral and follow-up as required)
- A determination of whether the person presently is or ever has been a member of the U.S. Armed Services
- for children and youth, whether they have system involvement (such as child welfare and juvenile justice)

All people receiving CCBHC services receive a comprehensive evaluation.

The comprehensive evaluation should gather the amount of information that is commensurate with the complexity of their specific needs and prioritize preferences of people receiving services with respect to the depth of evaluation and their treatment goals.

The comprehensive evaluation include:

- Reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the presentation to the CCBHC of the person receiving services
- An overview of relevant social supports; social determinants of health and health-related social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status
- A description of cultural and environmental factors that may affect the treatment plan of the person receiving services, including the need for linguistic services or supports for people with LEP
- Pregnancy and/or parenting status
- Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments
- Relevant medical history and major health conditions that impact current psychological status
- A medication list including prescriptions, over-the counter medications, herbal remedies, dietary supplements, and other treatments or medications of the person receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies
- An exam that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement-based care) and substance use disorders (including tobacco, alcohol, and other drugs)
- Basic cognitive screening for cognitive impairment
- Assessment of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person
- The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services
- Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services)
- Assessment of any relevant social service needs of the person receiving services, with necessary referrals made to social services. For children and youth receiving services, assessment of systems involvement such as child welfare and juvenile justice and referral to child welfare agencies as appropriate
- An assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the primary care provider (with appropriate referral and follow-up) of the person receiving services
- The preferences of the person receiving services regarding the use technologies such as telehealth/telemedicine, video conferencing, digital therapeutics, remote patient monitoring, and asynchronous interventions

Screening and assessment conducted by the CCBHC related to behavioral health include those for which the CCBHC is accountable pursuant to program requirement 5 and Appendix B of the criteria.

Other screening and monitoring required (if any) by the certifying state.

The CCBHC uses standardized and validated and developmentally appropriate screening and assessment tools appropriate for the person and, where warranted, brief motivational interviewing techniques to facilitate engagement.

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

If screening identifies unsafe substance use, including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the person receiving services is provided a full assessment and treatment, if appropriate within the level of care of the CCBHC, or referred to a more appropriate level of care. If the screening identifies more immediate threats to the safety of the person receiving services, the CCBHC takes appropriate action as described in 2.b.1.

Criteria 4.E: Person-Centered and Family-Centered Treatment Planning[3]

Readiness Level				
Criteria 4.E	1	2	3	4
# of Clinics	8	1	0	0

The CCBHC directly, or through a DCO, provides person-centered and family-centered treatment planning including but not limited to, risk assessment and crisis planning.

The CCBHC develops an individualized treatment plan based on information obtained through comprehensive evaluation and the person receiving services' goals and preferences.

The plan addresses the person's prevention, medical, and behavioral health needs and is developed in collaboration with and be endorsed by the person receiving services, their family (if the person receiving services so wishes), and family/caregivers/legal guardians of youth and children.

The treatment plan development is coordinated with staff or programs necessary to carry out the plan and supports care in the least restrictive setting possible.

All necessary releases of information are obtained and included in the health record as a part of the development of the initial treatment plan.

The CCBHC uses the initial and comprehensive evaluations and ongoing screening assessments of the person receiving services to inform the treatment plan and services provided.

Treatment planning includes needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the words or ideas of the person receiving services or their family if appropriate.

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

The CCBHC seeks consultation where appropriate during treatment planning (e.g., eating disorders, traumatic brain injury, intellectual and developmental disabilities (I/DD), interpersonal violence and human trafficking.

The person's health record documents any advance directives related to treatment and crisis planning. If the person receiving services does not wish to share their preferences, that decision is documented. Please see 3.a.4., requiring the development of a crisis plan with each person receiving services.

Other aspects of person-centered and family-centered treatment planning required (if any) by the certifying states.

[3] For more information related to person-centered treatment planning see eCFR :: 42 CFR Part 485 Subpart J -- Conditions of Participation: Community Mental Health Centers (CMHCs) and eCFR :: 42 CFR Part 441 Subpart M -- State Plan Home and Community-Based Services for the Elderly and Individuals with Disabilities.

Criteria 4.F: Outpatient Mental Health and Substance Use Services

Readiness Level				
Criteria 4.F	1	2	3	4
# of Clinics	7	1	1	0

The CCBHC directly, or through a DCO, provides outpatient behavioral health care including psychopharmacological treatment that are evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for adults, children, and families.

SUD treatment and services are provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 and include treatment of tobacco use disorders.

In the event specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of outpatient mental and substance use disorder treatment the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine, in alignment with state and federal laws and regulations.

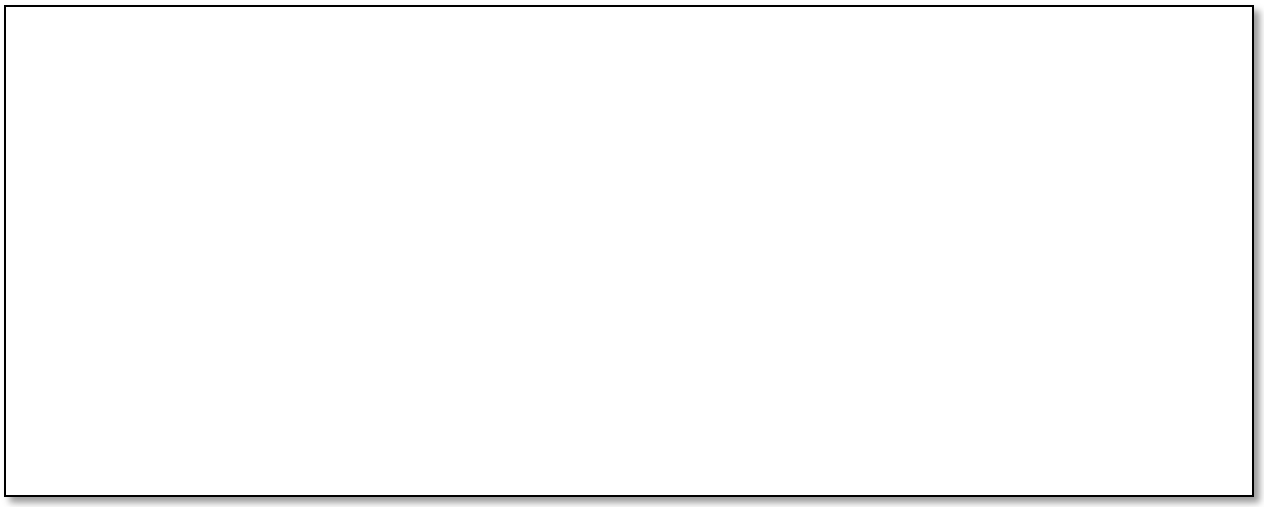
The CCBHC provides or makes available through a formal arrangement traditional practices/treatment as appropriate for the people receiving services served in the CCBHC area.

The CCBHC delivers the evidence-based practices as required by certifying states.

Treatments are provided that are appropriate for the phase of life and development of the person receiving services and delivered by staff with specific training in treating the segment of the population being served.

- When treating children and adolescents, CCBHCs provide evidenced-based services that are developmentally appropriate, youth-guided, and family/caregiver-driven.
- When treating older adults, the desires and functioning of the individual person receiving services are considered, and appropriate evidence-based treatments are provided.
- When treating individuals with developmental or other cognitive disabilities, level of functioning is considered, and appropriate evidence-based treatments are provided.

Supports for children and adolescents comprehensively address family/caregiver, school, medical, mental health, substance use, psychosocial, and environmental issues.



Criteria 4.G: Outpatient Clinic Primary Care Screening and Monitoring

Readiness Level				
Criteria 4.G	1	2	3	4
# of Clinics	9	0	0	0

The CCBHC monitors key health indicators and health risks, and coordinates care in a timely fashion. The Medical Director has established protocols that conform to screening recommendations with scores of A and B of the United States Preventive Services Task Force Recommendations for the following conditions:

- HIV and viral hepatitis
- Primary care screening pursuant to CCBHC Program Requirement 5 Quality and Other Reporting and Appendix B
- Other clinically indicated primary care key health indicators of children, adults, and older adults receiving services, as determined by the CCBHC Medical Director and based on environmental factors, social determinants of health, and common physical health conditions experienced by the CCBHC person receiving services population.

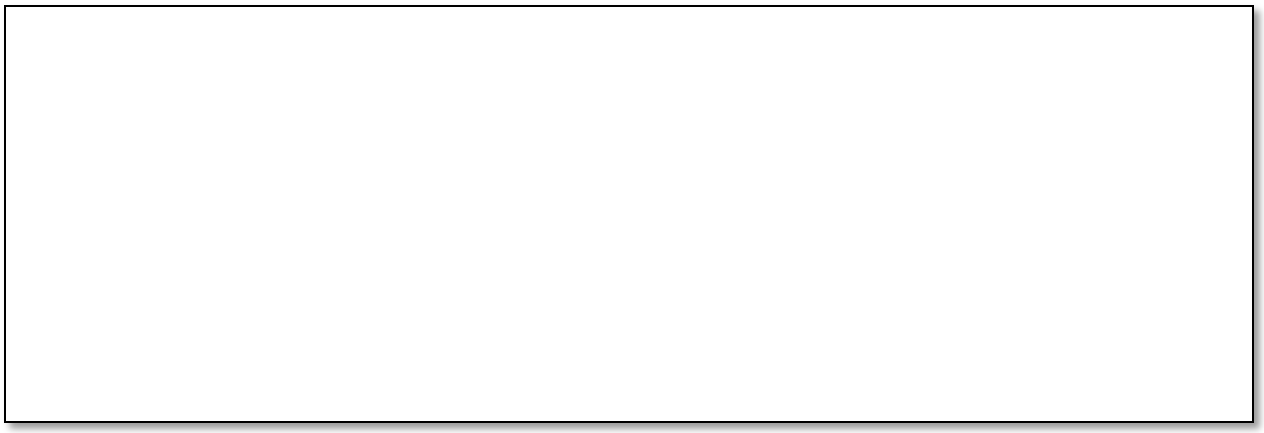
The Medical Director developed organizational protocols to ensure screening for common physical health conditions experienced by CCBHC populations across the lifespan. Protocols include:

- Identifying people receiving services with chronic diseases
- Ensuring that people receiving services are asked about physical health symptoms
- Establishing systems for collection and analysis of laboratory samples, fulfilling the requirements of 4.g.

The CCBHC should have the ability to collect biologic samples directly, through DCO, or through a formal agreement. Laboratory analyses can be done directly or through another arrangement with an organization separate from the CCBHC.

The CCBHC provides ongoing primary care monitoring of health conditions as identified in 4.g.1 and 4.g.2., and as clinically indicated for the individual. Monitoring includes the following:

- Ensuring individuals have access to primary care services
- Ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions
- Coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and promoting a healthy lifestyle



Criteria 4.H: Targeted Case Management Services

Readiness Level				
Criteria 4.H	1	2	3	4
# of Clinics	8	1	0	0

The CCBHC provides directly, or through a DCO, targeted case management services that assists people receiving services in sustaining recovery, and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports. CCBHC targeted case management should include supports for people deemed at high risk of suicide or overdose, particularly during times of transitions; individual with complex or serious mental health or substance use conditions and for individuals who have a short-term need for support in a critical period.

The CCBHC provides the scope of targeted case management services to the specific populations for which they are intended as specified (if any) by certifying states/

Criteria 4.I: Psychiatric Rehabilitation Services

Readiness Level				
Criteria 4.I	1	2	3	4
# of Clinics	9	0	0	0

The CCBHC or through a DCO provides evidence-based rehabilitation services for both mental health and substance use disorders. Psychiatric rehabilitation services include:

- Supported employment programs designed to provide those receiving services with on-going support to obtain and maintain competitive, integrated employment (e.g., evidence-based supported employment, customized employment programs, or employment supports that are run in coordination with Vocational Rehabilitation or Career One-Stop services)
- Services that help people to participate in supported education and other educational services; achieve social inclusion and community connectedness; participate in medication education, self-management, and/or individual and family/caregiver psychoeducation; and find and maintain safe and stable housing

Evidence-based and other psychiatric rehabilitation services above the minimum requirements described in 4.i as required (if any) by certifying states.

Criteria 4.J: Peer Supports, Peer Counseling, and Family/Caregiver Supports

Readiness Level				
Criteria 4.J	1	2	3	4
# of Clinics	6	3	0	0

The CCBHC or through a DCO provides peer supports, including peer specialist and recovery coaches, peer counseling, and family/caregiver supports.

The CCBHC or through a DCO provides the scope of peer and family services specified (if any) by certifying states.

Criteria 4.K: Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans

Readiness Level				
Criteria 4.K	1	2	3	4
# of Clinics	9	0	0	0

The CCBHC provides directly, or through a DCO, 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 and veterans living 40 miles or more (driving distance) from a VA medical facility, or as otherwise required by federal law. The CCBHC has demonstrated efforts to facilitate the provision of intensive community-based behavioral health services to veterans and active-duty military personnel.

With all individuals inquiring about services, the CCBHC documents whether they have ever served in the U.S. military. For those affirming current or former service in the U.S. military, CCBHCs either directs them to care or provides care through the CCBHC as required by criterion 4.k.2.

The CCBHC offers assistance with enrollment in the VHA for the delivery of health and behavioral health services to persons affirming former military service.

