



**Alabama
Department of
Mental Health
Comprehensive
Provider Manual for
Certified
Community
Behavioral Health
Clinics (CCBHCs)**

July 1, 2026

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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. 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, 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)
2	4/1/2026	Updates made to Provider Manual to incorporate the following changes: • Clarified the language about first contact with the CCBHC • Added more information about the CCBHC Certification process in Alabama, as well as how existing CCBHCs can request to add an additional site to their CCBHC Certification • Added a section on the CCBHC Community Needs Assessment requirement, in order to align Alabama's requirements with the SAMHSA CCBHC Certification criteria • Minor updates to align with the federal SAMHSA CCBHC Criteria updates made in August 2025 to align with administration priorities • Added information about CCBHC expectations related to providing services for individuals with co-occurring mental health and substance use needs

		• Clarified the requirements related to outpatient substance use services, including Level 1.0 and 2.1, including but not limited requirements related to SU services for youth • Clarified the expectations related to Alabama Assertive Community Treatment (A-ACT), which are carved out of the CCBHC model
3	5/4/2026	• Ran ADA Compliance Check ○ Fixed Contrast issues ○ Fixed Tables with split cells ○ Added ALT TEXT to pictures ○ Removed all resolved comments/mark-ups
4.	07/01/2026	• Throughout the manual - Changed references - ADMH (oversight related) and the Office of CCBHC (certification related) • Throughout the manual, replaced people/person receiving services to 'individual receiving services' • Throughout the manual, clarified the term 'agency' refers to both CCBHCs and prospective CCBHCs replacing the use of prospective CCBHCs in sections applicable to both CCBHCS and Prospective CCBHCs (i.e. desk audit, site visit, etc.) • Throughout the manual, replaced Alabama Medicaid with 'AMA • Throughout the manual, updated webpage links • Throughout the manual, revised wording and duplicative language (e.g., Deficiencies identified may impact desired entry date - placed in one area under Certification Process • Throughout the manual, CCBHC Medical Director was changed to 'Medical Director' • Throughout the manual, Each CCBHC was edited to 'CCBHC' • Throughout the manual, updated language to include 'rendering provider' for practitioners (where applicable) and the provider is reflective of the 'agency' • Throughout the manual, ADMH CCBHC Quality Manual changed to 'CCBHC Quality Manual' • Throughout the manual, changed medication-assisted treatment to "medications for addiction treatment" to align with current language • Throughout the manual, changed CCBHC Participant Enrollment to 'CCBHC Service Enrollment' • Throughout the manual, removed "the" from before ADMH • Throughout the manual, replaced designated collaborating organizations with 'DCO'

		• p.9 Removed, last sentence from the 2nd paragraph under Program Scope • p. 10 Added statement clarifying the use of 'agency' • p. 15 Replaced for each with 'inclusive of all' in first paragraph under CNA. Added 'will be scheduled' in the first paragraph of CCBHC Demonstration Interest Meeting • p. 17 Updated language regarding certification packet. Technical assistance language changed slightly • p. 17 Added OR under CCBHC Report Final Submission. Updated language throughout Desk Audit section and added some new language to provide more clarification of expectations • p. 18 Added ' or the CCBHC's certification timeframe' to first section. Added language in first paragraph about secure document management system. • p. 19 Removed initial from certification site visit under Site Visit header • pp. 20-22 Replaced certification with 'program implementation' in paragraph 2 under Site Visit section. Changed header and other areas throughout the manual from CCBHC Certification Scoring Framework to 'CCBHC Certification Findings and Rating Framework'; replaced score with 'rating' and added a rating criterion • p. 22 Removed Scoring and Review Requirements. Also combined the information for Provider NPI Submission under the Billing Requirements to this area to minimize duplicative language. • p. 24 Added 'note: any deficiencies identified during the initial certification process may affect a prospective CCBHC's desired entry date into the Demonstration' • p. 26 Changed implement to submit, under Rebasing • p. 28 Added 'administratively' under provisional approval section. Revised language in first paragraph under Organizational Authority and Finances • p. 32 Removed prospective CCBHC from the beginning of bullet items • p. 32 Removed 'providers' from paragraph regarding training roster and included additional instructions and required elements for training roster • p. 34 Adjusted language in first paragraph under Scope of Services. Paragraph under 9 required services, removed 'through the CCBHC'. First paragraph, removed 'certification/recertification' • p. 37 Second paragraph under Services Delivered Via Telehealth, replaced video conferencing, monitoring of individuals receiving CCBHC services, asynchronous
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		interventions with 'other approved technologies' to reduce wordiness/duplication • p. 40 Required Screening Tool Table - added 'OR' for HRSN • p. 45 Changed relapse prevention strategies to "strategies to prevent recurrence" • p. 57 Added 'required' in last paragraph - indicating required care coordination agreements must be reviewed annually. Provided guidance regarding care coordination agreements - allowing all other agreements to be reviewed no less than every 3 years or updated as needed. Provided required elements for agreement tracker. • p. 59 First paragraph under Emergency/Crisis, Urgent and Routine Needs Defined, removed the last two sentences since it was mentioned in the previous section • p. 60 Changed header from Individuals Already Engaged When CMHC is Certified as a CCBHC to 'Individuals Engaged in Services Prior to CCBHC Certification' • p. 65 CQI Plan paragraph updated language to clean up wording • p. 65 Removed jointly in reference to ADMH and AMA • p. 66 Removed CCBHC Specific NPI section from Billing Requirements and merged within the certification process for NPI • p. 67 Non triggering events - removed such as and inserted '(e.g., care coordination services)'
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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.

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

¹ <https://mh.alabama.gov/certified-community-behavioral-health-clinics/>

² <https://www.samhsa.gov/certified-community-behavioral-health-clinics/ccbhc-certification-criteria>

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).

When CCBHCs provide one or more services that are categorized as triggering events (see the most recent CCBHC triggering events list here: <https://mh.alabama.gov/certified-community-behavioral-health-clinics/for-current-ccbhc/>), they 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.

An individual's first contact with a CCBHC should include a triage screening to identify the acuity of the individual's needs (e.g., crisis, urgent, routine), which can be followed by one of three activities:

- An initial assessment (part of intake) that will enroll them into the CCBHC for ongoing care
- Engagement with a Certified Peer Specialist for the purpose of engaging the individual in the initial assessment and other services offered by 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.
- Crisis response to address crisis-level needs. If a *non-established/new individual* to the CCBHC receives a *CCBHC crisis service*, that 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*.

In other words, CCBHC Crisis Services and Peer Support Services are the only two services that can be provided and billed for prior to the individual being engaged in the initial CCBHC assessment.

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.

Assuring Non-Duplication Between CCBHC and Other Programs/Initiatives

CCBHCs are responsible for assuring that CCBHC Cost Reporting, billing, and service delivery does not duplicate other programs/initiatives/services for which they receive funding. Agencies seeking CCBHC certification should review their ADMH Contracts and other funding streams, in order to ensure activities included in their CCBHC are not otherwise funded by other sources. In addition, CCBHCs should ensure that individuals served do not receive services through two programs that are duplicative, such as those restricted CCBHC services that are outlined below related to non-allowable CCBHC services within certain Service Settings.

With each CCBHC, the Office of CCBHC will host a meeting (including other ADMH stakeholders as appropriate) to review the agency's ADMH MI contract and discuss what will be included under the CCBHC versus what will be carved out due to being non-CCBHC services. At any point, should you have any questions about what may constitute duplication with your CCBHC program, please do reach out to the Office of CCBHC at ccbhc.dmh@mh.alabama.gov.

For the purposes of this Manual, the term 'agency' refers to both CCBHCs and prospective CCBHCs. Any requirement or procedure that applies exclusively to prospective CCBHCs will be explicitly identified as such.

