ADMH
Alabama Department
of Mental Health
connecting mind and wellness

Alabama Comprehensive Provider Manual for Certified Community Behavioral Health Clinics (CCBHCs)

08/29/2025

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Introduction and Purpose of this Document

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (H.R. 4302) was enacted, laying the groundwork for the establishment of Certified Community Behavioral Health Clinics or CCBHCs. CCBHCs are a comprehensive community behavioral health provider that is meant to improve the behavioral health system by increasing access to high quality, integrated care. Section 223 of the law authorized the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS) under the United States Department of Health and Human Services (HHS) to develop certification criteria for CCBHCs Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria Updated March 2023, provide guidance to states on developing a prospective payment system (PPS) to reimburse CCBHCs, administer one year planning grants to states interested in developing a proposal for the four year Demonstration, and report findings and recommendations to Congress on CCBHC. On June 5, 2024, Alabama was one of ten states selected for the CCBHC Medicaid Demonstration Program by HHS in partnership with the SAMHSA.

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

The Alabama Comprehensive Provider Manual for CCBHCs is designed to guide CCBHCs in understanding and adhering to the state's requirements for service provision, documentation, and other required processes. For more information on CCBHC billing and reimbursement, please see the companion CCBHC Billing Manual (*to be released by ADMH and AL Medicaid shortly – Link will be inserted in the next Provider Manual update*). CCBHCs play a critical role in delivering comprehensive, community-based mental health and substance use disorder services to individuals regardless of their ability to pay. As part of a larger effort to enhance access to integrated behavioral health care, it is essential that CCBHCs follow consistent service provision and billing practices that ensure transparency, accountability, and efficient use of *resources*. Providers are urged to study the manual closely and update processes as necessary and as new material is supplied. The Manual will be updated quarterly as necessary to maintain the most current information.

The purpose of this manual is to:

- **Provide Standardized Guidance**: Establishing clear service delivery and operations protocols for CCBHCs that align with state and federal policies. This includes specific credentialing, staffing, and documentation requirements for services rendered.
- **Support Compliance with Regulations**: Ensure that CCBHCs meet state and federal regulatory requirements for billing and documentation. Compliance with these standards helps prevent fraud, waste, and abuse.
- **Ensure Accurate Reimbursement**: In conjunction with the associated CCBHC Billing Manual (linked above), outline processes for obtaining reimbursement for covered services, promoting financial sustainability, and enabling the continuous delivery of high-quality care to Alabama communities.

Please note that this Manual is not a legal description of all requirements related to the CCBHC Demonstration in Alabama. It is a practical guide for providers who participate in the Demonstration. Should there be a conflict between the material in this manual and applicable laws or terms of Alabama Administrative Code for this program, the latter are controlling. Please reach out to the ADMH CCBHC mailbox with any questions at ccbhc.dmh@mh.alabama.gov.

This Manual should be used in concert with:

- SAMHSA CCBHC Certification Standards
- HIPAA, 42 CFR Part 2, and other applicable state or federal laws
- Alabama Licensing and Certification Requirements, including (but not limited to) Chapters 105, 106, and 112, as well as all relevant Alabama Administrative Code requirements
- CCBHC Compliance Checklist which can be accessed here: https://www.samhsa.gov/sites/default/files/ccbhc-compliance-checklist.pdf

Version History

Version #	Date Published	Summary of Revisions
1	08/29/2025	Publication of the Alabama Comprehensive Provider Manual for Certified Community Behavioral Health Clinics (CCBHCs)

Program Scope

CCBHCs are certified by the Alabama Department of Mental Health (ADMH) based on their ability to meet all CCBHC Criteria requirements, including those promulgated by ADMH,[1] as well as the federal requirements from SAMHSA.[2]

To be eligible to become a CCBHC within Alabama's CCBHC Demonstration program (separate from SAMHSA's CCBHC Expansion Grant program), agencies must be the designated Community Mental Health Center (CMHC) for their region. This Guidance is applicable only to those CCBHCs that have been approved by ADMH to be part of the federal CCBHC Demonstration. This information is not applicable to a program that has received a CCBHC Expansion Grant from SAMHSA but has not been approved to participate in the CCBHC Demonstration by ADMH.

CCBHCs are required to provide the full array of outpatient mental health and substance use disorder treatment and support services outlined in the ADMH and SAMHSA CCBHC criteria to all individuals across the life span, seeking care, regardless of their ability to pay or other demographic characteristics (e.g., diagnosis, age, race, ethnicity, disability, sexual orientation, gender expression, justice system involvement, housing status).

[1] https://mh.alabama.gov/certified-community-behavioral-health-clinics/
[2] https://www.samhsa.gov/certified-community-behavioral-health-clinics/ccbhc-certification-criteria

CCBHC services (triggering events) will be reimbursed through a daily Prospective Payment System (PPS) rate, which is established with each participating CCBHC provider via a Cost Report process. As described in later sections, Alabama Medicaid Agency (AMA) and ADMH are using the PPS-1 methodology, which pays a daily rate for all CCBHC services delivered each day to a CCBHC-enrolled Medicaid beneficiary. **There are two exceptions to the enrollment requirement for CCBHC Crisis Services and Peer Support Services, which are the only two services that can be provided and billed for prior to the person being admitted to the CCBHC. Specifically:**

- If a *non-established/new individual* to the CCBHC receives a *CCBHC crisis service*, the service is a CCBHC-covered service (and the Provider can bill the PPS rate) *upon the completion of a crisis assessment, which must include a screening and risk assessment*.
- Additionally, to support engagement in the CCBHC, *Peer Support Services* may be provided (and the Provider can bill the PPS rate) to non-established/new individuals prior to CCBHC enrollment, as long as the explicit purpose of the peer services is *outreach and engagement of a new individual* not currently receiving services from the CCBHC.

For non-Medicaid enrollees (e.g., those enrolled in Medicare, those with private insurance, those with no insurance), CCBHCs will continue leveraging other reimbursement/funding sources to support service provision. *The PPS-1 rate will not be paid for services provided to populations outside of those enrolled in Medicaid*.

The following practices are **not** permitted under Alabama's PPS-1 structure:

- Billing Medicaid for more than one CCBHC daily visit per Medicaid enrollee served per specific date of service
- Billing Medicaid for a CCBHC daily visit when no CCBHC triggering event service was provided (based on procedure code)
- Billing Medicaid for CCBHC activities furnished through modalities that do not meet a billable CCBHC "visit" definition or in locations where the setting, service, or population is unallowable in the CCBHC Demonstration.

Enrollment as a CCBHC in Alabama

When a CMHC wants to join the Alabama CCBHC Demonstration program, they should alert the ADMH CCBHC Team via ccbhc.dmh@mh.alabama.gov, including their requested date for CCBHC certification, their proposed CCBHC catchment area, the sites for which they will be seeking CCBHC Certification, and what type of CCBHC site each location will be (see below). After review of the request, ADMH will provide the CCBHC with additional information about the certification process and timeline. For more information, see: https://mh.alabama.gov/certified-community-behavioral-health-clinics/for-prospective-ccbhcs/

Per SAMHSA guidance released in July of 2024, CCBHC Demonstration states are permitted to add CCBHCs to the Demonstration at the beginning of any fiscal quarter during the State's Demonstration Year.[3] For Alabama, this would be on either July 1, October 1, January 1, and April 1.

[3] https://www.samhsa.gov/sites/default/files/guidance-addition-of-ccbhcs-existing-state-demonstration-programs.pdf

CCBHC Site Types – Main, Satellite, and Access Point Sites

As part of the CCBHC Certification process, each provider must identify all physical site locations for which it is requesting certification and the approval to bill the PPS rate. This does not preclude agencies from providing CCBHC services at other community-based locations and settings (as allowable within the AL CCBHC initiative and Chapter 105/106 and AL Medicaid guidelines). However, any site where the CCBHC will be providing regular and routine services should be approved through ADMH's CCBHC Certification team as one of the following CCBHC site types:

- **Main CCBHC Site Locations** – These are CCBHC sites that fully adhere to the SAMHSA and AL CCBHC Criteria[4,5] and provide all nine CCBHC services at the site. ADMH's preference is, to the greatest extent possible, that each provider build capacity to provide all CCBHC services at as many of its existing sites (which would then be certified as main CCBHC sites) as possible.
- **Satellite Site of the Main CCBHC Sites** – These are CCBHC sites that provide, at minimum, the following core CCBHC services:
    - 24/7 crisis services;
    - screening, diagnosis, and risk assessment;
    - person and family centered treatment planning; and
    - outpatient mental health and substance use services.

  Based on federal restrictions[6], these sites must be operated under the governance and financial control of the CCBHC, and they must have been established prior to April 1, 2014.[7] Additionally, these sites must be reasonably accessible[8] to one or more main CCBHC site locations, to assure access to all CCBHC services when needed/desired by a client.
- **Access Points to the Main CCBHC Site** – These are CCBHC sites that deliver less than the four core CCBHC services referenced above, but that promote access to one or more CCBHC services for the population being served. These sites must also be reasonably accessible[9] to one or more main CCBHC site locations, in order to assure access to all CCBHC services when needed/desired by a client.

After approval, Main CCBHC Site Locations, Satellite Site Locations, and Access Point Locations are able to bill the PPS rate. Regardless of the type of site, all sites must be located within the agency's CCBHC catchment area, as identified in their Community Needs Assessment. Additionally, the site must adhere to the relevant CCBHC Criteria (based on the services being offered), including those related to Staffing, Access, Care Coordination, Scope of Services, Quality, and Governance.

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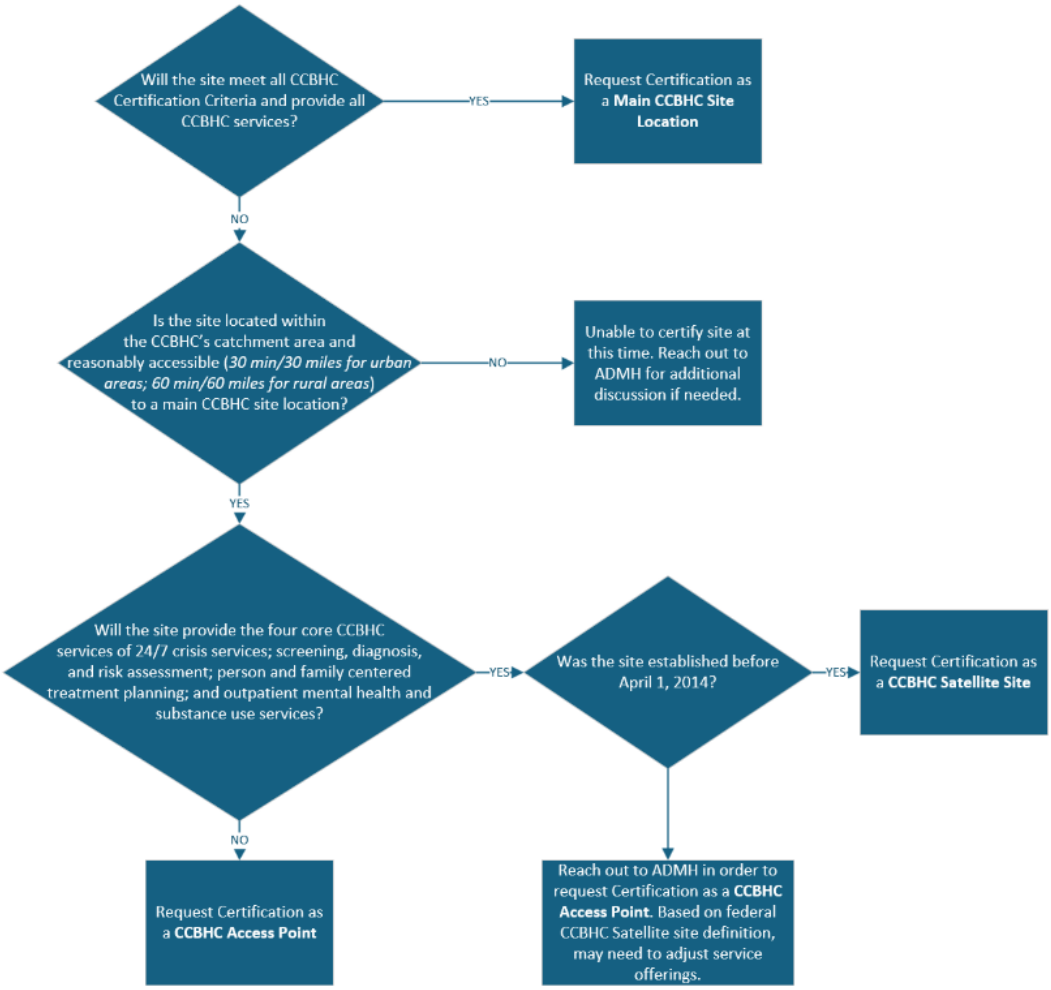
[4] https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria
[5] https://mh.alabama.gov/certified-community-behavioral-health-clinics/for-current-ccbhcs/
[6] https://www.samhsa.gov/sites/default/files/section-223-satellite-facility.pdf
[7] A behavioral health facility that was established before April 1, 2014, but that has been renovated, expanded, and/or replaced (e.g., via a relocation within the catchment area) after this date may be certified by the state as a CCBHC without jeopardizing their certification or the PPS payment.
[8] ADMH defines "reasonably accessible" for CCBHCs to be located within 30 miles/30 minutes for urban areas or 60 miles/60 minutes for rural areas.
[9] As stated above, ADMH defines "reasonably accessible" for CCBHCs to be located within 30 miles/30 minutes for urban areas or 60 miles/60 minutes for rural areas.

For each site location for which the agency is requesting CCBHC Certification, the following workflow can be used to identify what type of CCBHC site it will be:



In addition to the above, a CMHC may also request certification for CCBHC service delivery to occur at **Designated Collaborating Organization Sites**. These are sites where one or more of the CCBHC services will be provided by a contracted partner entity that is not under the direct supervision of the lead CCBHC agency. In order to qualify for payment for CCBHC services from the CCBHC, the DCO must be engaged in a formal relationship with the lead CCBHC (via a contract or MOU) and they must deliver services under the same requirements as the CCBHC.

CCBHC services may be offered through telehealth to meet the needs/preferences of the person receiving services, as long as each site also has capacity to offer the identified services in-person. All services provided via telehealth must follow Medicaid telehealth guidelines.

Organizational Authority and Finances

SAMHSA CCBHC Certification Criteria

In addition to being the designated CMHC for the region, prospective CCBHCs in Alabama must have the ability to meet all SAMHSA CCBHC Criteria. This includes the following General Requirements of Organizational Authority and Finances from SAMHSA's CCBHC Criteria.

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

- Is a non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code
- Is part of a local government behavioral health authority[10]
- Is operated under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.)
- Is an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.)

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

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

Application of Organizational Authority and Finance Requirements for Alabama CCBHCs

Based on the above, all Alabama CCBHCs:

- Must maintain and submit documentation they are a non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code.
- Must be a Community Mental Health Center under the authority of a 310 Board.
- Must complete an annual independent financial audit with federal audit requirements for its entire designation as a CCBHC.
    - The financial audit is made available to ADMH at site visits and upon requests.
    - CCBHCs must adhere to any corrective action plans to address any findings, questioned costs, reportable conditions, and/or material weaknesses noted in the audit. Corrective action plans must be made available to ADMH at site visits and upon request.

[10] A CCBHC is considered part of a local government behavioral health authority when a locality, county, region, or state maintains authority to oversee behavioral health services at the local level and utilizes the clinic to provide those services.

CCBHC Governance

SAMHSA CCBHC Certification Criteria

Based on the SAMHSA CCBHC Certification Criteria, Alabama CCBHCs must meet the following requirements related to governance.

CCBHC governance must be informed by representatives of the community being served, taking into account demographic and other factors to assure representation from individuals in their community who are impacted by health and behavioral health needs.

Meaningful participation from individuals with lived experience of mental and/or substance use disorders and their families including youth must be incorporated into the CCBHC's governance structure and processes. Meaningful participation should include involving a substantial number of people with lived experience and family members of people receiving services in developing initiatives; identifying community needs, goals, and objectives; providing input on service development and Continuous Quality Improvement (CQI) processes; and budget development and fiscal decision making.

Substantial participation can be reflected by one of two options (Alabama CCBHCs should be clear which governance option they are choosing as part of their CCBHC Certification):

- **Option 1:** At least 51% of the CCBHC governing board is comprised of individuals with lived experience of mental health and/or substance use disorders and their families.
  or
- **Option 2:** Other means are established to demonstrate meaningful participation of people with lived experience (see below for ADMH's Advisory Committee requirements related to Option 2). The CCBHC provides staff support to the individuals involved in any alternate approach that are equivalent to the support given to the governing board.
  Under Option 2, individuals with lived experience of mental and/or substance use disorders and family members of people receiving services must have representation in governance decision making that assures input into:
  1. Identifying community needs and goals and objectives of the CCBHC
  2. Service development quality improvement, and the activities of the CCBHC
  3. Fiscal and budgetary decisions
  4. Other Governance-related topics (staffing plan development, leadership recruitment and selection, etc.)

  Under Option 2, the governing board must establish protocols for incorporating input from individuals with lived experience and family members. Board meeting summaries are shared with those participating in the alternate arrangement and recommendations from the alternate arrangement shall be entered into the formal board record. In addition, a member or members of the arrangement established under Option 2 must be invited to board meetings and representatives of the alternate arrangement must have the opportunity to regularly address the board directly, share recommendations directly with the board and have their comments and recommendations recorded in the board minutes. The CCBHC shall provide staff support for posting an annual summary of the recommendations from the alternate arrangement under option 2 to the CCBHC's website.