The CCBHC ensures coordination for the care of substance use disorders and other mental health conditions for veterans and active-duty military personnel who experience both, to the extent those services are appropriately provided by the CCBHC in accordance with criteria 4.k.1 and 4.k.2.

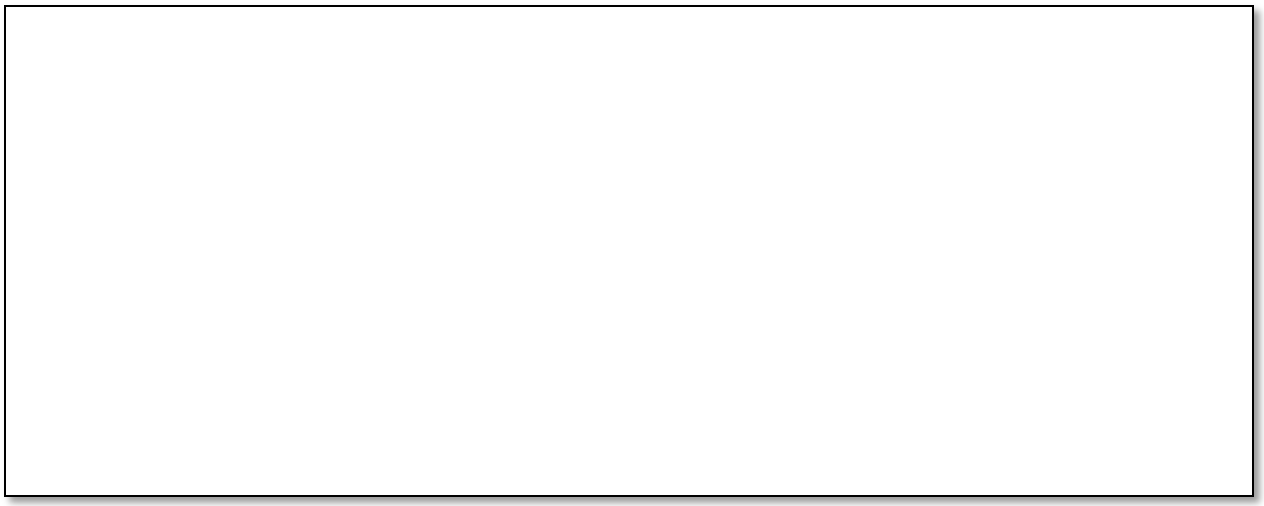
The CCBHC provides for integration and coordination of care for behavioral health conditions and other components of health care for all veterans and active-duty military personnel who experience both, to the extent those services are appropriately provided by the CCBHC in accordance with criteria 4.k.1 and 4.k.2.

The CCBHC assigns a Principal Behavioral Health Provider to every veteran seen, unless the VHA has already assigned a Principal Behavioral Health Provider. When veterans are seeing more than one behavioral health provider and when they are involved in more than one program, the identity of the Principal Behavioral Health Provider is made clear to the veteran and identified in the health record. The Principal Behavioral Health Provider fulfills requirements in accordance with accordance with criteria 4.k.4.

The CCBHC provides behavioral health services for veterans that are recovery-oriented and adhere to the guiding principles of recovery (outlined in criteria 4.k.5), VHA recovery, and other VHA guidelines.

CCBHC staff who work with people receiving CCBHC services who are military or veterans are trained in cultural competence, and specifically military and veterans' culture.

The CCBHC develops a behavioral health treatment plan for all veterans receiving behavioral health services compliant with provisions of Criteria 4.K.



Program Requirement 5: Quality and Other Reporting

Criteria 5.A: Data Collection, Reporting, and Tracking

Readiness Level				
Criteria 5.A	1	2	3	4
# of Clinics	9	0	0	0

The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including, but not limited to, data capturing of:

- Characteristics of people receiving services
- Staffing
- Access to services
- Use of services
- Screening, prevention, and treatment
- Care coordination
- Other processes of care
- Costs
- Outcomes of people receiving services

The CCBHC collects and reports the Clinic-Collected quality measures identified as required in Appendix B for all people receiving CCBHC services. CCBHCs report quality measures nine (9) months after the end of the measurement year as that term is defined in the technical specifications.

CCBHCs participating in Section 223 Demonstration report the data to their states.

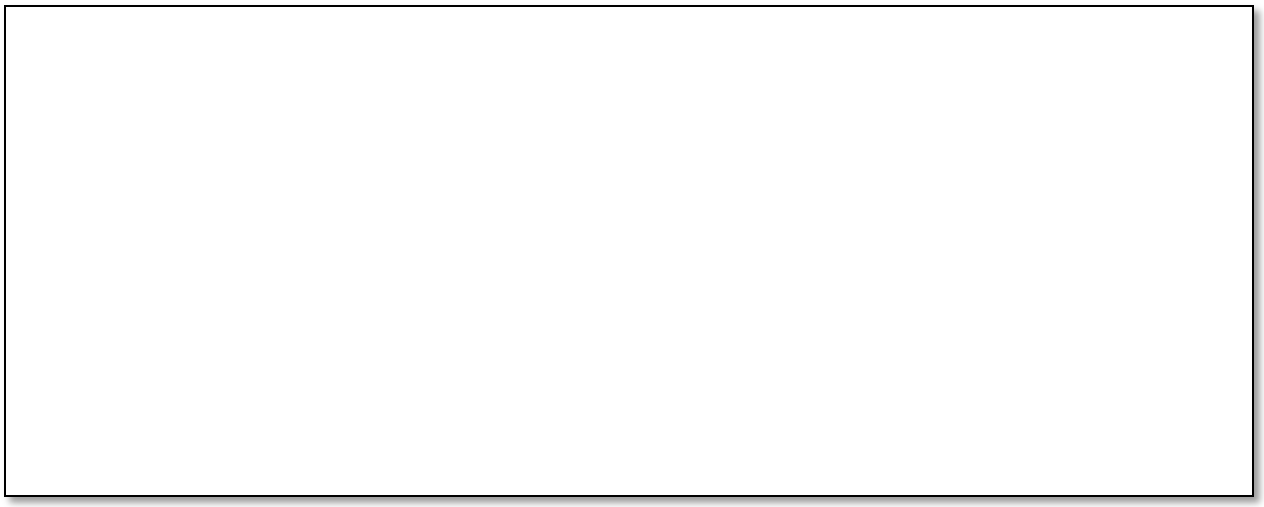
CCBHC-Es that are required to report quality measure data, report it directly to SAMHSA.

The CCBHC collects and reports any of the optional Clinic-Collected measures identified in Appendix B as required (if any) by certifying states.

CCBHCs participating in the Section 223 Demonstration have arrangements with DCOs for access to quality measures data for CCBHC services delivered by DCOs as legally permissible.

CCBHCs participating in the Section 223 Demonstration program participate in discussions with the national evaluation team and other evaluation-related data collection activities if requested.

CCBHCs participating in the Section 223 Demonstration program annually submit a cost report with supporting data within six months after the end of each Section 223 Demonstration year to the state.



Criteria 5.B: Continuous Quality Improvement (CQI) Plan

Readiness Level				
Criteria 5.B	1	2	3	4
# of Clinics	3	5	2	0

The CCBHC develops, implements, and maintains an effective, CCBHC-wide continuous quality improvement (CQI) plan for the services provided.

The CCBHC establishes a critical review process to review CQI outcomes and implement changes to staffing, services, and availability that improves the quality and timeliness of services.

The CQI plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance.

The Medical Director is involved in the aspects of the CQI plan that apply to the quality of the medical components of care, including coordination and integration with primary care.

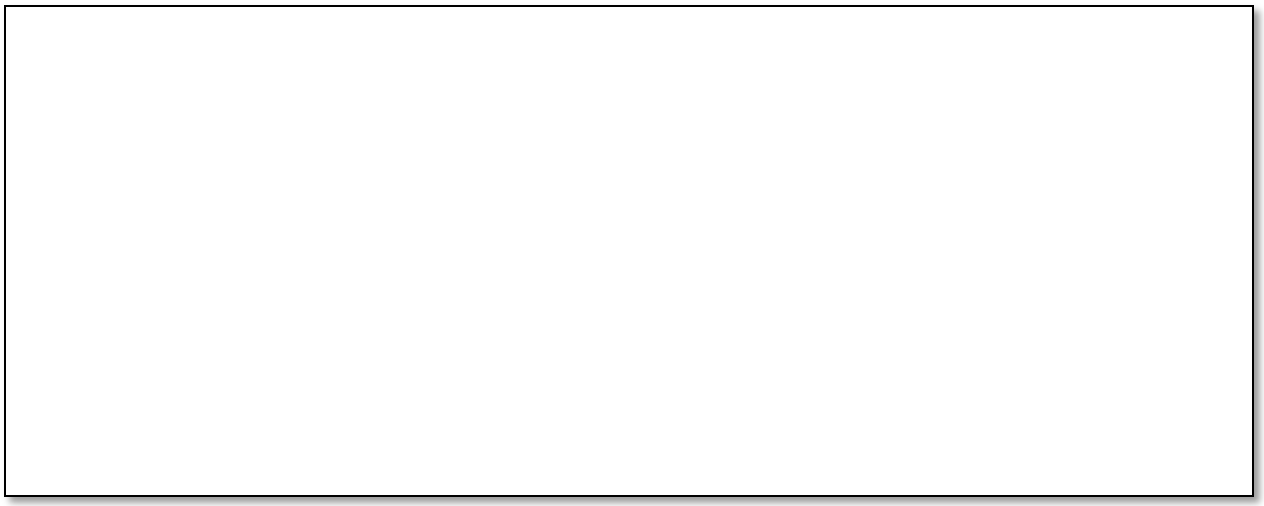
The CQI plan addresses how the CCBHC reviews known significant events including, at a minimum:

- Deaths by suicide or suicide attempts of people receiving services
- Fatal and non-fatal overdoses
- All-cause mortality among people receiving CCBHC services
- 30-day hospital readmissions for psychiatric or substance use reasons
- Such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan

The CQI plan is data-driven and the CCBHC considers the use of quantitative and qualitative data in their CQI activities.

CCBHCs participating in the Section 223 Demonstration address the data resulting from the CCBHC-collected and, as applicable for the, State-Collected, quality measures that may be required as part of the Demonstration.

The CQI plan includes an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and addresses how the CCBHC uses disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health disparities.



Program Requirement 6: Organizational Authority, Governance, and Accreditation

Criteria 6.A: General Requirements of Organizational Authority and Finances

Readiness Level				
Criteria 6.A	1	2	3	4
# of Clinics	9	0	0	0

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

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

To the extent CCBHCs are not operated under the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, CCBHCs has reached out to such entities within their geographic service area and enter into arrangements with those entities to assist in the provision of services to tribal members and to inform the provision of services to tribal members. To the extent the CCBHC and such entities jointly provide services, the CCBHC and those collaborating entities, as a whole, satisfy the requirements of these criteria.

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

Criteria 6.B: Governance

Readiness Level				
Criteria 6.B	1	2	3	4
# of Clinics	3	4	2	0

The CCBHC has identified how to integrate meaningful participation in leadership and decision-making positions within their governance by individuals with lived experience of mental and/or substance use disorders and their families, including youth.

- Option 1. At least fifty-one percent of the CCBHC governing board is comprised of individuals with lived experience of mental and/or substance use disorders and families.

OR

- Option 2. Individuals with lived experience of mental and/or substance use disorders and family members of people receiving services have representation in governance that assures input into Identifying community needs and goals and objectives of the CCBHC; service development, quality improvement, and the activities of the CCBHC; fiscal and budgetary decisions; and governance (human resource planning, leadership recruitment and selection, etc.).
    - The governing board must establish protocols for incorporating input from individuals with lived experience and family members
    - Board meeting summaries are shared with those participating in the alternate arrangement and recommendations from the alternate arrangement are entered into the formal board record
    - A member or members of the arrangement must be invited to board meetings; and
    - Representatives of the alternate arrangement must have the opportunity to regularly address the board directly, share recommendations directly with the board, and have their comments and recommendations recorded in the board minutes
    - The CCBHC provides staff support for posting an annual summary of the recommendations from the alternate arrangement under option 2 on the CCBHC website
    - Opportunity to share recommendations directly with the board.
        - The CCBHC provides staff support for posting an annual summary of the recommendations from the alternate arrangement on the CCBHC website.

    For Option 2, the certifying state or the federal grant funding agency determined that the approach to achieve meaningful participation is acceptable.

    - If not acceptable, the CCBHC has made satisfactory progress in the process of implementing additional mechanisms as required by the certifying state or federal grant funding agency to fulfill this requirement. CCBHC makes available the results of its efforts in terms of outcomes and resulting changes.

Note: See criteria 6.b.3 for CCBHC that are comprised of a governmental or tribal organization, subsidiary, or part of a larger corporate organization that cannot meet these requirements for board membership. Members of the governing or advisory boards are representative of the communities in which the CCBHC's service area is located and are selected for their expertise in health services, community affairs, local government, finance and accounting, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. No more than one half (50 percent) of the governing board members may derive more than 10 percent of their annual income from the health care industry.

Criteria 6.C: Accreditation

Readiness Level				
Criteria 6.C	1	2	3	4
# of Clinics	9	0	0	0

The CCBHC is enrolled as a Medicaid provider and licensed, certified, or accredited provider of both mental health and substance use disorder services including developmentally appropriate services to children, youth, and their families, unless there is a state or federal administrative, statutory, or regulatory framework that substantially prevents the CCBHC organization provider type from obtaining the necessary licensure, certification, or accreditation to provide these services.