Enrollment as a CCBHC in Alabama

When a Certified 310 Community Mental Health Center (CMHC) wants to join the Alabama CCBHC Demonstration program, they should submit a Letter of Intent/Letter of Interest and SAMHSA Compliance Checklist no less than six months before their desired entry date to the Office of CCBHC via ccbhc.dmh@mh.alabama.gov. The Letter of Intent/Letter of Interest should include the CMHC's desired start date for the Demonstration*, their proposed CCBHC catchment area, the sites for which they will be seeking CCBHC Certification, and proposed site type for each location (full CCBHC, satellite site, access point), as further described below). Within two weeks of submission of the Letter of Intent/Letter of Interest, the Office of CCBHC will schedule a CCBHC Demonstration Interest Meeting that will outline the work plan, timeline and technical assistance plan to prepare for entry into the Demonstration. For more information, see: [Certified Community Behavioral Health Clinics – Alabama Department of Mental Health](#)

** 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.*

CCBHC Site Definitions – Full, Satellite, and Access Point Sites

As part of the CCBHC Certification process, agencies must identify all physical site locations for which it is requesting certification and approval to bill the PPS rate. This should include any site

³ <https://www.samhsa.gov/sites/default/files/guidance-addition-of-ccbhc-existing-state-demonstration-programs.pdf>

where the provider will be delivering regular and routine CCBHC services and is operated by the CCBHC and/or one of its DCOs*.

Regardless of the site type, each 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.^{4,5}

Additionally, *CCBHC services may be offered through telehealth to meet the needs/preferences of the individual, 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.

Based on the services being provided, each location should be designated as one of the following site types:

- **Full CCBHC Site Locations** – These are CCBHC sites that provide all nine CCBHC services at the site. ADMH’s preference is, to the greatest extent possible, that each agency builds capacity to provide all CCBHC services at as many of its existing sites (which would then be certified as Full CCBHC sites) as possible.
- **Satellite Site of the Full CCBHC Sites** – These are CCBHC sites that provide, at minimum, all of 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.

A satellite site must be able to serve individuals of all ages, including both children and adults, via the above core CCBHC services.

In Alabama, while CCBHC Satellite sites can decide to offer ASAM Level 2.1 services based on community need, this is not a requirement of a Satellite Site (however, ASAM Level 1.0 must be offered). If the Satellite Site does not provide ASAM Level 2.1 services at the site, the provider must implement a detailed process for connecting an individual to ASAM Level 2.1 at another site location (e.g., the full CCBHC site).

Based on federal restrictions⁶, 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 accessible⁸ to one or more Full CCBHC site locations, to ensure access to all CCBHC services when needed/desired by a client.

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-ccbhc/>

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.

- **Access Points to the Full CCBHC Site** – These are sites that are operated by the CCBHC or one of its DCOs that are delivering less than the four core CCBHC services referenced above (satellite site). While an Access Point may serve particular populations (e.g., children or adults only), the Access Point must at minimum be able to serve individuals with mental health and substance use needs (as further outlined below). These sites will offer one or more CCBHC services, and they must also be reasonably accessible to a full CCBHC site location, in order to ensure access to all CCBHC services when needed/desired by an individual.

CCBHCs requesting approval for a CCBHC Access Point must submit documentation that outlines how the site adheres to the following requirements of an Access Point:

- Community Need: CCBHCs requesting an Access Point location must demonstrate the need for the service(s) being provided at the proposed Access Point location. This need must be based on the findings from their community needs assessment and demonstrate why the service is needed at that specific location.
- Mental Health and Substance Use Integration: **The location must be able to serve individuals with both mental health and substance use needs.** In particular, if the Access Point will be providing outpatient MH/SUD services, the CCBHC must demonstrate either the ability to:
 - Offer all outpatient levels of MH/SU care up to and including ASAM Level 2.1 at that site; or
 - Implement a detailed process for connecting an individual to ASAM Level 2.1 at another site location (e.g., the full CCBHC site)

In Community Services

The above guidance about service site certification does not preclude agencies from providing CCBHC services at other community-based locations and settings, such as schools, primary care service settings, etc. (as allowable within the AL CCBHC Provider/Billing Manuals, Chapter 105/106, and AL Medicaid guidelines).

To promote access to care in the settings where people can most easily access services, CCBHCs are encouraged to provide and/or co-locate services with community partners and in community settings. All CCBHC services delivered at a site/setting not operated by the CCBHC/DCO (e.g., schools, justice-focused service settings, benefits settings) will be considered ‘in community services’ and do not need to be certified as one of the above CCBHC site types through the above process.

However, if a CCBHC plans to provide in-community services, the CCBHC will be asked to submit a plan for how they will ensure non-duplication of services (based on the particular services they will be adding at the community setting). Please refer to the CCBHC Provider Manual and CCBHC Billing Manual, as well as Chapter 105/106 and Medicaid guidelines, for more information about unallowable services in particular settings (e.g., residential).

Additionally, the CCBHC will need to ensure the staff delivering in-community CCBHC services are connected to the full CCBHC, Access Point, or Satellite and can document in the CCBHC’s EHR. Records of in-community services are subject to review by the Office of CCBHC.

Alabama CCBHC Certification Process

Prospective CCBHCs will be certified by ADMH to participate in the CCBHC Demonstration program. Each agency's capacity will be evaluated using criteria established by Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Medicare & Medicaid Services (CMS), and ADMH. The process will include:

- Submission of the SAMHSA Criteria Checklist and an ADMH CCBHC Provider Application
- Submission of the CCBHC Cost Report and other certification documents
- Attainment of a Provider NPI for the CCBHC Program
- Enrollment with Alabama Medicaid as a CCBHC
- Desk Audits (Administrative and Clinical)
- Site Visit

Prospective CCBHCs will be supported by the Office of CCBHC to understand and complete each of the Certification steps. Each agency will identify an individual within their agency that will serve as the contact person to submit certification materials and communicate with the Office of CCBHC. That individual will have access to the ADMH CCBHC Certification SharePoint portal and may enter data and upload documents in the format required to ensure timely entry into Section 223 Medicaid Demonstration for CCBHCs.

The timeline and associated target dates are estimates and are provided for planning purposes only. While the Office of CCBHC anticipates that the Certification process may be completed within a six (6) month timeframe, the actual duration may vary based on the completeness, accuracy, and timeliness of submitted materials, as well as any deficiencies, corrective actions, or compliance concerns identified during the desk audit, site visit, or other components of the Certification Process.

Steps to Becoming a CCBHC

Interest Email

Prospective CCBHCs must submit an email to the Office of CCBHC expressing their interest in participating in the Demonstration. The email should also include the following documents: *SAMHSA Compliance Checklist* and *ADMH CCBHC Provider Application*. *At the time of interest, prospective CCBHCs should be prepared to attest to compliance with the CCBHC Certification Criteria requirements as well as standards and requirements governed and mandated by ADMH.* Interested applicants should send an email to the Office of CCBHC inbox at ccbhc.dmh@mh.alabama.gov.

The *SAMHSA CCBHC Certification Compliance Checklist* is a detailed self-assessment tool for prospective CCBHCs (and states) to evaluate readiness to meet the CCBHC Certification Criteria. As part of the certification process, prospective CCBHCs are required to complete (in entirety to be accepted by ADMH) and submit a Checklist.

Instructions for completing the Checklist: For each item on the Checklist, the prospective CCBHC should record a readiness rating (e.g., "1 -Ready to Implement", "2 - Mostly Ready", "3 -

Ready with Remediation”, “4 - Unready”) for each proposed *Full* site, as demonstrated below (ex. the prospective CCBHC will bring 3 Full sites into the Demonstration).

Criteria 1.A: General Service Provisions (Readiness Level)

Criteria 1.a.1	1 - Ready to Implement	2 - Mostly Ready	3 - Ready with Remediation	4 - Unready
# of Clinic Sites	2	1		

In addition to indicating the readiness level of each site, prospective CCBHCs must use the notes section to provide details (e.g., status update) and evidence of compliance (or progress toward it) as demonstrated in the example below.

General Service Provisions Notes

ABC Agency has identified 3 Full sites for entry into the CCBHC Demonstration: 2 of the Full sites are ready to fully implement CCBHC services as required by SAMHSA and ADMH. These sites have the capacity to provide services, which have been informed by our completed Community Needs Assessment. Staff at these locations have completed the appropriate trainings as outlined by our CCBHC Training Plan, and positions have been filled to ensure timeliness of care, with the exception of two Care Manager positions and three new Clinician positions (in the meantime, we do have some Care Manager and Clinician FTEs, who are ready to start CCBHC service delivery while we continue to hire to increase our capacity). The 3rd Full site is mostly ready to implement, but the Medical Director wants to ensure newly hired nursing staff complete training regarding new protocols for primary care screening and monitoring, which are currently scheduled to take place next month.

