Iowa Certified Community Behavioral Health Clinics (CCBHC) Demonstration Provider Guide

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IOWA Health and Human Services

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Background and Overview

History of the CCBHC Program

In March 2014, Congress passed the Protecting Access to Medicare Act (PAMA) which was signed into law on April 1, 2015 (P.L. 113-93). Section 223 of PAMA established certified community behavioral health clinics (CCBHCs) and authorized the Department of Health and Human Services (HHS) to:

1) Establish criteria used to certify clinics that will participate in a two-year CCBHC demonstration program.
2) Provide guidance on the development of a Prospective Payment System for CCBHC services.
3) Award grants to states for planning purposes and to develop proposals to participate in the demonstration program.
4) Select up to eight states to participate in the demonstration; pay states participating in the demonstration program enhanced federal matching funds.
5) Evaluate the project and prepare annual reports for the U.S Congress.

In 2022, under the Bipartisan Safer Communities Act (BSCA), funding was allocated to expand the number of states selected for the demonstration program.

The goals of the CCBHC Initiative are to:

- Expand Community-Based Services.
- Improve integration with medical care.
- Expand the use of evidence-based practice.
- Improve access to high-quality care.
- Improve data collection.
- Target people with serious mental illness (SMI), serious emotional disturbance (SED), and significant substance use disorder (SUD) while serving the whole community.

CCBHCs are required to serve individuals across their lifespans regardless of their ability to pay, the severity of their illness or geographic location.

HISTORY OF CCBHC IN IOWA

Iowa HHS has received two planning grants to inform their CCBHC planning work, securing one in 2015, and another as one of 15 states awarded a one-year planning grant in March 2023. Fifteen providers in Iowa have also received CCBHC expansion grants awarded through the Substance Abuse and Mental Health Services Administration's (SAMHSA) grant making process.

The 2023 planning grant required Iowa HHS to:

1) Solicit input for the development of a state CCBHC demonstration program from consumers (including youth), family members, providers, tribes, and other key stakeholders.
2) Ensure an initial set of at least two clinics, identified by the state for participation in the demonstration, are certified using the certification criteria and establish procedures and

necessary infrastructure to ensure clinic compliance throughout the CCBHC demonstration period.
3) Establish a Prospective Payment System (PPS) for behavioral health services offered by a CCBHC in accordance with the PPS Methodology Guidelines developed by the Centers for Medicare and Medicaid Services (CMS).
4) Establish the capacity to provide behavioral health services that meet the certification criteria.
5) Develop or enhance data collection and reporting capacity and provide information necessary for Iowa HHS to evaluate proposals submitted by states to participate in the CCBHC demonstration program.
6) Submit a proposal to participate in the CCBHC Demonstration Program.
7) If selected, agree to pay for services at the rate established under the PPS system during the CCBHC Demonstration Program.

Iowa HHS was selected to participate in the CCBHC Demonstration on June 4, 2024, and has the following objectives for the State's CCBHC Demonstration Program:

- Adopt an **evidence-based, comprehensive** outpatient behavioral health care model with demonstrated outcomes around access and cost savings in national models.
- Take advantage of enhanced **federal match dollars** to fund more comprehensive services that are less fractured and more consistent in delivery of behavioral health services to all populations (adults, kids, families) in all regions of Iowa, including Medicaid, Medicare, uninsured, and commercially insured Iowans.
- Establish **equitable services** for ALL populations, including those most in need (i.e., serious mental illness, substance use disorder, discharge from correctional settings, complex diagnoses, co-occurring conditions).
- Leverage **best practices** from other national models, based on federal criteria, to best position Iowa's CCBHC program for success.
- Incorporate **stakeholder feedback** to make needed program adjustments for Iowa-specific priorities and needs.
- Create a **process to ensure the necessary system infrastructure** and to support providers as they build out their model to meet all federal and state requirements.
- Develop **clear guidance** to define the CCBHC's role in the current system of health care in Iowa to minimize disruption and ensure access.

Under the Demonstration Authority, Iowa's CCBHC Demonstration Program will start on July 1, 2025.

CCBHC Model

CCBHCs provide:

- Comprehensive, coordinated mental health and substance use disorder services appropriate for individuals across the lifespan.
- Increased access to high-quality community mental health and substance use care, including crisis care.
- Integrated person- and family-centered services, driven by the needs and preferences of people receiving services and their families.
- A range of evidence-based practices, services, and supports to meet the needs of their communities.

- Services to anyone seeking help for a mental health or substance use condition, regardless of their diagnosis, place of residence, or ability to pay. PAMA establishes 113 standards in six areas that an organization must meet to achieve CCBHC designation:
    - Staffing.
    - Accountability.
    - Care coordination.
    - Service scope.
    - Quality/reporting.
    - Organizational authority.

Services must be provided to any individual with a mental or substance use disorder who seeks care, including those with SMI, SUD and opioid use disorder (OUD); children and adolescents with SED; individuals with co-occurring mental and substance disorders (COD) and individuals experiencing a mental health or substance use-related crisis. It also specifies that **nine required CCBHC services** are provided either directly or through formal designated collaborative organization (DCO) partnerships. These include:

1) Outpatient mental health & substance use services.
2) Person and family-centered treatment planning.
3) Community-based mental health care for veterans.
4) Peer, family peer support, peer counseling and peer recovery coaching services.
5) CCBHC case management.
6) Outpatient primary care screening & monitoring.
7) Psychiatric rehabilitation services.
8) Screening, diagnosis & risk assessment.
9) Crisis services.

Provider Eligibility

Eligible Providers must meet the following requirements:

1) Accreditation and Licensure:
    a. Accredited through 441 Iowa Admin. Code Ch. 24 as a Community Mental Health Center (CMHC) or accredited through 441 Iowa Admin. Code Ch. 24 as a Mental Health Service Provider (MHSP); and licensed through 641 Iowa Admin. Code Ch. 155 as an outpatient substance use disorder provider (SUD); and

2) Non-Profit Status:
    a. Non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code; or

3) A tribal health organization, clinic, or health center operated under authority of the Indian Health Service (IHS), an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with IHS under the Indian Self-Determination Act (PL 93-638).

Providers other than those under criteria 3 must hold at least one of the above Iowa licensures or accreditations for at least two years at the time of certification.

CCBHC Standards for Certification

To be certified by Iowa HHS as a CCBHC, a provider must complete the following:

1. Community needs assessment for the proposed service area.
2. CCBHC criteria assessment or certification by a national accrediting body.
3. Cost report and supporting material submission to support PPS rate development.
4. Submission of any requested documents or materials.
5. Participation in agency-mandated technical assistance.
6. Participation in on-site and virtual visits conducted by agency reviewers and auditors.
7. Report clinic and state measures using the approved methodology and reporting formats as designated by Iowa HHS.
8. State accreditation as a CMHC or MHSP: and state licensure as an outpatient SUD provider.

If a provider fails the national accreditor criteria assessment, the contractor will have 30 days to implement a corrective action plan to reach compliance and arrange a subsequent criteria assessment.

Certification by Iowa HHS is required to receive Medicaid PPS reimbursement for CCBHC services. ***CCBHC State Certifications are valid for three years.***

CCBHC On-Going Certification

State certification as a CCBHC is a continuous process. The Iowa HHS CCBHC team provides on-going monitoring and technical assistance throughout the certification term. Quality of services, timely patient access, and patient experience are all key components of the CCBHC model.
As part of the effort to monitor quality and drive improvements, each CCBHC will participate with Iowa HHS in regular quality improvement activities to review data and identify opportunities for program improvement.

The CCBHC team will provide the following oversight for certification:

- On-site visits, as well as virtual and record reviews.
- Ongoing communication and technical support for providers and stakeholders on certification requirements.
- Coordination of quality improvement, data analysis, and reporting.
- Oversight of CCBHC and provider performance improvement plans.

Decertification Process

A CCBHC's non-compliance with agency certification requirements could result in decertification as a CCBHC. Failure to abide by the terms of the federal CCBHC criteria and state contractual and policy requirements may result in disciplinary action, including placing the CCBHC in a probationary period and decertification as a CCBHC provider.

Reasons for decertification include:

- Failure to provide Iowa HHS with requested documentation demonstrating CCBHC requirements are met.

- Failure to correct identified deficiencies in meeting certification requirements.
- Consumer complaints related to non-compliance with CCBHC policies or not meeting CCBHC certification criteria.
- Failure to provide proof of required state and national licensures and certifications.
- Non-compliance with rate setting, including rebasing.
- Misrepresentation of data.

Iowa HHS will give CCBHCs written notice of the intent to de-certify. CCBHCs may either accept the decertification or respond with a detailed plan of correction to address the identified reasons for decertification. If Iowa HHS approves the plan, the CCBHC will be reverted to "provisional certification" status while the correction plan is being implemented. Iowa HHS will support the development, implementation and monitoring of the corrective action plan (CAP). CCBHCs in provisional certification status will have their PPS rate suspended until their CAP is completed. Iowa HHS may also deny the request for corrections and formal notice of decertification will be provided to the CCBHC.