If Option 1 is chosen, the CCBHC must demonstrate how they meet the requirement (or show a timeline of how they will do so by the date at which they will implement the CCBHC).

If Option 2 is chosen, ADMH will determine if the proposed approach meets the above requirements for meaningful engagement, and if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes.

CCBHCs that are part of a governmental, tribal organization, or part of a larger organization that cannot meet the above requirements will specify the reasons it cannot meet the CCBHC Governance criteria. They will establish an advisory structure and describe other methods engaging for individuals with lived experience to provide meaningful participation as defined in 6.b.1.

The governing or advisory board members will be representative of the communities in which the CCBHC's service area is located and will be selected for their expertise in health services, community affairs, local government, finance and accounting, legal affairs, trade unions, faith communities, commercial and industrial concerns or social service agencies within the communities served. No more than 50% of the governing board may derive more than 10% of their annual income from the health care industry.

Application of Governance Criteria Requirements for Alabama CCBHCs

Each of Alabama's CCBHCs must:

- Maintain a structure that allows their Governance Board to be informed by representatives of individuals being served by the CCBHC in terms of demographic factors identified in the CCBHC Needs Assessment.
- Incorporate meaningful participation by adult and youth consumers with mental illness, adults and youth recovering from SUD, and family members of CCBHC consumers.
- Demonstrate meeting one of the following CCBHC Governance options:
    - **Option 1**: 51% of the Board are families, consumers, or people in recovery from mental health and/or substance use conditions.
    - **Option 2**: Alabama has the following requirements for a CCBHC selecting Option 2:
        - A substantial portion but less than 51% of the governing board members are individuals with their own lived experience or a family member, and the CCBHC will be required to create an Advisory Committee. The Advisory Committee will consist of consumers, people in recovery, and family members who provide meaningful input to the Board about the CCBHC's policies, processes, and services.
        - CCBHCs choosing Option 2 are required to implement documented methods for individuals with lived experience, people in recovery, and family members to provide meaningful input into identifying community needs; goals and objectives of the CCBHC; service development, quality improvement, and the activities of the CCBHC; fiscal and budgetary decisions; and governance.
        - The Advisory Committee must be comprised of 100% of individuals with lived experience of mental or substance use disorders. The chairperson or a designee of the Advisory Committee must provide a standing report at the CCBHC's Board of Directors meetings. Additionally, Board Minutes must be provided to the Advisory Committee for review, and Advisory Committee Minutes must be provided to the Board.

        - The CCBHC's Governing Board and/or Advisory Committee shall be representative of the individuals being served by the CCBHC in terms of the community served, taking into account demographic and other factors.
        - Each CCBHC's community needs assessment will determine and inform whether the Board and/or Advisory Committee meets these criteria.
- Members of the CCBHC Governing Goard or Advisory Committee will be representative of the communities in which the CCBHC's service area is located and will be selected for their expertise in health services, community affairs local government, finance and accounting, legal affairs, trade unions, faith communities, commercial and industrial concerns or social service agencies within the communities served. No more than 50% of the governing board may derive more than 10% of their annual income from the health care industry.

Determination of Compliance with Governance Criteria

ADMH will not certify organizations that cannot meet the criteria related to Governance (either Option 1 or Option 2). ADMH will determine compliance during the certification process through review of:

- The CCBHC's policy and procedures regarding governing authority;
- Governing body bylaws, rules, and regulations;
- Governing body minutes;
- Membership lists; and
- Other documentation as needed.

CCBHC Training Plan

Each CCBHC should have a training plan for all CCBHC employed and contract staff who have direct contact with people receiving services or their families. At orientation and at reasonable intervals thereafter, the CCBHC must provide training on:

- Evidence-based practices
- Cultural competency (described below)
- Person-centered and family-centered, recovery-oriented planning and services
- Trauma-informed care (described below)
- The clinic's policy and procedures for continuity of operations/disasters
- The clinic's policy and procedures for integration and coordination with primary care
- Care for co-occurring mental health and substance use disorders

At orientation and annually thereafter, the CCBHC must provide training on:

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

Trainings may be provided on-line.

The CCBHC documents in staff personnel records that the training and demonstration of competency are successfully completed.

All individuals providing staff training are qualified as evidenced by their education, training, and experience.

Trauma-Informed Care

SAMHSA CCBHC Certification Criteria

Based on the SAMHSA CCBHC Certification Criteria, all of Alabama's CCBHCs must meet the following requirements related to Trauma Informed Care.

The CCBHC must have staff with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI) are required at CCBHCs.

The CCBHC's training plan for all staff, whether employed or contracted, who work directly with the person receiving services or their families must satisfy and include requirements of the state behavioral health authority, and any accreditation standards required by the state. At orientation or at reasonable intervals thereafter, the CCBHC must provide training on trauma-informed care, among other topics.

CCBHCs must include training specifically focused on the application of trauma-informed approaches during crises.

Alabama CCBHC Training on Trauma-Informed Care Requirements

In addition, ADMH is requiring the following for Alabama CCBHCs:

- People living with behavioral health conditions experience high rates of trauma. To prevent re-traumatization of persons served, CCBHCs must create trauma-informed environments with staff well trained in trauma-informed principles.
- To promote a trauma-informed environment, ADMH requires all CCBHCs to submit a trauma-informed training plan that includes, at a minimum, the following competency-based trainings; however, it is up to the discretion of the CCBHC to determine if a more rigorous training cycle is needed:

Training	Required Attendees	Frequency
Implementation of Trauma Informed Care (TIC) Systems	All Administrative Staff	At hire
Introduction to TIC	All Staff	At hire
How BH Disorders are Impacted by Trauma	All Staff	At hire and every other year
TIC for Non-Clinical Staff	All Non-Clinical Staff	At hire and every other year
TIC Delivery- Clinicians and Peer Support Specialists	All Direct Care Staff	At hire and every other year
Influence of Trauma on Substance Use	All Clinicians including QSAPs and those trained in MI and SUD	At hire and every other year
Trauma-Informed CBT	All Clinicians	At hire and every other year

- CCBHCs will be required to submit their trauma-informed care training plan to ADMH within 90 days of certification.

- CCBHCs are required to maintain records of trainings delivered to their staff, with verification of competency assessments.

Cultural Competency and National CLAS Standards

SAMHSA CCBHC Certification Criteria

The CCBHC training plan for all staff, whether employed or contracted, who work directly with the person receiving services or their families must satisfy and include requirements of the state behavioral health authority, and any accreditation standards required by the state. At orientation or at reasonable intervals thereafter, the CCBHC must provide training on Cultural Competency, among other topics.

Training shall be aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS)[11] to advance health equity, improve quality of services, and eliminate disparities. To the extent active-duty military or veterans are being served, such training must also include information related to military culture. Examples of training and materials that further the ability of the clinic to provide tailored training for a diverse population include, but are not limited to, those available through the HHS website,[12] the SAMHSA website,[13] the HHS Office of Minority Health,[14] or through the website of the Health Resources and Services Administration. All staff must receive cultural competency training.

In addition, any staff who is not a veteran has training about military and veterans' culture to be able to understand the unique experiences and contributions of those who have served their country. CCBHCs must ensure all staff complete an ADMH approved training on Military Culture, which meets current CLAS standards. Training is required for all new employees, direct and non-direct care, within 30 days of hire. Training will be required every other year thereafter.

All behavioral health care is to be provided at the CCBHC with cultural competence.

Application of Cultural Competency Requirements for Alabama CCBHCs

The state will require each CCBHC to track specific data to identify existing and emerging disparities among the clients they serve. On a statewide basis, these data will be reviewed by ADMH as part of its Steering Committee structure to identify additional trainings and resources needed in order to address identified disparities.

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[11] Access standards at, What is CLAS? - Think Cultural Health (hhs.gov) and Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care at National Minority Mental Health Awareness Month — New CLAS Implementation Guide (hhs.gov). https://thinkculturalhealth.hhs.gov/clas

[12] https://thinkculturalhealth.hhs.gov/education/behavioral-health

[13] https://www.samhsa.gov/resource/ebp/tip-59-improving-cultural-competence. Other suggested SAMHSA-supported resources include the African American Behavioral Health Center of Excellence (https://africanamericanbehavioralhealth.org/), LGBTQ+ Behavioral Health Equity Center of Excellence (https://www.samhsa.gov/resource/tta/lgb-center-excellence), Engage, Educate, Empower for Equity: E4 Center of Excellence for Behavioral Health Disparities in Aging, and Asian American (https://e4center.org/), and the Native Hawaiian, and Pacific Islander Behavioral Health Center of Excellence (https://www.samhsa.gov/resource/tta/asian-american-native-hawaiian-pacific-islander-aanhpi-ohana-center-excellence)

[14] https://minorityhealth.hhs.gov/

As outlined above, ADMH will require cultural competency training for CCBHC staff that occurs at least at point of hire and annually. The training will be aligned with SAMHSA CCBHC Certification and CLAS standards. ADMH will review specific required training topics in light of disparity data reporting and adjust requirements accordingly. Compliance with training requirements will be monitored through ADMH's Site Team through regular audits.

Linguistic Access to CCBHC Services

The CCBHC takes reasonable steps to provide meaningful access to services, such as language assistance, for those with Limited English Proficiency (LEP) and/or language-based disabilities.

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

Auxiliary aids and services are readily available, Americans with Disabilities Act (ADA) compliant, and responsive to the needs of people receiving services with physical, cognitive, and/or developmental disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines).

Documents or information vital to the ability of a person receiving services to access CCBHC services (e.g., registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available online and in paper format, in languages commonly spoken within the community served, taking account of literacy levels and the need for alternative formats. Such materials are provided in a timely manner at intake and throughout the time a person is served by the CCBHC. Prior to certification, the CCBHC's CNA will inform which languages require language assistance, to be updated as needed.

The CCBHC's policies must have explicit provisions for ensuring all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider. These include, but are not limited to, the requirements of the Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.

Scope of Services

ADMH requires that the full scope of SAMHSA-required CCBHC services be provided by each CCBHC provider in Alabama. These may be provided directly or through a Designated Collaborating Organization (DCO). However, the CCBHC must directly provide the majority (51% or more) of the service encounters.

Each CCBHC must have the capacity (either directly or via DCO agreement) to deliver the following nine required services:

1. Crisis Services
2. Screening, Assessment, and Diagnosis
3. Person-Centered, and Family Centered Treatment Planning
4. Outpatient Mental Health and Substance Use Disorder Services
5. Primary Care Screening and Monitoring

6. Targeted Case Management Services
7. Psychiatric Rehabilitation Services
8. Peer Supports and Family/Caregiver Supports
9. Community Care for Uniformed Service Members and Veterans

SAMHSA CCBHC Certification Criteria

Based on the SAMHSA CCBHC Certification Criteria, Alabama CCBHCs should meet the following requirements related to the Scope of Services.

CCBHC services, whether provided directly through the CCBHC, or through a DCO, are consistent with the freedom of the person receiving services to choose providers within the CCBHC and its DCOs. This requirement does not preclude the use of referrals outside the CCBHC or DCO if a needed specialty service is unavailable through the CCBHC or DCO entities.

People receiving services either by a CCBHC or DCO will be informed of and have access to the CCBHC's existing grievance procedures, which must satisfy the minimum requirements of Medicaid.

For people receiving CCBHC services from a DCO provider, services must meet the same quality standards as those provided by the CCBHC. The entities with which the CCBHC coordinates care and all DCOs, taken in conjunction with the CCBHC itself, satisfy the mandatory aspects of these criteria.

All services delivered to a person enrolled in the CCBHC should be based on the comprehensive assessment and documented in the treatment plan. Service delivery, modality (telehealth, face-to-face, etc.) and frequency should match the modality and frequency in the treatment plan.

The CCBHC directly, or through a DCO, provides person-centered and family-centered treatment planning, including but not limited to, risk assessment and crisis prevention/safety planning. CCBHCs may work collaboratively with DCOs to complete these activities.

These assessment, treatment planning, and service delivery activities are described in more detail below.

Services Delivered Via Telehealth

SAMHSA CCBHC Certification Criteria

Based on the SAMHSA CCBHC Certification Criteria, the requirements for Alabama CCBHCs include the following:

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

The CCBHC may utilize telehealth/telemedicine, video conferencing, patient monitoring, asynchronous interventions, and other technologies to alleviate shortages, provided that these services are coordinated with other services delivered by the CCBHC. The CCBHC is not precluded from utilizing providers working towards licensure if they are working under the requisite supervision.

For those presenting with emergency or urgent needs, the CCBHC may conduct the initial evaluation, by phone or through the use of technologies for telehealth/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.

For individuals and families who live within the CCBHC's service area but live a long distance from CCBHC clinic(s), the CCBHC should consider the use of technologies for telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies in alignment with the preferences of the person receiving services, and to the extent practical. These criteria do not require the CCBHC to provide continuous services, including telehealth, to individuals who live outside of the CCBHC service area.

CCBHCs may also consider developing protocols for populations that may transition frequently in and out of the services area, such as children who experience out-of-home placements and adults who are displaced by incarceration or housing instability.

Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time. Technologies also may be used to provide crisis care to individuals when remote travel distances make the 2-hour response time unachievable, but the ability to provide an in-person response must be available when it is necessary to assure safety.

When necessary and appropriate screening, assessment, and diagnosis can be provided through telehealth/telemedicine services.

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

Alabama CCBHC Telehealth Use Requirements

In addition to the above, Alabama CCBHCs should adhere to the following requirements:

- All CCBHC providers are responsible for ensuring that they are complying with all state regulations regarding telehealth including Medicaid provider guidance.
- All persons served via telehealth must have documentation that both in-person and telehealth services were offered to the individual, and that they prefer the selected service(s) to be provided via telehealth.
- Providers must document verification of the physical address of the person served and an accessible emergency contact at the beginning of each session to ensure the safety of the individual in the event of an emergency.
- Telehealth services must be provided through a platform that meets HIPAA compliance requirements.
- At each treatment plan update, the use of telehealth services should be reevaluated to determine whether this is the most effective modality for the person served. This should be documented in the file.

- Providers must ensure that they are delivering telehealth services in a location that maintains HIPAA and other confidentiality requirements.
- Providers must be approved, certified, and/or licensed to deliver the services they are providing in the state of Alabama.

Providers are expected to refer to Medicaid Policy Manual Chapter 112 for telehealth guidelines including included and excluded services. Providers are expected to always comply with both Medicaid and ADMH regulations, but if there are discrepancies between this Manual and Medicaid guidelines, the Medicaid guidelines should be followed. Please reach out to the ADMH CCBHC team at CCBHC.dmh@mh.alabama.gov with any questions.

Clinical Considerations for the Use of Telehealth

Staff will determine suitability for Telehealth sessions for each individual served by evaluating their needs and preferences prior to initiating ongoing Telehealth sessions. Telehealth may be utilized in an initial crisis situation if needed.

The practitioner and program staff will consider the following for the persons being served prior to employing Telehealth technology:

- Their awareness and familiarity with the process sufficient to provide informed consent
- Consideration related to symptoms that could worsen with Telehealth (psychosis, paranoid/delusions related to technology)
- Language or cultural preferences. Persons being served will have the option to request an interpreter at no charge (to the person). Persons being served will be made aware of the availability of an interpreter if staff assess this may be an appropriate service.
- Medical issues, as well as Clinical situations or symptomology (i.e., suicidal ideation, or any symptoms requiring an in-person evaluation due to severity of those symptoms, cognitive/sensory concerns).
- Access to secure and stable technology and internet to ensure continuity.
- Ability to safely engage, including the ability to implement a safety plan.
- Need or ability to respond to urgent/emergent situations.
- Ability to adequately assess risk.
- Risk for suicide or self-injurious behaviors.
- Return to substance use.
- Stability of housing.
- Whether the patient has adequate space to participate with minimal interruptions and privacy.
- Is there suspected or confirmed family violence, and/or other abuse.
- Use of emergency services/hospital admissions.
- Current symptoms or behaviors and whether they can reasonably be assessed via telehealth.
- Medications require an abnormal involuntary movement assessment.
- Symptoms or comorbidities that could preclude use of telehealth.

- Cognitive and developmental functioning including motor and communication.

CCBHCs will utilize a written agreement for Telehealth services retained in the health record of the person being served.

Required Core Services

1. Screening, Assessment and Diagnosis

SAMHSA CCBHC Certification Criteria

Based on the SAMHSA CCBHC Certification Criteria, Alabama CCBHCs will meet the following requirements related to Screening, Assessment, and Diagnosis.

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

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

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

If the screening identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the person receiving services is provided a full assessment and treatment, if appropriate within the level of care of the CCBHC or referred to a more appropriate level of care. If the screening identifies more immediate threats to the safety of the person receiving services, the CCBHC will take appropriate action based on the individual's safety plan, needs, and/or preferences.