Throughout the certification process, the Office of CCBHC will provide both oversight and aligned technical assistance to support prospective CCBHCs in meeting certification requirements and addressing identified compliance gaps.

Note: Once ADMH has prepared the prospective CCBHC’s application for SAMHSA’s approval, submission of an updated SAMHSA Compliance Checklist will be required. Updates should indicate “Ready to Implement” for each item, and the narrative space should indicate measures taken to build capacity towards compliance.

In addition to the Checklist, the *ADMH CCBHC Provider Application* serves as the prospective CCBHC’s formal attestation of compliance with the CCBHC Certification Criteria, as well as all applicable state-mandated standards and requirements. Submission of the application designates the prospective CCBHC as the responsible entity authorized to operate and bill for CCBHC services in Alabama, contingent upon certification approval.

Upon submission, the application will be reviewed by the Office of CCBHC for completeness and alignment with certification requirements. The Office of CCBHC may request additional documentation, clarification, or corrective action to address identified gaps or areas of noncompliance. Submission of a complete application does not guarantee certification. Final

certification determinations are made at the discretion of ADMH based on demonstrated compliance with all applicable requirements.

The review process may include multiple phases and is subject to established review timelines.

All attestations are subject to validation through supporting document review, site visits, and/or audits.

Community Needs Assessment (CNA)

As a condition of initial CCBHC certification, prospective CCBHCs are required to submit an ADMH approved Community Needs Assessment (CNA) inclusive of all designated service area, defined as each county in which the prospective CCBHC proposes to provide CCBHC services.

For more information about the CNA requirements, please see the [CCBHC Community Needs Assessment](#) section below.

ADMH may review CNA methodology, data sources, and findings as part of the certification determination. Changes to service areas or service delivery may require submission of an updated CNA.

Failure to submit an approved CNA or to demonstrate alignment between CNA findings and service delivery may result in delays to certification or re-certification approval.

CCBHC Demonstration Interest Meeting

Once the Office of CCBHC receives an email from the prospective CCBHC expressing interest in entering the CCBHC Demonstration program, a meeting with key leadership will be scheduled. The meeting will be virtual and is intended to discuss the prospective CCBHC's plans for CCBHC implementation. The prospective CCBHC should be prepared to address the following topics:

- Current and planned operations related to CCBHC services
- The proposed start date for the CCBHC Demonstration program
- Organizational strengths, and any identified gaps, risks, or areas for improvement related to the CCBHC certification criteria

During the meeting, the Office of CCBHC will also discuss the certification timeline, guidelines, processes, and expectations. Prospective CCBHCs will be provided with a CCBHC Certification Packet. Completion and submission of this packet, in addition to all other required certification documents, is mandatory for advancement in the certification process.

Netsmart Integration

Prospective CCBHCs will begin collaborating with ADMH & Netsmart to begin the integration process for electronic health records and data management.

To learn more about the integration process, please read Understanding the Transitions to CCBHC with Netsmart, available here: [Certified Community Behavioral Health Clinics – Alabama Department of Mental Health](#)

Technical Assistance (TA)

The Office of CCBHC will use the findings from the Compliance Checklist along with identified gaps, risks or areas for improvement shared by the prospective CCBHC to create an individualized technical assistance plan. Technical assistance will be provided to support prospective CCBHCs in building organizational capacity and achieving alignment with applicable SAMHSA, CMS, and ADMH requirements throughout the certification process.

As part of certification, certain technical assistance activities may require participation from the prospective CCBHC's administrative, financial, and programmatic leadership, as applicable.

Required participation in technical assistance activities will be communicated by the Office of CCBHC and may be necessary to address identified compliance gaps or support readiness for advancement within the certification process.

Lack of participation in required technical assistance activities may impact the prospective CCBHC's ability to demonstrate compliance with certification requirements and advance within the certification process.

Cost Report Initial Submission

Prospective CCBHCs are required to submit an initial version of their [cost report](#) for ADMH's review. This preliminary submission allows for feedback and technical assistance to ensure the cost report is completed accurately and in alignment with program requirements prior to final submission.

Prospective CCBHCs are required to complete and submit a CCBHC Cost Report using the CMS-approved CCBHC Cost Reporting Tool. The cost report must accurately reflect total allowable costs and total service volume (visits/encounters) and include all required support details. The “Comments” tab must be fully completed for each cost category or data element for which ADMH specifies additional explanation.

Preparation of the cost report is expected to be an organizational process that includes active participation from financial, operational, and programmatic leadership. While technical assistance or external consultants may be utilized, the prospective CCBHC retains full responsibility for the accuracy, completeness, and certification of the submitted data.

The prospective CCBHC will collaborate with ADMH and AMA throughout the Cost Report review and validation process to support the development and approval of the agency's PPS rate. ADMH and/or AMA may request clarification, additional documentation, or revisions as part of this process.

Certification of the PPS rate is a multi-step process, and immediate approval should not be anticipated. The PPS rate development may take approximately four (4) months. Disbursement of payment is contingent upon final PPS rate certification and approval of services rendered in accordance with state and federal requirements.

Certification Document Submission

Prospective CCBHCs must upload the remaining certification documents as well as ADMH's CCBHC Certification Packet to SharePoint as instructed below in the Desk Audit process.

Prospective CCBHCs should use the Certification Checklist to verify all required documents that have been submitted and/or identify any missing documents that have not been submitted.

Once the required documents have been reviewed by the Office of CCBHC, feedback will be provided to the prospective CCBHC during the Clinical/EHR and Program/Administrative Desk Audit processes.

Note: Instructions for uploading certification documents to SharePoint will be provided to agencies by the Office of CCBHC.

Cost Report Final Submission

Prospective CCBHCs will resubmit their cost report with adjustments based on feedback and technical assistance, if applicable, for final review and approval by ADMH. After ADMH's review to ensure the necessary adjustments have been made, there are a few options for next steps:

- The cost report adjustments have been made, and no other areas of concern are noted. The cost report will be provided to AMA for their review, feedback, and/or approval. **OR**
- The cost report adjustments are incomplete, and further discussion and/or technical assistance will be required. Moving forward in the certification process may be paused until the cost report is corrected and approved by ADMH. Once corrected and approved by ADMH, the cost report will be provided to AMA for their review, feedback, and/or approval.

Desk Audit

The desk audit allows the Office of CCBHC to evaluate readiness for compliance with CCBHC Demonstration standards, assess internal processes, and verify program eligibility. The desk audit is primarily conducted remotely; however, at various points during the certification process, ADMH may request additional information or assistance from the agency through alternative means, including email, telephone, or virtual meetings (e.g., via Zoom).

Agencies must identify contact person(s) who will be available during the scheduled desk audit period to address questions or assist with troubleshooting. If the point of contact(s) is unavailable for any reason, contact will be established with the Executive Director for assistance. Timely responses to questions during the desk audit are strongly encouraged, as some findings may require immediate discussion and resolution prior to proceeding with the CCBHC certification process. Other findings may not impact the prospective CCBHC's desired entry date, or the CCBHC's certification timeframe and plans for correction or clarification can be discussed following the desk audit (i.e. site visit, weekly check-in, etc.).

To support the agencies in preparing for the desk audit and site visit, the Office of CCBHC will provide a comprehensive Certification Checklist. All certification documents will be stored and managed in a central, secure document management system (i.e. SharePoint), which allows collaboration and access between the Office of CCBHC and the agencies. The Office of CCBHC will provide access to the designated staff members so all documents can be uploaded in a timely manner.

During the desk audit, the Office of CCBHC will evaluate the agency's readiness and capacity to deliver all nine required CCBHC services, as well as compliance with additional operational (i.e.,

accessibility and availability of services, improper designation of site, etc.) and clinical requirements (i.e., clinical documentation, treatment planning/teams, etc.). These include, but are not limited to, care coordination practices, medications for addiction treatment (MAT) protocols, screening and assessment processes, data collection and quality reporting mechanisms, and systems for monitoring and tracking service delivery. This evaluation ensures that the prospective CCBHC is fully prepared to implement the CCBHC model in accordance with state and federal requirements.