CCBHC Requirements

GENERAL SERVICE PROVISIONS

Required Services

CCBHCs must have the capacity to meet all **program requirements** included in PAMA Section 223: Demonstration Program for Certified Community Behavioral Health Clinics, including:

1) Staffing.
2) Availability and accessibility of services.
3) Care coordination.
4) Scope of services.
5) Quality and other reporting.
6) Organizational authority and governance.

CCBHCs must provide or coordinate the provision of the **nine required CCBHC services**, as defined by SAMHSA's CCBHC Certification Criteria from March 2023, for each county in the catchment area awarded to the CCBHC. This includes required screening and assessments, timely service provisions, and meaningful follow-up and care coordination.

CCBHCs may partner with a Designated Collaborating Organization (DCO) to coordinate the delivery of any of the nine required services if the CCBHC meets its requirement to provide 51% of behavioral health encounters across all services excluding crisis services. CCBHCs are responsible for ensuring that DCOs providing services on their behalf are Medicaid enrolled providers in good standing.

All CCBHC employed and contracted staff who have direct contact with people receiving services, or their families must complete training that satisfies CCBHC and state accreditation standards. Training should be aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality of services, and eliminate disparities. (SAMHSA Criteria 1.c.1)

Access Standards

The CCBHC shall have policies and procedures that ensure that services are **available to anyone seeking help for a mental health or substance use condition, regardless of their place of residence, ability to pay, illness severity, disability status or age.** This includes any individual with a mental or substance use disorder who seeks care, including those with Serious Mental Illness (SMI), Substance Use Disorder (SUD), Opioid Use Disorder (OUD), and severe SUD, children with Serious Emotional Disturbance (SED), individuals with Co-occurring Disorder (COD), and individuals experiencing a mental health or substance use-related crisis.

The CCBHC shall provide or coordinate provision of all nine required CCBHC core services in a way that ensures that all services are accessible within 60 minutes or 60 miles (whichever is less) of a client's home address. The following services have discrete access requirements:

1. **Psychosocial Rehabilitation Access Standard:** If a client's scheduled appointment time for psychosocial rehabilitation is longer than three hours on any given day, the access standard is the lesser of 60 minutes or 60 miles in urban areas and the lesser of 90 minutes or 90 miles in rural areas.
2. **Telehealth:** Telehealth access alone does not satisfy the network adequacy requirement; however, telehealth can be offered when clinically appropriate as a choice in addition to accessible in-person services.
3. **Crisis Services:** Mobile crisis services must comply with timeliness and accessibility rules**,** which requires an in-person, community-based response in accordance with the following standards:

    - One hour in urban areas and two hours in rural areas.
    - Any non-mobile crisis service offered directly by the CCBHC must meet the same accessibility standards as other CCBHC core services, as specified above.

All people new to receiving services, whether requesting or being referred for behavioral health services at the CCBHC, will receive a preliminary triage, including risk assessment, to determine acuity of needs at the time of first contact. This can be in-person, by phone or using remote communication. Preliminary triage may occur telephonically. If the triage identifies an ***emergency or crisis need***, appropriate action will be taken immediately, including plans to reduce or remove risk of harm and to facilitate any necessary subsequent outpatient follow-up.

At the time of initial contact and screening clients will be assigned one of the following acuity levels:

1. **Emergent**
   Severity: Involves acute symptoms that pose an immediate danger to the patient or others.
   Examples: Suicidal ideation with a plan, severe psychosis, violent behavior.

2. **Urgent**
   Severity: Involves significant symptoms that require prompt attention but are not immediately life-threatening.
   Examples: Severe anxiety attacks, moderate depression with functional impairment, worsening of chronic mental health conditions.

3. **Routine**
   Severity: Involves symptoms that are impair daily functioning on a level that does not require prompt attention but intervention

Key differences include:

- Response Time: Emergent cases need immediate intervention, while urgent cases can wait for a short period without significant risk.
- Resource Utilization: Emergent visits often require more resources, including specialized staff and equipment.
- Location: Emergent cases are typically handled through mobile crisis or crisis access centers, whereas urgent cases can be managed in access centers or outpatient setting.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) shall be provided as part of the screening and evaluation process when indicated. Screening for Social Determinants of Health (SDOH) and depression shall be conducted in accordance with the CCBHC quality measures specifications and technical assistance provided by Iowa HHS at https://www.samhsa.gov/certified-community-behavioral-health-clinics/guidance-and-webinars.

Brain injury screening is strongly recommended as part of the CCBHC comprehensive screening and evaluation process. Providers can access free brain injury screening tools in addition to other resources on the Your Life Iowa website. **Brain Injury | Your Life Iowa**.

- If the triage identifies an ***urgent need***, clinical services are provided, including an initial evaluation within one business day of the time the request is made.
- If the triage identifies ***routine needs,*** services will be provided, and the initial evaluation completed within 10 business days.
- For those presenting with ***emergency or urgent needs***, the initial evaluation may be conducted by phone or through use of technologies for telehealth or telemedicine and video conferencing, but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved, the person receiving services must be seen in person at the next subsequent encounter and the initial evaluation reviewed.

All new people receiving services will receive a comprehensive evaluation to be completed within 60 calendar days of the first request for services. (SAMHSA Criteria 2.b.1)

Community Needs Assessment

CCBHCs shall conduct a Community Needs Assessment (CNA), consistent with the required components and frequency outlined in SAMHSA's Published CCBHC Certification Criteria, updated March 2023. This must be used to inform the CCBHC's service planning and delivery, outreach, and engagement strategies, staffing and interventions and (EBPs). The initial CNA shall be submitted to the agency at the time of application and will be updated every three years using the Iowa HHS template provided to the CCBHC contractors. (SAMHSA Criteria 1.a.1)

Iowa Specifications: The contractor shall include in their needs assessments a summary of the behavioral health strengths and needs of their proposed service area, including:

1) The demographic composition.
2) The population of focus living in the area, including:
    a. Individuals with SMI.
    b. Individuals with SED.
    c. Individuals with SUD.
    d. Pregnant and parenting women with SUD concerns.

e. Veterans.
f. Youth with depression and SUD concerns.
g. Black, Indigenous, and People of Color (BIPOC) and other underrepresented populations.

3) How input was gathered from individuals with lived experience and persons residing in the proposed service area in assessing the behavioral health strengths and needs of the proposed service area.

SAMHSA REQUIREMENTS

A CNA is a systematic approach to identify community needs and determine the program capacity to address the needs of the population being served. CCBHCs will collaborate with other community stakeholders to conduct a CNA. The assessment should identify current conditions as well as desired services and outcomes in the community. Information should be based on data and input from key community stakeholders, including those being served by the CCBHC.

Specific CCBHC criteria are tied to the CNA including staffing, language and culture, services, locations, service hours and evidence-based practices. The CNA must be thorough and reflect the treatment and recovery needs of those who reside in the service area across the lifespan including children, youth, and families.

The CNA is comprised of the following elements:

1. 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.
2. Information about the prevalence of mental health and substance use conditions and related needs in the service area, such as suicide rates and overdose.
3. Information about the number and types of services provided in the service area
4. 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.
5. Cultures and languages of the populations residing in the service area.
6. The identification of the underserved population(s) within the service area.
7. A description of how the staffing plan does and/or will address the findings.
8. Plans to update the CNA every three years.
9. Input about:
    - 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 should come from the following entities if they are in the CCBHC service area:

- People with lived experience of mental and substance use conditions and individuals who have received or are receiving services from the clinic conducting the CNA.
- Health centers, including FQHCs in the service area.
- 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.

- Crisis response partners such as hospital emergency departments, emergency responders, crisis stabilization settings, crisis call centers and warmlines.

CCBHCs must engage also with other community partners, especially those who also 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.
- Other mental health and SUD treatment providers in the community.
- 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 and 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).

The assessment should include a description of:

- How the staffing plan does and/or will address the findings.
- Plans to update the community needs assessment every three years.

If a separate community needs assessment has been completed in the past year, the CCBHC may decide to augment or build upon the information to ensure that the required components of the CNA are collected.

INTEGRATED CARE

The CCBHC directly provides outpatient mental health and substance use disorder services that are evidence-based or best practices and are consistent with the needs of individual clients as identified in their individual care plan. In the event specialized services outside the expertise of the CCBHC are required for purposes of outpatient mental health and substance use disorder treatment (e.g., treatment of sexual trauma, eating disorders, specialized medications for substance use disorders), the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth or telemedicine services. (SAMHSA Criteria 4.f.1)

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

While CCBHCs are not required to provide primary care services, they are required to provide primary care screening and monitoring. CCBHCs may not pay for primary care services under the Section 223 CCBHC Demonstration PPS beyond those defined under SAMSHA CCBHC Requirements Section 4.g. CCBHCs should coordinate with primary care providers to support integrated provision of primary and behavioral health care.