Alabama CCBHCs will be required to complete Behavioral Health, Social Determinants of Health, and Primary Care Screenings for all persons served by the CCBHC. Within the Comprehensive Assessment process, the list of required screening tools include:

Required Screening Tools for AL CCBHCs for All Persons Served		
Tool	***Purpose***	***Age Range***
PHQ-9	Depression/Mental Health	12 years and older
Protocol for Responding to and Assessment Patient's Risks and Experiences (PRAPARE) (2016) (preferred) **or** another Standardized Health Related Social Needs (HRSN) Screening, such as: • Accountable Health Communities Health Related Social Needs	Social Determinants of Health	All persons served should receive a Social Determinants of Health screening. Children/youth may either complete the screening or have a parent/guardian complete the screening on behalf of the family. *Note*: If CCBHCs are using the PRAPARE tool as their standardized SDOH screening, this tool is intended for those 18

Screening Tool (2017) and (2021) • WellRx Questionnaire (2014) • American Academy of Family Physicians (AAFP) Screening Tool (2018)		years or older (including parents/guardians). For youth CCBHC clients whose parents/guardians are not available/able to complete the SDOH screening, CCBHCs may adapt their SDOH screening processes (i.e., use a different tool, such as the CANS), provided the screening includes an assessment of their household's food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.
Columbia Suicide Severity Rating Scale (C-SSRS)	Suicidality	6 years and older
Required Screening Tools for AL CCBHCs for Adults Only		
Tool	***Purpose***	***Age Range***
UNCOPE	Substance Use	19 years and older
AUDIT-C	Alcohol Use	18 years and older
Required Screening Tools for AL CCBHCs for Adults Only		
Tool	***Purpose***	***Age Range***
CRAFFT	Substance Use	12-18 years

In the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment, or diagnosis (e.g., neuropsychological testing or developmental testing and assessment), the CCBHC refers the person to an appropriate provider.

Scope of Screening, Assessment and Diagnosis

The initial evaluation (including information gathered as part of the preliminary triage and risk assessment, with information releases obtained as needed), includes at a minimum the following components:

- Preliminary diagnoses.
- The source of referral.
- The reason for seeking care, as stated by the person receiving services or other individuals who are significantly involved.
- Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services.
- A list of all current prescriptions and over-the counter medications, herbal remedies, and dietary supplements and the indication for any medications.
- A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful.

- The use of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications.
- An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors.
- An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence.
- Assessment of need for medical care (with referral and follow-up as required) .
- A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services.
- For children and youth, whether they have system involvement (such as child welfare and juvenile justice).

All new people receiving services will receive a comprehensive evaluation that is completed within 60 calendar days of their first request for services. This requirement does not preclude the initiation or completion of the comprehensive evaluation, or the provision of treatment during the 60-day period. If the individual is receiving independent screening and assessment services as part of their participation in another specialty program/initiative, the CCBHC should establish partnerships to incorporate findings and avoid duplication of effort.

Note that for people already receiving services at the time of CCBHC certification, CCBHCs will have 90 days from the date of CCBHC certification to gather and document updated assessment information from each individual (to ensure all of the required initial and comprehensive evaluation information is collected in alignment with the CCBHC criteria) and engage the individual to update their treatment plan to include all CCBHC services that are appropriate based on their needs and preferences. For more information, see the CCBHC Participant Enrollment section below.

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

The comprehensive evaluation should include the following components at a minimum:
- Reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the presentation to the CCBHC of the person receiving services.
- An overview of relevant social supports; social determinants of health and health related social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status.
- A description of cultural and environmental factors that may affect the treatment plan of the person receiving services, including the need for linguistic services or supports for people with LEP.
- Pregnancy and/or parenting status.
- Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments.
- Relevant medical history and major health conditions that impact current psychological status.

- A medication list including prescriptions, over-the counter medications, herbal remedies, dietary supplements, and other treatments or medications of the person receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies.
- An exam that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement-based care) and substance use disorders (including tobacco, alcohol, and other drugs).
- Basic cognitive screening for cognitive impairment.
- Assessment of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person.
- The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services.
- Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services).
- Assessment of any relevant social service needs of the person receiving services, with necessary referrals made to social services. For children and youth receiving services, assessment of systems involvement such as child welfare and juvenile justice and referral to child welfare agencies as appropriate.
- An assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the primary care provider (with appropriate referral and follow-up) of the person receiving services.
- The preferences of the person receiving services regarding the use of technologies such as telehealth/telemedicine, video conferencing, digital therapeutics, remote patient monitoring, and asynchronous interventions.

Screening, assessment and diagnosis shall be comprehensive of both mental health and substance use needs

<u>Alabama CCBHC Screening, Assessment, and Diagnosis Requirements:</u> [15]
In addition to the above requirements, Alabama CCBHCs should assure their ability to meet the following requirements:

- Screening- The provider shall have and implement written policies and procedures for a process to briefly screen individuals prior to initiation of a behavioral health assessment or diagnostic interview examination. At a minimum, these procedures shall:
    - Describe the screening process.
    - Specify the instrument(s) or process utilized to conduct the screening process. Substance Use Disorder providers shall use the ADMH approved screening instrument(s). Mental Health providers shall use an ADMH approved screening instrument(s) when applicable.
    - Describe the procedures followed when the screening process:
        - Identifies risk factors for mental health, substance use or co-occurring disorder(s).

[15] Alabama Administrative Code Rule 580-2-20-.09

        - Does not identify risk factors for a mental health, substance use or cooccurring disorder(s).
        - Identifies the need for crisis intervention.
        - Identifies special supports for recipients who have mobility challenges, hearing or vision loss, and/or Limited English proficiency.
    - Specify the procedures for documenting the screening process and that the results of the screening were explained to the recipient and recipient's lawful representative as appropriate.
- Intake/Assessment- The provider shall have and implement written policies and procedures for a process to engage an individual in an intake/assessment appropriate for admission to an ADMH certified level of care/service. For CCBHCs, intake/assessment shall be a clinical interview with recipient, and may include family members, lawful representative, significant other, as appropriate.

2. Person-Centered and Family Centered Treatment Planning

SAMHSA CCBHC Certification Criteria

Based on the SAMHSA CCBHC Certification criteria, Alabama CCBHCs will adhere to the following requirements for Person- and Family-Centered Treatment Planning.

The CCBHC directly, or through a DCO provides person-centered and family-centered treatment planning, including but not limited to, risk assessment and crisis-planning. CCBHCs may work collaboratively with DCOs to complete these activities. Person-centered and family-centered treatment planning satisfies the requirements below and is aligned with the requirements of Section 2402 of the Affordable Care Act, including person receiving services involvement and self-direction.

The CCBHC develops an individualized treatment plan based on information obtained through the comprehensive evaluation and the person receiving services' goals and preferences. The plan shall address the person's prevention, medical, and behavioral health needs. The plan shall be developed in collaboration with and be endorsed by the person receiving services; their family (to the extent the person receiving services so wishes); and family/caregivers of youth and children or legal guardians. Treatment plan development shall be coordinated with staff or programs necessary to carry out the plan. The plan shall support care in the least restrictive setting possible. Shared decision making is the preferred model for the establishment of treatment planning goals. All necessary releases of information shall be obtained and included in the health record as a part of the development of the initial treatment plan.

The CCBHC uses the initial evaluation, comprehensive evaluation, and ongoing screening and assessment of the person receiving services to inform the treatment plan and services provided.

The CCBHC treatment plan must include needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the words or ideas of the person receiving services and, when appropriate, those of the family/caregiver of the person receiving services.

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

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

The CCBHC must document any advance directives related to treatment and crisis prevention/safety planning in the record. At minimum, each person served should be engaged to develop a crisis prevention/safety plan. If the person receiving services does not wish to share their preferences, that decision is documented.

Alabama CCBHC Person-Centered and Family-Centered Treatment Planning Requirements

In addition to the above, Alabama CCBHCs will meet the following requirements:

- The person-centered and family-centered treatment plan will be completed by the fifth face to face service in the CCBHC.
- A person receiving services from a CCBHC must be an active part of the treatment planning process.
- All members of the interdisciplinary team should participate in the treatment planning process. This includes treatment team members from DCOs and other partnering agencies. The approving staff member should sign the treatment plan.
- Where clinically appropriate, the family and other supports of the person receiving services should be invited to participate in the treatment planning process.
- The treatment plan must be completed based on the information and diagnosis obtained through the comprehensive evaluation process. The treatment plan should include the following elements:
    - A crisis prevention/safety plan, focusing on crisis prevention and the person's preferred interventions in the event of a crisis.
    - Advanced directives where the person desires
    - Integration of behavioral health, physical health, and intellectual/developmental disability needs
    - Goals that are expressed in the words of the individual being served.
    - Interventions to address required needs and the modality and frequency of those interventions.

3. Outpatient Mental Health and Substance Use Services

Alabama CCBHCs are responsible for providing outpatient mental health and substance use services in accordance with the SAMHSA CCBHC Certification Criteria, either directly or via a DCO partnership. A primary component of CCBHC programming in Alabama includes outpatient mental health and substance use disorder treatment. When a person has cooccurring mental health and substance use treatment needs, providers should ensure that treatment is integrated and minimizes duplication of effort.

SAMHSA CCBHC Certification Criteria

Based on the SAMHSA CCBHC Certification Criteria, CCBHCs in Alabama must meet the following requirements related to Outpatient Mental Health and Substance Use Services.

The CCBHC directly, or through a DCO, provides outpatient behavioral health care, including psychopharmacological treatment. SUD treatment and services shall be provided as described in the American Society for Addiction Medicine (Third Edition) Levels 1 and 2.1 and include treatment of tobacco use disorders.

The CCBHC 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. See below for the Evidence Based Practices required for Alabama CCBHCs.

The CCBHC can deliver services via telehealth as long as the provisions of the telehealth section are met and the same criteria for evidence-based practices and ASAM Levels of Care are applied.

In the event that specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of outpatient mental health and substance use disorder treatment, the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine, in alignment with state and federal laws and regulations. Where specialist providers are not available to provide direct care to a particular 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.

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

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.

CCBHCs will establish care coordination agreements in alignment with the SAMHSA CCBHC criteria and the Care Coordination Section of this Manual.

Each CCBHC provides treatments that are appropriate for the phase of life and development of the person receiving services, specifically considering what is appropriate for distinct groups for whom life stage and functioning may affect treatment:

- Children
- Adolescents
- Transition-age youth
- Older adults

When treating children and adolescents, CCBHCs must provide evidenced-based services that are developmentally appropriate, youth-guided, and family/caregiver-driven. Supports for children and adolescents must comprehensively address family/caregiver, school, medical, mental health, substance use, psychosocial, and environmental issues.

When treating older adults, the desires and functioning of the person receiving services are considered, and appropriate evidence-based treatments are provided.

When treating individuals with co-occurring developmental or other cognitive disabilities, level of functioning is considered, and appropriate evidence-based treatments are provided.

All treatments are delivered by staff with specific training in treating the segment of the population being served. CCBHCs are encouraged to use evidence-based strategies such as measurement-based care (MBC) to improve service outcomes.

Alabama CCBHC Outpatient Mental Health and Substance Use Services Requirements
In addition to the above requirements, Alabama CCBHCs must meet the following requirements.

Individual Therapy/Counseling for mental health shall include at a minimum:[16]

- Face-to-face interaction where interventions are tailored toward achieving specific measurable goals and/or objectives of the recipient's treatment plan.
- On-going assessment of the recipient's preexisting condition and progress being made in treatment.
- Symptom management education and education about mental illness and medication effects.
- Psychological support, problem solving, and assistance in adapting to illness.
- Family Therapy for mental health shall include at a minimum:
    - Face-to-face interaction with the recipient, family, and/or significant others where interventions are tailored toward achieving specific measurable goals and/or objectives of the recipient's treatment plan.
    - On-going assessment of the recipient's presenting condition and progress being made in treatment.

Group Counseling for mental health shall include at a minimum:

- Face to face interaction with a group of recipients (not to exceed sixteen (16) for adults and ten (10) for children and adolescents) where interventions utilize the interactions of recipients and group dynamics to achieve specific goals and/or objectives of the recipient's treatment plan.
- On-going assessment of the recipient's presenting condition and progress being made in treatment.

The following is applicable to ASAM Level of Care 1 Outpatient Services for people with substance use disorders:[17]

- Core Services. Each Level I Outpatient Program shall demonstrate the capacity to provide a basic level of skilled treatment services appropriate to the needs of its clientele.
    - At a minimum, the entity shall directly or by referral provide the following core services:
        - Behavioral Health Screening.
        - Individual counseling.
        - Group counseling.
        - Family counseling.
        - Psychoeducation.
        - Mental health consultation.

[16] *Alabama Administrative Code 580-2-20-10*
[17] *Alabama Administrative Code 580-9-44-.15*

        - Recovery support services.
        - Peer counseling services.
        - Medication management.
        - Alcohol and/or drug screening/testing.
        - Smoking cessation.
        - Sign language interpreter services.
        - HIV early intervention services.
        - Case management:
            - Case planning.
            - Linkage.
            - Advocacy.
            - Monitoring.
    - Adolescent Program Specific Criteria: Each Level I Adolescent Outpatient Program shall document the capacity to provide each of the core services and to include:
        - Activity therapy
    - Co-occurring Disorders Program Specific Criteria: Each Level I Co-occurring Disorders Outpatient Program shall document the capacity to provide each of the core services to include basic living skills, crisis intervention services, and intensive case management.
    - Women and Dependent Children Program Specific Criteria: Each Level I Women and Dependent Children Outpatient Program shall document the capacity to provide each of the core services and/or arrange for the following services:
        - Transportation
        - Child sitting services
        - Developmental delay and prevention services
        - Activity therapy
        - Parenting skills development
- Therapeutic Component Implementation. The entity shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency and intensity appropriate to the client's assessed needs and expressed desires for care.
- Service strategies for each Level I Outpatient Program shall include, at a minimum:
    - Implementation of individualized counseling plan strategies.
    - Ongoing individualized assessment services.
    - Motivational enhancement and engagement strategies.
    - Relapse prevention strategies.
    - Interpersonal choice/decision-making skill development.
    - Health education.
    - Random drug screening
    - Family education.
    - Gender responsive treatment.
- Adolescent Program Specific Criteria: Each Level I Adolescent Outpatient Program shall document the capacity to provide the service strategies and the following therapeutic components:
    - Adolescent specific evidence based therapeutic interventions.
    - Client education on key adolescent development issues, including but not limited to, adolescent brain development and the impact of substance use, emotional and social

influence on behavior, value system development, puberty/physical development, sexuality and self-esteem.
    - Recreation and leisure time skills training.
    - Family, community and school reintegration services.
- Co-occurring Disorders Program Specific Criteria: Each Level I Co-occurring Disorders Outpatient Program shall document the capacity to provide the service strategies and the following therapeutic components:
    - Groups and classes that address the signs and symptoms of mental health and substance use disorders.
    - Groups, classes, and training to assist clients in becoming aware of cues or triggers that enhance the likelihood of alcohol and drug use or psychiatric decompensation and to aid in development of alternative coping responses to those cues.
    - Dual recovery groups that provide a forum for discussion of the interactions of and interrelations between substance use and mental health disorders.
- Women and Dependent Children Program Specific Criteria: Each Level I Women and Dependent Children Outpatient Program shall document the capacity to provide the service strategies and the following therapeutic components:
    - Specific services which address issues of relationships, parenting, abuse, and trauma.
    - Primary medical care, including prenatal care.
    - Primary pediatric care for children.
    - Therapeutic interventions for children which address their developmental needs and issues of sexual abuse and neglect.
    - Outreach to inform pregnant women of the services and priorities.
    - Interim services while awaiting admission to this level of care.
    - Recreation and leisure time skills training.
- Service Intensity. The entity shall document that the amount and frequency of Level I Outpatient services are established on the basis of the unique needs of each client served, not to exceed eight (8) contact hours weekly.

4. Outpatient Clinic Primary Care Screening and Monitoring

SAMHSA CCBHC Certification Criteria

Based on the SAMHSA CCBHC Certification Criteria, each CCBHC is responsible for providing outpatient primary care screening and monitoring of key health indicators and health risk. *Prevention is a key component of primary care screening and monitoring services provided by the CCBHC.*

Each CCBHC's Medical Director (or designee if using a DCO) will establish written protocols that conform to screening recommendations with scores of A and B, of the United States Preventive Services Task Force Recommendations.

Each CCBHC's written protocols for primary care screening and monitoring will include:

- Processes for identifying people receiving services who are living with chronic diseases, including but not limited to HIV and viral hepatitis;

- Ensuring that people receiving services are asked about physical health symptoms; and
- Establishing systems for collection and analysis of laboratory samples, as further outlined below.

Whether directly provided by the CCBHC or through a DCO, the CCBHC is responsible for ensuring these services are received in a timely fashion, preferably during the initial assessment, which is a whole-person assessment. Screenings should be performed routinely for some elements and when medically necessary for others, based on the guidance of the CCBHC's Medical Director or designee and in alignment with scores of A and B of the United States Preventive Services Task Force Recommendations.[18, 19]

The CCBHC must also coordinate with each individual's primary care provider to ensure that screenings occur for the identified conditions. If the person receiving services' primary care provider conducts the necessary screening and monitoring, the CCBHC is not required to do so if it has a documented record of the screening and monitoring and the results of any tests that address the health conditions included in the CCBHCs screening and monitoring protocols developed under this Manual and Criteria 4.g of the CCBHC criteria. Attempts to obtain all documentation should be documented in the record of the person receiving services.

The CCBHC should have the ability to collect biologic samples directly, either through a DCO or through protocols with an independent clinical lab organization. Required labs conducted as part of primary care screening and monitoring should be informed by each agency's Medical Director. They must include:

- Hemoglobin A1c Control for Patients with Diabetes (State Collected Measure)

Although this is a State Collected Measure, Criteria 5.a.3 states "To the extent CCBHCs participating in the Section 223 Demonstration program are responsible for the provision of data, the data will be provided to the state and as may be required, to HHS and the evaluator. Please refer to the Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual, February 2024, pages 168-175 for additional information.

The CCBHC will provide ongoing primary care monitoring of health conditions as identified in the screening protocols above, and as clinically indicated for the individual. Monitoring includes:

- Ensuring individuals have access to primary care services and a designated Primary Care Provider. CCBHCs should coordinate care with primary care and specialty health providers, including tracking attendance at needed physical health care appointments.
- Ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the individual's status of chronic health conditions.
- Promoting a healthy behavior lifestyle.