The information reviewed during the desk audit will be used to determine whether the agency moves forward to the next phase of the certification process. If the agency advances to the next phase of the certification process, details regarding site visit will be provided. If the agency does not advance to the next phase of certification (due to noncompliance or inability to implement required services), the Office of CCBHC will provide feedback and suggestions such as:

- Identification of areas of non-compliance
- Description of missing, incomplete or insufficient information
- Clarification of requirements that have not been adequately demonstrated
- Guidance to strengthen readiness for implementation
- Timelines or instructions for resubmitting corrected/updated or additional information
- Recommendation for technical assistance or resources needed

If desired, the agency will be supported to continue working towards meeting all applicable requirements and standards, which may result in an adjustment to the agency's desired entry date into the Demonstration or recertification date if currently a CCBHC.

Clinical/EHR Desk Audit (Remote Process)

This Desk Audit allows the Office of CCBHC an opportunity to review clinical records within the agency's Electronic Health Record (EHR) to verify compliance with federal and state regulations. This is not solely a documentation review, but a compliance verification process to ensure clinical practice aligns with the attested operational model.

As part of the Clinical/EHR Desk Audit, the Office of CCBHC will require "read or view only" access to the agency's EHR. Access to the EHR must be available until the completion of the site visit process. This allows the Office of CCBHC time to reassess or verify information the agency may provide as a response to audit findings.

The Office of CCBHC will request auditor login credentials in advance of the scheduled audit as this will allow sufficient time to coordinate with IT for support, if needed, and for auditors to become familiar with the EHR system prior to review. The Office of CCBHC will provide names and email addresses for auditors' EHR access. To ensure auditors can locate and review all required documentation, the Office of CCBHC may request support from the agency's clinical or IT staff in navigating the EHR system, including any modules or sections pertinent to clinical, administrative, or billing records.

For the purposes of this desk audit, the agency will submit chart information using the Chart Request Form, provided by the Office of CCBHC to ensure consistency and accuracy in documentation.

The chart sampling must represent both children/adolescent and adults Medicaid enrollees to support a balanced and accurate assessment of compliance across all lifespans.

Program/Administrative Desk Audit (Remote Process)

This Desk Audit allows the Office of CCBHC an opportunity to ensure regulatory compliance, evaluate internal processes (workflows, procedures and protocols), and verify program eligibility through the review of policies/procedures, staffing and training plan, and organizational governance.

The Certification Checklist provided by the Office of CCBHC will identify the specific documents needed for review. If documents are missing, incomplete, or have any deficiencies, the agency will be allowed an opportunity to correct the deficiencies during the review period or before the site visit report is issued, whichever occurs first. Any corrective actions and supporting documentation must be submitted within this timeframe to be considered as part of the review process.

Site Visit

The primary purpose of the certification site visit is for Office of CCBHC to:

1. Assess Compliance

- Ensure the agency is following relevant laws, regulations, standards, or contractual obligations.
- Verify that policies and procedures align with governing requirements (e.g., licensing, accreditation, or funding rules).

2. Evaluate Consistency between Policy and Practice

- Confirm that what's written in the policies and procedures is being done in daily operations.
- Identify gaps between documentation and real-world practice, which can indicate areas needing improvement or training.

3. Determine Effectiveness and Efficiency

- Determine whether workflows support efficient service delivery and quality outcomes.
- Pinpoint bottlenecks, redundancies, or outdated steps in the workflow that hinder performance.

4. Promote Quality Improvement

- Provide a foundation for recommendations on best practices, modernization, or risk mitigation.
- Encourage continuous improvement by identifying strengths and areas for development.

5. Ensure Accountability and Transparency

- Demonstrate that the agency has clear, consistent processes for decision-making, recordkeeping, and personalized service/care.
- Build trust with stakeholders (e.g., funders) by showing responsible management.

6. Support Training and Staff Development

- Identify if staff are properly trained to implement policies and follow workflows.
- Highlight the need for updated training materials or clearer guidance.

The site visit will be conducted in accordance with an established agenda and scheduled on a mutually agreed-upon date between the Office of CCBHC and the agency. During the visit, auditors may conduct facility tours, interview clinical, administrative, and/or leadership staff and individuals receiving services (as applicable). Structured observations of service delivery and operational processes may also be conducted.

The Office of CCBHC will provide verbal feedback to organizational leadership and/or designated staff during daily exit briefings, summarizing preliminary observations, areas of compliance, identified best practices, and opportunities for improvement related to CCBHC program implementation. Final certification determinations will be made following completion of the full review process.

Note: Site visits may include other ADMH staff, as appropriate. Pre-site visit materials may be requested in advance of the scheduled visit.

CCBHC Certification Findings and Rating Framework

The CCBHC Certification Findings and Rating Framework reflects a comprehensive assessment of both the desk audit and on-site review processes. This framework serves as a key indicator of the agency's overall compliance with CCBHC certification standards and operational readiness.

The CCBHC Certification Findings and Rating Framework will focus primarily on six (6) key areas:

1. Care Coordination
2. Staffing
3. Availability & Accessibility of Services
4. Scope of Services
5. Quality Improvement
6. Organizational Authority, Governance and Accreditation

Rating Criteria

The certification rating assigned to an agency is determined by its level of compliance with established standards, as evidenced through the certification review, desk audit, and site visit. The following criteria outline the conditions under which each certification status may be awarded or modified.

1. Full Certification (3 Years)

Agencies that demonstrate compliance with all required standards and maintain acceptable performance across all review areas are eligible for a three-year certification. Minor findings that do not materially impact service quality or compliance may be noted; however, they will not affect the certification period if adequately addressed through the agency's quality improvement activities.

2. One-Year Certification

A three-year certification period may be reduced to one year if an agency is found to have:

- Several deficiencies indicating inconsistent adherence to required standards.
- One or more major deficiencies that impact compliance or service quality.

Agencies receiving a one-year certification will be subject to an additional desk audit and follow-up site visit within the certification year to verify correction of deficiencies and ongoing compliance.

3. Provisional Certification

If significant or repeated major deficiencies are identified that pose substantial compliance concerns, the agency may be placed on Provisional Certification. Under Provisional Certification,

the agency must implement corrective actions within specified timeframes and demonstrate measurable improvement. Additional monitoring activities, including focused desk audits or targeted site visits, may be required.

4. Decertification

Decertification may occur if an agency fails to correct deficiencies, continues to demonstrate patterns of non-compliance, or does not meet minimum standards despite corrective action opportunities. Loss of certification may result in suspension of participation until the agency can demonstrate full compliance through reapplication and review. *For more information, see the Decertification and Termination section below.*

Findings

Within 30 days of the site visit, the agency will receive a formal written report detailing the findings and associated quality improvement recommendations. If additional time is required due to complex or extensive findings, the Office of CCBHC will notify the agency and provide an updated completion timeline. The final report will be submitted to the Executive Director.

Rating Components

The overall site visit rating is derived from two primary components:

1. Programmatic Review

Evaluates clinical and service delivery practices, including chart reviews, care observation, and interviews with staff and individuals receiving CCBHC services. This component assesses the prospective CCBHC's ability to deliver person-centered, recovery-oriented, and evidence-based care consistent with CCBHC standards.

2. Administrative Review

Examines organizational and operational compliance, including staff training plans, policies and procedures, governance structure, workflows, personnel records, incident reporting, and other administrative systems that support effective service delivery.

Depending on the prospective CCBHC's capacity, permission may be granted to fully launch by implementing all requested sites at once. However, if there are concerns about capacity, a phased-in approach or partial launch will be required. If the phased in approach is utilized, prospective CCBHCs will begin their CCBHC Demonstration with an initial set of sites, adding additional sites/service locations subsequently once the initial site is fully operational (as approved by ADMH and described in the "Request for Existing CCBHCs to Add a New Site" section below).

Provider NPI Submission

As part of the CCBHC certification process, prospective CCBHCs will be responsible for obtaining a unique, CCBHC-specific NPI, 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.

The NPI must be obtained through the National Plan and Provider Enumeration System (NPPES) online application process. Prospective CCBHCs are responsible for ensuring that the NPI application is completed accurately and reflects the organizational structure and service delivery model under which CCBHC services will be provided.

Submission of proof of NPI application and/or confirmation of the assigned NPI will be required as part of the certification process. Certification approval and authorization to bill for CCBHC services are contingent upon successful issuance and validation of the CCBHC-specific NPI.