The CCBHC adheres to any applicable state accreditation, certification, and/or licensing requirements.

The CCBHC participates in SAMHSA Behavioral Health Treatment Locator.

Attachment 2

March 18, 2024

As Director of the Iowa Department of Health and Human Services (Iowa HHS), I attest that all CCBHCs provisionally certified to be part of Iowa's CCBHC demonstration program will be in compliance with CCBHC Certification Criteria by the start date of our demonstration and that all participating CCBHCs will participate in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) treatment locator.

Iowa has provisionally certified nine CCBHCs in diverse geographic areas that include rural, urban, and underserved areas. A detailed list of provisionally certified CCBHCs is located in Attachment 4 and Part 2 of the application. I attest that these CCBHCs are in substantial compliance with CCBHC Certification Criteria as published by SAMHSA in March of 2023 and at least two CCBHCs serving rural and underserved areas will fully meet the certification criteria by our proposed start date of July 1, 2024, for Iowa's entry into the CCBHC demonstration.

Kelly Garcia

Kelly Garcia, Director, Iowa HHS

Mar 18, 2024

Date

Attachment 3
Iowa HHS CCBHC Demonstration Application
Target Medicaid Population

The Iowa Department of Health and Human Services is submitting an application for the Certified Community Behavioral Health Clinic (CCBHC) demonstration program proposing to serve a target Medicaid population that includes: individuals with serious mental illness (SMI), substance use disorders (SUD), serious emotional disturbance (SED), historically underserved populations (including, black, indigenous, and other people of color [BIPOC], Native American and tribal populations, individuals identifying as LGBTQIA+), pregnant and parenting persons, and Veterans.

Attachment 4
Iowa HHS CCBHC Demonstration Application
List of proposed CCBHCs and DCOs

1. **Abbe Center for Community Mental Health, Cedar Rapids, IA**
   - **DCOs:**
     - **Foundation 2 -** Mobile Crisis Services (4 of 6 counties)
     - **CommUnity -** Mobile Crisis Services (2 of 6 counties)

2. **North Central Iowa Mental Health Center (Berryhill Center), Fort Dodge, IA**
   - **DCOs:**
     - **Eyerly Ball Community Mental Health Center -** Mobile Crisis Services (2 of 4 counties)
     - **Plains Area Mental Health Center -** Mobile Crisis Services (2 of 4 counties)
     - **UCS Healthcare -** Medication Assisted Treatment (4 of 4 counties)
     - **Community and Family Resources –** Youth Outpatient SUD Services (4 of 4 counties)
     - **YSS –** Multidimensional Family Therapy (4 of 4 counties)

3. **Eyerly Ball Community Mental Health Center, Des Moines, IA**
   - **DCO**
     - **Broadlawns Health Center -** Mobile Crisis Services (1 of 4 counties)

4. **Heartland Family Service, Council Bluffs, IA**
   - **DCOs:**
     - **Myrtue Behavioral Health -** Screening, Diagnosis and Risk Assessment, Outpatient MH/SUD (2 of 9 counties)
     - **Waubonsie Mental Health Center -** Screening, Diagnosis and Risk Assessment; Outpatient MH/SUD; Peer and Family Support (2 of 9 counties)
     - **Zion Integrated BH -** Screening, Diagnosis and Risk Assessment; Outpatient MH/SUD; Medication Assisted Treatment; Peer and Family Support (3 of 9 counties)

5. **Prairie Ridge Integrated Behavioral Health, Mason City, IA**
   - **DCOs:**
     - **SATUCI –** Outpatient MH/SUD; Person - & Family-centered Treatment Planning; Community-Based MH for Veterans; Peer & Family Peer Support, Peer Counseling & Peer Recovery Coaching Services; CCBHC Case Management; Outpatient Primary Care Screening and Monitoring; Screening, Diagnosis and Risk Assessment; Crisis Services (4 of 13 counties)
     - **YSS –** Youth and Children Outpatient MH/SUD; Person- & Family-centered Treatment Planning; CCBHC Case Management; Screening, Diagnosis and Assessment; Crisis Services (2 of 13 counties)
     - **Community and Family Resources –** Outpatient MH/SUD; Person - & Family-centered Treatment Planning; Screening, Diagnosis and Risk Assessment (1 of 13 counties)
     - **Berryhill –** Assertive Community Treatment (1 of 13 counties)
     - **Elevate -** Mobile Crisis (3 of 13 counties)
     - **Eyerly Ball CMHC -** Mobile Crisis (10 of 13 counties)

Attachment 4
Iowa HHS CCBHC Demonstration Application
List of proposed CCBHCs and DCOs

6. **Pathways Behavioral Services, Waterloo, IA**
   - **DCOs**
     - **Elevate -** Mobile Crisis (4 of 6 counties)
     - **Foundation 2 -** Mobile Crisis (2 of 6 counties)
     - **Four Oaks -** Functional Family Therapy (6 of 6 counties)
     - **Black Hawk Grundy MHC -** Outpatient MH (2 of 6 counties)
     - **Resources for Human Development -** Assertive Community Treatment (6 of 6 counties)

7. **Plains Area Mental Health Center, Le Mars, IA**
   - **DCOs**
     - **New Opportunities -** Outpatient SUD services (3 of 8 counties)

8. **Robert Young Center, Muscatine, IA**
   - **DCOs**
     - **Foundation 2 -** Mobile Crisis (5 of 5 counties)
     - **Vera French CMHC –** Multisystemic Therapy and Peer Services (5 of 5 counties)

9. **Northwest Iowa Mental Health Center (Seasons Center), Spencer, IA**
   - **No DCOs**

Attachment 5

March 19, 2024

As Director of Iowa Medicaid & Division of Administration and HHS Deputy Director, I verify that the Iowa Department of Health and Human Services (Iowa HHS) has agreed to pay for CCBHC services at a rate established under the prospective payment system (PPS). For our demonstration, Iowa HHS intends to implement a daily PPS (PPS-1) rate effective July 1, 2024.

Elizabeth Matney
Director, Iowa Medicaid & Division of Administration and HHS Deputy Director

03/18/2024
Date

Attachment 6
Iowa HHS CCBHC Demonstration Application
Scope of Services

Enclosed please find a description of the scope of services required by Iowa in compliance with CCBHC Criteria, Scope of Services, that will be provided by CCHBCs in our demonstration program, available under the state Medicaid program, and that will be paid for under the CCBHC PPS-1 payment methodology. Iowa-specific program additions and Evidence Based Practices are listed below. Those with specific Medicaid billing codes are highlighted in yellow in the attached scope of services overview. Others are included within outpatient behavioral health treatment.

- Assertive Community Treatment
- Multisystemic Therapy
- Multidimensional Family Therapy
- Functional Family Therapy
- Trauma Focused – Cognitive Behavioral Therapy
- Screening, Brief Intervention and Referral to Treatment

PLACE OF SERVICE

(03140)

PLACE OF SERVICE INDICATES WHERE THE SERVICE WAS RENDERED. THIS DATA ELEMENT CONTAINS THE VALID VALUES ACCEPTED ON MEDICAL CLAIMS (HCFA 1500 AND TARGETED MEDICAL CARE.)

01	Pharmacy **(NOT CURRENTLY USED)**
02	Telehealth
03	School
04	Homeless Shelter
05	Indian Health Service Free Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
09	Correction Facility **(NOT CURRENTLY USED)**
10	Telehealth in patient home
11	Office
12	Patient's Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
19	Off Campus Outpatient Hospital
20	Urgent Care Facility
21	Inpatient Hospital
22	On Campus Outpatient Hospital
23	Emergency Room Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Home
33	Custodial Care Facility
34	Hospice
41	Ambulance (Land)
42	Ambulance – Air or Water
49	Independent Clinic
50	FQHC (Federally Qualified Health Center)
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Daycare Facility Psych
54	Intermediate Care Facility (ID)
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-Residential Substance Abuse Treatment Facility
58	Non-Residential Opioid Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehab
62	Comprehensive Outpatient Rehab
65	End Stage Renal Disease Treatment
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Lab
99	Other Unlisted Facility

Definitions

Threshold Services	A service which triggers payment of the CCBHC clinic-specific PPS rate.
Allowed Services	A service which can be included as an allowable activity in a CCBHC's cost report but does not on its own trigger PPS payment.
Excluded Services	A service which cannot be included as an allowable activity in a CCBHC cost report nor can it be billed under the PPS model.
CCBHC Provider Type	A provider type assigned to certified CCBHCs for billing purposes under the CCBHC Demonstration.
Shadow Claim	Detailed data about individual services, reported in a manner similar to that of a standard claim form.

Threshold Services

CCBHC Service Category	Code	Definition
Criteria 4.C. Crisis Behavioral Health Services	H0007	Alcohol/drug crisis intervention/outpatient
Criteria 4.C. Crisis Behavioral Health Services	H0014	Alcohol and/or drug services; ambulatory detoxification
Criteria 4.C. Crisis Behavioral Health Services	H2011	Crisis intervention service, per 15 minutes
Criteria 4.C. Crisis Behavioral Health Services	S9484	Crisis intervention mental health services, per hour□
Criteria 4.C. Crisis Behavioral Health Services	T2034	Crisis intervention
Criteria 4.C. Crisis Behavioral Health Services	90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
Criteria 4D: Screening, Assessment and Diagnosis	90785	Interactive complexity (List separately in addition to the code for primary procedure)
Criteria 4D: Screening, Assessment and Diagnosis	90791	Psychiatric diagnostic evaluation
Criteria 4D: Screening, Assessment and Diagnosis	90792	Psychiatric diagnostic evaluation with medical services
Criteria 4D: Screening, Assessment and Diagnosis	90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
Criteria 4D: Screening, Assessment and Diagnosis	96100	Psychological testing w/interp and repor
Criteria 4D: Screening, Assessment and Diagnosis	96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
Criteria 4D: Screening, Assessment and Diagnosis	96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face□
Criteria 4D: Screening, Assessment and Diagnosis	96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report□

Threshold Services		
CCBHC Service Category	**Code**	**Definition**
Criteria 4D: Screening, Assessment and Diagnosis	96127	Brief emotional behavioral assessment-Comm MH
Criteria 4D: Screening, Assessment and Diagnosis	96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
Criteria 4D: Screening, Assessment and Diagnosis	96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary
Criteria 4D: Screening, Assessment and Diagnosis	96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
Criteria 4D: Screening, Assessment and Diagnosis	96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
Criteria 4D: Screening, Assessment and Diagnosis	96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
Criteria 4D: Screening, Assessment and Diagnosis	96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
Criteria 4D: Screening, Assessment and Diagnosis	96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only
Criteria 4D: Screening, Assessment and Diagnosis	96156	HLTH BHV ASSMT/REASSESSMENT
Criteria 4D: Screening, Assessment and Diagnosis	99408	Alcohol/sub abuse scrn&intervention 15-30 min

Threshold Services

CCBHC Service Category	Code	Definition
Criteria 4D: Screening, Assessment and Diagnosis	99409	AUDIT/DAST OVER 30 MIN
Criteria 4D: Screening, Assessment and Diagnosis	G0396	Alcohol &/or sub misuse assessment 15-30 minutes
Criteria 4D: Screening, Assessment and Diagnosis	G0397	Alcohol %/or sub misuse assessment >30 minutes
Criteria 4D: Screening, Assessment and Diagnosis	G0442	Annual alcohol screen 15 min
Criteria 4D: Screening, Assessment and Diagnosis	G0444	Depression screen annual
Criteria 4D: Screening, Assessment and Diagnosis	H0001	Alcohol and/or drug assessment
Criteria 4D: Screening, Assessment and Diagnosis	H0003	ALCOHOL/DRUG SCREENING
Criteria 4D: Screening, Assessment and Diagnosis	H0031	Mental health assessment, by nonphysician
Criteria 4D: Screening, Assessment and Diagnosis	H0032	Mental health service plan development by nonphysician
Criteria 4D: Screening, Assessment and Diagnosis	H0049	Alcohol and/or drug screening
Criteria 4E: Person-Centered and Family-Centered Treatment Planning	H0033	Mental health service plan development by nonphysician
Criteria 4F: Outpatient Mental Health and Substance Use Services	90832	Psychotherapy, 30 minutes with patient
Criteria 4F: Outpatient Mental Health and Substance Use Services	90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
Criteria 4F: Outpatient Mental Health and Substance Use Services	90834	Psychotherapy, 45 minutes with patient
Criteria 4F: Outpatient Mental Health and Substance Use Services	90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
Criteria 4F: Outpatient Mental Health and Substance Use Services	90837	Psychotherapy, 60 minutes with patient
Criteria 4F: Outpatient Mental Health and Substance Use Services	90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

Threshold Services		
CCBHC Service Category	**Code**	**Definition**
Criteria 4F: Outpatient Mental Health and Substance Use Services	90839	Psychotherapy for crisis; first 60 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)
Criteria 4F: Outpatient Mental Health and Substance Use Services	90846	Family psychotherapy (without the patient present), 50 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	90849	Multiple-family group psychotherapy
Criteria 4F: Outpatient Mental Health and Substance Use Services	90853	Group psychotherapy (other than of a multiple-family group)
Criteria 4F: Outpatient Mental Health and Substance Use Services	90863	Pharmacologic management with psychotherapy
Criteria 4F: Outpatient Mental Health and Substance Use Services	90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 30 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 45 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	90899	Unlisted psychiatric service or procedure
Criteria 4F: Outpatient Mental Health and Substance Use Services	96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
Criteria 4F: Outpatient Mental Health and Substance Use Services	96118	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report□