Documentation of all screening and monitoring must be present in the primary chart housed by the CCBHC.

[18] https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf
[19] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-brecommendations.

5. Targeted Case Management Services

SAMHSA CCBHC Certification Criteria

Based on the SAMHSA CCBHC Certification Criteria, each CCBHC must adhere to the following requirements related to Targeted Case Management.

CCBHC targeted case management (TCM) 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 targeted case management should include supports for people deemed at high risk of suicide or overdose, particularly during times of transitions such as discharge from:

- Residential treatment
- Hospital emergency department
- Psychiatric hospitalization

CCBHC targeted case management should also be used during other critical periods, such as:

- Episodes of homelessness
- Transitions to the community from jails or prisons

CCBHC targeted 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.

The CCBHC is responsible for providing directly, or through a DCO, targeted case management services that will assist people receiving services in sustaining recovery and gaining access to the following needed supports:

- Medical
- Social
- Legal
- Educational
- Housing
- Vocational
- Other services and supports as needed and/or as defined by the state

Alabama CCBHC Targeted Case Management Requirements

In addition to the above requirements, Alabama CCBHCs must adhere to Chapter 106 guidelines when implementing TCM services. In addition to the Chapter 106 Target Populations, CCBHCs are free to determine whether TCM services may be appropriate for those deemed high risk (i.e., complex or serious MH or SU conditions, homeless, at risk for suicide or overdose, etc.). In Alabama, CCBHCs should consider the following individuals as being able to possibly benefit from TCM services:

- Persons transitioning from carceral settings.
- Persons transitioning from residential treatment.
- Persons transitioning from inpatient treatment.

- Persons transitioning from a hospital emergency department.
- Persons screening high on social determinants of health screening.
- Persons who have a short-term need for support in a critical period, such as an acute episode or care transition.
- Persons experiencing episodes of homelessness.

CCBHCs should also consider the specific needs of other priority populations of focus when assessing the need for TCM, including but not limited to Persons with Opioid Use Disorder (OUD) with emphasis on communities showing a high risk of fatal overdose (e.g., the African American population) and Pregnant and Parenting Women (PPW).

6. Psychiatric Rehabilitation Services

Psychiatric Rehabilitation Services (PRS) promote recovery for anyone with a mental health or substance use issue that has hindered them from completing tasks to achieve their self-defined goals.

SAMHSA CCBHC Certification Criteria
Based on the SAMHSA CCBHC Certification Criteria, Alabama CCBHCs will adhere to the following requirements related to Psychiatric Rehabilitation Services.

The CCBHC is responsible for providing directly, or through a DCO, evidence-based rehabilitation services for both mental health and substance use disorders.

Rehabilitative services include services and recovery supports that help individuals develop skills and functioning to:
- Facilitate community living
- Support positive social, emotional, and educational development
- Facilitate inclusion and integration
- Support pursuit of their goals in the community.

These skills are important to addressing social determinants of health and navigating the complexity of:
- Finding housing or employment
- Filling out paperwork
- Securing identification documents
- Developing social networks
- Negotiating with property owners or property managers
- Paying bills
- Interacting with neighbors or co-workers

Psychiatric rehabilitation services must include supported employment programs designed to provide those receiving services with ongoing support to obtain and maintain competitive, integrated employment. Examples include:
- Evidence-based supported employment
- Customized employment programs

- Employment supports run in coordination with Vocational Rehabilitation or Career OneStop services

Psychiatric rehabilitation services must also support people receiving services to:
- Participate in supported education and other educational services
- Achieve social inclusion and community connectedness
- Participate in medication education, self-management, and/or individual and family/caregiver psychoeducation
- Find and maintain safe and stable housing

Other psychiatric rehabilitation services that might be considered include:
- Training in personal care skills
- Community integration services
- Cognitive remediation
- Facilitated engagement in substance use disorder mutual help groups and community supports
- Assistance for navigating healthcare systems

Other recovery support services that could be part of a CCBHC's psychiatric rehabilitation services include:
- Illness Management & Recovery
- Financial management
- Dietary and wellness education

These services may be provided or enhanced by peer practitioners.

Coordination of services and inclusion of psychiatric rehabilitation in treatment planning is also required.

Alabama CCBHC Psychiatric Rehabilitation Requirements

In addition to the above, Alabama CCBHCs are required to provide the following services:
- Individualized Placement Support -Supported Employment Program
- Connection to Supportive Housing Program

7. Peer Supports, Peer Counseling, and Family Caregiver Supports

ADMH is committed to incorporating certified peers within services across the state. Certified peers offer valuable lived experience in recovery that can help to inform CCBHC participant's treatment and recovery journey.

SAMHSA CCBHC Certification Criteria
Based on the SAMHSA CCBHC Certification Criteria, Alabama CCBHCs will meet the following requirements related to the provision of peer supports, peer counseling, and family caregiver support services.

The CCBHC is responsible for directly providing, or through a DCO, peer supports, including:

- Peer specialist and recovery coaches
- Peer counseling
- Family/caregiver supports

Peer services may include:
- Peer-run wellness and recovery centers
- Youth/young adult peer support
- Recovery coaching
- Peer-run crisis respites
- Warmlines
- Peer-led crisis prevention/safety planning
- Peer navigators to assist individuals transitioning between different treatment programs and especially between different levels of care
- Mutual support and self-help groups
- Peer support for older adults
- Peer education and leadership development
- Peer recovery services

Potential family/caregiver support services that CCBHCs might consider include:
- Community resources education
- Navigation support
- Behavioral health and crisis support
- Parent/caregiver training and education
- Family-to-family caregiver support

Coordination of services and inclusion of psychiatric rehabilitation in treatment planning is also required.

<u>Alabama CCBHC Peer Supports, Peer Counseling, and Family Caregiver Supports Requirements:</u>
In addition to the above, for Alabama CCBHCs, Peer Services are defined as:

- The provision of scheduled interventions by a certified peer counselor, who is in recovery from a substance use or co-occurring substance use and mental illness disorder, to assist a client in the acquisition and exercise of skills needed to support recovery.
- Services may include activities that assist clients in:
    - Accessing and/or engaging in treatment and in symptom management
    - Promote socialization, recovery, and self-advocacy
    - Provide guidance in the development of natural community supports and basic daily living skills

Peer Support Services provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, by Certified Peer Specialists (Adult, Youth, Family Peer Specialists, Recovery Support Specialist).

Peer Support services actively engage and empower an individual and his/her identified supports in leading and directing the design of the service plan and thereby ensures that the plan reflects the needs and preferences of the individual (and family when appropriate) with the goal of active participation in this process. Additionally, this service provides support and coaching interventions to individuals (and family when appropriate) to promote recovery, resiliency, and healthy lifestyles and to reduce identifiable behavioral health and physical health risks and increase healthy behaviors intended to prevent the onset of disease or lessen the impact of existing chronic health conditions.

Peer supports provide effective techniques that focus on the individual's self-management and decision making about healthy choices, which ultimately extend the members' lifespan. Family peer specialists assist children, youth, and families to participate in the wraparound planning process, access services, and navigate complicated adult/child-serving agencies.

A peer support specialist must meet the following minimum qualifications:

- Certified Mental Health Peer Specialists (DMH-MI) – Youth, Adult, Parent and Certified Recovery Support Specialists (DMH-SA) who successfully complete an approved AMA Peer training program authorized by the appropriate state agency department within six (6) months of date of hire.

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

SAMHSA CCBHC Certification Criteria

Based on the SAMHSA CCBHC Certification Criteria, all Alabama CCBHCs must meet the following requirements related to providing services to members of the armed forces and veterans.

All individuals inquiring about services are asked whether they have ever served in the U.S. military.

Persons affirming current military service will be offered assistance in the following manner:

- Active-Duty Service Members (ADSM) must use their servicing Military Treatment Facility (MTF), and their MTF Primary Care Managers (PCMs) are contacted by the CCBHC regarding referrals outside the MTF.
- ADSMs and activated Reserve Component (Guard/Reserve) members who reside more than 50 miles (or one hour's drive time) from a military hospital or military clinic enroll in TRICARE PRIME Remote and use the network PCM or select any other authorized TRICARE provider as the PCM. The PCM refers the member to specialists for care he or she cannot provide and works with the regional managed care support contractor for referrals/authorizations.
- Members of the Selected Reserves, not on Active Duty (AD) orders, are eligible for TRICARE Reserve Select and can schedule an appointment with any TRICARE authorized provider, network or non-network.

Persons affirming former military service (veterans) are offered assistance to enroll in VHA for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA. These include clinical guidelines contained in the Uniform Mental Health Services Handbook as excerpted below (from VHA Handbook 1160.01, Principles of Care found in the Uniform Mental Health Services in VA Centers and Clinics[20]).

The CCBHC ensures there is integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both, and for integration or coordination between care for behavioral health conditions and other components of health care for all veterans.

Every veteran seen for behavioral health services is assigned a Principal Behavioral Health Practitioner. When veterans are seeing more than one behavioral health practitioner and when they are involved in more than one program, the identity of the Principal Behavioral Health Practitioner is made clear to the veteran and identified in the health record. The Principal Behavioral Health Practitioner is identified on a tracking database for those veterans who need case management. The Principal Behavioral Health Practitioner ensures the following requirements are fulfilled:

- Regular contact is maintained with the veteran as clinically indicated if ongoing care is required.
- A psychiatrist or such other independent prescriber as satisfies the current requirements of the VHA Uniform Mental Health Services Handbook reviews and reconciles each veteran's psychiatric medications on a regular basis.
- Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision maker's consent when the veteran does not have adequate decision-making capacity).
- Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained.
- The treatment plan is revised, when necessary.
- The principal therapist or Principal Behavioral Health Practitioner communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision-making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2).
- The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the Principal Behavioral Health Practitioner suspects the veteran lacks the capacity to make a decision about the mental health treatment plan, the practitioner must ensure the veteran's decision-making capacity is formally assessed and documented. For veterans who are determined to lack capacity, the practitioner must identify the authorized surrogate and document the surrogate's verbal consent to the treatment plan.

[20] https://www.va.gov/vhapublications/publications.cfm?pub=1

Behavioral health services are recovery oriented. The VHA adopted the National Consensus Statement on Mental Health Recovery in its Uniform Mental Health Services Handbook. SAMHSA has since developed a working definition and set of principles for recovery updating the Consensus Statement. Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The following are the 10 guiding principles of recovery:

- Hope
- Person-driven
- Many pathways
- Holistic
- Peer support
- Relational
- Culture
- Addresses trauma
- Strengths/responsibility
- Respect

As implemented in VHA recovery, the recovery principles also include the following:

- Privacy
- Security
- Honor

Care for veterans provided at the CCBHC must conform to that definition and to those principles in order to satisfy the statutory requirement that care for veterans adheres to guidelines promulgated by the VHA.

All behavioral health care is provided to veterans with cultural humility:

- Any staff who is not a veteran has training about military and veterans' culture in order to be able to understand the unique experiences and contributions of those who have served their country.
- All staff receive cultural competency training.

There is a behavioral health treatment plan for all veterans receiving behavioral health services. The treatment plan will include the following:

- The veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis.
- Approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself.
- Interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness (as appropriate to each individual).

The plan should be recovery-oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments.

The treatment plan is developed with input from the veteran and, when the veteran consents, appropriate family members. The veteran's verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1.[21]

Alabama CCBHC Intensive Community-Based Mental Health Care for Members of the Armed Forces and Veterans Requirements:

In addition to the requirements outlined above, ADMH will guide and monitor compliance with SAMHSA's regulations through ongoing site visits and audits that will ensure that CCBHCs are adhering to the state and federal guidelines regarding veteran care.

ADMH will ensure that people with lived experience as veterans help to guide CCBHC implementation and operations through requiring representation of veterans in:

- CCBHC Implementation and Oversight Subcommittee
- Community Needs Assessment participation

9. Crisis Services

SAMHSA CCBHC Certification Criteria

Based on the SAMHSA CCBHC Criteria, Alabama CCBHCs will meet the following requirements for 24/7 crisis 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. The CCBHC provides crisis management services that are available and accessible 24 hours a day, seven days a week.

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.

Individuals who are served by the CCBHC are educated about crisis prevention/safety planning, psychiatric advanced directives, and how to access crisis services, including the 988 Suicide & Crisis Lifeline (by call, chat, or text) and other area hotlines and warmlines, and overdose prevention, if risk is indicated, at the time of the initial evaluation meeting following the preliminary triage. This includes individuals with LEP or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels).

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 as well as any service capacity registries as appropriate. Quality coordination means that protocols have been established to track referrals made

[21] https://www.ethics.va.gov/docs/policy/VHA_Handbook_1004_01_Clinical_IC.pdf

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.

24-hour Mobile Crisis Teams

The CCBHC provides community-based behavioral health crisis intervention services using a 2-person mobile crisis team (one team member must be qualified to conduct a comprehensive assessment) twenty-four hours per day, seven days per week, 365 days a year to adults, children, youth, and families anywhere within the service area including at home, work, or anywhere else where the crisis is experienced.

Mobile crisis teams are expected to arrive in-person within one hour (2 hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed 3 hours.

Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health practitioners during the interim travel time. Technologies also may be used to provide crisis care to individuals when remote travel distances make the 2-hour response time unachievable, but the ability to provide an in-person response must be available when it is necessary to assure safety.

Crisis receiving/stabilization

The CCBHC provides crisis receiving/stabilization services that must include at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals. Services should be available, regardless of whether individuals present on their own, with a concerned individual, such as a family member, or with a human service worker, and/or law enforcement, in accordance with state and local laws. The CCBHC is encouraged to provide crisis receiving/stabilization services in accordance with the *SAMHSA National Guidelines for Behavioral Health Crisis Care*.

Urgent care/walk-in services identify the individual's immediate needs, deescalate the crisis, and connect them 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 acuity; however, the facility need not manage the highest acuity individuals in this ambulatory setting.

Virtual on call crisis stabilization services (via a 24/7 hotline) should ideally be available 24 hours per day, 7 days a week.

In addition to these activities, the CCBHC may consider supporting or coordinating with peer-run crisis respite programs.

Other Crisis Service Requirements

As part of its crisis services, CCBHCs must offer:

- Suicide prevention and intervention services
- Services capable of addressing crises related to substance use including the risk of drug and alcohol related overdose and support following a nonfatal overdose after the individual is medically stable.

- Overdose prevention activities, including ensuring access to naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to their family members.

The CCBHC or its DCO crisis care provider should offer developmentally appropriate responses, sensitive de-escalation supports, and connections to ongoing care, when needed.

The CCBHC will have an established protocol specifying the role of law enforcement during the provision of crisis services:

- Protocols, including those for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a behavioral health crisis. Shared protocols are designed to maximize the delivery of recovery-oriented treatment and services.
- The protocols should minimize contact with law enforcement and the criminal justice system, while promoting individual and public safety, and complying with applicable state and local laws and regulations.

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

A description of the methods for providing a continuum of crisis prevention, response, and postvention services shall be included in the policies and procedures of the CCBHC and made available to the public.

The CCBHC maintains a working relationship with local hospital emergency departments (EDs). Protocols are established for CCBHC staff to address the needs of CCBHC people receiving services in psychiatric crisis who come to those EDs.

Following a psychiatric emergency or crisis, in conjunction with the person receiving services, the CCBHC creates, maintains, and follows a crisis prevention/safety plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises.

The CCBHC develops a crisis prevention/safety plan with each person receiving services. At minimum, people receiving services should be counseled about the use of the National Suicide & Crisis Lifeline, local hotlines, warmlines, mobile crisis, and stabilization services should a crisis arise when practitioners are not in their office.

Crisis prevention/safety plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving services. Psychiatric Advance Directives, if developed, are entered in the electronic health record of the person receiving services so that the information is available to providers in emergency care settings where those electronic health records are accessible.
If the person receiving services does not wish to share their preferences, that decision is documented.
Crisis prevention/safety planning may be peer-led, such as through a Wellness Recovery Action Plan (WRAP).

<u>Alabama CCBHC Crisis Service Requirements</u>

In addition to the above requirements, each Alabama CCBHC will be required to:

- Either directly provide or establish a care coordination agreement/process with the nearest 24/7 Crisis Stabilization Center, in order to assist individuals to engage in CCBHC services following their discharge (when appropriate based on their needs and preferences).
- Provide follow up and further de-escalation support as needed by the individual/family for 72 hours following a mobile crisis response.

Key service functions for CCBHC crisis services include the following:

- Specifying factors that led to the person receiving services crisis state, when known
- Identifying the maladaptive reactions exhibited by the person receiving services
- Evaluating the potential for rapid regression
- Resolving the crisis
- Referring the person receiving services for treatment at an alternative setting, when indicated

Required Evidence Based Practices

Based upon the findings of the CCBHC's CNA, the ADMH has established a minimum set of evidence-based practices required of the CCBHCs. This list is not intended to be all-inclusive. CCBHCs are encouraged to, based on their community needs assessment, determine whether other evidence-based treatments may be appropriate.

The following Evidence-Based Practices (EBPs) are required to be implemented by each CCBHC:

- Motivational Interviewing
- Assertive Community Treatment (ACT)*
- Cognitive Behavioral Therapy
- Integrated Treatment for Co-occurring Disorders (COD)
- Medications for Addiction Treatment (MAT)
- Trauma-Focused CBT
- Individualized Placement Support, Supported Employment, and linkage to Supportive Housing
- Peer and Family Support

*While Assertive Community Treatment (ACT) is a carved-out service that is not included in the AL CCBHC Scope, ADMH recognizes that ACT is a critical EBP for individuals living with SMI. Therefore, Alabama CCBHCs are expected to establish care coordination agreements and linkage processes with ACT teams in their catchment area, in order to promote opportunities to step-down to outpatient CCBHC services when an individual is ready to be discharged from ACT.