Failure to obtain a CCBHC-specific NPI may delay certification approval and reimbursement for services rendered.

The website to apply for a new NPI can be found [here](#).

Alabama Medicaid Application Submission

The CCBHC NPI is required before applying for Medicaid Enrollment Application.

As a condition of CCBHC certification, prospective CCBHCs are required to submit a Medicaid Enrollment Application for each service delivery site to obtain a site-specific Medicaid Provider Identification (Medicaid ID) number.

Medicaid enrollment applications must be completed and approved prior to the prospective CCBHC site's entry into the CCBHC Demonstration and before any claims for CCBHC services provided at that site may be submitted or reimbursed. *Submission of an application alone does not constitute approval or authorization to bill.*

Prospective CCBHCs are responsible for ensuring that all Medicaid enrollment applications are completed accurately, including all required documentation.

ADMH and/or AMA may request additional information or clarification, as part of the enrollment review process.

Failure to obtain an approved Medicaid ID for each site may result in delays to certification approval, Demonstration participation, and reimbursement for services rendered.

Currently, the required application to obtain new Medicaid Site ID is available in paper format only. The Office of CCBHC will provide the Medicaid ID application to the prospective CCBHC at the appropriate stage of the certification process.

Upon completion, the prospective CCBHC must mail the original application packet to the Office of CCBHC in accordance with the instructions provided on the application. The Office of CCBHC will coordinate distribution of the application to AMA for review, processing, and approval.

Applications submitted outside of the established certification timeline or without ADMH authorization may not be accepted or reviewed.

Cost Report Submission to Medicaid

Upon ADMH's review and approval of the prospective CCBHC cost report, a copy will be submitted to AMA for the establishment of the PPS rate. The review and approval process requires a minimum

of ninety (90) days. AMA may request additional information or clarification from the prospective CCBHC as needed during this process.

Certification Progress Meeting

Following completion of the desk audit and/or site visit, the Office of CCBHC will conduct regularly scheduled progress meetings, typically on a weekly basis, with the prospective CCBHC. These meetings are intended to monitor progress toward certification readiness, identify and address outstanding compliance issues, and discuss any potential barriers to meeting certification requirements. As part of this process, the Office of CCBHC may request additional documentation, clarification, or corrective actions and may provide targeted technical assistance, as appropriate. Participation in scheduled progress meetings is required as part of the certification process.

Substance Abuse and Mental Health Administration (SAMHSA) Approval:

Acceptance into the Demonstration does not guarantee a preferred entry date.

As a condition of entry into the CCBHC Demonstration, ADMH is required to obtain approval from SAMHSA prior to determining a prospective CCBHC eligible for Demonstration participation.

ADMH will submit a complete Demonstration approval packet to SAMHSA on behalf of the prospective CCBHC. The packet will include all required certification, compliance, and supporting materials necessary for federal review.

To support timely submission and review, the prospective CCBHC must submit all required materials to ADMH no later than sixty (60) calendar days prior to the proposed Demonstration entry date. Submission of materials by this deadline is necessary to allow sufficient time for state and federal review, engagement, and the exchange of additional information or clarifications, as needed. Application submission to SAMHSA by ADMH does not guarantee SAMHSA's approval. Demonstration entry is contingent upon receipt of formal approval from SAMHSA, CMS and completion of all ADMH certification requirements. Failure to meet submission deadlines may result in delays to the desired entry date.

Following SAMHSA approval for Demonstration participation, and upon verification that all state certification requirements have been satisfied, ADMH will issue written notification of certification, formally designating the agency as a Certified Community Behavioral Health Clinic (CCBHC).

Note: Any deficiencies identified during the initial certification process may affect a prospective CCBHC's desired entry date into the Demonstration.

Certification Status

CCBHC certification lasts for a period of time determined by ADMH but no longer than three (3) years before recertification. *Violation of federal and/or state terms of the CCBHC Criteria and/or program specific standards may result in corrective action, and/or termination of CCBHC designation for CCBHCs.*

For recertification, the Office of CCBHC will send out a notification at least ninety (90) days before the CCBHC recertification process is scheduled. In response to the notification, if the CCBHC has not submitted all their documentation, as well as scheduled and completed their desk audit and site visit by the required deadline, the CCBHC certification will be terminated unless permission

from the Office of CCBHC has been granted for an extension. The CCBHC will no longer participate in the CCBHC Demonstration and no longer eligible to receive the PPS rate; the agency will return to standard fee for service provision. Therefore, CCBHCs should coordinate accordingly with ADMH to ensure continuation of certification. CCBHCs with expired certifications may reapply for certification during one of the Demonstration entry periods (January 1, April 1, July 1 and October 1).

To maintain CCBHC certification, CCBHCs must notify ADMH of any significant changes in services, policy, or practice that would impact a CCBHCs' ability to meet certification criteria. Significant changes requiring immediate notification to ADMH include but are not limited to:

- Opening, closing or changing a site/service location that is certified as a CCBHC (full, satellite, or access point)
- Beginning or ending a DCO agreement
- Inability to provide one of the required CCBHC services due to workforce shortages or other capacity limitations
- Inability to accept new individuals for CCBHC services due to workforce shortages or other capacity limitations
- Change in capacity to implement required evidence-based practices
- Staff vacancies for required positions (e.g., Medical Director, Executive Director, Clinical Director, Outreach Worker)

Other less significant changes should be reported via email and/or during the Annual Site Visit.

CCBHCs may elect to terminate CCBHC certification status and return to standard fee for service provision. In this instance, the CCBHC must provide 90-calendar day notice to the ADMH prior to ending CCBHC certification status.

CCBHC Decertification and Termination

Violation of federal and/or state terms of the CCBHC Criteria and/or program specific standards may result in corrective action, such as placing the CCBHC on a probationary period and/or termination as a CCBHC provider.

Reasons for decertification may include but are not limited to the following:

- Failure to provide any of the nine (9) core services as attested.
- Failure to provide ADMH with requested documentation demonstrating CCBHC requirements and compliance.
- Failure to correct identified deficiencies in meeting program specific standards of the certification.
- A validated complaint related to non-compliance of CCBHC policies and/or CCBHC certification criteria.
- Failure to maintain the appropriate staffing, required licensures and certifications, and availability and accessibility of services.
- Non-compliance with quality and other reporting requirements.
- Failure to maintain the ADMH approved organizational authority and governance requirements.

- Non-compliance with the CCBHC requirements set forth by Centers for Medicare and Medicaid Services (CMS), Alabama Medicaid, and PPS setting/rebasing standards. Falsifying data or other quality documentation required for CCBHC reporting.

ADMH will provide a 45-day notice of the intent to decertify. The CCBHC may respond with a detailed Plan of Action (PoA) to address the identified reasons for decertification. If ADMH approves the PoA, the CCBHC will be placed on Provisional Certification and must adhere to the guidelines identified above under the CCBHC Site Visit section unless more stringent requirements are enforced by ADMH. The Office of CCBHC will support the development, implementation, and monitoring of the PoA.

ADMH may deny the request for corrections, and formal notice of decertification will be provided to the CCBHC. If the CCBHC disagrees with the decertification determination, they may send an appeal in writing to the Office of CCBHC at ccbhc.dmh@mh.alabama.gov

Upon receipt, a copy of the appeal will be reviewed by the Office of Risk Management and the Bureau of Legal Services. Requests should support reasons why decertification should not be commenced to include documentation to support decertification reversal. The CCBHC State Project Director will review the recommendations from the Offices of Risk Management and Bureau of Legal Services, and provide a written recommendation to the Commissioner affirming, reversing, or modifying the initial determination for approval and final disposition.

Note: ADMH may recoup any payments made for CCBHC services provided after the decertification date. *Decertification from CCBHC only removes the CCBHC certification, not the agency's ADMH 310 certification designation.*

Termination: If CCBHC certification is terminated by the ADMH, the CCBHC will revert to previous billing processes prior to becoming a CCBHC and must reapply at the beginning of any fiscal quarter during the state's Demonstration period and follow the steps as outlined by the ADMH CCBHC Certification Process.

Recertification and Rebasing

Recertification will take place every three (3) years during the Demonstration. The Office of CCBHC will conduct site visits for each designated CCBHC annually during the demonstration period, verifying that program requirements are met and consistently implemented in practice.