Care Coordination is the cornerstone of behavioral healthcare integration. It involves actively bringing together various providers and information systems to coordinate health services, client needs and information to improve outcomes. It is the CCBHCs responsibility, as the primary provider of care, to ensure the needs of the client are being addressed in a coordinated way. The CCBHC is responsible for care coordination with any other provider or facility providing any of the required CCBHC services. (SAMHSA Criteria 3.a)

CCBHCs are required to offer a full array of services to treat and support the client. CCBHCs are expected to promote enhanced integration and coordination of behavioral health, primary care, acute care, and long-term services and supports (LTSS) for persons across the lifespan with chronic illness, including adults with SMI and children with SED.

CRISIS BEHAVIORAL HEALTH SERVICES

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 behavioral health services. PAMA requires provision of these three crisis behavioral health services, whether provided directly by the CCBHC or by a DCO:

Emergency crisis intervention services: 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. The CCBHC should participate in any state, regional, or local air traffic control (ATC) systems which provide quality coordination of crisis care in real time and any service capacity registries as appropriate. Quality coordination means that 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.

Mobile crisis services require an in-person, community-based response in accordance with the following standards:

a. One hour in urban areas.
b. Two hours in rural areas.
c. Any non-mobile crisis services offered directly by the CCBHC must meet the same accessibility standards as other CCBHC core services, as specified above.

Additional Mobile Crisis Requirements include the provision of 24/7/365 mobile crisis services:

1. Outside of a hospital or other facility setting.
2. To individuals experiencing a mental health or substance use disorder crisis.
3. Furnished by a multidisciplinary mobile crisis team that includes at least one behavioral health care professional who is capable of conducting an assessment of the individual, in accordance with the professional's permitted scope of practice under state law, and other professionals or paraprofessionals with appropriate expertise in behavioral health or mental health crisis response.
    - This includes nurses, social workers, peer support specialists and others, as designated by the state through a state plan amendment or waiver of such plan.

4. Whose members are trained in trauma-informed care, de-escalation strategies, and harm reduction in a timely manner, and where appropriate, provide:
    - Screening and assessment.
    - Stabilization and de-escalation.
    - Coordination with, and referrals to, health, social, and other services and supports as needed, and health services as needed.
5. Maintains relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, crisis respite centers and managed care organizations (if applicable).

The CCBHC shall leverage an existing State Sanctioned Crisis Provider as a DCO. The State Sanctioned Crisis Provider must be compliant with the criteria identified in SAMHSA's Published CCBHC Certification Criteria, updated March 2023 and the Iowa HHS Provider Guide.

Crisis receiving/stabilization: The CCBHC provides crisis receiving and stabilization services that must include at minimum, urgent care and walk-in mental health and substance use disorder services for voluntary individuals. Urgent care and walk-in services identify the individual's immediate needs, de-escalate the crisis, and connect the individual to a safe and least-restrictive setting for ongoing care, including care provided by the CCBHC.

Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted. The CCBHC should have a goal of expanding the hours of operation as much as possible. Ideally, these services are available to individuals of any level of need; however, the facility need not manage the highest need individuals in this emergency setting. Crisis stabilization services should ideally be available 24 hours per day, 7 days a week, whether individuals present on their own, with a concerned individual like a family member, or with a human service worker, and/or law enforcement, in accordance with state and local laws.

In addition to these activities, the CCBHC may consider supporting or coordinating with peer-run crisis respite programs. The CCBHC is encouraged to provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care. (SAMHSA Criteria 4.C.1)

Mobile Crisis Guidance for Cost Reporting and Billing under CCBHC Demonstration

The following information can also be found in the CCBHC Billing Guide. For mobile crisis being contracted through a DCO, reimbursement can be set according to the way mobile crisis is provided by the DCO. The fee structure established by the CCBHC and DCO should be set to mirror the service the DCO is providing to the CCBHC. (i.e., fees can be set up monthly to reimburse for "firehouse" response models or call center or can be set on a per service basis). If DCO mobile crisis costs are built into the CCBHC cost report and therefore reimbursed according to the CCBHC/DCO agreement, the DCO would not bill the Iowa Department of Health and Human Services (Iowa HHS) for any duplicative costs now covered by the CCBHC. Any costs not funded through the CCBHC (i.e., services that are outside scope of the defined CCBHC crisis service) may continue to be billed according to their contract with the Behavioral Health – Administrative Service Organization (BH-ASO).

If a CCBHC is providing mobile crisis costs directly, their cost report should include all the direct costs for standing up services compliant with CCBHC mobile crisis service criteria.

As a reminder, the PPS rate is a loaded, daily, cost-based rate, which will include these crisis costs and will be billed each time a Medicaid eligible member is served for a threshold CCBHC service, regardless of whether it is a mobile crisis encounter. Mobile crisis is a threshold event, but it is not the only threshold event where these costs will be paid according to the CCBHC PPS methodology.

For CCBHC billing purposes, please see the following guidance with respect to how to bill in the event of a threshold mobile crisis service:

1. CCBHCs will bill for mobile crisis when they (or their DCO) provide services to a confirmed, active CCBHC client.
    a. A confirmed, active CCBHC client can be verified directly by the client or their family/guardian/support system at the time of the mobile crisis event
    b. A confirmed, active CCBHC client can also be verified at the next outpatient BH visit following the client's crisis event

**** Please note: CCBHCs will bill for mobile crisis on behalf of their DCO partners and then pay DCO partners according to the terms of their DCO agreement. DCOs may not bill the PPS rate directly.**

2. If the mobile crisis visit is to a person who is not yet a client of the CCBHC, the crisis event can be a triggering event for referring and connecting that individual to the CCBHC in their service area. The mobile crisis team will assess and triage. With the individual's consent, the team will notify the CCBHC of the encounter to provide follow-up. CCBHCs are responsible for follow-up care either by providing an evaluation within the timeline determined by the assessment (urgent or routine) and per CCBHC criteria standards, or if the individual is hospitalized, following up with the individual to assist with discharge and connection to appropriate community services (CCBHC case management). CCBHCs can bill for the mobile crisis encounter whether provided directly or through their DCO on their behalf once follow up efforts have occurred. Follow up efforts include specific documentation of phone calls, text messages, and in-person visits.

3. If the confirmed and active CCBHC client is a Medicaid beneficiary, the CCBHC should bill Medicaid the PPS rate for the mobile crisis encounter (for themselves or on behalf of the DCO). If the client is dual eligible, the CCBHC should follow the process for billing dual eligible clients.

4. If the confirmed and active CCBHC client is not a Medicaid beneficiary (uninsured, commercial, Medicare, etc.), the CCBHC, if providing mobile crisis directly should bill Iowa HHS for the mobile crisis encounter, pursuant to their current contractual agreement with the BH-ASO.

5. CCBHCs and their DCOs who are state sanctioned mobile crisis providers are responsible for billing Iowa HHS directly for non-Medicaid enrolled individuals.

6. Crisis services outside the CCBHC model (which include residential-based crisis services) should be billed according to existing, allowable reimbursement methodologies, including billing through Iowa HHS, Medicaid, or other insurance.

7. Mobile crisis providers who operate as a DCO for a CCBHC may draw down funding pursuant to a contractual agreement with the BH-ASO, however, they must not seek funding for any mobile

crisis encounters for Medicaid members for whom they receive reimbursement from a CCBHC per their DCO relationship and agreement.

OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE SERVICES

The CCBHC directly, or through a DCO, provides outpatient behavioral health care, including psychopharmacological treatment. The CCBHC or the DCO must provide 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 shall be 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 intensive services are required outside the expertise of the CCBHC or DCO for purposes of outpatient mental and substance use disorder treatment, the CCBHC makes them available through referral or other formal arrangement with other providers. This can also be provided, where necessary and appropriate, through the use of telehealth or telemedicine, in alignment with state and federal laws and regulations.

The CCBHC also provides availability or makes available through a formal arrangement traditional practices and treatment as appropriate for the people receiving services in the CCBHC area. Where specialist providers are not available to provide direct care to a person receiving CCBHC services, or specialist care is not practically available, the CCBHC professional staff may consult with specialized services providers for highly specialized treatment needs.

For people receiving services with potentially harmful substance use, the CCBHC is strongly encouraged to engage the person receiving services with motivational techniques and harm reduction strategies to promote safety and/or reduce substance use. (SAMHSA Criteria 4.f)

Iowa Specifications:

If the CCBHC is not an Opioid Treatment Program (OTP), it shall establish a community partnership with OTPs in the service area to ensure access to Methadone for MAT. The contractor is expected to provide directly or coordinate with a DCO to provide other MAT services as part of its required scope of services for outpatient Mental Health & Substance Use Services.