In addition to the required EBPs, CCBHCs may also utilize the following:

- Dialectical Behavior Therapy (DBT)
- Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)
- Seeking Safety
- Long-acting injectable medications to treat both mental and substance use disorders
- Multi-Systemic Therapy
- Cognitive Behavioral Therapy for psychosis (CBTp)
- High-Fidelity Wraparound

- Parent Management Training
- Effective but underutilized medications such as clozapine and FDA-approved medications for substance use disorders including smoking cessation

This list is not intended to be all-inclusive. ADMH has the discretion to determine whether other evidence-based treatments may be appropriate as a condition of certification.

CCBHCs are encouraged to use evidence-based strategies such as measurement-based care (MBC) to improve service outcomes. Measurement-based care (MBC) is the systematic use of patient-reported information to inform clinical care and shared decision making among clinicians and patients and to individualize ongoing treatment plans.

Required Additional Capacity

In addition, ADMH requires the following additional capacity to be implemented by each CCBHC:

- Connection to the AL Health Information Exchange, One Health platform, to exchange data with community partners like hospital systems and residential providers for care coordination.
- Connection to the state-sanctioned crisis system, including a care coordination agreement with the nearest 24/7 Crisis Stabilization Center (if the CCBHC itself is not certified to provide this service).
- Include an Outreach Worker in the CCBHC's staffing plan, who can conduct outreach and engagement activities in the community, with a focus on engaging historically underserved individuals/ communities based on the CCBHC's CNA. CCBHCs are encouraged to consider the needs of Alabama's priority sub-populations, including Pregnant and Parenting Women (PPW), people experiencing homelessness, and people with Opioid Use Disorder (OUD) with emphasis on communities showing a high risk of fatal overdose, including the African American population).

Role of the Medical Director

SAMHSA CCBHC Certification Criteria

Based on the CCBHC Certification Criteria, Alabama CCBHCs must include a Medical Director on their CCBHC Management Team. The Medical Director will provide guidance regarding behavioral health clinical service delivery, ensure the quality of the medical component of care, and provide guidance to foster the integration and coordination of behavioral health and primary care. The Medical Director does not need to be a full-time position.

If a CCBHC is unable, after reasonable efforts, to employ or contract with a psychiatrist as Medical Director, a medically trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law, may serve as the Medical Director. In addition, if a CCBHC is unable to hire a psychiatrist and hires another prescriber instead, psychiatric consultation will be obtained regarding behavioral health clinical service delivery, quality of the medical component of care, and integration and coordination of behavioral health and primary care.

If the Medical Director is not experienced with the treatment of substance use disorders, the CCBHC must have experienced addiction medicine physicians or specialist on staff, or arrangements that ensure access to consultation on addiction medicine for the Medical Director and clinical staff.

The Medical Director will also assist with establishing, enhancing, and maintaining the CCBHC's primary care screening and monitoring protocols that conform to screening recommendations with the scores of A and B, of the US Preventive Services Task Force.

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

Alabama CCBHC Requirements for the Role of the Medical Director

In addition to the above requirements, all Alabama CCBHCs must designate a Medical Director, listed as Key Staff with ADMH and on all CCBHC documents. If unable to designate a Medical Director as referenced above, the CCBHC must inform the ADMH immediately.

If the CCBHC is unable to locate a psychiatrist to serve in this role, they must document attempts to locate and document the behavioral health experience of the physician hired into the role of Medial Director. This information must be made available to ADMH at site visits or upon request.

The CCBHC Medical Director will establish primary care protocols in writing to be made available to ADMH at site visits or upon request.

The CCBHC Medical Director will establish organizational screening protocols for primary care screening and monitoring. The protocols must include how to identify CCBHC participants with chronic disease, and protocols to ask about physical health symptoms as part of the assessment process and establishing sample collection policies and procedures. Protocols will be made available to ADMH at site visits or upon request.

The CCBHC Medical Director will establish measures and monitor the ongoing quality improvement efforts related to medical care. The CCBHC Medical Director, or designee, will cochair the CQI committee. CQI policies and minutes will be made available to ADMH at site visits or upon request.

The CCBHC will maintain liability/malpractice insurance adequate for the staffing and scope of services provided.

Designated Collaborating Organizations (DCO)

SAMHSA CCBHC Certification Criteria

Based on the SAMHSA CCBHC Certification Criteria, Alabama CCBHCs must meet the following requirements related to establishing agreements with Designated Collaborating Organizations (DCOs).

A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC to deliver one or more (or elements of) of the required CCBHC services outlined above.

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. To this end, 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 package with other CCBHC services and not simply accessing services through another provider organization. To this end, the DCO agreement shall take active steps to reduce administrative burden on people receiving services and their family members when accessing DCOs services through measures such as coordinating intake process, coordinated treatment planning, information sharing, and direct communication between the CCBHC and DCO to prevent the person receiving services or their family from having to relay information between the CCBHC and DCO. CCBHCs and their DCOs are further directed to work towards inclusion of additional integrated care elements (e.g., including DCO providers on CCBHC treatment teams, collocating services). Regardless of the CCBHC's 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. The CCBHC is responsible for coordinating care and services provided by DCOs in accordance with the current treatment plan.

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.

CCBHCs must develop and implement a plan within two years from CCBHC certification or submission of attestation to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan must include information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care. To support integrated evaluation planning, treatment, and care coordination, the CCBHC must work with DCOs to integrate clinically relevant treatment records generated by the DCO for people receiving CCBHC services and incorporate them into the CCBHC health record. Further, 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.

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

DCO-provided services for people receiving CCBHC services must meet the same quality standards as those provided by the CCBHC. The entities with which the CCBHC coordinates care and all DCOs, taken in conjunction with the CCBHC itself, must satisfy the mandatory aspects of these criteria.

It is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship with DCOs. CCBHCs should ensure that consent is obtained and documented as appropriate, and that releases of information are obtained for each affected person.

Alabama CCBHC DCO Requirements

In addition to the above requirements, Alabama CCBHCs must meet the following requirements:

- For any of the 9 required core services not provided directly by the CCBHC, the CCBHC must identify a DCO.
- If the CCBHC must develop a contractual agreement with a DCO(s) to provide any of the required CCBHC core services, the CCBHC must develop policies and procedures to monitor the DCO(s) and ensure it is compliant with all CCBHC requirements for the contracted services provided. The DCO agreement must include, at a minimum:
    - Payment mechanisms
    - Quality of care
    - Reporting on required quality measures
    - Communication expectations and mechanisms
    - Mechanisms for participation in the interdisciplinary team, to include treatment planning and treatment team meetings
    - Mechanisms for the CCBHC to ensure adherence to all CCBHC criteria
    - Specific actions to reduce administrative burden on the person being served, creating a seamless service delivery system.
- All DCO(s) must be appropriately licensed or certified by ADMH to perform the activities and procedures detailed within the CCBHC approved scope of services.
- All DCO(s) clinical staff must be appropriately licensed or certified to perform the activities and procedures detailed within the CCBHC approved scope of services.
- DCO agreements must be made available to ADMH at site visits and/or upon request.
- The DCO and CCBHC must develop a mechanism for coordinating treatment including data sharing, participation as part of the interdisciplinary team, and treatment planning.
- CCBHCs who utilize DCOs must include the services delivered by the DCO in their cost report and develop a payment mechanism for services rendered.
- CCBHCs using a DCO, the CCBHC must submit to ADMH a plan to improve data sharing and coordination within 2 years of certification as a CCBHC. seamless service delivery system.

Care Coordination Activities

SAMHSA CCBHC Certification Criteria

CCBHCs must have established care coordination partnerships with all entities outlined in the SAMHSA CCBHC Criteria. These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with

the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover. This includes the following:

CCBHCs must have a partnership establishing care coordination expectations with Federally Qualified Health Centers (FQHCs) (and, as applicable, Rural Health Clinics (RHCs)) to provide health care services, to the extent the services are not provided directly through the CCBHC. For people receiving services who are served by other primary care providers, including but not limited to FQHC Look-Alikes and Community Health Centers, the CCBHC must establish protocols to ensure adequate care coordination.

CCBHCs must have partnerships that establish care coordination expectations with programs that can provide inpatient psychiatric treatment, OTP services, medical withdrawal management facilities and ambulatory medical withdrawal management providers for substance use disorders, and residential substance use disorder treatment programs (if any exist within the CCBHC service area). These include tribally operated mental health and substance use services including crisis services that are in the service area. CCBHCs must track when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity. CCBHCs must establish protocols and procedures for transitioning individuals from EDs, inpatient psychiatric programs, medically monitored withdrawal management services, and residential or inpatient facilities that serve children and youth such as Psychiatric Residential Treatment Facilities and other residential treatment facilities, to a safe community setting. This includes transfer of health records of services received (e.g., prescriptions), active follow-up after discharge, and, as appropriate, a plan for suicide prevention and safety, overdose prevention, and provision for peer services.

CCBHCs must develop partnerships with a variety of community or regional services, supports, and providers. Partnerships support joint planning for care and services, provide opportunities to identify individuals in need of services, enable the CCBHC to provide services in community settings, enable the CCBHC to provide support and consultation with a community partner, and support CCBHC outreach and engagement efforts. CCBHCs are required by statute to develop partnerships with the following organizations that operate within the service area:

- Schools
- Child welfare agencies
- Juvenile and criminal justice agencies and facilities (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
- Other social and human services

CCBHCs may develop partnerships with other entities based on the population served, the needs and preferences of people receiving services, and/or needs identified in the community needs assessment.

CCBHCs must develop a care coordination partnership with the 988 Suicide & Crisis Lifeline call center serving the area in which the CCBHC is located.

CCBHCs must develop partnerships with the nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department. To the extent multiple Department facilities of different types are located nearby, the CCBHC should work to establish care coordination agreements with facilities of each type.

CCBHCs must have care coordination partnerships establishing expectations with inpatient acute-care hospitals in the area served by the CCBHC and their associated services/facilities, including emergency departments, hospital outpatient clinics, urgent care centers, and residential crisis settings. This includes procedures and services, such as peer recovery specialist/coaches, to help individuals successfully transition from ED or hospital to CCBHC and community care to ensure continuity of services and to minimize the time between discharge and follow up. Ideally, the CCBHC should work with the discharging facility ahead of discharge to assure a seamless transition. These partnerships shall support tracking when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged. The partnerships shall also support the transfer of health records of services received (e.g., prescriptions) and active follow-up after discharge. CCBHCs should request of relevant inpatient and outpatient facilities, for people receiving CCBHC services, that notification be provided through the Admission-Discharge Transfer (ADT) system.

The CCBHC must make and document reasonable attempts to contact all people receiving CCBHC services who are discharged from these settings within 24 hours of discharge. For all people receiving CCBHC services being discharged from such facilities who are at risk for suicide or overdose, the care coordination agreement between these facilities and the CCBHC includes a requirement to coordinate consent and follow-up services with the person receiving services within 24 hours of discharge and continues until the individual is linked to services or assessed to be no longer at risk.

Alabama CCBHC Care Coordination Requirements:

In addition to the above requirements, Alabama CCBHCs must:

- Establish care coordination agreements with the following entities:
    - 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
    - Opioid Treatment Programs (OTPs)
    - Inpatient and residential MH and SUD services
    - Ambulatory and inpatient/residential withdrawal management services
    - Acute care inpatient settings
    - The nearest Veterans Affairs institutions
    - Other social and human services
- Use their CNA to identify care coordination partners needed in the community, for the services not provided by the CCBHC. With these entities, the CCBHC must attempt to develop formal, written care coordination agreements.

- Develop internal procedures to coordinate care with partners.
- Make care coordination agreements available to ADMH at monitoring visits and upon request.

The complexity of the care coordination agreement between the CCBHC and each partner agency will be contingent upon the service being coordinated. It may include:

- Services provided
- Service level agreements
- Mechanisms for reporting information to support care coordination activities for shared clients
- Communication mechanisms
- Closed-loop referral processes
- Mechanisms to facilitate smooth transitions
- Data sharing requirements, as applicable
- For acute inpatient and ED this should include mechanisms to transition people back to the CCBHC, tracking for receipt of services, and Alerts of admission, discharge and transfer (ADTs).

All care coordination agreements must be signed by agency leadership and reviewed a minimum of annually and updated as needed. Annual reviews should include a documented review of the effectiveness of the linkage/care coordination activities on behalf of clients served.

⚠ *CCBHCs must make every attempt to contact individuals being served by the CCBHC once they are discharged from an acute inpatient setting, ED or other levels of care. These attempts should be documented.*

Access and Availability of Services

SAMHSA CCBHC Certification Criteria

Based on the SAMHSA CCBHC Certification Criteria, Alabama CCBHCs must meet the following requirements related to access and availability of services.

The CCBHC's environment must be safe, functional, clean, sanitary, and welcoming for everyone. CCBHCs are encouraged to operate tobacco-free campuses.

Informed by the CNA, CCBHCs must:

- provide services during times that facilitate accessibility and meet the needs of the population served by the CCBHC, including some evening and weekend hours.
- provide services at locations that ensure accessibility and meet the needs of the population to be served, and, as appropriate and feasible, in the homes of people receiving services.

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

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

Informed by the CNA, CCBHCs must conduct outreach, engagement, and retention activities to support inclusion and access for underserved individuals and populations.

CCBHCs should have the capacity to offer both voluntary and court- ordered services. Both services are subject to all state standards for the provision of both.

CCBHCs must have a continuity of operations/disaster plan. The plan will include the ability to effectively notify staff, people receiving services, and healthcare and community partners when a disaster/emergency occurs or services are disrupted, alternative locations and methods to sustain service delivery and access to behavioral health medications, and health IT systems security/ransomware protection and backup and access to these IT systems, including health records, in case of disaster.

All people new to receiving services, whether requesting or being referred for behavioral health services at the CCBHC, will, at the time of first contact, whether that contact is in-person, by telephone, or using other remote communication, receive a preliminary triage and risk assessment to determine acuity of needs. That screening may occur telephonically. The preliminary triage and risk assessment will be followed by:

- an initial evaluation, and
- a comprehensive evaluation, with components specified above. All new people receiving services will receive a comprehensive evaluation to be completed within 60 calendar days of the first request for services. If the individual is engaged in screening and assessment processes being provided by an external entity, the CCBHC should establish partnerships to incorporate findings and avoid duplication of effort.

In addition to completing an eligibility determination, the initial face-to-face encounter with an individual seeking services should include the provision of a clinical intervention to address the individual's immediate identified need.

Emergency/crisis, Urgent, and Routine Needs Defined

An emergency/crisis need is indicated when an individual presents a likelihood of immediate harm to self or others. When this occurs, appropriate action (e.g., crisis services) is taken immediately. The initial evaluation may be conducted via phone or through the use of other technology, but in person is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved, the individual receiving services must be seen in person at the next subsequent encounter and the initial evaluation reviewed.

An urgent need is indicated when an individual presents a need for service that, if not addressed immediately, could result in the individual becoming a danger to self or others or could cause a health risk. The initial evaluation is required within one (1) business day of the time the request is made.

A routine service need is indicated when a person requests services or follow-up but otherwise presents no significant impairment in the ability to care for self and no apparent harm to self or others. The initial evaluation is required within ten (10) business days.

CCBHCs must track and report the number and percentage of individuals seeking services with emergency/crisis, urgent, and routine service needs.

CCBHCs must track and report the average time (# of days) from the date of first contact to the date when the individual is first seen face-to-face, an eligibility determination is completed, and initial services provided. CCBHCs must also track the average time (# of hours) from time of first crisis contact to in person mobile crisis response.

Same-Day/Next-Day Access Defined

A CCBHC is considered to be providing same-day/next-day access if any individual contacting the CCBHC in person or by phone during any day of the work week is given the opportunity to meet with qualified staff, who will complete an eligibility determination and provide initial services, on the same workday or the next workday, at the CCBHC site or via telehealth.

CCBHCs must track and report the number of persons receiving same/next day access services.

Application of Access Requirements for Alabama CCBHCs that Provide Same-Day/Next-Day Access

For a person with an emergency/crisis needs, "first contact" is defined as the date and time on which a person seeking services calls, or presents in person, whichever comes first. For a person with an urgent or routine needs, "first contact" is defined as the date on which a person presents in person at the CCBHC seeking services.

For CCBHCs providing same-day/next-day access, the required preliminary triage and risk assessment to determine acuity of needs shall occur on the date that a person first presents in person seeking services.

Application of Access Requirements to CCBHCs that Do Not Provide Same-Day/Next- Day Access

For CCBHCs that do not provide same day/next day access, "first contact" is defined as the date on which a person seeking services calls, or presents in person, whichever comes first.

When a call is received, if the call does not constitute an emergency/crisis call, the CCBHC must determine whether the call is an urgent or routine call.

For CCBHCs that do not provide same-day/next-day access, the required preliminary triage and risk assessment to determine acuity of needs shall occur on the date that a person seeking services calls, or presents in person, whichever comes first.

CCBHC Participant Enrollment

The following guidelines are based on the 2023 CCBHC Certification Requirements[22] and the CCBHC Compliance Checklist.[23]

The CCBHC ensures that no individuals are denied CCBHC services because of an individual's inability to pay for such services. The CCBHC reduces or waives any fees or payments required by the clinic for such services to enable the clinic to fulfill the assurance described in clause.