Threshold Services		
CCBHC Service Category	**Code**	**Definition**
Criteria 4F: Outpatient Mental Health and Substance Use Services	96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
Criteria 4F: Outpatient Mental Health and Substance Use Services	96120	Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report
Criteria 4F: Outpatient Mental Health and Substance Use Services	96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)
Criteria 4F: Outpatient Mental Health and Substance Use Services	96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
Criteria 4F: Outpatient Mental Health and Substance Use Services	96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary

Threshold Services		
CCBHC Service Category	**Code**	**Definition**
Criteria 4F: Outpatient Mental Health and Substance Use Services	99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
Criteria 4F: Outpatient Mental Health and Substance Use Services	99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
Criteria 4F: Outpatient Mental Health and Substance Use Services	99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.☐
Criteria 4F: Outpatient Mental Health and Substance Use Services	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
Criteria 4F: Outpatient Mental Health and Substance Use Services	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.☐

Threshold Services		
CCBHC Service Category	**Code**	**Definition**
Criteria 4F: Outpatient Mental Health and Substance Use Services	99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional
Criteria 4F: Outpatient Mental Health and Substance Use Services	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
Criteria 4F: Outpatient Mental Health and Substance Use Services	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
Criteria 4F: Outpatient Mental Health and Substance Use Services	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
Criteria 4F: Outpatient Mental Health and Substance Use Services	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.☐
Criteria 4F: Outpatient Mental Health and Substance Use Services	99354	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for outpatient Evaluation and Management or psychotherapy service, except with office or other outpatient services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215])

Threshold Services		
CCBHC Service Category	**Code**	**Definition**
Criteria 4F: Outpatient Mental Health and Substance Use Services	99417	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)
Criteria 4F: Outpatient Mental Health and Substance Use Services	99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
Criteria 4F: Outpatient Mental Health and Substance Use Services	99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
Criteria 4F: Outpatient Mental Health and Substance Use Services	99499	Unlisted evaluation and management service
Criteria 4F: Outpatient Mental Health and Substance Use Services	99510	Home visit for individual, family, or marriage counseling
Criteria 4F: Outpatient Mental Health and Substance Use Services	G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	G0445	Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior
Criteria 4F: Outpatient Mental Health and Substance Use Services	G0446	Intensive behavioral therapy 15 min: Annual, face to face intensive behavioral health therapy for cardiovascular disease,
Criteria 4F: Outpatient Mental Health and Substance Use Services	G0447	Face to face behavioral counseling for Obesity, 15 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	G0473	Face to face beahvioral counseling for Obesity, group (2-10), 30 minutes

Threshold Services		
CCBHC Service Category	**Code**	**Definition**
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2068	Medication assisted treatment, **buprenorphine** (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy and toxicology testing
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2069	Medication assisted treatment, **buprenorphine** (injectable); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy and toxicology testing
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2070	Medication Assisted Treatment, Buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2071	Medication assisted treatment, buprenorphine (implant removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2072	Medication assisted treatment, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2073	Medication assisted treatment, naltrexone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2074	Medication assisted treatment, weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy and toxicology testing
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2075	Medication Assisted Treatment, Medication not otherwise specified; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare enrolled opioid treatment program)

Threshold Services

CCBHC Service Category	Code	Definition
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2079	Take home supply of buprenorphine (oral); up to 7 additional day supply (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure
Criteria 4F: Outpatient Mental Health and Substance Use Services	H0004	Behavioral health counseling and therapy, 15 mins
Criteria 4F: Outpatient Mental Health and Substance Use Services	H0015	Alcohol and/or drug services, intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based ona n individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
Criteria 4F: Outpatient Mental Health and Substance Use Services	H0040	Assertive Community Treatment
Criteria 4F: Outpatient Mental Health and Substance Use Services	H0046	Mental health services, not otherwise specified
Criteria 4F: Outpatient Mental Health and Substance Use Services	H0050	Alcohol and/or drug services, brief intervention, per 15 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	H2010	Comprehensive Medication Services/15 min
Criteria 4F: Outpatient Mental Health and Substance Use Services	H2035	Alcohol and/or other drug treatment program, per hour
Criteria 4F: Outpatient Mental Health and Substance Use Services	T1016	Case management, each 15 minutes
Criteria 4G: Outpatient Clinic Primary Care Screening and Monitoring	99401	Preventative Medicine counseling/risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 mins
Criteria 4G: Outpatient Clinic Primary Care Screening and Monitoring	99402	Preventative Medicine counseling/risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 min
Criteria 4G: Outpatient Clinic Primary Care Screening and Monitoring	99403	Preventative Medicine Counseling/risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 min
Criteria 4G: Outpatient Clinic Primary Care Screening and Monitoring	99404	Preventative Medicine Counseling/risk factor redction intervention(s) provided to an individual (separate procedure); approximately 60 min

Threshold Services

CCBHC Service Category	Code	Definition
Criteria 4G: Outpatient Clinic Primary Care Screening and Monitoring	G2077	Periodic assessment; asssessing periodcally by qualified personnel to determine the most appropriate combination of services and treatment(provision of the services by a medicare-enrolled opioid treatment program; list sepaarately in addition to code for primary procedure
Criteria 4H: Targeted Case Management Services	According to federal guidance, Case Management Services are not considered Threshold Services. These codes are included as allowed CCBHC services.	
Criteria 4I. Psychiatric Rehabilitative Services	90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
Criteria 4I. Psychiatric Rehabilitative Services	H0034	Medication training and support, per 15 minutes
Criteria 4I. Psychiatric Rehabilitative Services	H2012	Behavioral health day treatment, per hour
Criteria 4I. Psychiatric Rehabilitative Services	H2031	Mental Health Clubhouse Service, per diem
Criteria 4I. Psychiatric Rehabilitative Services	H2033	Multisystemic therapy, per 15 minutes
Criteria 4I. Psychiatric Rehabilitative Services	S9480	Intensive outpatient psychiatric services, per diem
Criteria 4J. Peer Supports, Peer Counseling and Family/Caregiver Supports	H0038	Self-help/peer services, per 15 minutes
Criteria 4J. Peer Supports, Peer Counseling and Family/Caregiver Supports	T1027	FAMILY TRAINING & COUNSELING/PER 15 MIN.

Allowed Services	
Code	**Definition**
81000	UA, NON-AUTOMATED, WITH MICROSCOPY
83992	PHENCYCLIDINE (PCP)
90460	IM ADMIN 1ST/ONLY COMPONENT
90461	IM ADMIN EACH ADDL COMPONENT
90472	IMMUNIZATION ADMIN EACH ADD
90473	IMMUNE ADMIN ORAL/NASAL
90474	IMMUNE ADMIN ORAL/NASAL ADDL
90611	SMALLPOX AND MONKEYPOX VACCINE, 0.5ML
90622	VACCINIA VIRUS VACCINE, 0.3 ML
90634	HEPA VACC PED/ADOL 3 DOSE
90674	CCIIV4 VAC NO PRSV 0.5 ML IM
90682	RIV4 VACC RECOMBINANT DNA IM
90689	VACC IIV4 NO PRSRV 0.25ML IM
90750	HZV VACC RECOMBINANT IM
90756	CCIIV4 VACC ABX FREE IM
90782	THER. INJ. OF MEDICATION (SPECIFY);SUBQ
91300	SARS-COV-2 COVID-19 VACCINE, 30 MCG/0.3M
91301	SARS-COV-2 COVID-19 VACCINE, 100 MCG/0.5
91303	SARS-COV-2 [COVID-19], 0.5ML DOSAGE
91304	Sarscov2 vac 5mcg/0.5ml im
91305	Sarscov2 vac 30 mcg trs-sucr
91306	Sarscov2 vac 50mcg/0.25ml im
91307	Sarscov2 vac 10 mcg trs-sucr
91308	Sarscov2 vac 3 mcg trs-sucr
91309	Sarscov2 vac 50mcg/0.5ml im
91311	Sarscov2 vac 25mcg/0.25ml im
91312	SARS-COV-2 COVID-19 VACCINE, 30 MCG/0.3
91313	SARS-COV-2 COVID-19 VACCINE, 50 MCG/0.5

Allowed Services	
Code	**Definition**
91314	SARS-COV-2 VACCINE, BIVALENT, 25 MCG/.25
91315	SARS-COV-2 VACCINE, BIVALENT, 10 MCG/0.2
91316	SARS-COV-2 VACCINE, BIVALENT, 10MCG/0.2M
91317	SARS-COV-2 VACCINE, BIVALENT, 3MCG/0.2ML
96001	MOTION TEST W/FT PRESS MEAS
96105	Assessment of aphasia
96110	Developmental screening
96112	development test
96113	development test
96125	cognitive test by hc pro
96158	HLTH BHV IVNTJ INDIV 1ST 30
96164	HLTH BHV IVNTJ GRP 1ST 30
96165	HLTH BHV IVNTJ GRP EA ADDL
96167	HLTH BHV IVNTJ FAM 1ST 30
96168	HLTH BHV IVNTJ FAM EA ADDL
96170	HLTH BHV IVNTJ FAM WO PT 1ST
96171	HLTH BHV IVNTJ FAM W/O PT EA
96372	THER/PROPH/DIAG INJ SC/IM
96967	TELEPHONE A/M SERVICE, 11-20MIN OF DISC
97151	BHV ID ASSMT BY PHYS/QHP
97152	BHV ID SUPRT ASSMT BY 1 TECH
97153	ADAPTIVE BEHAVIOR TX BY TECH
97154	GRP ADAPT BHV TX BY TECH
97155	ADAPT BEHAVIOR TX PHYS/QHP
97156	FAM ADAPT BHV TX GDN PHY/QHP
97157	MULT FAM ADAPT BHV TX GDN
97158	GRP ADAPT BHV TX BY PHY/QHP
98966	HC PRO PHONE CALL 5-10 MIN

Allowed Services	
Code	**Definition**
98967	HC PRO PHONE CALL 11-20 MIN
98968	HC PRO PHONE CALL 21-30 MIN
99483	Assmt & care pln pt cog imp
99484	CARE MGMT SVC BHVL HLTH COND
99484	CARE MGMT SVC BHVL HLTH COND
99492	1ST PSYC COLLAB CARE MGMT
99492	1ST PSYC COLLAB CARE MGMT
99493	SBSQ Psych collab care mgmt
99493	SBSQ Psych collab care mgmt
99494	1st/SBSQ psych collab care
99494	1st/SBSQ psych collab care
0001A	Immunization administration of SARS-COV
0002A	Immunization administration of SARS-COV
0003A	Adm sarscov2 30mcg/0.3ml 3rd
0004A	Adm sarscov2 30mcg/0.3ml bst
0011A	IMMUNIZATION ADMINISTRATION OF SARS-COV-
0012A	IMMUNIZATION ADMINISTRATION OF SARS-COV-
0013A	Adm sarscov2 100mcg/0.5ml3rd
0031A	IMMUNIZATION ADMINISTRATION OF SARS-COV-
0034A	Adm sarscov2 vac ad26 .5ml b
0041A	Adm sarscov2 5mcg/0.5ml 1st
0042A	Adm sarscov2 5mcg/0.5ml 2nd
0044A	ADMIN SARS-COV-2, 5 MCG/0.5 ML BOOSTER
0051A	Adm sarscv2 30mcg trs-sucr 1
0052A	Adm sarscv2 30mcg trs-sucr 2
0053A	Adm sarscv2 30mcg trs-sucr 3
0054A	Adm sarscv2 30mcg trs-sucr b
0064A	Adm sarscov2 50mcg/0.25mlbst

Allowed Services	
Code	**Definition**
0071A	Adm sarscv2 10mcg trs-sucr 1
0072A	Adm sarscv2 10mcg trs-sucr 2
0073A	Adm sarscv2 10mcg trs-sucr 3
0074A	Adm sarscv2 10mcg trs-sucr b
0081A	Adm sarscv2 3mcg trs-sucr 1
0082A	Adm sarscv2 3mcg trs-sucr 2
0083A	Adm sarscv2 3mcg trs-sucr 3
0091A	IMMUNIZATION ADMIN COVID-19 VACCINE, 50
0092A	IMMUNIZATION ADMIN COVID-19 VACCINE, 50
0093A	IMMUNIZATION ADMIN COVID-19 VACCINE, 50
0094A	Adm sarscov2 50 mcg/.5 mlbst
0111A	Adm sarscov2 25mcg/0.25ml1st
0112A	Adm sarscov2 25mcg/0.25ml2nd
0113A	IMMUNIZATION ADMIN COVID-19 VACCINE, 25
0124A	IMMUNIZATION ADMIN OF COVID-19 VACCINE
0134A	IMMUNIZATION ADMINISTRATION OF SARS-COV-
0144A	ADMIN SARS-COV-2, BIVALENT, 25 MCG/.25 M
0154A	ADMIN SARS-COV-2, BIVALENT, 10 MCG/0.2 M
0164A	IMMUNIZATION ADMIN COVID-19 VACCINE, 10M
0173A	IMMUNIZATION ADMIN COVID-19 VACCINE, 3MC
G0310	Immunization Counseling
G0311	Immunization Counseling
G0312	Immunization Counseling
G0313	Immunization Counseling
G0314	Immunization Counseling
G0315	Immunization Counseling
G0449	Annual face-to-face obesity screening
G0450	Screen for sexually transmitted infection