The CCBHC shall implement and maintain ongoing compliance and fidelity to evidence-based practices (EBPs) that address the unique needs of the individuals in their service area (as informed by the contractor's CNA). The contractor shall directly provide or partner with 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.
3. Motivational Interviewing.
4. Trauma Focused Cognitive Behavioral Therapy (TF-CBT).
5. Screening, Brief Intervention and Referral to Treatment (SBIRT)

Appropriate treatments are provided for the phase of life and development of the person receiving services, specifically considering what is appropriate for children, adolescents, transition-age youth, and older adults. These are distinct groups for whom life stage and functioning may affect treatment.

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

Treatment of Tobacco Use Disorder: Contractors shall follow American Society of Addiction Medicine (ASAM) guidelines for treatment of tobacco use disorder. These are provided in ***Appendix B*** and aligned with CCBHC requirements.

CCBHC CARE COORDINATION AND CASE MANAGEMENT

Care Coordination

Care Coordination is the cornerstone of behavioral healthcare integration. It involves actively bringing together various providers and information systems to coordinate health services, client needs and information to improve outcomes. It is the CCBHCs responsibility, as the primary provider of care, to ensure the needs of the client are being addressed in a coordinated way. Care coordination is available to any client of the CCBHC as needed. (SAMHSA Criteria 3.a)

Required Care Coordination Elements

1. 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.
2. Procedures to coordinate care in collaboration with the family/caregiver of the person receiving services.
3. Procedures to coordinate care for medication reconciliation with other providers.
4. The CCBHC tracks when people receiving services are admitted to and discharged from 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.
5. Established protocols and procedures for transitioning individuals from above settings to a safe community setting. 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.
6. Makes and documents reasonable attempts to contact all people receiving CCBHC services who are discharged from these settings within 24 hours of discharge.
7. Treatment teams include the person receiving CCBHC services, their family, or 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.
8. Designates interdisciplinary treatment teams that is responsible, with the person receiving services and their family, caregivers, or legal guardians, to the extent the person receiving services desires their involvement for directing, coordinating, and managing care and services.
9. Work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic and recovery support needs of people receiving services and traditional approaches to care for people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups.

10. Payment for referred services is not through the Prospective Payment System (PPS), if offered, but is made through traditional mechanisms within Medicaid or other funding sources.
11. The best practice for care coordination agreements is to codify expectations in a formal linkage agreement, MOU, etc.
12. 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. This includes criminal and juvenile justice as well as child welfare.

CCBHC Case Management

The CCBHC is responsible for providing directly, or through a DCO, case management services that will assist people receiving services in sustaining recovery. They will also gain access to needed medical, social, legal, educational, housing, vocational and other services and supports. **CCBHC case management provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC.**

CCBHC case management services are separate and distinct from existing Iowa-defined Targeted Case Management (TCM), Community-Based Case Management (CBCM) or Intensive Care Coordination (ICC) provided through Medicaid. CCBHC case management must be offered to CCBHC clients based on medical necessity, regardless of eligibility for other state programs and ability to pay.

CCBHC case management should include supports for people deemed at high risk of suicide or overdose, particularly during times of transitions from a residential treatment, hospital emergency department or psychiatric hospitalization. CCBHC case management should also be accessible during other critical periods, such as periods of homelessness or transitions to the community from jails or prisons.

CCBHC case management should be used for individuals 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, such as an acute episode or care transition. Intensive case management and team-based intensive services through Assertive Community Treatment are required as a component of CCBHC services. (SAMHSA Criteria 4.h.1)

Individuals are not required to receive clinical services through a CCBHC as a condition of receiving CCBHC case management or care coordination. Individuals receiving services through CCBHCs have freedom of choice for all services that they choose to receive.

Integrated Health Home (IHH) and CCBHC

Due to CCBHC and IHH programs containing duplicative activities, CCBHCs are unable to receive their PPS rate for any CCBHC services provided to individuals enrolled in any tier level of IHH except for mobile crisis response. CCBHCs are expected to bill using their non-CCBHC NPI and follow standard behavioral health billing practices for any services provided to IHH enrolled members apart from mobile crisis response. CCBHCs should follow guidance in the CCBHC Billing Guide for how to bill appropriately for mobile crisis response to receive the PPS for individuals enrolled in an IHH.

DCO AND PARTNERSHIP REQUIREMENTS

Overview

A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal partnership with the CCBHC to deliver one or more of the **nine required services**. CCBHC services provided through a DCO must conform to the relevant applicable CCBHC criteria. The formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal, legal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized. The formal relationship between CCBHCs and DCOs creates the platform for seamlessly integrated services delivered across providers under the umbrella of a CCBHC. DCO agreements shall include provisions that ensure that the required CCBHC services that DCOs provide under the CCBHC umbrella are delivered in a manner that meets the standards set in the CCBHC certification criteria. This includes provision of training and technical assistance to the DCO to ensure adherence to CCBHC criteria. DCOs are more than care coordination or referral partners, and there is an expectation that relationships with DCOs will include more regular, intensive collaboration across organizations than would take place with other types of care coordination partners.

From the perspective of the person receiving services and their family members, services received through a DCO should be part of a coordinated care package with other CCBHC services and not simply accessing services through another provider organization. The DCO agreement will take active steps to reduce burden on individuals receiving services and their families when accessing DCOs' services. This includes coordinating intake processes, coordinated treatment planning, information sharing and direct communication between the CCBHC and DCO to prevent the individual or their families from having to relay information between the CCBHC and DCO. CCBHCs and their DCOs are directed to work towards the inclusion of additional integrated care elements such as sharing EHR access, including DCO providers on CCBHC treatment teams and co-locating services. Regardless of DCO relationships, the CCBHC maintains responsibility for assuring that people receiving services from the CCBHC receive all nine services as needed in a manner that meets the requirements of the CCBHC certification criteria. With regards to crisis services, specifically mobile crisis, Iowa HHS expects to see a strong warm handoff/closed loop referral process occur between CCBHCs and their DCOs.

In the Section 223 CCBHC Demonstration, payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. To the extent that services are needed by a person receiving services or their family that cannot be provided by either the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for care coordination including services to which it refers consumers. Payment for those referred services is not through the PPS but is made through traditional mechanisms within Medicaid or other funding sources. (SAMHSA Criteria Definitions)

The CCBHC may partner with a DCO to coordinate the delivery of any of the nine required services if the CCBHC meets its requirement to provide 51% of behavioral health encounters across all services, excluding crisis services. DCOs must operate in a manner consistent with SAMHSA's Published CCBHC Certification Criteria, updated March 2023. The contractor shall provide both outpatient mental health and substance use treatment services directly but may use DCO providers to supplement service and access capacity. Per SAMHSA requirements, CCBHCs are responsible for establishing appropriate oversight, grievance, data sharing, and coordination codified through policies and procedures with their DCO partners.

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 interactions with the DCO. Services that the DCOs provide for children and adolescents are family centered, youth-guided, and developmentally appropriate. CCBHC coordinates care and services provided by DCOs in accordance with the current treatment plan.

The CCBHC must notify Iowa HHS before entering to any DCO agreement for one or more of the nine required services. CCBHCs are also required to notify Iowa HHS of any changes in service to their DCO agreement including termination.

Definition of a CCBHC Client when served by a DCO

The DCO agreement should identify criteria to determine which clients should be attributed to the CCBHC and eligible for reimbursement by the CCBHC to the DCO. CCBHC clients are/may be identified in the following ways:

1. Referred to the DCO by the CCBHC for the DCO-contracted service.
2. Self-referred to the DCO and requests to be a CCBHC client for the purposes of receiving the service or other CCBHC services.
3. Referred by the DCO to the CCBHC for services based on client choice.
4. As otherwise negotiated between the CCBHC and DCO

CCBHC Clinical and Financial Responsibility

CCBHCs must maintain clinical and financial oversight of CCBHC services provided by DCOs. This includes the responsibility for billing CCBHC services rendered under a DCO agreement by a DCO. This also includes ensuring a DCO meets all clinical parameters required of CCBHCs. CCBHCs are required to regularly ensure that their DCOs are licensed and accredited and are enrolled in Medicaid in good standing for the services they are providing. This includes ensuring exclusion checks are conducted using all known names of the individual, or organization prior to contracting for services and then monthly thereafter to assure compliance. Exclusion databases can be found on the **Excluded Individuals and Entities** webpage on the Iowa HHS website. Financial and payment processes must follow the Iowa CCBHC billing and cost reporting guidance and this provider guide.

In the Section 223 CCBHC Demonstration, payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. Payments for referred services are not through the PPS but are made through traditional mechanisms within Medicaid or other funding sources.

CCBHC develops and implements a plan within two years from CCBHC certification 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.