CCBHCs will be required to rebase according to the CMS Cost Report and PPS timeline.

Regardless of whether a CCBHC's rate is being re-based, an annual Cost Report with actual costs/visits is due at the end of each Demonstration Year. Alabama Medicaid is establishing a due date for these Cost Reports within 90 days of the end of each Demonstration Year. **Therefore, all CCBHCs operating in Alabama will be expected to submit their annual Cost Report (along with any requested supporting documentation) by September 30th of each year.**

Note: Please contact the Office of CCBHC for rebase specific information based on your entry into the Demonstration.

Annual Site Visit & Recertification

Recertification site visits are conducted in accordance with the same standards, methodologies, and certification steps (i.e., desk audit and site visit) required for initial certification to ensure ongoing compliance with all applicable requirements. The notable difference being initial certification, prospective CCBHCs shall submit chart identifiers for purposes of the desk audit. For all subsequent recertification reviews, the Office of CCBHC shall independently and randomly select charts for review.

The Office of CCBHC will conduct a site visit on an annual basis in alignment with the agency's entry date into the Demonstration.

During each site visit, the Office of CCBHC will:

- Perform structured onsite observations of service delivery and operational processes.
- Interview clinical, administrative, and leadership staff to evaluate adherence to CCBHC standards.
- Review and audit documentation within the electronic health record (EHR) system to assess accuracy, completeness, and compliance with regulatory and quality requirements.

The Office of CCBHC will provide verbal feedback to designated staff and leadership during daily exit briefings, highlighting areas of compliance, best practices, and opportunities for improvement related to CCBHC service delivery and quality monitoring.

If the Office of CCBHC determines that an imminent risk to the health, safety, or welfare of individuals receiving services exists, the CCBHC shall immediately initiate corrective action, including a review of the identified issue and implementation of necessary measures to eliminate or mitigate the risk. The Office of CCBHC may also require immediate suspension or discontinuation of the related service(s) until the issue is resolved and verified by ADMH.

For serious but non-imminent concerns, the CCBHC must submit corrective action within five (5) business days. If the fifth business day falls on a Saturday or Sunday, the corrective action must be completed and submitted no later than the following Monday before close of business.

All remaining findings that do not require immediate or five (5) day corrective action will be documented and included in the formal written site visit report.

A formal written report summarizing findings, required corrective actions (if applicable), and recommendations for quality improvement will be issued within 30 days of the site visit. If additional time is needed due to complex or extensive findings, the Office of CCBHC will notify the CCBHC and provide an updated timeline for report completion.

Requests for an Existing CCBHC to Add Additional Sites

For currently operating CCBHCs seeking to add/certify an additional site, the CCBHC must hold full CCBHC Certification at their current sites, be in good standing, and not currently under a Performance Improvement Plan (PIP). If these requirements are met, the CCBHC must submit an email to ccbhc.dmh@mh.alabama.gov; the subject line for these requests must read "[CCBHC name] Request for Additional Site."

The request should include the following:

1. Name and address of the site seeking to be included in the existing Demonstration
2. Date the site was established and what type of site you are seeking (Full, Satellite, Access Point) based on the above guidance
3. The CCBHC services the site intends to provide, along with a narrative of the identified community need and why the need cannot be met at the current Full Site
4. A copy of the most recent CNA that confirms the community need
5. Whether the site has other co-located programs that will not be part of the CCBHC. If the site has other programs that are co-located at that physical location (e.g., Day Treatment), the application must also include a description of:
 - a. The service gap that would be filled
 - b. How that service is best fulfilled by a CCBHC Access Point (as opposed to in-community CCBHC services)
 - c. How the site will avoid duplication of services provided across the CCBHC and co-located program
6. Narrative on program design related to how individuals with both MH and SUD needs will have access to each service provided
7. A narrative on how individuals will be screened for, offered, and connected to additional services at the Full CCBHC Site, when a need is identified
8. A narrative on how staff at the additional site will be engaged in the overall CCBHC processes, including Interdisciplinary Team meetings and staff education and training
9. A narrative on how individuals at the additional site will be engaged as part of the CCBHC's population health and integrated care workflows (e.g., identified for case conferencing, flagged for high-risk monitoring, etc.)
10. Verification that staff at the additional site will have access to the CCBHC EHR

The Office of CCBHC will review each request, and provide a written response within 30 days, with one of the following responses:

- **Provisional Approval** pending the site passing the Life Safety Visit and attaining a CCBHC Medicaid ID. The Office of CCBHC will alert relevant stakeholders that the site has been administratively approved, including Medicaid, and the ADMH Certification/Life Safety Team. The CCBHC should coordinate with the Office of CCBHC to complete the Medicaid ID Application process and the Life Safety team (who will conduct a Site Assessment) as required to accomplish these tasks.
 - Following approval of the site, the CCBHC will have up to six months to start up CCBHC services at that new site location. The Office of CCBHC will schedule a post-implementation Site Visit to review CCBHC operations after this time.
- **Request for clarification or more information**
- **Deny Approval**, along with the reason for the denial.
 - CCBHCs receiving a denial have 14 days to request an appeal in writing to the Associate Commissioner.
 - The Associate Commissioner will review the appeal and issue a response within 14 days of receiving the request.

- CCBHCs who receive a denial can continue to develop capacity and re-submit the request for additional sites after 60 days from the determination time, if the reason for denial has been resolved.

For any site location, the CCBHC must attain written approval of that site's certification in writing prior to billing the PPS rate.

CCBHC Community Needs Assessment

Before certification, all agencies must complete and submit to the Office of CCBHC a community needs assessment. The needs assessment should be updated regularly, but no less frequently than every three years. The needs assessment and subsequent needs assessment updates should inform the CCBHC's staffing plan, as well as decision related to program operations (e.g., site locations, hours of operation, etc.).

The community needs assessment should include each of the following components:

1. A description of the physical boundaries and size of the service area, including identification of sites where services are delivered by the CCBHC, including through DCOs.
2. Information about the prevalence of mental health and substance use conditions and related needs in the service area, such as rates of suicide and overdose.
3. Economic factors and social determinants of health affecting the population's access to health services, such as percentage of the population with incomes below the poverty level, access to transportation, nutrition, and stable housing.
4. Cultures and languages of the populations residing in the service area.
5. The identification of the population(s) within the service area.
6. A description of how the staffing plan does and/or will address findings.
7. Plans to update the community needs assessment every 3 years.
8. Community Stakeholder Input* with regard to:
 - a. cultural, linguistic, physical health, and behavioral health treatment needs;
 - b. evidence-based practices and behavioral health crisis services;
 - c. access and availability of CCBHC services including days, times, and locations, and telehealth options; and
 - d. potential barriers to care such as geographic barriers, transportation challenges, economic hardship, lack of culturally responsive services, and workforce shortages.

Note: The agency should describe in its Needs Assessment its process for engaging community stakeholders, and how that process ensures representation of the community served.

Overall, the community needs assessment should identify current conditions and desired services or outcomes in the community, based on data and input from key community stakeholders. The community needs assessment must be comprehensive and reflect the treatment and recovery needs of individuals across the lifespan within the service area, including individuals of all ages and their families.

The CNA must be updated and resubmitted at a minimum of every three (3) years in alignment with the CCBHC recertification cycle, or more frequently if required by ADMH.

In addition, as referenced above, the CNA is expected to inform and support the agency's service delivery model, including but not limited to the selection of services offered, service locations, hours of operation, access points, and staffing configurations. CNA findings must demonstrate alignment between identified community needs and proposed CCBHC service capacity.

Organizational Authority and Finances

CCBHCs must be a CMHC under the authority of a 310 Board and follow General Requirements of Organizational Authority and Finances:

- CCBHCs must maintain and submit documentation demonstrating non-profit status, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code.
- CCBHCs 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 the Office of CCBHC at site visits and upon requests.
 - 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 the Office of CCBHC at site visits and/or upon request.

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.

CCBHC Governance

Related to CCBHC Governance, CCBHCs must:

- Maintain a structure that allows their Governance Board to be informed by representatives of People with Lived Experience (PWLE) of mental health and substance use conditions , as well as individuals being served by the CCBHC in terms of demographic factors identified in the CCBHC Needs Assessment.
- Incorporate meaningful participation by adult and youth receiving CCBHC services with mental illness, adults and youth recovering from SUD, and family members of individuals receiving CCBHC services.
- Demonstrate meeting one of the following CCBHC Governance options:
 - **Option 1:** 51% of the Board are families, individuals receiving CCBHC services, or PWLE.
 - 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).