Allowed Services	
Code	**Definition**
G0451	DEVELOPMENT TESTING, WITH I & R
G0480	Drug test(s); utilizing drug identificat
G0501	Resource intensive services for patients
G0659	Drug test(s); utilizing drug identificat
G2080	Each additional 30 minutes of counseling
G2212	Prolong outpt/office visit
G2212	Prolong outpt/office visit
G2214	Initial or subsequent psychiatric collab
G9012	OTHER SPECIFIED CASE MANAGEMENT SERVICE
G9012	OTHER SPECIFIED CASE MANAGEMENT SERVICE
H0003	ALCOHOL/DRUG SCREENING
H0033	Oral medication administration (psychotropic)
H0033	Oral medication administration (psychotropic)
H0036	Mental Health outreach; 15 minute unit Elderly
H0036	Mental Health outreach; 15 minute unit Elderly
H2010	Comprehensive Medication Services/15 min
Q3014	Telehealth facility fee
Q3014	Telehealth facility fee
T1013	Sign language or oral interpretation services
T1013	Telephonic interpretive services
T2023	Targeted case management; per month

Excluded Services	
Code	**Definition- suggest remove excluded list as it doesn't cover everything.**
96158	Behavioral Programing (i.e. health and behavioral intervention); first 30 mins BI Waiver
96159	Behavioral Programing (i.e. health and behavioral intervention); each additonal 15 mins BI Waiver
G0501	Resource intensive services for patients
G0506	Comprehensive Care Management-IHH informational code
G0506	Comprehensive Care Management-IHH informational code
G2077	Periodic assessment; assessing periodically by qualified personnel to determine the most appropriate combination of services and treatment *Intensity Add-on codes
G2080	Each additional 30 minutes of counseling
G2213	Initiation of medication for the treatment
G9008	Care Coordination-IHH Informational Code
G9008	Care Coordination-IHH Informational Code
H0004	Counseling (individual) (i.e. health and behavior intervention); first 15 mins HIV and HD Waiver
H0018 TF	Level III.3 & III.5 Clinically Managed Medium/High Intensity Residential Substance Use Disorder Treatment – CommunityBased
H0018 TG	Level III.7 Communitybased Substance Use Disorder Treatment
H2014	SKILLS TRAINING & DEV, PER 15 MIN
H2034	Level III.1 Clinically Managed Low Intensity Residential Substance Use Disorder Treatment
J1630	Haldol injection, up to 5 mg
J1631	Haldol decanoate injection, per 50 mg
J2358	Injection, olanzapine, long acting, 1 mg
J2680	Injection fluphenazine deconoate 25 mg
J2794	Injection risperidone, long acting .5mg
J2798	Injection, risperidone (perseris), .5
J3490	Unclassified drug
J7306	Levonorgestrel implant sys
J8498	Antiemetic rectal/supp nos
J8499	Prescription drug, oral, nos
J8597	Antiemetic drug oral nos
S0201	23 hour crisis observation and holding
S0201	Crisis Intervention Mental Health
T2011	Preadmission screening pasarr/II encount
T2034	Crisis intervention , waiver; per diem

Attachment 7
Iowa HHS CCBHC Demonstration Application
Budget Justification and No Cost Extension Budget

Enclosed please find the original budget narrative submitted in December 2022 with the Iowa CCBHC Planning Grant application and the revised budget submitted in January 2024 for the state's No Cost Extension Application which projects expenditures for March 31, 2024-March 30, 2025.

Applicant/Recipient	Application/Award Number
Iowa Department of Human Services	SM-23-015

Project Title:	Iowa CCBHC Planning Grant

	Start Date	End Date	Budget Year
Budget Period:	03/30/2023	03/29/2024	1

For Multi-Year Funded (MYF) awards only
(not applicable to new applications for funding)
Check the box to select the Incremental Period ☐

COST SHARING AND MATCHING

Matching Required: ☐ YES ☒ NO

A. Personnel

Line Item #	Position	Name	Key Position per the NOFO	Check if Hourly Rate	Calculation: Hourly Rate	Hours	# of Staff	Annual Salary	% Level of Effort (LOE)	Personnel Cost	FEDERAL REQUEST
1	CCBHC Project Coordinator - Management Analyst 3	TBD	☐	☐			1	$75,000	100.00%	$75,000	$75,000
									TOTAL	**$75,000**	**$75,000**

Line Item #	**Personnel Narrative:**						
1	CCBHC Project Coordinator -Management	TBD		Salary $75,000	# of Staff 1	LOE 100.00%	Personnel Cost $75,000
	The CCBHC Project Coordinator/management analyst will assist the Project Director with CCBHC oversight and implementation including management of contractors, with emphasis on integration of CCBHC outcomes into the state IBHRS data system.						

☒ Show In-Kind Personnel Table

In-Kind Personnel

Line Item #	Position	Name	Key Position per the FOA	Check if Hourly Rate	Hourly Rate	Hours	# of Staff	Annual Salary	% Level of Effort (LOE)
1	Project Director	Laura Larkin	☒	☐			1	$98,196	50.00%
2	State Director of Behavioral Health and Disability Services, SMHA and SSA	Marissa Eyanson	☐	☐			1	$140,886	5.00%
3	State Medicaid Director, State Medicaid Authority	Elizabeth Matney	☐	☐			1	$168,251	5.00%
4	Bureau Chief	Theresa Armstrong	☐	☐			1	$128,523	5.00%
5	Bureau Chief	DeAnn Decker	☐	☐			1	$113,152	5.00%
6	Medicaid Policy Subject Matter Expert	Hannah Olson	☐	☐			1	$83,096	5.00%

7	CCBHC Evaluator	Pat McGovern	☐	☐			1	$76,585	5.00%
8	State 988 Coordinator	Julie Maas	☐	☐			1	$73,237	5.00%

Line Item #	In-Kind Personnel Narrative:							
1	Project Director	Laura Larkin	Key Personnel	Salary $98,196	# of Staff 1	LOE 50.00%	Personnel Cost $49,098	
	Laura Larkin, Executive Officer 2 will be the CCBHC project director, will coordinate all CCBHC-grant related activities, direct contracted staff, and be the primary state contact with SAMHSA.							
2	State Director of Behavioral Health and	Marissa Eyanson		Salary $140,886	# of Staff 1	LOE 5.00%	Personnel Cost $7,044	
	Marissa Eyanson, State Director, Behavioral Health and Disability Services,is the SMHA and SSA for the state of Iowa. She will provide oversight and direction for the CCBHC Planning Grant.							
3	State Medicaid Director, State Medicaid Authority	Elizabeth Matney		Salary $168,251	# of Staff 1	LOE 5.00%	Personnel Cost $8,413	
	Elizabeth Matney, State Medicaid Director, is the SMA for the state of Iowa. She will provide oversight and direction for the Medicaid-related activities of the CCBHC Planning Grant.							
4	Bureau Chief	Theresa Armstrong		Salary $128,523	# of Staff 1	LOE 5.00%	Personnel Cost $6,426	
	Theresa Armstrong, Bureau Chief, Behavioral Health and Disability Services, Performance, Innovation, and Mental Health, directly supervises the Project Director and will provide oversight and direction of the CCBHC Planning Grant.							
5	Bureau Chief	DeAnn Decker		Salary $113,152	# of Staff 1	LOE 5.00%	Personnel Cost $5,658	
	DeAnn Decker, Bureau Chief for Behavioral Health and Disability Services, Substance Use Disorder Prevention, Treatment and Recovery will provide oversight and direction regarding substance-use disorder programs, services, and supports.							
6	Medicaid Policy Subject Matter Expert	Hannah Olson		Salary $83,096	# of Staff 1	LOE 5.00%	Personnel Cost $4,155	
	Hannah Olson, Iowa Medicaid Behavioral Health Policy Analyst, is a subject matter expert for Medicaid-funded behavioral health and will provide expertise on Medicaid policy and programs.							
7	CCBHC Evaluator	Pat McGovern		Salary $76,585	# of Staff 1	LOE 5.00%	Personnel Cost $3,829	
	Pat McGovern, Behavioral Health and Disability Services, Substance Use Disorder Prevention, Treatment and Recovery, will serve as the Program Evaluator and assist with oversight of the CCBHC Planning Grant Evaluation and modifications to the state IBHRS system to include mental health data indicators for CCBHC providers.							
8	State 988 Coordinator	Julie Maas		Salary $73,237	# of Staff 1	LOE 5.00%	Personnel Cost $3,662	
	Julie Maas, State 988 Coordinator, will provide direction on integration of the state's CCBHC planning efforts with the state's 988 implementation work.							

B. Fringe Benefits

Our organization's fringe benefits consist of the components shown below:

Fringe Component	Rate (%)
State of Iowa Fringe Benefits-(FICA, IPERS, Health, Dental and Life Insurance, Deferred Compensation and Disability Insurance	32.26%
Total Fringe Rate	32.26%

Fringe Benefits Cost

Line Item #	Position	Name	Calculation				FEDERAL REQUEST
			Personnel Cost	Total Fringe Rate (%)	Fixed / Lump Sum Fringe (if any)	**Fringe Benefits Cost**	
1	CCBHC Project Coordinator -Management Analyst 3	TBD	$75,000	32.26%		$24,195	$24,195
					TOTAL	**$24,195**	**$24,195**

Fringe Benefits Narrative:
State of Iowa Fringe Benefits-(FICA, IPERS, Health, Dental and Life Insurance, Deferred Compensation and Disability Insurance

C. Travel

Trip #	Purpose	Destination	Calculation: Item	Cost / Rate per Item	Basis	Quantity per Person	Number of Persons	Travel Cost	FEDERAL REQUEST
1	CCBHC site visits and other local travel for state staff to attend stakeholder meetings/ engagement	approximately 9 CCBHC sites across Iowa-locations to be determined	Local Travel (POV Mileage)	$0.50	Mile	3,000.00	3	$4,500	$4,500
							TOTAL	$4,500	**$4,500**

Trip #	Travel Narrative:		
1	CCBHC site visits and other local travel for state staff to attend stakeholder meetings/engagement	approximately 9 CCBHC sites across Iowa-locations to be determined	Travel Cost $4,500
	As part of the certification process, the CCBHC project director and other state staff will participate in site visits to each identified CCBHC and participate in stakeholder engagement activities.		

D. Equipment

Line Item #	Item	Check if Item is a Vehicle	Calculation: Quantity	Purchase or Rental/Lease Cost	Percent Charged to the Project	Equipment Cost	FEDERAL REQUEST
1		☐				$0	$0
					TOTAL	**$0**	**$0**

Line Item #	Equipment Narrative:					
1		Quantity	Purchase or Rental/Lease Cost	% Charged to the Project	Equipment Cost	$0
	N/A					

E. Supplies

Line Item #	Item	Calculation: Unit Cost	Basis	Quantity	Duration	Supplies Cost	FEDERAL REQUEST
1	Laptop computers, docking stations, and software package	$1,450.00		3.00		$4,350	$4,350
2	Cell phone services $40 per month	$40.00		3.00	12.00	$1,440	$1,440
3	Cell phone purchase-one time cost	$50.00		3.00		$150	$150
4	Printing	$0.20		5,000.00		$1,000	$1,000
5	General office supplies	$25.00		3.00	12.00	$900	$900

Line Item #	Item	Calculation					FEDERAL REQUEST
		Unit Cost	Basis	Quantity	Duration	Supplies Cost	
					TOTAL	$7,840	$7,840

Line Item #	Supplies Narrative:					
1	Laptop computers, docking stations, and software pac	Unit Cost $1,450.00	Basis	Quantity 3.00	Duration	Supplies Cost $4,350
	Laptops for 3 project coordinators for work on the CCBHC planning grant.					
2	Cell phone services $40 per month	Unit Cost $40.00	Basis	Quantity 3.00	Duration 12.00	Supplies Cost $1,440
	Cell phone service for 3 project coordinators for work on the CCBHC planning grant					
3	Cell phone purchase-one time cost	Unit Cost $50.00	Basis	Quantity 3.00	Duration	Supplies Cost $150
	Purchase of 3 cell phones for project coordinators for work on the CCBHC planning grant					
4	Printing	Unit Cost $0.20	Basis	Quantity 5,000.00	Duration	Supplies Cost $1,000
	Printing for stakeholder engagement events and presentations.					
5	General office supplies	Unit Cost $25.00	Basis	Quantity 3.00	Duration 12.00	Supplies Cost $900
	Miscellaneous office supplies for project coordinators					

F. Contractual

Summary of Contractual Costs

Agree-ment #	Name of Organization or Consultant	Type of Agreement	Contractual Cost	FEDERAL REQUEST
1	University of Iowa-Center for Disabilities and Development	Subaward	$176,000	**$176,000**
2	Project Evaluation Entity-TBD	Subaward	$160,000	**$160,000**
3	Contracts with CCBHC grantees	Subaward	$180,000	**$180,000**
4	PPS Rate Development	Subaward	$100,000	**$100,000**
5	State Data System Enhancements/IBHRS	Subaward	$180,000	**$180,000**
6	Learning Collaboratives for CCBHCs-TBD	Subaward	$92,465	**$92,465**
	TOTAL		**$888,465**	**$888,465**

Contractual Details for **University of Iowa-Center for Disabilities and Development**

Agree-ment #	Services and Deliverables Provided
1	Services of 2 FTE Program Coordinators to assist state staff in management and coordination of all required grant activities including CCBHC certification processes, PPS development, learning collaboratives, and stakeholder engagement with behavioral health providers, stakeholders, individuals and family members of individuals with lived experience.