To support integrated evaluation planning, treatment, and care coordination; the CCBHC works with DCOs to integrate clinically relevant treatment records for people receiving CCBHC services and incorporate 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.

CCBHC ensures all services, if not available directly through the CCBHC, are provided through a DCO, consistent with the freedom of the person receiving services to choose providers. This requirement does not preclude the use of referrals outside the CCBHC or DCO if a needed specialty service is unavailable through the CCBHC or DCO entities.
Regarding either CCBHC or DCO services, people receiving services will be informed of and have access to the CCBHC's existing grievance procedures.
DCO-provided services for people receiving CCBHC services must meet the same quality standards as those provided by the CCBHC.

Coordination with Other Programs

Care coordination activities are the foundation of the CCBHC program and should guide all aspects of treatment to support effective partnerships among the individual, family and other key natural supports and service providers. This includes coordination with other Iowa programs including but not limited to IHHs, waiver programs, and TCM. CCBHC care coordination is a provider practice that facilitates the transition of care in and out of CCBHC services. CCBHC care coordination facilitates integrated care by intentionally organizing client care services, information needs and preferences across all appropriate care settings. (SAMHSA Criteria 3.c)

Expected Partnerships

- Federally Qualified Health Centers and, where relevant, Rural Health Clinics, unless health care services are provided by the CCBHC.
- Programs that 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.
- Schools.
- Child welfare agencies.
- Juvenile and criminal justice agencies and facilities, including drug, mental health, veterans and other specialty courts.
- Indian Health Service youth regional treatment centers.
- State licensed and nationally accredited child placing agencies for therapeutic foster care service.
- 988 Suicide & Crisis Lifeline call center serving the area in which the CCBHC is located.
- Based on the population served, the needs and preferences of people receiving services, and/or needs identified in the community needs assessment.
- Nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, etc.

Iowa Partnership Requirements

The CCBHC shall engage and partner with behavioral health stakeholders in its service area consistent with SAMHSA's Published CCBHC Certification Criteria, updated March 2023, and key Iowa behavioral health system partners, including but not limited to:

- Behavioral Health Safety Net Providers.
- Access Centers.

- Behavioral Health Administrative Service Organizations (BH-ASOs).
- Disability Access Points (DAPs).
- Crisis service providers.
- Integrated Health Homes (IHH).
- Federally Qualified Health Centers (FQHCs).
- Providers of inpatient psychiatric care for children and adults.
- Providers of residential substance use treatment for children and adults.

ELIGIBLE POPULATIONS

Any person with a mental health or substance use disorder is eligible for CCBHC services. Individuals with a dual diagnosis of intellectual disability or a developmental disability in addition to a mental health or SUD diagnosis are eligible for CCBHC services. For the Iowa Demonstration, Iowa HHS has chosen to focus on the following populations for improved outcomes:

- Individuals with SMI.
- Individuals with SED.
- Individuals with SUD.
- Pregnant and parenting women with SUD concerns.
- Veterans.
- Youth with depression and SUD concerns.
- Black, Indigenous, and People of Color (BIPOC) and other underrepresented populations.

QUALITY MEASURES

Reporting data and quality measures serve various purposes. According to Section 223 of PAMA, providers are required to report encounter data, clinical data, quality data, and any other data specified by the Secretary of HHS. The gathering and reporting of this information provides a better way of evaluating how care is both accessed and delivered. The information gathered from these data can be used for internal quality improvement (QI) processes to determine the degree of progress achieved or to determine whether new or additional improvement is needed. This data can be used for accountability and may be used to evaluate programs to help Iowa have a better understanding of the quality of care that consumers at CCBHCs receive.

In some cases, quality measure reporting is mandatory for incentive programs like Quality Bonus Measures (QBMs) and Quality Bonus Payments (QBPs) under the Section 223 Demonstration Medicaid PPS methodology. Overall, the collected data aid states and the federal government in gaining a better understanding of the quality of health care received by clients at CCBHCs.

CCBHCs are expected to demonstrate data collection, reporting, and sharing capabilities to facilitate meaningful care coordination, follow-up, and continuous quality improvement activities. Specifically, the following data sharing and reporting capacities are required:

- Electronic Health Record (EHR) in compliance with Section 3.b.3 of Published CCBHC Certification Criteria, updated March 2023.
- Data sharing capacity with key partners, including DCOs.
- Ability to report on all required measures for the Demonstration Program and QBP program as identified in the CCBHC Certification Criteria, March 2023.

Use of Quality Measures

State Use: The state will use the quality measures for overseeing and monitoring both the overall program and individual CCBHCs. Although the federal reporting requirement for states in the program is annual, federal guidance recommends more frequent collection of interim measures, such as monthly or quarterly. These measures are then shared with CCBHCs for use in their quality plans. The state has the option to provide a CCBHC with their specific measures and a statewide average of all CCBHCs for comparison. Additionally, the state can utilize the data to identify any errors or omissions in reporting.

CCBHC Use: Measurement information is valuable for internal QI processes, aiding in gauging the extent of progress made and identifying areas that require new or additional improvement. Iowa HHS recommends that CCBHCs regularly review their data and promptly take corrective action as needed.

Federal Reporting: Measurement data will be used by the state to submit required quality measures to CMS/SAMHSA annually. The reported data and measures also contribute to program evaluation, such as the national evaluation of the CCBHC Demonstration Program.

Below are the required measures for individual CCBHC Demonstration providers, as well as State-collected measures.
Full technical specifications for each of these measures can be found in SAMHSA's **CCBHC Technical Specifications manual published in September 2023**.

Required Clinic-level Measures:	**Required Tool**
1. Time to Services (I-SERV) 2. Depression Remission at Six Months (DEP-REM-6)	**PHQ-9**
3. Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	**SBIRT single-question** screening can be used as initial screening with positive resulting in full **AUDIT-C** or **AUDIT**
4. Screening for Social Drivers of Health (SDOH) **	
5. Screening for Clinical Depression and Follow-up Plan (CDF-AD & CDF-CH) *	**PHQ-2** can be used for initial screening with a positive resulting in a full **PHQ-9**
Required State-Collected Measures:	**Required Tool**
1. Patient Experience of Care Survey (PEC) 2. Youth/Family Experience of Care Survey (Y/FEC) 3. Antidepressant Medication Management (AMM-AD) 4. Use of Pharmacotherapy for OUD (OUD-AD) 5. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD) 6. Plan All-Cause Re-Admissions Rate (PCR-AD) 7. Follow-up Care for Children Prescribed with Attention Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH) 8. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)	**MHSIP** **MHSIP Youth & Family**

9. Follow-up After Hospitalization for Mental Illness (FUH-AD, FUH-CH) * 10. Follow-up After Emergency Department Visit for Mental Illness (FUM-AD, FUM-CH) * 11. Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-AD, FUA-CH) * 12. Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)	

**Measure collected for both adult (AD) and youth (CH)*
***Must use a standardized instrument that has been determined to be valid and reliable when administered and scored in a manner consistent with its validation in a given population.*

Quality Measure Reporting Requirements

1. Iowa is aligning with the CMS-defined set of mandatory measures for reporting by CCBHC providers and demonstration states.
2. **Data Collection and Reporting Capacity**: CCBHCs must have the capacity to collect, report and track encounter, outcome, and quality data, including, but not limited to:
    a. Consumer characteristics
    b. Staffing
    c. Access to services
    d. Use of services
    e. Screening, prevention, and treatment
    f. Care coordination
    g. Other processes of care
    h. Costs
    i. Consumer outcomes
3. **Data Sources:** Measures will be gathered and calculated from various sources including:
    a. CCBHC medical record data
    b. Claims data
    c. Data collected and reported by CCBHCs through IBHRS*
4. **Eligible Population for Measurement:** According to CMS guidance, the eligible population for these measures encompasses all CCBHC consumers served by a CCBHC provider. The denominator-eligible population for each measure comprises CCBHC consumers who meet measure-specific criteria, which may involve factors like age and continuous enrollment. It is the responsibility of the CCBHC to ensure that all eligible recipients of CCBHC services are appropriately assigned and included in the calculation, covering both Medicaid and non-Medicaid participants.
5. **Stratification by Payer Type:** Whenever feasible, CCBHCs are encouraged to report on the entire consumer population, encompassing all insurers, for each CCBHC-reported measure. Rates should be delineated for the following mutually exclusive categories:
    a. Individuals covered by Medicaid only.
    b. Individuals who are dually eligible for both Medicare and Medicaid.
    c. All other individuals, which include those who are uninsured, commercially insured and individuals with Medicaid coverage that does not cover CCBHC services (such as Medicaid for family planning services only).
6. **CCBHC Template:** CCBHCs are required to fill out the **SAMHSA Section 223 Data Reporting Template (xlsx file)** for each clinic-reported measure. This template has non-editable worksheets. CCBHCs should adhere to the specifications outlined in the CCBHC Demonstration Handbook. Section E of each template contains cells indicating whether

different types of individuals are in the denominator (e.g., Medicaid, Title XIX-eligible CHIP population, commercially insured). This is to assist national evaluators in understanding the population composition in the denominator. Note that there doesn't need to be representation from each insurance type. CCBHCs should report any deviations from the technical specifications related to the calculation of the measure or the population included in the denominator. This information should be provided for all payer types (Medicaid, dual, other).