OR

- **Option 2:** A substantial portion but less than 51% of the governing board members are PWLE or a family member, and the CCBHC will be required to create an Advisory Committee consisting of individuals receiving CCBHC services, people in recovery, and family members. The Advisory Committee will provide meaningful input to the governing board about the CCBHC's policies, processes, and services. In addition:
 - CCBHCs choosing Option 2 are required to implement documented protocols for PWLE 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% PWLE. 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 individuals in their community who are impacted by health and behavioral health needs, taking into account demographic and other factors.
 - Each CCBHC's community needs assessment will determine and inform whether the governing board and/or Advisory Committee meets these criteria.
- If Option 2 is chosen, The Office of CCBHC 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.
- Members of the CCBHC governing board 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.

The Office of CCBHC will determine compliance with the above Governance requirements 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

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

- Evidence-based practices
- Cultural competency
- 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 in person or online.

CCBHCs must maintain a current training and staff roster that includes all personnel delivering CCBHC services. At minimum, the roster must include the following elements for each staff member:

1. Name
2. Job Title
3. Date of Hire
4. Education/Degree
5. Credentials (e.g., licensure and certifications)
6. Credential Expiration Date
7. Training Topic/Course
8. Training Frequency OR upload a Copy of the Training Calendar
9. Most Recent Training Date for all required trainings

The training roster or calendar should identify the required training category that each training satisfies (e.g., Cultural Competency includes the following trainings: Cultural Humility and Linguistic Competency and Interpreters).

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

Trauma-Informed Care

Individuals living with behavioral health conditions experience high rates of trauma. To prevent re-traumatization of individuals 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 ensure their training plan includes at a minimum, the following competency-based trainings:

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 Cognitive Behavioral Therapy	All Clinicians	At hire and every other year

In addition to the above, CCBHCs must include training specifically focused on the application of trauma-informed approaches during crises. It is up to the discretion of the CCBHC to determine if a more rigorous training cycle is needed.

CCBHCs will be required to submit their Training Plan, inclusive of how they plan to implement these trauma-informed care trainings, to the Office of CCBHC within 90 days of certification.

As introduced above, CCBHCs are required to maintain records of all trainings delivered to their staff, with verification of competency assessments.

CCBHC Cultural Competence and Other Standards

The CCBHC training plan for all staff, whether employed or contracted, who work directly with the individuals' 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 and annually thereafter, the CCBHC must provide training on Cultural Competency, among other topics.

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 ADMH approved training on Military Culture. 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 services are to be provided at the CCBHC with cultural competence.

Compliance with training requirements will be monitored through the Office of CCBHC 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 an individual 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 an individual is served by the CCBHC. Prior to certification, the CCBHC's CNA will inform which languages require language assistance, to be updated as needed.

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 individual receiving CCBHC services' privacy requirements specific to the care of minors.

Scope of Services

ADMH requires each CCBHC to provide the full scope of services as defined by SAMHSA's -CCBHC requirements. Services may be provided directly or through a DCO. However, the CCBHC must directly provide the majority (51% or more) of the service encounters.

CCBHCs 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

CCBHC services, whether provided directly , or through a DCO, are consistent with the freedom of the individual 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.

Individuals 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 AMA.

For individuals 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 an individual 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.

CCBHC assessment, treatment planning, and service delivery activities are described in more detail below under the Required Core Services section.

Interdisciplinary Team Structure within the CCBHC

A CCBHC organizes treatment through an interdisciplinary team that includes individuals who are working together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of the individual receiving services, based on the person's assessed needs. All members of the interdisciplinary team should participate in the treatment planning process. Treatment plan development and updates developed in collaboration with and be endorsed by the individual receiving services and shall be coordinated with interdisciplinary team staff or programs necessary to carry out the plan.

Information flows through shared documentation systems, case reviews, and team meetings to ensure every involved interdisciplinary team member understands the individual's full clinical picture and is able to monitor the individual's evolving needs and attainment of service plan goals.

Expectations and interventions by each member of the IDT should be documented in the electronic health record and in a manner that is clear and accessible to all members of the team.

CCBHCs must develop a written procedure for how the interdisciplinary team functions as an integrated team. The procedure must include methods for implementing the following:

- A process for team meetings, frequency based on risk, and a process for documenting the recommended actions in the record of the individual served
- Every individual receiving ongoing CCBHC services is assigned an interdisciplinary team
- The interdisciplinary team jointly develops and maintains one integrated, person-centered (Master) treatment plan, which can be supported by service plans as appropriate to the assessed needs of the individual receiving services and in alignment with Alabama state regulations (e.g., Chapter 105/106)
- Communication between the interdisciplinary team members about actions necessary to support the individual to receive coordinated, integrated care at the CCBHC should be reflected in the individual's health record

During site visits, the Office of CCBHC will review the policy and procedure and select records in each risk area to ensure documentation aligns with the policy and procedure.

Integrated Care for Individuals with Co-occurring Disorders

It is essential that CCBHCs have the capacity to provide services to individuals with co-occurring mental health and substance use needs. At the heart of the CCBHC model is the principle that individuals seeking behavioral health services should not have to “piece together” supports; instead, the CCBHC serves as a “one-stop shop” delivering, or coordinating, the broad array of interventions needed across crises, outpatient treatment, rehabilitation, and physical health screening and monitoring. Moreover, by bundling behavioral, substance use, and basic physical health care under one roof or coordinated network, CCBHCs are operationalizing a “whole person” approach which recognizes that mental health, addiction, and physical health are deeply interrelated, and that addressing them in isolation undermines long-term recovery, wellness, and stability.

Screening for co-occurring mental health and SUD needs must be universal, timely, and initiated at the very first point of contact. Providers are expected to use standardized, evidence-supported tools that assess for risk of harm to self or others, risk for overdose or withdrawal, the presence of mental health and SUD symptoms, and social determinants of health (SDOH) needs. These tools should be integrated directly into intake workflows, supported by electronic health record (EHR) prompts, and demonstrated to be either effective for, or at minimum neutral toward, the populations being screened. Screening must be designed to identify co-occurring needs early and reliably while helping to indicate who might be in need of crisis or urgent care.

When initial or early-stage screening suggests a possible Opioid Use Disorder or Alcohol Use Disorder, there must be an operational process that enables individuals to be connected with a prescriber for Medications for Addiction Treatment (MAT) quickly (if clinically appropriate and aligned with the preferences of the individual receiving services), preferably the same day. CCBHCs will need to determine how this workflow is embedded within their electronic health record, including the necessary alerts and scheduling functions. Before MAT can be started, individuals should receive a preliminary medical screening conducted by a licensed practitioner. The purpose of this screening is to verify that the person meets criteria for prescribing and that no contraindications to MAT initiation are present.

The screening and triage processes are then followed by an initial and comprehensive evaluation (described in more detail below), which informs integrated service delivery. Integrated service delivery is essential for people with co-occurring mental health and substance use disorders because these conditions influence one another in ways that make separate, uncoordinated treatment ineffective. When care is siloed, individuals often receive fragmented recommendations, conflicting treatment plans, or duplicative services. For example, an individual with major depression and alcohol use disorder may be referred to a mental health clinic for therapy while separately attending an outpatient substance use program, each unaware of the other's interventions. Without shared information or aligned strategies, the individual may experience gaps in care, inconsistent messaging, and reduced engagement, ultimately limiting progress in both areas.

Evidence-based practices for both MH and SUD, including MAT, are intentionally combined within a single treatment framework and interwoven into group and individual treatments and supports. There are circumstances where mental health and substance use disorder services can appropriately occur separately. For instance, an individual with stable, well-managed depression who seeks short-term peer recovery coaching for mild substance use may not need to attend a group for COD. Likewise, an individual in remission from a substance use disorder who now wants focused trauma therapy can safely receive that service on its own. Separate services work when conditions are mild, stable, or clearly unrelated, and when the individual receiving services does not require coordinated medications or interdisciplinary supports.