☒ Personnel ☒ Travel ☐ Supplies ☐ Indirect Charges
☐ Fringe Benefits ☐ Equipment ☐ Other

Contractual Personnel Costs for University of Iowa-Center for Disabilities and Development

Line Item #	Position	Name	Key Position per the NOFO	Check if Annual Salary	Calculation						FEDERAL REQUEST
					Hourly Rate	Hours	# of Persons	Annual Salary	% Level of Effort (LOE)	**Contractual Personnel Cost**	
1	Program Coordinator 1	TBD	☐	☒			1	$85,000	100.00%	$85,000	$85,000
2	Program Coordinator 2	TBD	☐	☒			1	$85,000	100.00%	$85,000	$85,000
									TOTAL	**$170,000**	**$170,000**

Line Item #	Contractual Personnel Narrative:						
1	Program Coordinator 1	TBD		Salary $85,000	# of Persons 1	LOE 100.00%	Personnel Cost $85,000
	Program Coordinator 1 will assist state staff in management and coordination of all required grant activities including CCBHC certification processes and stakeholder engagement with behavioral health providers, stakeholders, consumers, and family members of consumers of behavioral health services. This position will also assist with coordination of the Medicaid PPS rate development process.						
2	Program Coordinator 2	TBD		Salary $85,000	# of Persons 1	LOE 100.00%	Personnel Cost $85,000
	Program Coordinator 2 will assist state staff in management and coordination of all required grant activities including CCBHC certification processes and stakeholder engagement with behavioral health providers, stakeholders, consumers, and family members of consumers of behavioral health services.						

Contractual Travel Costs for University of Iowa-Center for Disabilities and Development

Trip #	Purpose	Destination	Calculation						FEDERAL REQUEST
			Item	Cost / Rate per Item	Basis	Quantity per Person	Number of Persons	**Contract Travel Cost**	
1	CCBHC site visits and other local travel for stakeholder meetings/ engagement	approximately 9 sites across Iowa-location to be determined	Local Travel (POV Mileage)	$0.50	Mile	6,000.00	2	$6,000	$6,000
							TOTAL	$6,000	**$6,000**

Trip #	Contractual Travel Narrative:			
1	CCBHC site visits and other local travel for stakeholder meetings/ engagement	approximately 9 sites across Iowa-location to be determined	Travel Cost	$6,000
	Mileage for contracted staff to conduct site visits to CCBHC sites.			

Contractual Total Direct Charges for University of Iowa-Center for Disabilities and Development

TOTAL DIRECT CHARGES FOR THIS AGREEMENT	TOTAL FEDERAL REQUEST
	$176,000

Contractual Total Cost for University of Iowa-Center for Disabilities and Development

TOTAL COST	TOTAL FEDERAL REQUEST
$176,000	$176,000

Contractual Details for Project Evaluation Entity-TBD

Agreement #	Services and Deliverables Provided
2	Provide required evaluation services for planning grant activities and provide assistance to the state in development of evaluation and data analysis for the Demonstration Grant application

☐ Personnel ☐ Travel ☐ Supplies ☐ Indirect Charges
☐ Fringe Benefits ☐ Equipment ☒ Other

Contractual Other Costs for Project Evaluation Entity-TBD

Line Item #	Item	Check for Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	Contractual Other Cost	
1	Evaluation services	☐	$160,000.00		1.00		$160,000	$160,000
						TOTAL	$160,000	$160,000

Line Item #	Contractual Other Narrative:					
1	Evaluation services	Unit Cost/Rate $160,000.00	Basis	Quantity 1.00	Duration	Other Cost $160,000
	The state intends to contract with an external evaluator with expertise in research and evaluation of federal grants. The contracted evaluation entity will be responsible for collection and reporting of CCBHC performance outcome measures, measurement of progress toward the state goals and objectives as defined in this grant application, and support participation in all aspects of the National Evaluation of the program.					

Contractual Total Direct Charges for Project Evaluation Entity-TBD

TOTAL DIRECT CHARGES FOR THIS AGREEMENT	TOTAL FEDERAL REQUEST
	$160,000

Contractual Total Cost for Project Evaluation Entity-TBD

TOTAL COST	TOTAL FEDERAL REQUEST
$160,000	$160,000

Contractual Details for Contracts with CCBHC grantees

Agreement #	Services and Deliverables Provided
3	Contracts for 9 CCBHC grantees selected through a competitive process

☐ Personnel ☐ Travel ☐ Supplies ☐ Indirect Charges
☐ Fringe Benefits ☐ Equipment ☒ Other

Contractual Other Costs for Contracts with CCBHC grantees

Line Item #	Item	Check for Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	**Contractual Other Cost**	
1	Funds to CCBHC selected through competitve process to support completion of certification requirements	☐	$20,000.00		9.00		**$180,000**	$180,000
						TOTAL	**$180,000**	**$180,000**

Line Item #	Contractual Other Narrative:					
1	Funds to CCBHC selected through competitve pro	Unit Cost/Rate $20,000.00	Basis	Quantity 9.00	Duration	Other Cost $180,000
	Iowa plans to contract with 9 community behavioral health organizations who will work toward certification as CCBHCs. Funds will be used by organizations to address EHR enhancements, PPS development, and other activities required to meet CCBHC certification criteria.					

Contractual Total Direct Charges for Contracts with CCBHC grantees

TOTAL DIRECT CHARGES FOR THIS AGREEMENT	TOTAL FEDERAL REQUEST
	$180,000

Contractual Total Cost for Contracts with CCBHC grantees

TOTAL COST	TOTAL FEDERAL REQUEST
$180,000	$180,000

Contractual Details for PPS Rate Development

Agree-ment #	Services and Deliverables Provided
4	Develop the state's PPS and quality bonus payment methodology

☐ Personnel ☐ Travel ☐ Supplies ☐ Indirect Charges
☐ Fringe Benefits ☐ Equipment ☒ Other

Contractual Other Costs for PPS Rate Development

Line Item #	Item	Check for Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	**Contractual Other Cost**	
1	PPS rate development	☐	$100,000.00		1.00		**$100,000**	$100,000
						TOTAL	**$100,000**	**$100,000**

Line Item #	Contractual Other Narrative:					
1	PPS rate development	Unit Cost/Rate $100,000.00	Basis	Quantity 1.00	Duration	Other Cost $100,000
	The state will contract with Iowa Medicaid's actuarial provider to develop PPS-1 uniform cost reporting and rate development for the CCBHC demonstration program.					

Contractual Total Direct Charges for PPS Rate Development

TOTAL DIRECT CHARGES FOR THIS AGREEMENT	TOTAL FEDERAL REQUEST
	$100,000

Contractual Total Cost for PPS Rate Development

TOTAL COST	TOTAL FEDERAL REQUEST
$100,000	$100,000

Contractual Details for State Data System Enhancements/IBHRS

Agree-ment #	Services and Deliverables Provided
5	The state will contract with the vendor for the Iowa Behavioral Health Reporting System (IBHRS) to develop capacity for reporting of CCBHC demonstration program outcomes within the existing state system used for SUD provider reporting.

☐ Personnel ☐ Travel ☐ Supplies ☐ Indirect Charges
☐ Fringe Benefits ☐ Equipment ☒ Other

Contractual Other Costs for State Data System Enhancements/IBHRS

Line Item #	Item	Check for Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	**Contractual Other Cost**	
1	Expansion of Iowa Behavioral Health Reporting System to include CCBHC outcome datasets	☐	$150,000.00	Estimated costs to add new datasets to existing system	1.00		**$150,000**	$150,000
2	Monthly hosting and maintenance costs	☐	$5,000.00	estimated monthly costs	6.00		**$30,000**	$30,000
						TOTAL	**$180,000**	**$180,000**

Line Item #	Contractual Other Narrative:						
1	Expansion of Iowa Behavioral Health Reporting S	Unit Cost/Rate $150,000.00	Basis Estimated costs to add	Quantity 1.00	Duration	Other Cost $150,000	
	The state will work with the vendor for the IBHRS system to develop capacity for reporting of CCBHC Demonstration grant outcomes.						
2	Monthly hosting and maintenance costs	Unit Cost/Rate $5,000.00	Basis estimated monthly costs	Quantity 6.00	Duration	Other Cost $30,000	
	Costs for monthly support, maintenance and hosting of the IBHRS system						

Contractual Total Direct Charges for State Data System Enhancements/IBHRS

TOTAL DIRECT CHARGES FOR THIS AGREEMENT	TOTAL FEDERAL REQUEST
	$180,000

Contractual Total Cost for State Data System Enhancements/IBHRS

TOTAL COST	TOTAL FEDERAL REQUEST
$180,000	$180,000

Contractual Details for Learning Collaboratives for CCBHCs-TBD

Agree-ment #	Services and Deliverables Provided
6	The contractor will develop learning collaboratives for prospective CCBHCs and DCOs to support the programs to make programmatic changes required to meet CCBHC certification criteria. These learning collaboratives will cover topics such as redesigning workflows to meet access standards, managing DCO relationships, PPS cost reporting and calculation, identifying and eliminating health disparities, measurement-based treatment, primary care screening and monitoring, military cultural competence, implementing and monitoring fidelity to evidence-based practices, data collection and sharing, enhancing consumer voice in agency governance, and other topics.

☐ Personnel ☐ Travel ☐ Supplies ☐ Indirect Charges
☐ Fringe Benefits ☐ Equipment ☒ Other

Contractual Other Costs for Learning Collaboratives for CCBHCs-TBD

Line Item #	Item	Check for Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	**Contractual Other Cost**	
1	Learning Collaboratives-training and TA for potential CCBHCs and DCOS	☐	$92,465.00		1.00		**$92,465**	$92,465
						TOTAL	**$92,465**	**$92,465**

Line Item #	Contractual Other Narrative:					
1	Learning Collaboratives-training and TA for poten	Unit Cost/Rate $92,465.00	Basis	Quantity 1.00	Duration	Other Cost $92,465
	Contract for provision of learning collaboratives for prospective CCBHCs and DCOs to support the programs to make programmatic changes required to meet CCBHC certification criteria.					

Contractual Total Direct Charges for Learning Collaboratives for CCBHCs-TBD

TOTAL DIRECT CHARGES FOR THIS AGREEMENT	TOTAL FEDERAL REQUEST
	$92,465

Contractual Total Cost for Learning Collaboratives for CCBHCs-TBD

TOTAL COST	TOTAL FEDERAL REQUEST
$92,465	$92,465

G. Construction: Not Applicable

H. Other

Line Item #	Item	Check if Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	Other Cost	
1		☐					$0	$0
						TOTAL	$0	$0

Line Item #	Other Narrative:					
1		Unit Cost/Rate	Basis	Quantity	Duration	Other Cost $0

I. Total Direct Charges

TOTAL DIRECT CHARGES	TOTAL FEDERAL REQUEST
	$1,000,000

J. Indirect Charges

Type of IDC Rate / Cost Allocation Plan

We will not charge IDC to the award

Indirect Charges

End Date of Effective Period of Approved IDC Rate Agreement	Calculation			FEDERAL REQUEST
	Approved IDC Rate (%)	Approved Base	IDC	
N/A	0.00%	$0	$0	$0
		TOTAL	$0	$0

Indirect Charges Narrative:

REVIEW OF COST SHARING AND MATCHING

Cost sharing or matching is not required for this grant.

BUDGET SUMMARY: YEAR 1

BUDGET CATEGORY	FEDERAL REQUEST
A. Personnel	$75,000
B. Fringe Benefits	$24,195
C. Travel	$4,500

D. Equipment	$0
E. Supplies	$7,840
F. Contractual	$888,465
G. Construction (N/A)	$0
H. Other	$0
I. Total Direct Charges (sum of A to H)	**$1,000,000**
J. Indirect Charges	$0
Total Projects Costs (sum of I and J)	**$1,000,000**

BUDGET SUMMARY FOR REQUESTED FUTURE YEARS

	Year **2**	Year **3**	Year **4**	Year **5**
Budget Category	**FEDERAL REQUEST**	**FEDERAL REQUEST**	**FEDERAL REQUEST**	**FEDERAL REQUEST**
A. Personnel				
B. Fringe Benefits				
C. Travel				
D. Equipment				
E. Supplies				
F. Contractual				
G. Construction	$0	$0	$0	$0
H. Other				
I. Total Direct Charges (sum A to H)	**$0**	**$0**	**$0**	**$0**
J. Indirect Charges				
Total Project Costs (sum of I and J)	**$0**	**$0**	**$0**	**$0**

Budget Summary Narrative:

FUNDING LIMITATIONS / RESTRICTIONS

Funding Limitation/Restriction
No more than 20% of the total award for the budget period may be used for data collection, performance measurement, and performance assessment activities required.