7. **Measure Calculation and Reporting**: Quality measure performance calculation will be carried out either by the CCBHC or by Iowa HHS, as specified below:
    a. For clinic-collected measures, CCBHCs will submit data quarterly on the SAMHSA excel sheets. Iowa HHS will calculate these measures and provide them to each CCBHC on a quarterly and annual basis, along with a statewide average.
    b. For state-collected measures, Iowa HHS will calculate performance on quarterly and annual basis based on claims data submissions.
    c. Certain measures will be captured through surveys which will be coordinated by Iowa HHS.
    d. For a subset of measures, each CCBHC must calculate its own performance and submit a separate report to Iowa HHS quarterly and annually.
    e. CCBHCs are responsible for including relevant reporting data for any applicable DCO partners.
    f. All CCBHC performance data must be captured and reported by site, based on catchment area.

Quality Bonus Payment (QBP)

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. 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. 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* Time to Service – Initial Clinical Service* Time to Service – Crisis Service*	1 day 10 days 1 hour	$500,000	50%
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	6.8%	$80,000	8%
Plan All Cause Readmission	7.4%	$80,000	8%

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

HEALTH INFORMATION TECHNOLOGY

CCBHCs are required to incorporate HIT in their clinical processes to increase individual and population healthcare quality and improvement. Furthermore, CCBHCs are required to have a certified Electronic Health Record (EHR), utilize a Health Information Exchange (HIE) and utilize and contribute client information to a population performance management system.
CCBHCs are required to use technology that has been certified to current criteria under the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program that aligns with key clinical practice and care delivery requirements for CCBHCs. See CCBHC Certification Criteria March 2023 for citations to the required health IT certification criteria and standards:

- Capture health information, including demographic information such as race, ethnicity, preferred language, sex 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.

CCBHCs are expected to demonstrate data collection, reporting, and sharing capabilities to facilitate meaningful care coordination, follow-up, and continuous quality improvement activities. Specifically, the following data sharing and reporting capacities are required:

- EHR in compliance with Section 3.b.3 of published CCBHC Certification Criteria, updated March 2023.
- Data sharing capacity with key partners, including DCOs.
- Ability to report on all required measures for the Demonstration Program and QBP program as identified in the CCBHC Certification Criteria, March 2023.

CCBHC PAYMENT

CCBHC reimbursement for CCBHC direct services via PPS is applicable only to identified Medicaid-reimbursable CCBHC services, provided to members during the Medicaid Demonstration program period.

Reimbursement for Medicaid-eligible members shall be calculated using PPS-1. The CCBHC certification by the Agency is required to receive Medicaid reimbursement for CCBHC services. A CCBHC's non-compliance could result in decertification of the CCBHC. Certified CCBHCs are required to enroll with Iowa Medicaid using the Provider Type 88 and with a CCBHC-specific NPI number.

PPS is a Medicaid per-encounter rate that is set based on a cost report that documents a CCBHC's allowable costs and qualifying patient encounters over a year, either on a monthly or daily basis. In the first year of a CCBHC demonstration, CCBHCs complete a cost report on current costs and anticipated future costs associated with complying with the CCBHC certification criteria. The costs are divided by the number of qualifying encounters to arrive at a clinic-specific rate, which is paid to the CCBHC each time an encounter occurs, regardless of the number or intensity of services provided.

PAMA Section 223 stipulates that no payment shall be made to a satellite facility of a CCBHC established after April 1, 2014. This definition does not limit the provision of services in non-clinic settings such as shelters and schools or at other locations managed by the CCBHC that do not meet the definition of a satellite facility.

Contractors will follow the Iowa CCBHC Demonstration Billing Guide for specific instructions on billing and payment.

Appendix A: Definitions

When appearing as capitalized terms, the following quoted terms (and the plural thereof, when appropriate) have the meanings set forth in this section.

"Agency" means the Iowa Department of Health and Human Services.

"Access Center" is defined in Iowa Administrative Code 441.25.1 and means the coordinated provision of intake assessment, screening for multi-occurring conditions, care coordination, crisis stabilization residential services, subacute mental health services and substance abuse treatment for individuals experiencing a mental health or substance use crisis who do not need inpatient psychiatric hospital treatment, but who do need significant amounts of supports and services not available in other home-and community-based settings.

"Assertive community treatment" or **"ACT"** is defined in Iowa Administrative Code 441.25.1 and means a program of comprehensive outpatient services consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration. ACT is provided in the community and directed toward the advancement of symptoms and the rehabilitation of behavioral, functional, and social deficits of individuals with severe and persistent mental illness, and individuals with complex symptoms who require multiple mental health and supportive services to live in their community.

"ASAM Criteria": The American Society for Addiction Medicine (ASAM) criteria inform adolescent and adult substance use disorder treatment plan development through a complex patient assessment over five levels of treatment. The treatment is based on the degree of direct medical management provided, the structure, safety and security provided, and the intensity of treatment services provided. (Source: ASAM)

"Behavioral health" or **"BH"** refers to mental health and substance use disorders, life stressors and crises and stress-related physical symptoms. Behavioral health care refers to the prevention, diagnosis, and treatment of those conditions. (Source: American Medical Association - AMA)

"Behavioral Health Administrative Service Organization" or **"BH-ASO"** means the lead entities designated by the Agency to plan, develop, coordinate, and ensure behavioral health services throughout a district in accordance with the statewide behavioral health service system plan.

"Behavioral Health Safety Net Provider" means agencies that are primarily publicly funded; provide behavioral health services and supports with a focus on uninsured and under insured individuals, at-risk populations and individuals, or special or targeted populations; coordinate care for individuals served; and meet minimum access standards. Behavioral health safety net service providers may receive access funds, training, tools, and technical assistance to provide a level of accessibility beyond that of other behavioral health providers.

"Certified Community Behavioral Health Clinic" or **"CCBHC"** means a state-certified clinic designed to ensure access to coordinated comprehensive behavioral health care. CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, acuity, or age. This includes developmentally appropriate care for children and youth. CCBHCs must meet state and federal standards for the range of services required to be provided by CCBHCs.

“Centers for Medicare and Medicaid Services” or **“CMS**” is the federal agency that provides health coverage through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.

“CCBHC Client” means an individual who has received at least one on the nine required CCBHC services from a state certified CCBHC, at any time during the Demonstration period. CCBHC quality measures define specific parameters for inclusion in quality reporting. Attribution to a CCBHC requires one enumerated visit that falls within the CCBHC scope of services regardless of location.

“CCBHC Targeted Case Management” or **“CCBHC Case Management”** is defined as the following: CCBHC Case Management (Criteria 4.H - Targeted Case Management Services) is distinct and separate from the current service definition of Targeted Case Management as a billable service in Iowa Medicaid. To this initiative, CCBHC Case Management is an intensive support beyond care coordination that assists people receiving service in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational and other services and supports. CCBHC case management includes support for people deemed at high risk of suicide or overdose, particularly during times of transition such as from higher levels of care. CCBHC case management should also be accessed during episodes of houselessness or transitions to community from jails, prisons, or shelters. CCBHC case management should be used for individuals with complex or serious mental health or substance use conditions and for individuals who have short-term need for support in a critical period, such as an acute episode or care transition.

"Community mental health center" or **"CMHC"** is defined in Iowa Administrative Code 441.24.50 and means an organization providing mental health services that is established pursuant to Iowa Code chapters 225C and 230A and accredited in accordance with Division III of this chapter. (Source: Iowa Administrative Code 441.24)

“Community Needs Assessment” or **“CNA”** is a systematic approach to identifying community needs and determining program capacity to address the needs of the population being served.

“Community Partners” are community or regional services, supports and providers with whom the CCBCHC coordinates through (1) a formal, signed agreement detailing roles of each party or (2) unsigned joint protocols that describe procedures for working together and roles in care coordination.

“Co-Occurring Disorder” or **“COD”** means the coexistence of both a mental illness and a substance use disorder.

“Designated Collaborating Organization” or **“DCO”** means an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements. Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. The CCBHC maintains clinical responsibility for the services provided for CCBHC consumers by the DCO.

“Disability Access Point” or **“DAP”** means a local organization designated by the Agency to serve as the primary access points for people with disabilities and their caregivers.

“Electronic Health Record” or **“EHR”** means an electronic version of a patient’s medical history, that is maintained by the provider over time and may include all the key administrative clinical data relevant to that person’s care under a particular provider. This includes demographics, progress

notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports.