The CCBHC ensures no individual is denied CCBHC services because of place of residence, homelessness, or lack of a permanent address.

The CCBHC has protocols addressing the needs of individuals who do not live close to the CCBHC or within the CCBHC service area. The CCBHC is responsible for providing, at a minimum, crisis response, evaluation, and stabilization services in the CCBHC service area regardless of an individual's place of residence. The required protocols should address management of the individual's on-going treatment needs beyond that which may include referral agreements with clinics in other localities.

The CCBHC directly, or through a DCO, provides screening, assessment, and diagnosis, including risk assessment for behavioral health conditions. All individuals served by the CCBHC are engaged in an initial evaluation inclusive of all requirements listed in the initial evaluation section. The CCBHC uses the initial evaluation, comprehensive evaluation, and ongoing screening and assessment of each person receiving services to inform the treatment plan and services provided.

<u>Alabama CCBHC Participant Enrollment Requirements:</u>
Any individual with a mental health or substance use disorder diagnosis is eligible to receive CCBHC services. Eligible CCBHC recipients should be identified by the CCBHC using a multifaceted outreach and engagement approach for both Medicaid and non-Medicaid beneficiaries.

*Receipt of duplicative services (e.g., **outpatient** co-enrollment between CCBHCs and/or **another** CMHC) should not occur. Programs should contact ADMH when issues with potential co-enrollment arise.*

ADMH requires that all individuals who are provided one or more of the nine required CCBHC services at an approved CCBHC site location be enrolled in the CCBHC program through the above initial and comprehensive evaluation processes.

For individuals who were already engaged in CMHC services at the time of CCBHC certification, CCBHCs will have 90 days from the date of CCBHC certification to gather and document updated assessment information from each individual served (to assure all of the required initial and comprehensive evaluation information is collected in alignment with the CCBHC criteria) and engage the individual to update their Treatment Plan to include all CCBHC services that are appropriate based on their needs and

[22] https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf
[23] https://www.samhsa.gov/sites/default/files/ccbhc-compliance-checklist.pdf

preferences. CCBHCs should also review each Treatment Plan to assure that it meets all requirements outlined in the SAMHSA CCBHC Criteria Section 4.E here: https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf.

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Special consideration should be given to promoting access to the full range of CCBHC services for all individuals being served. (e.g., If an agency has built capacity to provide primary care screening and monitoring services as part of becoming a CCBHC), as part of this process they should assess each of their current individuals' need for this service and add it to their Treatment Plans when a need is identified. CCBHCs should educate each individual receiving services about the full breadth of services available within the CCBHC and assist with making informed decisions about their integrated care.

During site visits and audit reviews, ADMH will randomly select CCBHC individuals receiving CCBHC services' charts to assure that all individuals are enrolled in the CCBHC using the above initial and comprehensive evaluation processes. While providers can begin billing the PPS-1 daily rate for CCBHC services provided to individuals who were previously served under their CMHC designation on the first date of CCBHC operations (once certification is received from ADMH), the state retains the right to withhold funds should ADMH identify that the steps outlined in the CCBHC Participant Enrollment section of this Manual have not been completed within the specified timeline.

For individuals whose first CCBHC service received is a crisis stabilization service provided by the CCBHC, the crisis service is a CCBHC covered service upon crisis assessment (which will include a screening and risk assessment). Following the resolution of the crisis situation, the CCBHC must make a determination to either enroll the individual in the CCBHC for longer term care (in which case they should be engaged in the initial and comprehensive evaluation processes referenced in sections 3.6-3.8 in order to enroll them in the CCBHC program) or connect them to another level of care (e.g., if the acuity of their needs warrants more intensive services, such as those provided by a residential or hospital provider).

See Appendix C for a Provider Checklist for Enrolling an Existing Individual into the CCBHC

Alabama Target Subpopulations

CCBHCs should ensure the ability to serve individuals of all ages, races, ethnicities, genders, disability statuses, sexual orientations, and gender identities with serious emotional disturbance (SED), serious mental illness (SMI), substance use disorder (SUD), opioid use disorder (OUD), and co-occurring mental and substance disorders (COD), and those with or at risk of HIV and/or Hepatitis C due to injection drug use.

In addition, based on disparities in service access and outcomes, ADMH has identified the following priority populations of focus for CCBHCs:

- People living with Opioid Use Disorder with emphasis on communities showing a high risk of fatal overdose, including the African American Population
- Pregnant and Parenting Women (PPW)
- This population is defined as: women who are pregnant, postpartum, or parenting dependent children.

- People experiencing homelessness according to 42 US Code § 11302
- CCBHCs will use the SDOH ICD-10-CM Chapter Z codes to identify the specific designation of the Social Drivers of Health (SDOH) – and in this case Homeless (Z59.0), Sheltered Homeless (Z59.1), and Unsheltered Homeless (Z59.2)

CCBHCs may choose additional populations based on any emerging groups facing disparities in the community, including but not limited to:

- The rural population[24]
    - Non-metropolitan counties
    - Outlying metropolitan counties with no population from an urban area of 50,000 or more people
    - Census tracts with RUCA codes 4-10 in metropolitan counties
    - Census tracts of at least 400 square miles in area with population density of 35 or fewer people per square mile with RUCA codes 2-3 in metropolitan counties
    - Census tracts with RRS 5 and RUCA codes 2-3 that are at least 20 square miles in area in metropolitan counties.
- Youth and adults who are at high risk of suicide based on data; persons who identify as LGBTQ+,
- Individuals identified by federal data as being at at risk of gun violence, which include but are not limited to:[25, 26]
    - Minority youth living in poverty
    - African American individuals, including children and adolescents
    - White individuals ages 45 and older
    - Male children ages 19 and under

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Agencies may use the following resource to determine whether a particular geography is rural.[27]

This list is not intended to be all-inclusive. Each CCBHC should utilize its Community Needs Assessment in order to identify which priority populations are experiencing disparities in their catchment area, and tailor its CCBHC approach based on these findings.

CCBHCs must actively track outcomes and disparities for their identified Populations of Focus (POFs). All required POFs data must be submitted for evaluation purposes and reporting SAMHSA and CMS. Additional POFs data will also be collected and reported to the ADMH. Any disparities noted will be addressed through the agency's formal CQI process.

CCBHCs must complete a CNA at minimum once every 3 years. The CNA should be used to inform focus areas for treatment and should strive to have representation from the CCBHC's populations of focus. Additionally, the CNA should be used to identify any emerging groups facing disparities in the community. If new high-risk populations are identified, this should be shared with ADMH to update communications with SAMHSA and demonstration priorities.

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[24] https://www.hrsa.gov/rural-health/about-us/what-is-rural
[25] https://www.hhs.gov/sites/default/files/firearm-violence-advisory.pdf
[26] https://www.apa.org/pubs/reports/gun-violence-prevention
[27] https://data.hrsa.gov/tools/rural-health

It will be incumbent upon the CCBHCs to ensure accessibility and meet the needs of the population to be served, such as settings in the community and as appropriate and feasible, in the homes of people receiving services.

Transportation or vouchers should be used to the extent possible with relevant funding. Also, services should be available in the evenings or on the weekends.

Staffing plans should also align with needs of community to include positions such as community outreach workers, etc.

CCBHCs must ensure that services are offered on some evenings and/or weekends to meet the needs of the population while ensuring access and availability to care.

Training around cultural competency, Social Drivers of Health (SDOH) Data Capturing and National CLAS standards are applicable to implementation.

Data Reporting and Continuous Quality Improvement (CQI)

CCBHCs must have the capacity to collect, report, and track encounter, outcome, and quality data, including, but not limited to, data capturing: (1) characteristics of people receiving services; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) outcomes of people receiving services. Additionally, CCBHCs must collect and report Clinic-Collected quality measures, as specified in the most current CCBHC Quality Measure Technical Specifications and Resource Manual.[28] *Currently, ADMH is only requiring CCBHCs to report externally on the CCBHC clinic-level quality measures, one of which relates to an outcome - Depression Remission at 6 Months.* However, as a best practice, CCBHCs should be internally moving towards a system that promotes Measurement-based Care.

Continuous Quality Improvement Requirements

In order to maintain a continuous focus on quality improvement, the CCBHC develops, implements, and maintains an effective, CCBHC-wide continuous quality improvement (CQI) plan for the services provided. The CCBHC must establish a critical review process to review CQI outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services. The CQI plan needs to focus on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance. The CQI plan needs to address how the CCBHC will review known significant events including, at a minimum: (1) deaths by suicide or suicide attempts of people receiving services; (2) fatal and non-fatal overdoses; (3) all-cause mortality among people receiving CCBHC services; (4) 30 day hospital readmissions for psychiatric or substance use reasons; and (5) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan. The CQI plan must be data-driven with explicit focus on sub-populations of focus.

[28] https://www.samhsa.gov/sites/default/files/ccbhc-quality-measures-technical-specifications-manual.pdf

SAMHSA CCBHC Certification Criteria

Based on the SAMHSA CCBHC Certification Criteria, Alabama CCBHCs must meet the following requirements related to Continuous Quality Improvement.

CCBHCs must develop, implement, and maintain an effective, CCBHC-wide continuous quality improvement (CQI) plan for the services provided. The CCBHC must establish a critical review process to review CQI outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services. The CQI plan must focus on indicators related to improved behavioral and physical health outcomes and take actions to demonstrate improvement in CCBHC performance. The CQI plan should also focus on improved patterns of care delivery, such as reductions in emergency department use, rehospitalization, and repeated crisis episodes. The Medical Director is involved in the aspects of the CQI plan that apply to the quality of the medical components of care, including coordination and integration with primary care.

The CQI plan must be developed by the CCBHC and address how the CCBHC will review known significant events including, at a minimum: (1) deaths by suicide or suicide attempts of people receiving services; (2) fatal and non-fatal overdoses; (3) all-cause mortality among people receiving CCBHC services; (4) 30 day hospital readmissions for psychiatric or substance use reasons; and (5) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.

The CQI plan must be data-driven and the CCBHC must consider use of quantitative and qualitative data in their CQI activities. At a minimum, the plan must address the data resulting from the CCBHC-collected and, as applicable for the Section 223 Demonstration, State-Collected, quality measures that may be required as part of the Demonstration. The CQI plan must include an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and addresses how the CCBHC will use disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health disparities.

As part of a data-driven quality improvement approach, SAMHSA requires the Disparity Impact Study to identify populations at risk of experiencing behavioral health disparities.1

Alabama Quality Improvement Requirements:

In addition to the above requirements, Alabama CCBHCs must:

- Develop and maintain a CQI Plan that is approved by the Medical Director and the Clinical Director. CQI Plans are to be submitted to ADMH on an annual basis, no later than July 1st of each Demonstration year. Plans will be reviewed by ADMH with feedback provided 60 days from submission. Each CCBHC's CQI Plan must include:
    - Data-driven Disparity Impact Study to assist with the identification and service of underserved populations within the service area.
    - All CCBHC Clinic Level required reporting
    - Specific goals for clinical outcomes
    - Annual updates must include planned performance improvement for any goals for which the target is not met, and any areas identified by ADMH as needing improvement.

- Each plan must include a Disparity Impact Statement to identify and prevent disparities in Alabama and the CCBHC's populations of focus, identified above. ADMH-approved Disparity Impact Statements are recommended for use at CCBHCs to demonstrate data-driven service determinations. This standard will be applicable to all CCBHCs. CCBHCs will (1) identify disparities, (2) address disparities and (3) add a Disparity Reduction Plan into the CQI. The DIS must align with the Community Needs Assessment (CNA) which will be submitted every 3 years. At minimum, the CCBHC's Disparity Impact Plan must include:
    - Specific actions to reduce disparities in the identified populations
    - A comparison of local population demographics with demographics and outcomes of persons referred/served to ensure that the CCBHC is delivering effective and equitable services to all communities, and the ratio of the demographics of persons served is reflective of the community.
        - If not, an outreach and engagement goal must be established
    - Evaluation of the person receiving services outcomes by demographic
    - Evaluation of the person receiving services experience survey results by demographic
- ADMH expects that each CCBHC will actively track outcomes and disparities for the populations of focus. Any disparities noted will be addressed through the agency's formal CQI process. To implement the Disparity Impact Plan each CCBHC must develop an internal disparity reduction team that evaluates the data at a minimum twice per year. All outcomes will be noted in the CQI plan and specific performance improvement activities for any disparities identified
- The data and progress must be submitted annually as part of the CQI plan. ADMH will review and approve all performance improvement activities.
- Each CCBHC is required to complete a Community Needs Assessment (CNA) at minimum once every 3 years. The CNA should be used to inform focus areas for treatment and should strive to have representation from all populations of focus. Additionally, the CNA should be used to identify any emerging groups facing disparities in the community. If new high-risk populations are identified, this should be shared with ADMH in order to update communications with SAMHSA

Clinic Reporting Requirements

SAMHSA CCBHC Certification Criteria

Based on the SAMHSA CCBHC Certification Criteria, Section 223 Demonstration CCBHCs, must collect and report the Clinic-Collected quality measures identified as required in Appendix B of the 2023 SAMHSA CCBHC Certification Criteria and listed in the following table:

Measure Name and Designated Abbreviation	**Steward**	**CMS Medicaid Core Set (2023)[1]**
✓ Time to Services (I-SERV)	SAMHSA	n/a
✓ Depression Remission at Six Months (DEP-REM-6)	MN Community Measurement	n/a
✓ Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	NCQA	n/a
✓ Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD)	CMS	Adult and Child

✓	Screening for Social Drivers of Health (SDOH)	CMS	n/a

⚠ *Quality measures to be reported for the Section 223 Demonstration program may relate to services individuals receive through DCOs. It is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship with DCOs. CCBHCs should ensure that consent is obtained and documented as appropriate, and that releases of information are obtained for each affected person. CCBHCs that are not part of the Section 223 Demonstration are not required to include data from DCOs into the quality measure data that they report.*

Reporting is annual, and, for Clinic-Collected quality measures, reporting is required for all individuals receiving CCBHC services. CCBHCs are to report quality measures nine months after the end of the measurement year as that term is defined in the technical specifications. Section 223 Demonstration CCBHCs report the data to their states.

ADMH will report State-Collected quality measures identified as required in Appendix B of the CCBHC Certification Criteria. These State-Collected measures are to be reported for all Medicaid enrollees in the CCBHCs, as further defined in the technical specifications. Whether the measures are State- or Clinic-Collected, all must be reported to SAMHSA annually via a single submission from the state twelve months after the end of the measurement year, as that term is defined in the technical specifications.

ADMH will also share the results from the State-Collected measures with the Alabama Demonstration CCBHCs. For this reason, Section 223 Demonstration program states may elect to calculate their State-Collected measures more frequently to share with their Section 223 Demonstration program CCBHCs, to facilitate quality improvement at the clinic level. ADMH will provide participating CCBHCs with more information about its plans related to data sharing in the future.

In addition to the State- and Clinic-Collected quality measures described above, Section 223 Demonstration program states may be requested to provide CCBHC identifiable Medicaid claims or encounter data to the evaluators of the Section 223 Demonstration program annually for evaluation purposes. These data also must be submitted to CMS through T-MSIS in order to support the state's claim for enhanced federal matching funds made available through the Section 223 Demonstration program. At a minimum, Medicaid claims and encounter data provided by the state to the national evaluation team, and to CMS through T-MSIS, should include a unique identifier for each person receiving services, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. Clinic site identifiers are very strongly preferred.

In addition to data specified in this program requirement and in Appendix B that the Section 223 Demonstration state is to provide, the state will provide other data as may be required for the evaluation to HHS and the national evaluation contractor annually.

To the extent CCBHCs participating in the Section 223 Demonstration program are responsible for the provision of data, the data will be provided to the state and as may be required, to HHS and the evaluator.

CCBHCs participating in the Section 223 Demonstration program may also be requested to participate in discussions with the national evaluation team and participate in other evaluation-related data collection activities as requested.

ADMH Support to CCBHCs for Reporting: ADMH is committed to ensuring all certified CCBHCs comply with regulations regarding clinic reporting. This compliance will be monitored by the state through quarterly and annual reporting, including state oversight of data completeness and timeliness.

ADMH will submit annual data reports to all CCBHCs, including state and clinic CCBHC performance measure data. Reports will identify average rates and performance ranges for all measures, stratifications of performance data by available demographic characteristics, and benchmarks and targets set by the State. These data will be available to CCBHCs in their Netsmart dashboards, which will allow for more real-time and granular sub-analysis and stratification. Following submission of annual data reports, the State will host statewide CCBHC meetings as well as help CCBHCs facilitate, if necessary, individual CCBHC debriefing to discuss results, identify opportunities for improvement, and review best practices for targeted improvement activities.

Clinic Reporting Details - Disparity Identification: SAMHSA requirements stipulate that CCBHC quality measures will be stratified by, at minimum, payer, race, and ethnicity. ADMH hopes to move beyond these requirements and drive towards more advanced quality disparity and inequity identification and tracking. To accomplish this, CCBHCs will be responsible for entering into Netsmart, to the best of their ability, client level information on the following:

- Payer
- Race
- Ethnicity
- Religion
- Language
- Marital status
- Veteran status
- Disability status
- Pregnancy status
- Rurality
- Sexual orientation
- Individuals otherwise adversely affected by persistent poverty or inequity.

Alabama CCBHC Data Reporting, Collection, and Tracking Processes

Quality Monitoring Processes: ADMH has taken appropriate measures to ensure high quality data collection and reporting capacity through leveraging a comprehensive population health platform that is key for ADMH's connection to various networks and healthcare providers. The platform draws data from various sources, such as the state HIE, One Health Record; Hospital Admission, Discharge, Transfer (ADT) data; Medicaid Management Information System (MMIS); and CCBHC EHRs, among others, to create one real-time central data repository and dashboard. ADMH selected this tool specifically to work with CCBHCs and other state and community partners, rather than require them to undergo costly adaptations to their existing platforms and data programs.