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total for Budget Category**
A. Personnel						

B. Fringe Benefits						
C. Travel						
D. Equipment						
E. Supplies						
F. Contractual	$160,000					$160,000
H. Other						
I. Total Direct Charges (sum A to H)	**$160,000**					**$160,000**
J. Indirect Charges						
TOTAL for the Budget Year	**$160,000**					**$160,000**
Percentage of the Budget	16.000%					

Funding Limitation/Restriction Narrative:

The state intends to contract with an external evaluator with expertise in research and evaluation of federal grants. The contracted evaluation entity will be responsible for collection and reporting of CCBHC performance outcome measures, measurement of progress toward the state goals and objectives as defined in this grant application, and support participation in all aspects of the National Evaluation of the program. The amount budgeted is 16% of the total budget and under the grant limit.

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 02/28/2022

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. SM-23-015 CCBHC Planning Grant	93.829			$1,000,000	$0	$1,000,000
2.						
3.						
4.						
5. Totals				$1,000,000	$0	$1,000,000

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1) CCBHC Planning Grant	(2)	(3)	(4)	
a. Personnel	$75,000	$0			$75,000
b. Fringe Benefits	$24,195	$0			$24,195
c. Travel	$4,500	$0			$4,500
d. Equipment	$0	$0			$0
e. Supplies	$7,840	$0			$7,840
f. Contractual	$888,465	$0			$888,465
g. Construction	$0	$0	$0	$0	$0
h. Other	$0	$0			$0
i. Total Direct Charges (sum of 6a-6h)	$1,000,000	$0			$1,000,000
j. Indirect Charges	$0	$0			$0
k. TOTALS (sum of 6i and 6j)	$1,000,000	$0			$1,000,000
7. Program Income					

Authorized for Local Reproduction

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. SM-23-015 CCBHC Planning Grant				
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)				

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$1,000,000	$250,000	$250,000	$250,000	$250,000
14. Non-Federal					
15. TOTAL (sum of lines 13 and 14)	$1,000,000	$250,000	$250,000	$250,000	$250,000

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. SM-23-015 CCBHC Planning Grant	$0	$0	$0	$0
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$0	$0	$0	$0

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges:
23. Remarks:	

Applicant/Recipient	**Application/Award Number**
Iowa Department of Human Services	SM-23-015
Project Title:	Iowa CCBHC Planning Grant no-cost extension

	Start Date	End Date	Budget Year
Budget Period:	03/31/2024	03/30/2025	1

For Multi-Year Funded (MYF) awards only
(not applicable to new applications for funding) ☐
Check the box to select the Incremental Period

COST SHARING AND MATCHING

Matching Required: ☐ YES ☒ NO

A. Personnel

Line Item #	Position	Name	Key Position per the NOFO	Check if Hourly Rate	Calculation						FEDERAL REQUEST
					Hourly Rate	Hours	# of Staff	Annual Salary	% Level of Effort (LOE)	**Personnel Cost**	
1	CCBHC Project Coordinator	Wendy DePhillips	☐	☐			1	$71,988	100.00%	$71,988	$71,988
2	CCBHC Certification Specialist	Clay Gemmill	☐	☐			1	$83,512	100.00%	$83,512	$83,512
3	CCBHC Management Analyst-Data and Quality	TBD	☐	☐			1	$75,680	50.00%	$37,840	$37,840
									TOTAL	**$193,340**	**$193,340**

Line Item #	**Personnel Narrative:**							
1	CCBHC Project Coordinator	Wendy DePhillips		Salary $71,988	# of Staff 1	LOE 100.00%	Personnel Cost $71,988	
	The CCBHC Project Coordinator position will be responsible to coordinate all activities related to CCBHC implementation, including assisting with CCBHC certification and quality monitoring, provider technical assistance activities, and community and stakeholder outreach. The individual serving as Project Coordinator must have prior experience and/or knowledge of behavioral health issues and service delivery in Iowa, an understanding of the provider network and the needs of individuals with lived experience. Must be able to travel the state of Iowa to support CCBHC implementation actvities. Salary based on a 12 month term. This position will carry out ongoing support of state CCBHC implementation during the NCE.							
2	CCBHC Certification Specialist	Clay Gemmill		Salary $83,512	# of Staff 1	LOE 100.00%	Personnel Cost $83,512	
	This CCBHC Certification Specialist position will be responsible for supporting the deployment and implementation of CCBHC certification in Iowa. The Certification Specialist will support the development certification requirements aligned with SAMHSA and CMS requirements and lead/monitor the certification process supported by data and outcomes gathered from CCBHCs and other behavioral health providers. The individual serving as Certification Specialist must have prior experience and/or knowledge of national certification and best practices for behavioral health providers, behavioral health issues and service delivery in Iowa, and an understanding of the provider network and the needs of individuals with lived experience. Must be able to travel the state of Iowa to support CCBHC implementation actvities. Salary based on a 12 month term. This position will carry out ongoing support of state CCBHC implementation during the NCE.							
3	CCBHC Management Analyst-Data and Quality	TBD		Salary $75,680	# of Staff 1	LOE 50.00%	Personnel Cost $37,840	
	The CCBHC Management Analyst-Data and Quality will be responsible for providing evaluation activities related to CCBHC implementation, including data and outcomes reporting, updates to IBHRS, CCBHC outcomes process, provider training, and monitoring. This position will coordinate and monitor data activity to support Iowa's planning activities, including any SAMHSA and CMS data collection requirements. Individuals serving in this role must have prior experience and/or							

Line Item #	Personnel Narrative:
	knowledge of behavioral health outcomes and data collection, BH service delivery in Iowa, an understanding of the provider network and the needs of individuals with lived experience. Must be able to travel the state of Iowa to support CCBHC implementation activities. Salary based on a 12 month term. As part of ongoing monitoring and oversight of the CCBHCs during the NCE period, this position will continue to work with Iowa's providers and the data systems to ensure that required data is collected and reported.

☒ Show In-Kind Personnel Table

In-Kind Personnel

Line Item #	Position	Name	Key Position per the FOA	Check if Hourly Rate	Hourly Rate	Hours	# of Staff	Annual Salary	% Level of Effort (LOE)
1	Project Director	Laura Larkin	☒	☐			1	$101,150	50.00%
2	State Director of Behavioral Health and Disability Services, SMHA and SSA	Marissa Eyanson	☐	☐			1	$140,886	5.00%
3	State Medicaid Director, State Medicaid Authority	Elizabeth Matney	☐	☐			1	$168,251	5.00%
4	Bureau Chief	Theresa Armstrong	☐	☐			1	$128,523	5.00%
5	Bureau Chief	DeAnn Decker	☐	☐			1	$113,152	5.00%
6	Medicaid Policy Subject Matter Expert	Hannah Olson	☐	☐			1	$83,096	5.00%
7	State 988 Coordinator	Julie Maas	☐	☐			1	$73,237	5.00%

Line Item #	In-Kind Personnel Narrative:							
1	Project Director	Laura Larkin	Key Personnel	Salary $101,150	# of Staff 1	LOE 50.00%	Personnel Cost $50,575	
	Laura Larkin, Executive Officer 2 will be the CCBHC project director, will coordinate all CCBHC-grant related activities, direct contracted staff, and be the primary state contact with SAMHSA.							
2	State Director of Behavioral Health and	Marissa Eyanson		Salary $140,886	# of Staff 1	LOE 5.00%	Personnel Cost $7,044	
	Marissa Eyanson, State Director, Behavioral Health and Disability Services, is the SMHA and SSA for the state of Iowa. She will provide oversight and direction for the CCBHC Planning Grant.							
3	State Medicaid Director, State Medicaid Authority	Elizabeth Matney		Salary $168,251	# of Staff 1	LOE 5.00%	Personnel Cost $8,413	
	Elizabeth Matney, State Medicaid Director, is the SMA for the state of Iowa. She will provide oversight and direction for the Medicaid-related activities, including PPS rate development, of the CCBHC Planning Grant.							
4	Bureau Chief	Theresa Armstrong		Salary $128,523	# of Staff 1	LOE 5.00%	Personnel Cost $6,426	
	Theresa Armstrong, Bureau Chief, Behavioral Health and Disability Services, Performance, Innovation, and Mental Health, directly supervises the Project Director and will provide oversight and direction of the CCBHC Planning Grant.							
5	Bureau Chief	DeAnn Decker		Salary $113,152	# of Staff 1	LOE 5.00%	Personnel Cost $5,658	
	DeAnn Decker, Bureau Chief for Behavioral Health and Disability Services, Substance Use Disorder Prevention, Treatment and Recovery will provide oversight and direction regarding substance-use disorder programs, services, and supports.							
6	Medicaid Policy Subject Matter Expert	Hannah Olson		Salary $83,096	# of Staff 1	LOE 5.00%	Personnel Cost $4,155	
	Hannah Olson, Iowa Medicaid Behavioral Health Policy Analyst, is a subject matter expert for Medicaid-funded behavioral health and will provide expertise on Medicaid policy and programs.							
7	State 988 Coordinator	Julie Maas		Salary $73,237	# of Staff 1	LOE 5.00%	Personnel Cost $3,662	
	Julie Maas, State 988 Coordinator, will provide direction on integration of the state's CCBHC planning efforts with the state's 988 implementation work.							

B. Fringe Benefits

Our organization's fringe benefits consist of the components shown below:

Fringe Component	Rate (%)
State of Iowa Fringe Benefits-(FICA, IPERS, Health, Dental and Life Insurance, Deferred Compensation and Disability Insurance	
Retirement (IPERS)	9.44%
FICA	7.44%
Health and Dental	14.78%
Life Insurance	0.02%
Deferred Compensation and Disability	0.59%
Total Fringe Rate	32.27%

Fringe Benefits Cost

Line Item #	Position	Name	Calculation				FEDERAL REQUEST
			Personnel Cost	Total Fringe Rate (%)	Fixed / Lump Sum Fringe (if any)	**Fringe Benefits Cost**	
1	CCBHC Project Coordinator	Wendy DePhillips	$71,988	32.27%	$0	$23,231	$23,231
2	CCBHC Certification Specialist	Clay Gemmill	$83,512	32.27%	$0	$26,949	$26,949
3	CCBHC Management Analyst-Data and Quality	TBD	$37,840	32.27%	$0	$12,211	$12,211
					TOTAL	**$62,391**	**$62,391**

Fringe Benefits Narrative:
The State of Iowa offers competitive salary and benefits to its employees and provides a total fringe rate of 32.27% which is comprised of 9.44% for Retirement, 7.44% FICA, 14.8% Health, Dental and Life Insurance, and .59% Deferred Compensation and Disability.

C. Travel

Trip #	Purpose	Destination	Calculation						FEDERAL REQUEST
			Item	Cost / Rate per Item	Basis	Quantity per Person	Number of Persons	**Travel Cost**	
1	CCBHC site visits and other local travel for stakeholder engagement	Approximately 10 CCBHC sites across Iowa	Local Travel (POV Mileage)	$0.65	Mile	3,720.00	1	$2,418	$2,418
2	Hotel for staff when visiting multiple sites per trip	Approximately 10 CCBHC sites across Iowa	Hotel/Lodging	$100.00	Night	10.00	3	$3,000	$3,000
3	Meal per diem for staff if trip is overnight	Approximately 10 CCBHC sites across Iowa	Per Diems (M&IE only)	$37.00	Day	20.00	3	$2,220	$2,220
							TOTAL	$7,638	**$7,638**

Trip #	Travel Narrative:		
1	CCBHC site visits and other local travel for stakeholder engagement	Approximately 10 CCBHC sites across Iowa	Travel Cost $2,418
	As part of the state's CCBHC certification process and quality monitoring activities during the NCE, the CCBHC project director and 2 other state staff will participate in meetings and site-visits with each of the identified 10 CCBHCs across the state of Iowa. The mileage included is a reasonable estimate for the travel associated with certification monitoring and technical assistance activities. The rate per mile is consistent with the 2023 standard mileage rate provided by the Internal Revenue Service.		
2	Hotel for staff when visiting multiple sites per trip	Approximately 10 CCBHC sites across Iowa	Travel Cost $3,000
	As part of the CCBHC certification process and quality monitoring activities during the NCE, the CCBHC project director and 2 other state staff will participate in meetings and site-visits with each of the identified 10 CCBHCs across the state of Iowa twice during the NCE. For sites over 2 hours drive from Des Moines, visits will include overnight stays to allow coordination with multiple sites in one trip. The hotel rate is the state of Iowa allowed rate for in-state lodging.		
3	Meal per diem for staff if trip is overnight	Approximately 10 CCBHC sites across Iowa	Travel Cost $2,220
	As part of the CCBHC certification process and quality monitoring activities during the NCE, the CCBHC project director and 2 other state staff will participate in meetings and site-visits with each of the identified 10 CCBHCs across the state of Iowa. For sites over 2 hours drive from Des Moines, visits will include overnight stays to allow coordination with multiple sites in one trip. Meal reimbursement occurs when staff have an overnight stay which is estimated at $37 per day which is the state of Iowa in-state maximum allowed daily meal reimbursement.		