“Evidence-based practices” or **“EBP”** is defined in Iowa Administrative Code 441.25.1 and means using interventions that have been rigorously tested and have yielded consistent, replicable results, and have proven safe, beneficial, and effective and have established standards for fidelity of the practice.

“Family peer support specialist” or **“FPSS”** means a parent, primary caregiver, foster parent, or family member of an individual who has successfully completed standardized training to provide information, teach coping skills, provide emotional support, and help guardians become advocates. Specialists often help families navigate child serving systems and help them understand available options for their child. They may accompany parents to meetings to ensure parents’ voices are heard. They can assist families by modeling good communication skills and sharing their own experiences in a positive manner.

“Federally Qualified Health Center” or **“FQHC”** means nonprofit health centers or clinics funded by the Health Resources Services Administration (HRSA) that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of ability to pay. Services are provided on a sliding scale fee based on ability to pay.

“Functional Family Therapy” or **“FFT”** is an evidence-based intervention for youth and families. This strength- focused family counseling model is designed primarily for at-risk youth who have been referred by the juvenile justice, mental health, school, or child welfare systems. Services are short-term and conducted in both clinic and home settings, and can also be provided in schools, child welfare facilities, probation and parole systems, and mental health facilities. (Functional Family Therapy LLC)

"Medication-assisted treatment" or **“MAT”** is the medically monitored use of certain substance use disorder medications in combination with other treatment services. MAT is defined in Iowa Administrative Code 641.155.1.

“Mental Illness” and **“Mental Health”** are disorders, ranging from mild to severe, that affect a person’s thinking, mood and/or behavior. According to the National Institute of Mental Health, nearly one-in-five adults live with a mental illness. Many factors contribute to mental health conditions, including biological factors, such as genes or brain chemistry, life experiences, such as trauma or abuse and/or a family history of mental health problems. Mental health includes people’s emotional, psychological, and social well-being. It affects how people think, feel, and act and helps determine how they handle stress, relate to others, and make choices. (Source: SAMHSA)

“Mental health service provider” or **“MHSP”** is defined in Iowa Administrative Code 441.24.1 and means an organization where services are established to specifically provide mental health assistance to individuals or the administration of facilities in which these services are provided. Organizations included are:

- Those contracting with a county board of supervisors to provide mental health services in lieu of that county’s affiliation with a community mental health center (Iowa Code chapter 230A).
- Those that may contract with a county board of supervisors for special services to the public or special segments of the public and that are not accredited.

These standards do not apply to individual practitioners or partnerships of practitioners covered under Iowa’s professional licensure laws.

“Motivational Interviewing” or **“MI”** is an evidence-based person-centered counseling method for addressing the common problem of hesitancy about change.

“Multidimensional Family Therapy” or **“MDFT”** is an evidence-based, manualized, family-centered treatment and substance misuse prevention program for youth with substance use disorders and problem behaviors such as aggression, truancy, and other mental issues. The program is designed to address and reduce a range of youth behavior challenges, such as drug use and juvenile offences. (Liddle et al., 2001).

“Multisystemic Family Therapy” or **“MST”** is an evidence-based intensive treatment process that focuses on diagnosed behavioral health disorders and on environmental systems, like family, school, peer groups, culture, neighborhood, and community, that contribute to, or influence an individual’s involvement or potential involvement in the juvenile justice system.

“National Accrediting Body” means the following organizations: The Joint Commission, Commission on Accreditation of Rehabilitation Facilities or Social Current.

“Opioid treatment program” or **“OTP”** is a substance use disorder treatment program and problem gambling treatment program licensed to provide opioid treatment services in accordance with Iowa Code section 125.21 and rules 641—155.2(125,135) and 641—155.35(125,135).

“Opioid Use Disorder” or **“OUD”**, a substance use disorder, is a problematic pattern of opioid use that causes significant impairment or distress. OUD is a treatable, chronic disease that can affect anyone – regardless of race, gender, income level, or social class. A diagnosis of OUD is based on specific criteria such as unsuccessful efforts to cut down or control use or use resulting in a failure to fulfill obligations at work, school, or home, among other criteria. It can lead to overdose and death. (Source: CDC)

“Protecting Access to Medicare Act” or **“PAMA”, Section 223** is the Excellence in Mental Health Act which establish certified community behavioral health clinics (CCBHCs).

“Peer Recovery Coach” or **“PRC”** is an individual with lived experience of substance misuse who is doing well in recovery. A PRC uses their lived experience and recovery story to instill hope in others. They discuss recovery issues from a peer perspective and support other peers in reaching and maintaining their own personal recovery goals. In addition, a PRC may serve as an advocate, guide peers on accessing resources and model competency in recovery and wellness. PRCs promote skills for improving mental and physical wellbeing and increasing resiliency. They promote self-determination, recognize there are multiple pathways of recovery and help peers become and stay engaged in their own recovery. (Source: Connecticut Community for Addiction Recovery – CCAR)

“Peer support services” is defined in Iowa Administrative Code 441.25.1. It means a program provided by a peer support specialist including but not limited to education and information, individual advocacy, family support groups, crisis response and respite to assist individuals in achieving stability in the community.

“Peer support specialist” or **“PSS”** is an individual who is personally in recovery from a serious mental illness who has completed training to best use their personal recovery story to instill hope in others. They assist individuals in reaching and maintaining their personal recovery goals. A PSS can serve as an advocate, provide information, help access community resources, and model

competency in recovery and wellness. They promote skills for improving mental and physical wellbeing and increasing resiliency by promoting self-determination and supporting peers in maintaining relationships thus increasing life satisfaction.

"Prospective Payment System" or **"PPS"** means a cost-based, per clinic rate that applies uniformly to all CCBHC services rendered by a certified clinic, including those delivered by qualified satellite facilities established prior to April 1, 2014. In demonstration year one (DY1), the state uses cost and visit data from the demonstration planning phase, updated by the Medicare Economic Index (MEI) to create the rate for DY1. The DY1 rate will be updated again for future demonstration years by rebasing the PPS rate.

"Quality Bonus Payment" or **"QBP"** means an incentive payment available under the CCBHC Demonstration. It is distributed based on program participants meeting benchmarks for a subset of required performance and outcome measures.

"SAMHSA CCBHC Certification Criteria" are an established a set of uniform standards that providers must meet to be a CCBHC, published by SAMHSA in 2015 and revised in March 2023. All references to the SAMHSA CCBHC Criteria refer to the criteria updated in March 2023 and located at this website: https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

"Satellite Facility" is a facility that was established by the CCBHC prior to April 2014, operated under the governance and financial control of the CCBHC, and provides all four of the following services: crisis services; screening, diagnosis, and risk assessment; person and family centered treatment planning; and outpatient mental health and substance use services as specified in CCBHC certification criteria Program Requirement 4.

"Screening, Brief Intervention, and Referral to Treatment" or **"SBIRT"** is a comprehensive, integrated, and public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.

"Serious emotional disturbance" or **"SED"** means a child under the age of 18 who has a diagnosable mental, behavioral, or emotional disorder that is of sufficient duration to meet diagnostic criteria for the disorder specified by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. The child's behavior has resulted in a functional impairment that substantially interferes with or limits a consumer's role or functioning in family, school, or community activities. SED as defined in Iowa Administrative Code 441.24.1 does not include neurodevelopmental disorders, substance-related disorders or conditions or problems classified in the current version of the DSM as "other conditions that may be a focus of clinical attention," unless those conditions co-occur with another diagnosable serious emotional disturbance.

"Serious mental illness" or **"SMI"** means, for an adult, a persistent or chronic mental health, behavioral, or emotional disorder that (1) is specified within the most current version of DSM or its most recent International Classification of Diseases, and (2) causes serious functional impairment and substantially interferes with or limits one or more major life activities. This could include functioning in the family, school and employment or community. "Serious mental illness" may co-occur with substance use disorder, developmental disabilities, neurodevelopmental disabilities, or intellectual disabilities.

“State-sanctioned crisis services provider” means a crisis provider accredited to provide crisis services through IAC Chapter 24, Division II.

“Substance Abuse and Mental Health Services Administration” or **“SAMHSA”** is the federal agency within U.S. HHS that leads public health efforts to advance the behavioral health.

“Substance use disorder” or **“SUD”** is defined in Iowa Administrative Code 641.155.1. It means a substance use disorder that results in a functional impairment of sufficient impact and duration to meet the diagnostic criteria specified within the most current DSM.

“Supported employment” is an approach to help individuals participate in competitive work in integrated work settings that are consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals. Services are targeted for individuals with significant disabilities where competitive employment has not traditionally occurred; or for competitive employment has been interrupted or intermittent because of a significant disability which includes individual or group supported employment, or both, consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

“Telehealth” or **“Telemedicine"** is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include video conferencing, use of the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

“Trauma-Focused Cognitive Behavioral Therapy” or **“TF-CBT”** is an evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers.