All CCBHCs will receive:

- A provider access authorization form for each user
- Login information and support to access ADMH's data platform

- Ongoing technical assistance and training for ADMH's data platform
- Ongoing data requirement technical assistance and training

Quality Monitoring Processes - Demographic and Social Data Collection for Measure Stratification: With the exception of the state-collected PEC and YFEC survey measures, all state and clinic level CCBHC quality measures will be stratified by, at minimum, payer, race, and ethnicity. Given the importance of using data to identify and target inequities and disparities in care, ADMH has been working to improve the standardized collection and reporting of demographic and social determinants data across state and clinic-level databases. Required data, collected through Medicaid enrollment, includes client race, ethnicity, sex, age, language, marital status, pregnancy status, and veteran status. For non-Medicaid CCBHC clients, CCBHCs will be required to collect demographic data.

CCBHCs should work with their IT teams and staff to identify opportunities to improve the standardized collection of demographic and social data. CCBHCs should also bring challenges or successes to regular meetings with ADMH and other CCBHCs to promote a culture of learning and improvement.

Quality Monitoring Processes - Quality Measures: CCBHC clinics are responsible for reporting a defined set of quality measures, as specified by SAMHSA. Even though these measures are programmed into ADMH's data collection system and updated regularly, each measure should be carefully reviewed and understood by CCBHCs. For each measure, CCBHCs should ensure they have a clear understanding of the technical specifications, including:

- Measure terms and definitions (e.g., what is an Index Event Date?)
- Eligible population
- Denominator criteria (and exclusions if any)
- Numerator criteria (and exclusions if any)
- Required measure stratifications (including race and ethnicity)
- Any published FAQS Importantly, CCBHCs are required to report quality measures in a standardized format, which has been specified in the SAMHSA CCBHC Data Reporting Template.

ADMH has made a commitment to ensuring all CCBHCs within the state feels equipped and empowered to transform their clinics, as necessary, to support data collection, reporting, and data-informed decision making. ADMH will provide CCBHCs with a robust training and education program. This education and training will include a thorough overview of the CCBHC performance measures and specifications, required data elements, reporting timeline and expectations, as well as best practices for improving data collection and clinical workflows to support program goals. Further, the State will engage CCBHCs in group education and assistance activities to identify and share best practices and ideas for building data collection and standardization into practice workflows and ways in which ADMH's data platform, clinic EHRs, and other data sources and systems can be leveraged to remind and alert providers of key processes (e.g., screenings, tests) that should take place during patient visits or outreach efforts.

Clinics are required to collect data for all clients served by the CCBHC, regardless of payor. For quality measurement purposes, all CCBHC clients with one or more visits within the scope of CCBHC core services during the calendar year should be attributed to the clinic. As stated above, detailed information on all required quality measures are specified in the most current CCBHC Quality Measure Technical

Specifications and Resource Manual.[29] These specifications are also integrated into the Netsmart platform for automatic calculation and display. However, clinics should also calculate and validate quality measure performance rates outside of the Netsmart system, as a best practice. Of note, unlike other reporting programs, CCBHCs will be responsible for reporting denominators, regardless of size (e.g., fewer than 30) to ADMH.

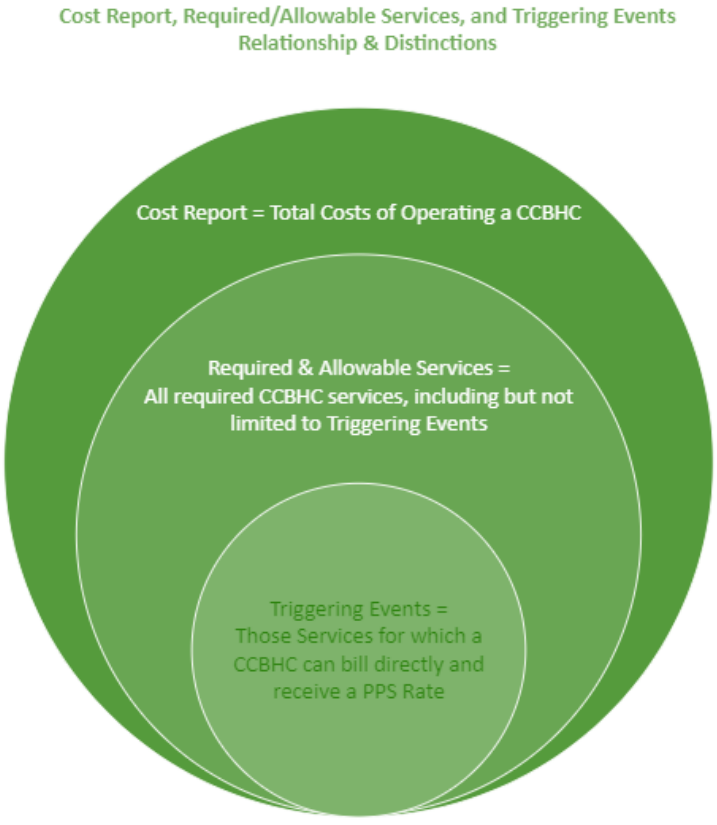
The unit of reporting for quality measures is the CCBHC, regardless of how many clinics or entities comprise a single CCBHC. If a core service is rendered by a DCO, it is the responsibility of the CCBHC to arrange for access to relevant DCO data, as legally permissible upon creation of the relationship. As a best practice, integration of DCO data into the CCBHC medical record and the Netsmart platform is recommended. Per SAMHSA CCBHC requirements, it is the responsibility of the CCBHC to arrange for access to quality data, as legally permissible, upon creation of a relationship with a DCO. CCBHCs should ensure that consent is obtained and documented as appropriate, and that releases of information are obtained for each affected person. CCBHCs should work with the State, their clinic IT team, and the DCO to ensure there is appropriate data exchange for the purposes of quality reporting. The CCBHC is responsible for ensuring DCO data is included in clinic quality reporting efforts.

Cost Reporting

CCBHCs must submit annual Cost Reports based on actual CCBHC spend and visit data from the most recent CCBHC Demonstration year (July 1-June 30) within six (6) months after the end of each Demonstration Year (DY).

ADMH has elected to utilize the federal Cost Report template developed and promulgated by CMS. CCBHCs should complete this Cost Report following each year of their participation in the CCBHC Demonstration Program. After each Cost Report submission, AMA and ADMH will jointly review the submission to validate the information reported and ensure compliance with federal and state requirements. To facilitate these reviews, AMA and ADMH reserve the right to request supporting information and documentation from providers to substantiate the information reported on the Cost Report.

For detailed instructions on completing the Cost Report, CCBHCs should see:



[29] https://www.samhsa.gov/sites/default/files/ccbhc-quality-measures-technical-specifications-manual.pdf

https://www.medicaid.gov/medicaid/financial-management/downloads/ccbhc-cost-rptinstr.pdf. As Alabama is utilizing the PPS-1 rate structure, providers should follow the instructions pertinent to PPS-1 when completing their annual Cost Reports.

⚠

In order for a clinic participating in the Section 223 Demonstration Program to receive payment using the CCBHC PPS, it must be certified by a Section 223 Demonstration state as a CCBHC.

Changes to the Provision of the CCBHC Core Services

Failure to provide any of the nine (9) core services as attested may result in corrective action and/or decertification. Please review the ADMH Section 223 Medicaid Demonstration for CCBHC Certification Process for details on this requirement.

The following changes ***must first be reviewed and approved by the Alabama Department of Mental Health (ADMH):***

- Any changes to the provision of any of the nine (9) required services that are related to DCO/ Partnership arrangements and other contractual agreements
- Changes to the agency's certification status (any program area)
- Contractual agreements and/or
- Changes to the CCBHC's ability to meet data and reporting requirements.

Billing Requirements

CCBHCs in the Alabama Medicaid Demonstration are paid using a Prospective Payment System, or PPS. The PPS payment model supports clinics' costs of expanding services and increasing the number of people receiving services while improving their flexibility to deliver person-centered care. CCBHCs receive a daily rate for a triggering event provided to a Medicaid recipient, set at a level calculated to cover the clinic's anticipated costs of delivering care throughout the year. Each CCBHC has unique payment rate based on its own care delivery and population served.

To be eligible for payment, CCBHCs must have an approved provider agreement on file with ADMH. Through this agreement, the CCBHC assures that requirements are met and assures compliance with all applicable federal and State Medicaid law, including, but not limited to, state administrative rules, the Code of Federal regulations, and the State Medicaid Plan. These agreements are renewed annually with each provider. In addition to billing the PPS rate, using procedure code **T1040**, CCBHCs are required to report all shadow claims/services provided. These services will be paid at 0.00.

CCBHC Specific National Provider Identifier (NPI)

Participating CCBHC providers will be responsible for obtaining a unique, CCBHC-specific NPI upon certification, using the appropriate taxonomy. The taxonomy code is chosen by the provider when applying for an NPI. This 10-digit code describes the specialty provider type. Providers should enroll as a Medicaid provider using that NPI. The NPI will represent the billing provider. Providers should bill all CCBHC qualified

services provided to CCBHC attributed members using this NPI. Chapter 105/106 services that are carved out of the CCBHC's Cost Report should be billed under the existing, non-CCBHC NPI.

Triggering and Non-Triggering Events

There are two primary categories of CCBHC Services:

- **Triggering Events** – an allowable service under the CCBHC program that when provided, will trigger the daily PPS-1 payment. PPS payment can be triggered only once each day, per person receiving services by the CCBHC. For more details about Triggering Events, see the "Triggering Events" spreadsheet linked here: https://mh.alabama.gov/certified-community-behavioral-health-clinics/for-current-ccbhcs/. A visit is defined as triggering "billable event," when the person receiving services receives at least one face-to-face encounter or telehealth visit with a qualified CCBHC staff person in an approved setting during which triggering events are provided and documented, consistent with the guidance within this manual
- **Non-Triggering Events**– an allowable service under the CCBHC program that does not trigger a daily PPS-1 payment, such as care coordination services. The expense of non-triggering service encounters is an allowable cost in the cost report (e.g., the cost of staff time to deliver these services) and therefore the expense is built into the PPS rate for each clinic. However, these services, when delivered alone, do not qualify as a triggering event for the purpose of billing the PPS-1 daily rate. This means the delivery of these services by themselves will not trigger a payment of the PPS rate.

At least one triggering event service must be provided on a date of service before a claim can be submitted to Medicaid.

Billing Restrictions

Please note the following billing restrictions: CCBHC services cannot be reimbursed if they are provided in a setting or as part of a service in which behavioral health care is already part of a bundled payment. Service provision is limited to discharge planning activities in the following settings:

- Inpatient hospitals
- Institutes of Mental Disease (IMD)
- Non-community based residential facilities
- Intermediate Care Facilities

Payer of Last Resort

CCBHCs who receive direct funding from SAMHSA grants must utilize third party reimbursements and other revenue realized from the provision of services to the extent possible and use SAMHSA grant funds only for:

- Services to individuals who are not covered by public or commercial health insurance programs,
- Individuals for whom coverage have been formally determined to be unaffordable, or
- Services that are not sufficiently covered by an individual's health insurance plan.

CCBHCs are also expected to facilitate the health insurance application and enrollment process for eligible uninsured person receiving services.

Using Grant Funds (including CCBHC Planning, Development and Implementation (PDI) and Improvement and Advancement (IA)) to Supplement Not Supplant CCBHC Services: Grant funds may be used to supplement existing activities that cannot be charged to the individual's insurance. Grant funds may not be used to supplant current funding of existing activities. "Supplant" is defined as replacing funding of a recipient's existing program with funds from a federal grant (2 CFR Part 200, Appendix XI).

Enrollment and Credentialing

To ensure the safety and quality of services delivered in the CCBHC, all CCBHCs are required to follow AMA and ADMH credentialing guidelines to ensure services are delivered by staff with the appropriate training, licensure, and certification.

Items Needed for Credentialing

- Collect and verify detailed information about the provider's qualifications.
    - Official government-issued identification (Driver's License, Non-Driver's ID, and passport are the only acceptable forms of identification).
    - Personal details like contact information
    - Educational background
    - Work history
    - Professional licenses and certifications related to the job
    - Malpractice history and disciplinary actions[30] (e.g., ethical violations)
    - Malpractice insurance coverage (maybe required if not provided by CCBHC).
- All staff's credentials and backgrounds must be reviewed post-offer and before interaction with CCBHC participants to ensure:
    - They are not excluded from providing services or through the Alabama Medicaid program.[31]
    - They are not conflicted from providing services through Medicare, Medicaid, or other federal funding.[32]
- All staff must undergo a criminal background check and child maltreatment screenings post-offer and pass before interaction with people receiving CCBHC services.
- Obtain and verify references (including program director, department chair)

Primary Source Verification (PSV)

All credentials must be verified through PSV. Secondary sources of information (e.g., a resume, application, verbal verification) might be inaccurate, unreliable, or biased to verify up-to-date licensure and malpractice history.

- The following information must be verified only through PSV:
    - Criminal background status and child abuse clearance

[30] To find out if a practitioner has a malpractice history, you can check their license status with your state's licensing board, which will usually include any disciplinary actions taken against them, including malpractice claims; you can also access the National Practitioner Data Bank (NPDB) which contains information about malpractice payments made by healthcare practitioners across the United States.

[31] https://medicaid.alabama.gov/content/8.0_Fraud/8.7_Suspended_Providers.aspx

[32] https://exclusions.oig.hhs.gov/

- Highest level of education reported (verification through school's Registrar (database, sealed letter from school's registrar's office)
- Where applicable, the practitioner's board certification status, licenses, certifications, DEA registration status, and malpractice history (see Appendix A for a list of Alabama licensing, malpractice history, databases by profession)
- Practitioner's work history
- Professional liability coverage

All PSV review records must be stored in a password-protected file or secure location for potential certifier/auditor review.

Evidence Based Practices (EBPs)

A CCBHC may demonstrate it is meeting the following requirements through the provision of training and/or credentialing/certification of staff members. Where an EBP requires credentialing/certification to be delivered, staff members who deliver treatment must be credentialed/certified or seeking credentialing/certification as demonstrated by enrollment in such a process. Any EBPs with a certification verification process should be verified to ensure the practitioner is qualified to provide the treatment modality. It is the responsibility of the CCBHC to review the requirements for each EBL implemented.

Assessment and Identification of Gaps or Discrepancies

- After the verification process, the gathered data is thoroughly assessed for inconsistencies or gaps in the practitioner's history. Check for missing employment periods, unreported malpractice claims, or disciplinary actions not initially disclosed.

Any discrepancies or red flags must be investigated and resolved before proceeding. Credentialing staff rarely make decisions about credentialing. Rather, they provide the data and key insight for leaders in administrative roles or on committees to move the provider forward in the process.

Recredentialing

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

CCBHC Service Monitoring and Reporting

To ensure that CCBHCs in Alabama provide effective, efficient, and coordinated care to individuals while preventing services paid in error, this section outlines the requirements for monitoring and reporting services to payers, which have been determined to be paid in error. In addition, this process applies to all staff members, including clinical, administrative, and support staff within the CCBHC, as well as external partners and service providers involved in the delivery of behavioral health services. Services paid in error are described in the table below.

Action	Description
Duplication of Services	The provision of the same or similar behavioral health services to an individual by multiple provider agencies within an episode of care, leading to unnecessary costs and potential confusion in care delivery.
Upcoding	Upcoding refers to the practice of billing for a service at a higher complexity level than what was provided, often leading to increased reimbursement. **Note**: This includes billing for time-based procedure codes where the "8-minute rule" applies. The "8-minute rule" states, for any single timed CPT code on the same day, measured in 15-minute units, practitioners must bill a single 15-minute unit for treatment greater than or equal to 8 minutes through (and including) 22 minutes.
Unbundling	Unbundling involves separating related services into individual billable components instead of using a bundled code, which can also inflate costs. CCBHCs must use the PPS rate for persons served, unless the service provided is carved out of the PPS rate. While each CCBHC is expected to provide information about all services provided during the visit day, only one claim per Medicaid enrollee per visit day is to be submitted for reimbursement under the PPS rate.

Implementation of Auditing and Monitoring

The CCBHC will implement a system to monitor services provided to each person being served, including:

- Regular audits of the individual being served records to identify any overlapping CCBHC services across multiple providers.
- Utilization reviews to assess the appropriateness and necessity of services being delivered.
- Staff will be trained to recognize and report any instances of duplicate services.

The CCBHC will also maintain a reporting protocol to notify payers of any services paid in error. This may consist of:

- **Internal Audits.** Comprehensive reviews of clinical and administrative processes, focusing on billing practices, service delivery, and adherence to regulations.
- **Performance Audits.** Evaluating the effectiveness of programs and services offered by the CCBHC, including patient outcomes and satisfaction.
- **Compliance Audits.** Assessing adherence to federal and state regulations, including those set forth by AMA and other relevant bodies.

As a condition of payment, Medicare and Medicaid require that items and services be medically reasonable and necessary. Therefore, CCBHCs should ensure that any claims reviews and audits include a review of the medical necessity of the item or service by appropriately credentialed

personnel. CCBHCs that do not include clinical review of medical necessity in their claim's audits may fail to identify important compliance concerns relating to medical necessity.