D. Equipment

Line Item #	Item	Check if Item is a Vehicle	Calculation				FEDERAL REQUEST
			Quantity	Purchase or Rental/Lease Cost	Percent Charged to the Project	Equipment Cost	
1		☐				$0	$0
					TOTAL	$0	$0

Line Item #	Equipment Narrative:				
1		Quantity	Purchase or Rental/Lease Cost	% Charged to the Project	Equipment Cost $0

E. Supplies

Line Item #	Item	Calculation					FEDERAL REQUEST
		Unit Cost	Basis	Quantity	Duration	Supplies Cost	
1	Laptop computer, docking station, and software package	$1,450.00	Cost per laptop, docking station, and software package	0.50	1.00	$725	$725
2	Cell phone service	$40.00	Cost per cellular phone service contract per month	2.50	12.00	$1,200	$1,200
3	Cell phone	$150.00	Cost per cellular phone purchase	0.50	1.00	$75	$75
					TOTAL	$2,000	$2,000

Line Item #	Supplies Narrative:					
1	Laptop computer, docking station, and software packa	Unit Cost $1,450.00	Basis Cost per laptop, docking	Quantity 0.50	Duration 1.00	Supplies Cost $725
	Costs include outfitting .5 FTE CCBHC evaluator/data and quality coordinator identified in the personnel plan with laptop computer, docking station, and software package to facilitate CCBHC planning work and activities. The rate provided is the standard purchase rate for similar supplies and equipment and provided by the Iowa HHS Division of Information Technology.					
2	Cell phone service	Unit Cost $40.00	Basis Cost per cellular phone	Quantity 2.50	Duration 12.00	Supplies Cost $1,200
	Costs include outfitting 2.5 FTE CCBHC coordinators and specialists identified in our personnel plan with a cellular service plan to facilitate their CCBHC planning work and activities. Cellular service plan costs are consistent with the current contractual rate provided by the Iowa HHS Division of Information Technology for 12 months or one year of service during the NCE period to continue CCBHC implementation activities.					
3	Cell phone	Unit Cost $150.00	Basis Cost per cellular phone	Quantity 0.50	Duration 1.00	Supplies Cost $75
	Costs include outfitting the .5FTE CCBHC evaluator/data and quality coordinator identified in our personnel plan with a cellular phone to facilitate CCBHC planning work and activities. Cellular phone costs are consistent with the current contractual rate provided by the Iowa HHS Division of Information Technology.					

F. Contractual

Summary of Contractual Costs

Agree-ment #	Name of Organization or Consultant	Type of Agreement	Contractual Cost	FEDERAL REQUEST
1	Myers and Stauffer (Medicaid Provider Cost Audit contractor)	Contract	$10,197	**$10,197**
2	FEI- State Data System Enhancements/IBHRS	Contract	$206,000	**$206,000**
3	10 Iowa CCBHCs for National Accreditation Costs	Contract	$200,000	**$200,000**
	TOTAL		**$416,197**	**$416,197**

Contractual Details for Myers and Stauffer (Medicaid Provider Cost Audit contractor)

Agree-ment #	Services and Deliverables Provided
1	Myers and Stauffer is the provider cost audit contractor for the state of Iowa and has worked closely with the CCBHC project team to develop the PPS cost reporting system and review and approve CCBHC cost reports. The contractor would finalize cost reports if the state is awarded a demonstration program.

☐ Personnel ☐ Travel ☐ Supplies ☐ Indirect Charges
☐ Fringe Benefits ☐ Equipment ☒ Other

Contractual Other Costs for Myers and Stauffer (Medicaid Provider Cost Audit contractor)

Line Item #	Item	Check for Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	**Contractual Other Cost**	
1	PPS-1 Rate Development and CCBHC cost report review	☐	$101.97	Hourly rate provided by Medicaid contractor	100.00		**$10,197**	$10,197
						TOTAL	**$10,197**	**$10,197**

Line Item #	Contractual Other Narrative:						
1	PPS-1 Rate Development and CCBHC cost repor	Unit Cost/Rate $101.97	Basis Hourly rate provided by	Quantity 100.00	Duration	Other Cost $10,197	
	Review and finalize PPS rates for CCBHCs during the NCE period if awarded a Demonstration grant.						

Contractual Total Direct Charges for Myers and Stauffer (Medicaid Provider Cost Audit contractor)

TOTAL DIRECT CHARGES FOR THIS AGREEMENT	TOTAL FEDERAL REQUEST
	$10,197

Contractual Total Cost for Myers and Stauffer (Medicaid Provider Cost Audit contractor)

TOTAL COST	TOTAL FEDERAL REQUEST
$10,197	$10,197

Contractual Details for FEI- State Data System Enhancements/IBHRS

Agree-ment #	Services and Deliverables Provided
2	HHS has expanded its scope of work with FEI, the technical vendor, for the Iowa Behavioral Health Reporting System (IBHRS) to develop additional reporting capacity for the CCBHC demonstration program, including expanded CCBHC outcomes measurement leveraging the existing statewide data collection system used for SUD provider reporting. HHS and FEI have collaborated on this process extensively to integrate CCBHC outcomes measurement into the existing system. This work will need to be completed during the no cost extension period due to the complexity of making changes to existing data collection systems.

☐ Personnel ☐ Travel ☐ Supplies ☐ Indirect Charges
☐ Fringe Benefits ☐ Equipment ☒ Other

Contractual Other Costs for FEI- State Data System Enhancements/IBHRS

Line Item #	Item	Check for Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	**Contractual Other Cost**	
1	Product development and deployment inclusive of development, testing, and user interface updates.	☐	$153,000.00	Estimate based on costs in existing contract	1.00		**$153,000**	$153,000
2	Trainings of new users, includes new/ updated user guides	☐	$2,000.00	Estimate based on costs in existing contract	4.00		**$8,000**	$8,000
3	Monthly hosting and maintenance costs	☐	$4,500.00	Estimated monthly maintenance costs	10.00		**$45,000**	$45,000
						TOTAL	**$206,000**	**$206,000**

Line Item #	Contractual Other Narrative:						
1	Product development and deployment inclusive o	Unit Cost/Rate $153,000.00	Basis Estimate based on	Quantity 1.00	Duration	Other Cost $153,000	
	The state will work with the HHS vendor for the IBHRS system to build and deploy the enhancements needed to integrate						

Line Item #	Contractual Other Narrative:
	CCBHC data elements into the IBHRS system. This is an estimate based on previous updates to the IBRHS system. The state will refine it once the final changes to the IBHRS system are determined.
2	Trainings of new users, includes new/updated use Unit Cost/Rate $2,000.00 Basis Estimate based on Quantity 4.00 Duration Other Cost $8,000 The state will work with the HHS vendor for the IBHRS system develop technical assistance, training and user guides for IBHRS CCBHC users.
3	Monthly hosting and maintenance costs Unit Cost/Rate $4,500.00 Basis Estimated monthly Quantity 10.00 Duration Other Cost $45,000 Estimated cost for monthly support, maintenance and hosting of the IBHRS system for CCBHC reporting.

Contractual Total Direct Charges for FEI- State Data System Enhancements/IBHRS

TOTAL DIRECT CHARGES FOR THIS AGREEMENT	TOTAL FEDERAL REQUEST
	$206,000

Contractual Total Cost for FEI- State Data System Enhancements/IBHRS

TOTAL COST	TOTAL FEDERAL REQUEST
$206,000	$206,000

Contractual Details for 10 Iowa CCBHCs for National Accreditation Costs

Agree-ment #	Services and Deliverables Provided
3	Fund the cost of National Accreditation through CARF, COA or Joint Commission required for Iowa-specific CCBHC certification criteria.

☐ Personnel ☐ Travel ☐ Supplies ☐ Indirect Charges
☐ Fringe Benefits ☐ Equipment ☒ Other

Contractual Other Costs for 10 Iowa CCBHCs for National Accreditation Costs

Line Item #	Item	Check for Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	**Contractual Other Cost**	
1	National Accreditation costs	☐	$20,000.00	Accreditation fee per CCBHC	10.00	1.00	**$200,000**	$200,000
						TOTAL	**$200,000**	**$200,000**

Line Item #	Contractual Other Narrative:
1	National Accreditation costs Unit Cost/Rate $20,000.00 Basis Accreditation fee per Quantity 10.00 Duration 1.00 Other Cost $200,000 Fund cost of CCBHC national accreditation as part of the state certification process. The CCBHCs have started this process but due to delays in the National Accreditation Bodies' rollout of CCBHC accreditation, will be completed during the NCE period.

Contractual Total Direct Charges for 10 Iowa CCBHCs for National Accreditation Costs

TOTAL DIRECT CHARGES FOR THIS AGREEMENT	TOTAL FEDERAL REQUEST
	$200,000

Contractual Total Cost for 10 Iowa CCBHCs for National Accreditation Costs

TOTAL COST	TOTAL FEDERAL REQUEST
$200,000	$200,000

G. Construction: Not Applicable

H. Other

Line Item #	Item	Check if Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	Other Cost	
1		☐					$0	$0
						TOTAL	$0	$0

Line Item #	Other Narrative:					
1		Unit Cost/Rate	Basis	Quantity	Duration	Other Cost $0

I. Total Direct Charges

TOTAL DIRECT CHARGES	TOTAL FEDERAL REQUEST
	$681,566

J. Indirect Charges

Type of IDC Rate / Cost Allocation Plan

We will not charge IDC to the award

Indirect Charges

End Date of Effective Period of Approved IDC Rate Agreement	Calculation			FEDERAL REQUEST
	Approved IDC Rate (%)	Approved Base	IDC	
N/A	0.00%	$0	$0	$0
		TOTAL	$0	$0

Indirect Charges Narrative:

Indirect Charges Narrative:

REVIEW OF COST SHARING AND MATCHING

Cost sharing or matching is not required for this grant.

BUDGET SUMMARY: YEAR 1

BUDGET CATEGORY	FEDERAL REQUEST
A. Personnel	$193,340
B. Fringe Benefits	$62,391
C. Travel	$7,638
D. Equipment	$0
E. Supplies	$2,000
F. Contractual	$416,197
G. Construction (N/A)	$0
H. Other	$0
I. Total Direct Charges (sum of A to H)	**$681,566**
J. Indirect Charges	$0
Total Projects Costs (sum of I and J)	**$681,566**

BUDGET SUMMARY FOR REQUESTED FUTURE YEARS

	Year 2	Year 3	Year 4	Year 5
Budget Category	**FEDERAL REQUEST**	**FEDERAL REQUEST**	**FEDERAL REQUEST**	**FEDERAL REQUEST**
A. Personnel	$0	$0	$0	$0
B. Fringe Benefits	$0	$0	$0	$0
C. Travel	$0	$0	$0	$0
D. Equipment	$0	$0	$0	$0
E. Supplies	$0	$0	$0	$0
F. Contractual	$0	$0	$0	$0
G. Construction	$0	$0	$0	$0
H. Other	$0	$0	$0	$0
I. Total Direct Charges (sum A to H)	**$0**	**$0**	**$0**	**$0**
J. Indirect Charges	$0	$0	$0	$0
Total Project Costs (sum of I and J)	**$0**	**$0**	**$0**	**$0**

Budget Summary Narrative:

FUNDING LIMITATIONS / RESTRICTIONS

Funding Limitation/Restriction
No more than 20% of the total award for the budget period may be used for data collection, performance measurement, and performance assessment activities required.

	Year 1	Year 2	Year 3	Year 4	Year 5	Total for Budget Category
A. Personnel	$37,840	$0	$0	$0	$0	$37,840
B. Fringe Benefits	$12,211	$0	$0	$0	$0	$12,211
C. Travel		$0	$0	$0	$0	$0
D. Equipment	$0	$0	$0	$0	$0	$0
E. Supplies	$1,040	$0	$0	$0	$0	$1,040
F. Contractual		$0	$0	$0	$0	$0
H. Other	$0	$0	$0	$0	$0	$0
I. Total Direct Charges (sum A to H)	**$51,091**	**$0**	**$0**	**$0**	**$0**	**$51,091**
J. Indirect Charges		$0	$0	$0	$0	$0
TOTAL for the Budget Year	**$51,091**	**$0**	**$0**	**$0**	**$0**	**$51,091**
Percentage of the Budget	7.496%					

Funding Limitation/Restriction Narrative:
Iowa HHS will hire a .5 Evaluator to oversee CCBHC data and quality requirements. This amount includes salary, fringe and supply costs.

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 02/28/2022

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. SM-23-015 CCBHC Planning Grant	93.829			$681,566	$0	$681,566
2.						
3.						
4.						
5. Totals				$681,566	$0	$681,566

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1) CCBHC Planning Grant	(2)	(3)	(4)	
a. Personnel	$193,340	$0			$193,340
b. Fringe Benefits	$62,391	$0			$62,391
c. Travel	$7,638	$0			$7,638
d. Equipment	$0	$0			$0
e. Supplies	$2,000	$0			$2,000
f. Contractual	$416,197	$0			$416,197
g. Construction	$0	$0	$0	$0	$0
h. Other	$0	$0			$0
i. Total Direct Charges (sum of 6a-6h)	$681,566	$0			$681,566
j. Indirect Charges	$0	$0			$0
k. TOTALS (sum of 6i and 6j)	$681,566	$0			$681,566
7. Program Income					

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SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. SM-23-015 CCBHC Planning Grant				
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)				

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$681,566	$170,392	$170,392	$170,391	$170,391
14. Non-Federal					
15. TOTAL (sum of lines 13 and 14)	$681,566	$170,392	$170,392	$170,391	$170,391

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. SM-23-015 CCBHC Planning Grant	$0	$0	$0	$0
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$0	$0	$0	$0

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges:
23. Remarks:	