Appendix B: CCBHC Tobacco Use Disorder Treatment Guidelines

The American Society of Addiction Medicine (ASAM) offers a guide on integrating tobacco use disorder interventions in addiction treatment. The recommendations listed under each CCBHC Criteria are guided by the ASAM. The full guide can be downloaded at

- https://www.asam.org/quality-care/clinical-recommendations/tobacco.

CCBHC Criteria 1.B: Licensure and Credentialing of Providers

- 1.b.1 - CCBHC staff must include a medically trained behavioral health provider, either employed or 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.
    - Staff who screen for tobacco and nicotine use and advise clients to quit are strongly recommended to hold the Tobacco Treatment Specialist Certification through Mayo Clinic.

CCBHC Criteria 2.A: General Requirements of Access and Availability

- 2.a.1 - The CCBHC provides a safe, functional, clean, sanitary, and welcoming environment for people receiving services and staff, conducive to the provision of services identified in program requirement four.
    - CCBHC's are strongly encouraged to adopt 100% comprehensive tobacco and nicotine free campus policies. These policies help set a standard of health and encourage tobacco and nicotine free lifestyle choices. The Iowa HHS Division of Behavioral Health provides a model comprehensive tobacco and nicotine free workplace policy. (See TF/NF Policy below)
    - Iowa HHS provides free of cost tobacco and nicotine free signage for buildings and grounds for both for indoor and outdoor use.

CCBHC Criteria 4.d: Screening, Assessment, and Diagnosis

- 4.d.4 - A comprehensive evaluation is required for all people receiving CCBHC services. Subject to applicable state, federal or other accreditation standards, clinicians should use their judgment with respect to the depth of questioning within the assessment so that it actively engages the person receiving services around their concern(s). The evaluation should gather the amount of information that is comparable with the complexity of their specific needs and prioritize preferences of people receiving services with respect to their evaluation and their treatment goals. The evaluation should include:
    - 4.d.4. 8 - An examination 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.
        - Individuals receiving CCBHC services should be screened for nicotine and tobacco use. For individuals who screen positive, nicotine and tobacco use history should be assessed, accounting for all types of nicotine and tobacco product use. In addition, the duration and frequency of use, prior quit attempts, and motivation to quit/stage of change should be reviewed.

- https://ndceducation.mayo.edu/store/pages/certification

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

- 4.f.1 - The CCBHC directly, or through a DCO, provides outpatient behavioral health care, including psychological and pharmacological treatment. The CCBHC or DCO must provide evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for all audiences. SUD treatment and services shall be 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 SUD treatment the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, using telehealth/telemedicine, in alignment with state and federal laws and regulations. The CCBHC also provides through a formal arrangement traditional practices or treatments as appropriate for people receiving direct care to a particular person receiving CCBHC services, or specialist care is not practically available the CCHC professional staff may consult with specialized services providers for highly specialized treatment needs. For people receiving services with potentially harmful substance use, the CCBHC is strongly encouraged to engage the person receiving services with motivational techniques and harm reduction strategies to promote safety and/or reduce substance use.
    - Treatment providers and programs should address tobacco use in treatment planning as they would treatment of any other substance.
        - CCBHC should provide barrier-free access to evidence-based tobacco cessation interventions. For all people who use tobacco products and are willing to engage in treatment, ASAM recommends pharmacologic therapy; including nicotine replacement therapy/NRT, varenicline, and bupropion; and behavioral interventions; including cognitive behavioral therapy, contingency management. These interventions are applicable to all types of tobacco and nicotine product use.
        - Quitline Iowa provides free tobacco and nicotine cessation counseling services to all Iowans, and nicotine replacement therapy. Referrals to Quitline Iowa can be made by any staff member online at **https://www.quitlineiowa.org/en-US/Health-Professionals/Make-a-Referral**. Individuals can connect with Quitline Iowa for cessation counseling and additional support by calling 1-800-QUIT-NOW (1-800-784-8669).
        - My Life My Quit is a free, confidential tobacco and nicotine cessation counseling service for all Iowa youth between 12 to 17 years old. Youth can enroll in web cessation counseling sessions online at **https://co.mylifemyquit.org/index** or by texting Start My Quit to 1-855-891-9989.
        - Iowa Tobacco Use Prevention and Control Community Partnership Grantees will provide technical assistance to CCBHCs seeking training, education, and resources on the “Ask, Advise, Connect” model for Quitline Iowa and My Life My Quit. **https://hhs.iowa.gov/programs/mental-health/tobacco-use-prevention-control**

Table from the ASAM Integrating Tobacco Use Disorder Interventions in Addiction Treatment Guidebook

Table 2: FDA-Approved Tobacco Cessation Interventions

	Nicotine Replacement Therapies (NRT)					Other Therapies	
Medication	**Transdermal Nicotine Patch[2]**	**Nicotine Polacrilex gum[2]**	**Nicotine Lozenge[2]**	**Nicotine Nasal Spray**	**Nicotine Inhaler**	**Bupropion (SR or XL) (Zyban, Wellbutrin)**	**Varenicline (Chantix, Champix)**
Suggested Regimen[1]	Transdermal Nicotine Patch <= 10 cig/d, start with 14mg/d x 6 wks or longer; can consider increasing dose up to 21mg/d >10 cig/d, start with 21mg/d x 6 wks or longer If needed	1st cig >30 mins after awakening, 2 mg/hr 1st cig =<30 mins after awakening, 4 mg/hr If needed for smokers <= 10 cig/d, feel comfortable prescribing 4mg gum[4]	1st cig >30 mins after awakening, 2 mg/hr 1st cig =<30 mins after awakening, 4 mg/hr If needed for smokers <= 10 cig/d, feel comfortable prescribing 4mg lozenges[4]	1-2 sprays per nostril/hr, PRN. Increase to 5 sprays per nostril per hr (max 80 sprays total) x 3 mos maximum[3]	4 puffs/min x 20-30 mins per cartridge = 1½-2 cigarettes PRN	Days 1-3: 150mg po qam Day 4 to 12 weeks (or end of treatment[5]): 150mg SR bid or 300mg XL po qam	Start >= 1 week before target quit date 0.5mg po qam x 3days then 0.5mg po bid x 4days then 1 mg po bid x 11 weeks to 6 months. Target quit date can be delayed or extended if needed.

[1] Suggested regimens are based on the CHEST Foundation Tobacco Dependence Treatment Toolkit and are meant to provide general guidelines that can be individualized to each patient as needed (e.g., side effects, comorbid health conditions). Tobacco cessation treatments should have an extended duration (i.e., > 12 weeks), especially when individuals have a high level of nicotine dependence and/or serious tobacco-related health comorbidities. Adverse events associated with the approved treatments for smoking cessation are not considered clinically important and are well tolerated.[51]

[2] The patch, gum, and lozenge are available over-the counter and can be used in combination including more than one transdermal patch.

[3] This prescription cannot exceed 3 months. The patient should be tapered off or switched to an alternative NRT within 3 months.

[4] If the patient experiences throat pain, consider reducing the dose.

[5] Target quit date can be delayed as needed.

Model Tobacco-Free/Nicotine-Free Policy

Business Name:

POLICY

The use of any tobacco, vape, or nicotine product is strictly prohibited. Prohibited tobacco, vape, and nicotine products include but are not limited to cigarettes, cigars, chew, other tobacco or tobacco-like products, vapes, and all nicotine products not approved by the Food and Drug Administration (FDA) for tobacco cessation. (Check all that apply)

- This policy always applies.
- This policy applies to all vehicles owned or leased by the business.
- This policy applies to all enclosed areas within the business.
- This policy applies to the entire property (outside and inside).
- All persons (employees, visitors, vendors, contract workers, volunteers, etc.) are expected to observe this policy.

The policy complies with the Iowa Smokefree Air Act in Iowa Code. s*mokefreeair.iowa.gov.*

RESPONSIBILITY

All employees share in the responsibility for enforcing the policy.

PROCEDURES

- All persons are asked to extinguish and/or cease from using all tobacco, nicotine, or tobacco-like products before coming onto property.
- Visitors or other non-employees will be politely informed of any policy violation and asked to cease use or leave the property.
- Applicants and interviewees will be advised that this is a tobacco-free/ nicotine free worksite.
- Employees who violate the policy will be subject to disciplinary action up to and including termination.

Effective Date: _____
Approved by _____

To ensure the business has a strong tobacco-free/nicotine-free policy, and to qualify for free window clings and outdoor signage, the policy must explicitly include all the following:

- Policy must extend to all types of tobacco, nicotine, and electronic smoking devices (ESD) products. This not only applies to cigarettes, but also includes all tobacco, ESDs and nicotine products not approved by the FDA for cessation.
- Policy must extend to employees & visitors.
- Policy must always apply.
- Policy must extend to company vehicles.
- Policy must extend to entire business property to receive outdoor signage.