Compliance and Program Integrity

The CCBHC will provide timely reporting summarizing any claims where services were paid in error and did not result in a Medicaid denial or adjustment. Detailed documentation of the nature of the services, the practitioners involved, and the actions taken to resolve any errors and duplications should be retained. The CCBHC will engage in ongoing communication with ADMH and AMA to ensure transparency and compliance with reimbursement policies.

Overpayments

Overpayments occur when a CCBHC receives funds from AMA that exceed the amount owed for services rendered. Common causes of overpayments in a CCBHC setting may include:

- Billing for services not provided or not medically necessary.
- Errors in coding or billing practices.
- Duplicate claims submissions for the same service.
- Misinterpretation of service limits or eligibility criteria.

Upon identification of an overpayment, CCBHCs must take immediate corrective action such as:

Item	Description
Reporting Overpayments	CCBHCs are required to report overpayments to Alabama Medicaid no later than 60 days after the overpayment is identified. This reporting is crucial for maintaining compliance and avoiding potential penalties.
Correcting Overpayment	Once an overpayment is reported, CCBHCs must initiate a withhold process, which involves withholding future payments to correct the overpayment to the CCBHC
Documentation	CCBHCs must maintain thorough documentation of all overpayment investigations, corrective actions taken, and communications with Alabama Medicaid regarding the resolution of the issue.

If a CCBHC identifies billing mistakes or other non-compliance with program rules leading to an overpayment, the provider must repay the overpayments to Medicare and/or Medicaid to avoid False Claims Act liability.

Preventing Fraud, Waste, and Abuse (FWA)

CCBHCs must implement robust policies and practices to prevent fraud, waste, and abuse, which is defined as:

Item	Description
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Waste	As defined by CMS, "The overutilization of services or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather misuse of resources".
Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

It is the policy of the state of Alabama for providers to have an FWA compliance program which reflect the regulations, recommendations, standards, and guidance set forth by the following agencies towards the detection, deterrence, and prevention of FWA in Medicaid-funded behavioral health care:

- U.S. Justice Department (DOJ)
- Office of Inspector General (OIG)
- Attorney General's Medicaid Fraud Control Section (MFCS)
- Medical Assistance/Medicaid program
- Bureau of Program Integrity (BPI)
- Office of Mental Health and Substance Abuse Services (OMHSAS) of the Department of Human Services (DHS)
- Centers for Medicare and Medicaid Services (CMS)

CCBHCs should leverage tools and references that include, but are not limited to the following:

- Code of Federal Regulations
- Medical Assistance Regulations and Bulletins
- Alabama Annotated Code
- Licensing regulations
- Fee schedules
- Provider manuals
- Provider alerts

Failure to address issues related to fraud, waste, and abuse can lead to severe consequences, including:

- **Negative Financial Impact.** CCBHCs may incur fines and/or withholds for identified overpayments or fraudulent activities.
- **Loss of Medicaid Enrollment.** Serious violations can result in the termination of the clinic's participation in the Alabama Medicaid program, severely impacting service delivery.
- **Legal Action.** Engaging in fraudulent practices can expose CCBHCs and their staff to criminal prosecution and civil liability.

Claims Submission Process

In addition to billing the PPS rate code and modifier, Alabama requires CCBHCs to submit claims for the individual triggering and non-triggering events that were provided during a CCBHC visit.[33] These detailed claims or encounter data, known as "shadow claims," are needed to track important performance measures. Only triggering events should be submitted to Medicaid for payment. All information, including triggering events and shadow claims are sent to ADMH for state reporting only.

Detailed claims or encounter data are also critical to successful PPS rate setting and rebasing. CCBHCs that under report these shadow claims will risk substantive reductions in future PPS rates that may be tested and justified against these claims.

Providers are required to include all shadow claims on the submitted claim. While it should be rare, if a provider identifies that there was a service that was missed, any corrections should be submitted using an electronic process. Within the electronic process an adjustment is called a replacement claim (replacing an original paid claim), and a recoupment is called a void.

The PPS rate code and modifier should be bundled with the corresponding triggering and non-triggering events provided to the attributed member for that month, including all relevant billing codes as specified in *Appendix C*. Please note, providers must update date span to include dates of all services.

Billing Format and Claim Form

Alabama recognizes two standard claim forms (UB-04 and CMS-1500). This also includes HIPAA transactions 837 Professional and 837 Institutional. Providers should list the appropriate procedure code(s), modifiers when applicable, place of service code, and units of service. Procedure codes for all PPS-covered services delivered to the customer on that date of service must be included. Claims must include an ICD-10 diagnosis code.

Electronic Claims

AMA providers can electronically submit claims using the Provider Electronic Solutions (PES) software or by using software vendor, Gainwell[34].

Electronic Remittance Advice (ERA)

The 835 Health Care Payment/Advice, also known as the Electronic Remittance Advice (ERA), provides information for the payee regarding claims in their final status, including information about the payee, the payer, the payment amount, and any payment identifying information.

Timely Filing

AMA requires all claims to be filed within 365 days of the date of service.

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[33] https://mh.alabama.gov/certified-community-behavioral-health-clinics/for-current-ccbhcs/

[34] Gainwell Technologies is a company that provides technology solutions and services for various state Medicaid programs, including Alabama Medicaid. Their role typically involves managing and processing claims, providing data analytics, and improving the overall efficiency and effectiveness of Medicaid services. Gainwell may also support the implementation of Medicaid policies, enhance the provider and member experience, and help with compliance and reporting requirements. Their technology solutions aim to streamline operations and ensure that beneficiaries receive the services they need.

Financial Reconciliation and Settlement

The financial reconciliation and settlement process is critical to ensure that CCBHCs are appropriately reimbursed for services provided. This chapter provides an overview of financial reconciliation, outlines the steps required to complete it, and explains the settlement process that ensures alignment between actual costs and payments received. Understanding this process will help CCBHCs maintain financial viability while meeting regulatory requirements.

Financial reconciliation and settlement serve to:

- Verify that the payments received align with actual costs incurred in providing covered services.
- Identify discrepancies and potential overpayments or underpayments.
- Ensure compliance with payer contracts, state and federal guidelines, and grant requirements.
- Maintain accurate financial reporting and transparency.

Utilization Review and Management

AMA provides access and utilization management of Medicaid-covered services, including Medicaid-covered services for individuals enrolled in CCBHC. AMA and ADMH will utilize the Visit Encounter data to monitor the cost and utilization of services provided by CCBHCs.

These measures are reported annually to SAMHSA:

- The number of provider staff who had mental health and substance use disorder treatment training.
- The number of provider staff newly credentialed or certified to provide mental health and/or substance use disorder treatment activities.
- The number of providers that share information with other providers about the people they serve and types of services they provide.
- The number of providers coordinating and sharing resources with other providers.
- The number and percentage of work group, advisory group, and council members who are service recipients or family members of recipients.
- The number of organizational changes made to support improvement of mental health and substance use disorder treatment activities.
- The number of changes made in finance or other policies.

The State also collects encounter, clinical outcome, and other quality improvement data from the CCBHCs for annual reporting to SAMHSA. The data includes: 1) access to community-based behavioral health services; 2) quality of services provided by CCBHCs compared to non-CCBHC providers; and 3) federal and state costs of a full range of behavioral health services including inpatient, emergency, and ambulatory services (PAMA § 223(d)(7)(A)).

Medicaid Financial Auditing, Corrective Action, and Decertification Standards and Processes

CCBHCs must undergo regular financial audits to ensure compliance with Medicaid billing regulations. The auditing process will involve:

- **Frequency of Audits.** CCBHCs will be audited at least annually, with additional audits conducted as needed based on previous audit results or reports of non-compliance.
- **Scope of Audits.** Audits will review billing practices, clinical documentation, service delivery, and financial records to ensure adherence to Medicaid guidelines.
- **Audit Findings.** All findings must be documented, and CCBHCs will receive a written report detailing the results. Findings will be categorized as minor, moderate, or major based on the severity of the non-compliance.

APPENDICES

Appendix A – Primary Source Verification by Profession

Role/Function	Potential Disciplines	Information Collected	Required Source
Licensed Behavioral Health Practitioner	Psychologist (PSY) Licensed Independent Clinical Social Worker (LICSW) Licensed Master Social Worker (LMSW) Licensed Baccalaureate Social Worker (LBSW) Licensed Professional Counselor (LPC) Alcohol and Drug Counselor (ADC) Substance Abuse Counselor (SADC) or Certified Alcohol and Drug Counselor (CADC) Qualified Substance Abuse Professional (QSAP I)[35]	1. State License 2. Malpractice History	1. Primary Verification Sources (see Appendix B) 2. NPDB Query

[35] There are 3 ways to qualify: 1) Copy of license or evidence of license (LPC, LICSW, LMSW, Psychiatric CNS, Psychiatric CRNP, LMFT, Psychologist, PA, MD, DO) or a copy of Official Master's Level College Transcripts for Psychiatric Nurse applicants; 2) Copy of Official Master's Level College Transcripts from a nationally or regionally accredited college or university in psychology, social work, counseling, psychiatric nursing, or other behavioral health area with requisite course work equivalent to that of a degree in counseling, psychology, social work, or psychiatric nursing, and has successfully

	Licensed Marriage and Family Therapist		
Paraprofessionals	Certified Recovery Support Specialist (CRSS) Medical Assistant (MA) or Certified Medical Assistant (CMA) Qualified Mental Health Professional (QMHP) Qualified Practitioner of Psychology (QPP)[36] Certified Peer Specialists (CPS) or Peer Support Specialist (PSS)[37] Targeted Case Management (TCM)[38]	1. State Certification	1. Primary Verification Sources (see Appendix B)
Nursing	Certified Nursing Assistant (CAN) Licensed Practical Nurse (LPN)	1. State License	1. Primary Verification Sources (see Appendix B)

completed a clinical practicum (or six month's post master's clinical experience) and a Copy of Substance Abuse Counselor Certification, if active at time of application

[36] An individual who meets the following minimum qualifications: (a) A high school diploma or equivalent, and (b) One (1) year of work experience directly related to job responsibilities, and (c) Concurrent participation in clinical supervision by a licensed or certified QSAP I.

[37] An individual who meets the following minimum qualifications: (a) A high school diploma or equivalent, and (b) At least two (2) years of continuous sobriety, and (c) Concurrent participation in clinical supervision by a licensed or certified QSAP I – OR- An individual who meets the following minimum qualifications: (a) Certified by ADMH as a Certified Recovery Support Specialist (CRSS), and (b) Concurrent participation in clinical supervision by a licensed or certified QSAP I.

[38] An individual who meets the following minimum qualifications: (a) A Bachelor of Arts or a Bachelor of Science degree, preferably in a human service-related field, and (b) Training in a case management curriculum approved by ADMH, and (c) Concurrent participation in clinical supervision by a licensed or certified QSAP I.

	Registered Nurse (RN) Psychiatric Clinical Nurse Specialist (PCNS)		
Advanced Practice Clinicians	Physicians Assistants (PA) Psychiatric Certified Registered Nurse Practitioners (Psych CRNP)	1. State License 2. Collaborative Agreement with Physician (CRNP only)[39] 3. DEA Number[40] 4. Malpractice History	1. Primary Verification Sources (see Appendix B) 2.Alabama Board of Nursing 3. DEA 4. NPDB Query
Pharmacist	Registered Pharmacist (RPH)	1. State License 2. DEA Number[3] 3. Malpractice History	1.Primary Verification Sources (see Appendix B) 2.DEA 3.NPDB Query
Physicians	Medical Doctors (MD) Psychiatrist (MD) Doctor of Osteopathic Medicine (DO)	1. State License and Board Certifications 2. DEA Number[3] 3. Malpractice History	1.Primary Verification Sources (see Appendix B) 2.DEA 3.NPDB Query

[39] Verify that the physician named in the agreement is licensed to practice in Alabama; Verify the services the APRN is authorized to perform under the collaborative agreement, such as prescribing medications; Ensure the agreement is current and that it has not expired or been terminated.

[40] DEA Numbers must be renewed every three years. If you find that a practitioner's DEA number is not valid, it could be that their DEA number has expired.

Appendix B – Primary License and Certification Verification Sources

Provider Profession	Verification Source
Licensed Behavioral Health Professional	
Psychologist (PSY)	Alabama Board of Examiners in Psychology
Licensed Independent Clinical Social Worker (LICSW) Licensed Master Social Worker (LMSW) Licensed Baccalaureate Social Worker (LBSW)	Alabama State Board of Social Work Examiners
Licensed Professional Counselor (LPC) Alcohol and Drug Counselor (ADC) Substance Abuse Counselor (SADC) or Certified Alcohol and Drug Counselor (CADC)	Alabama Board of Examiners in Counseling

Qualified Substance Abuse Professional (QSAP I[41] II[42]and III[43]	
Licensed Marriage and Family Therapist	**Alabama Board of Examiners in Marriage and Family Therapy**
Paraprofessionals	
Certified Recovery Support Specialist (CRSS) Medical Assistant (MA) or Certified Medical Assistant (CMA) Certified Peer Specialists (CPS) or Peer Support Specialist (PSS)[44] or Certified Peer Recovery Specialist (CPRS)	**Website: Alabama Department of Mental Health (ADMH)** **Phone: (334) 242-3454** **Email: You can contact ADMH via the "Contact Us" page on their website for more specific inquiries.**

[41] There are 3 ways to qualify: 1) Copy of license or evidence of license (LPC, LICSW, LMSW, Psychiatric CNS, Psychiatric CRNP, LMFT, Psychologist, PA, MD, DO) or a copy of Official Master's Level College Transcripts for Psychiatric Nurse applicants; 2) Copy of Official Master's Level College Transcripts from a nationally or regionally accredited college or university in psychology, social work, counseling, psychiatric nursing, or other behavioral health area with requisite course work equivalent to that of a degree in counseling, psychology, social work, or psychiatric nursing, and 3) has successfully completed a clinical practicum (or six month's post master's clinical experience) and a Copy of Substance Abuse Counselor Certification, if active at time of application

[42] An individual who: 1) Has a Bachelor's Degree from a nationally or regionally accredited college or university in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and 2) Is licensed in the State of Alabama as a Bachelor Level Social Worker – OR- An individual who: 1) Has a Bachelor's Degree from a nationally or regionally accredited college or university in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and 2) Holds a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium.

[43] An individual who: 1) Has a Bachelor's Degree from a nationally or regionally accredited college or university in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and 3) Participates in ongoing supervision by a certified or licensed QSAP I for a minimum of one (1) hour individual per week until attainment of a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, or Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. which shall be obtained within thirty (30) months of hire

[44] An individual who meets the following minimum qualifications: (a) A high school diploma or equivalent, and (b) At least two (2) years of continuous sobriety, and (c) Concurrent participation in clinical supervision by a licensed or certified QSAP I – OR- An individual who meets the following minimum qualifications: (a) Certified by ADMH as a Certified Recovery Support Specialist (CRSS), and (b) Concurrent participation in clinical supervision by a licensed or certified QSAP I.

Targeted Case Management (TCM)[45]	
Qualified Mental Health Professional (QMHP)	Licensee Search – Alabama Board of Examiners in Counseling
Qualified Practitioner of Psychology (QPP)[46]	Licensee Search – Alabama Board of Examiners in Psychology
Nursing	
Certified Nursing Assistant (CAN) Licensed Practical Nurse (LPN) Registered Nurse (RN) Psychiatric Clinical Nurse Specialist (PCNS)	Alabama Board of Nursing
Advanced Practice Clinicians	
Physicians Assistants (PA)	Licensee Search | Alabama Board of Medical Examiners & Medical Licensure Commission
Psychiatric Certified Registered Nurse Practitioners (Psych CRNP)	Alabama Board of Nursing
Pharmacist	
Registered Pharmacist (RPH)	Alabama Board of Pharmacy
Physicians	
Medical Doctors (MD) Psychiatrist (MD) Doctor of Osteopathic Medicine (DO)	Alabama Board of Medical Examiners and Medical Licensure Commission

[45] An individual who meets the following minimum qualifications: (a) A Bachelor of Arts or a Bachelor of Science degree, preferably in a human service-related field, and (b) Training in a case management curriculum approved by ADMH, and (c) Concurrent participation in clinical supervision by a licensed or certified QSAP I.

[46] An individual who meets the following minimum qualifications: (a) A high school diploma or equivalent, and (b) One (1) year of work experience directly related to job responsibilities, and (c) Concurrent participation in clinical supervision by a licensed or certified QSAP I.

Appendix C – Provider Checklist for Enrolling an Existing Individual into the CCBHC

CCBHCs must take specific steps to enroll individuals into the CCBHC program (which will allow a CCBHC to bill the PPS-1 daily rate for services provided).

The intent of this guidance is not to place undue burden on individuals being served or providers, but rather to ensure compliance with the CCBHC requirements (which are distinct from Alabama's CMHC regulations) and support access to the nine required CCBHC services for all individuals being served.

Within 90 days from the date of the agency's certification as a CCBHC the CCBHC must do the following related to all individuals who were previously served by them as a CMHC and will continue receiving services from the agency as a CCBHC:

- Engage each individual to update their assessments, assuring that information about each required component of the initial and comprehensive evaluations is collected
- Document all newly collected assessment information in the agency's Electronic Health Record
- Educate each individual about the expanded services offered by the agency as a CCBHC
- Document the fact that this education was provided in the agency's Electronic Health Record
- Engage each individual to update their Treatment Plan to include any additional CCBHC services (and recovery goals related to these services) that are appropriate based on their needs and preferences
- Assure each individual's Treatment Plan meets all requirements of the SAMHSA CCBHC Criteria Section 4.E here: https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf.
- Document all Treatment Plan updates (or the fact that the Treatment Plan was reviewed, and no updates were needed based on the individual's needs/preferences)