However, when mental health and substance use disorders interact, services must be integrated. Integrated care means the individual receiving services receives coordinated, simultaneous treatment from a single team that understands the interplay of their conditions and aligns interventions accordingly. This approach prevents the common pitfalls of sequential or parallel treatment, such as untreated symptoms destabilizing recovery, medication plans conflicting, or teams providing contradictory recommendations.

Importantly, the CCBHC model also includes proactive care coordination with external partners (ex: primary care, hospitals, housing providers) to ensure that integrated care extends beyond the clinic walls.

Services Delivered Via Telehealth

CCBHCs may use telehealth/telemedicine, video conferencing, remote monitoring, asynchronous interventions, and other technologies, to the extent possible, in alignment with the preferences of the individual receiving services to support access to all required services.

CCBHCs may also utilize telehealth/telemedicine, and other approved technologies to alleviate shortages, provided that these services are coordinated with other services delivered by the CCBHC. The CCBHC is not precluded from utilizing rendering providers working towards licensure if they are working under the requisite supervision.

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

- All CCBHC rendering providers are responsible for ensuring that they are complying with all state regulations regarding telehealth including Medicaid provider guidance.

- All CCBHC rendering providers utilizing telehealth should have emergency procedures that address the unique needs of telehealth that includes the identification and phone number of an emergency contact and local emergency resources for the individual receiving services; and the provider must be familiar with applicable emergency procedures at the location where the individual receives services.
- All individuals receiving services via telehealth must have documentation that both in-person and telehealth services were offered to the individual receiving services, and that they prefer the selected service(s) to be provided via telehealth.
- All CCBHC rendering providers must document verification of the physical address of the individual served and an accessible emergency contact at the beginning of each session to ensure the safety of the individual receiving services in the event of an emergency.
- Telehealth services must be provided through a platform that meets HIPAA compliance requirements.
- All CCBHC rendering providers must ensure they are delivering telehealth services in a location that maintains HIPAA and other confidentiality requirements.
- All CCBHC rendering providers must be approved, certified, and/or licensed to deliver the services they are providing in the state of Alabama.
- 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 reflecting the factors in “Clinical Considerations for the Use of Telehealth”.

Note: Rendering providers are expected to refer to Medicaid Chapter 112 for telehealth guidelines including included and excluded services. Rendering providers are expected to always comply with both AMA 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 Office of CCBHC at ccbhc.dmh@mh.alabama.gov with any questions.

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.

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.

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

Clinical Considerations for the Use of Telehealth

Rendering providers will determine suitability for telehealth sessions for each individual by evaluating their needs and preferences prior to initiating ongoing telehealth sessions. Telehealth may be utilized in an initial crisis if needed and assessed to be clinically appropriate.

The rendering provider and program staff will consider the following for the individuals receiving services prior to employing telehealth technology:

- Their awareness and familiarity with the process is sufficient to provide informed consent.
- Consideration related to symptoms that could worsen with telehealth (psychosis, paranoid/delusions related to technology).
- Language or cultural preferences. Individuals receiving services will have the option to request an interpreter at no charge (to the individual). Individuals receiving services 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 individual receiving services 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.
- Whether the individual is receiving medications that increase risks related to and/or require an abnormal involuntary movement assessment and whether that assessment can be effectively conducted via telehealth.
- 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 individual being served.

Required Core Services

1. Screening, Assessment and Diagnosis

Screening, assessment, and diagnosis are conducted in a time frame responsive to the needs and preferences of the individual receiving services and are of sufficient scope to assess the need for all services required to be provided by the CCBHC.⁹

The CCBHC 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 should 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).
 - 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.

The CCBHC shall also 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 the individual, and may include family members, lawful representative, significant other, as appropriate.

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

Required Screening Tools for AL CCBHCs for All Individuals 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	Social Determinants of Health	All individuals 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

⁹ Alabama Administrative Code Rule 580-2-20-.09¹⁰ *Alabama Administrative Code 580-2-20-10*

Related Social Needs Screening Tool (2017) and (2021) OR - WellRx Questionnaire (2014) OR - American Academy of Family Physicians (AAFP) Screening Tool (2018)		SDOH screening, this tool is intended for those 18 years or older (including parents/guardians). For youths receiving CCBHC services whose parents/guardians are not available or 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 Youth Only*

Tool	Purpose	Age Range
CRAFFT	Substance Use	12-18 years

In addition to the above tools that are a required part of your Comprehensive Assessment process, CCBHCs may use other standardized and validated instruments to assess SDOH, Alcohol/Substance Use, and Depression needs (in alignment with the Quality Manual Screening and Symptom Monitoring Tools section). If the CCBHC plans to deviate from the above list, **CCBHCs should submit a list of the other tools and instruments they plan to use (with the population and clinical justification) to the ADMH CCBHC Data Team inbox for approval within the first quarter of the Measurement Year (by March 31 of each year). This information will be useful to ADMH for future planning and implementation support, as well as ensuring all CCBHCs are using validated and acceptable instruments.*

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 individual to an appropriate provider.

All new individuals receiving services will receive a comprehensive evaluation that is completed within sixty (**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 receives 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: For individuals already receiving services at the time of CCBHC certification, CCBHCs will have ninety **(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 Service Enrollment section below.

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

2. Person-Centered 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.

The person-centered and family-centered treatment plan will be completed by the fifth face to face service in the CCBHC. An individual 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 interdisciplinary 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 individual 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 individual's preferred interventions in the event of a crisis.
- Advanced directives where the individual 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.

The plan shall address the individual's prevention, medical, and behavioral health needs. The plan shall be developed in collaboration with and be endorsed by the individual receiving services; their family (to the extent the individual receiving services so wishes); and family/caregivers of youth and children or legal guardians. 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 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 individual served should be engaged to develop a crisis prevention/safety plan. If the individual receiving services does not wish to share their preferences, that decision is documented.

3. 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 (ASAM) Third Edition Levels 1 and 2.1 and include treatment of tobacco use disorders. While only full CCBHC sites need to offer onsite ASAM Level 2.1 services, Satellite Sites and Access Points (if they do not have onsite ASAM Level 2.1 services) should have an established process for connecting individuals receiving services with this level of SUD needs to their Level 2.1 program at a full CCBHC site when appropriate.

The IDT requirements listed above are applicable in addition to the standards listed below:

Individual Therapy/Counseling for mental health shall include at a minimum:¹⁰

- 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.

¹⁰ Alabama Administrative Code 580-2-20-10

The following is applicable to ASAM Level of Care 1 Outpatient Services for people with substance use disorders:¹¹

- Each Level I Outpatient Program shall demonstrate the capacity to provide a basic level of skilled treatment services appropriate to the needs of people receiving CCBHC services:
 - 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.
 - 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.
 - Services for Adolescents: Each Level I Program serving Adolescents shall document the capacity to provide each of the core services and to include:
 - Activity therapy
 - Adolescent specific evidence-based therapeutic interventions.
 - 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.
 - Services for Individuals with Co-occurring Disorders Program Specific Criteria: Each Level I Program serving Co-occurring Disorders shall document the capacity to provide each of the core services to include basic living skills, crisis intervention services, and intensive case management. In addition, the CCBHC 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 people receiving CCBHC services in becoming aware of cues or triggers that enhance the likelihood of alcohol

¹¹ Alabama Administrative Code 580-9-44-.15

- 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.
- Services for Women and Dependent Children: Each Level I Program serving Women and Dependent Children 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
- In addition, the CCBHC 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.
- Additionally, the CCBHC shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency and intensity appropriate to the individual receiving CCBHC services' 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.
 - Strategies to prevent recurrence
 - Interpersonal choice/decision-making skill development.
 - Health education.
 - Random drug screening
 - Family education.
 - Gender responsive treatment.
- 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 individual receiving CCBHC services, not to exceed eight (8) contact hours weekly.

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. For substance use services specifically, CCBHCs must offer Level 1.0 outpatient services

to children/youth and adults at the time of certification. At minimum, Level 2.1 services must be available for adults. If at certification the CCBHC does not offer Level 2.1 for youth:

- The CCBHC must build capacity to provide Level 2.1 services for youth if/when a community need arises (e.g., multiple young people are engaged who are clinically appropriate for and in need of this level of service)
- The CCBHC should ensure their ability to provide a sufficiently appropriate level of support through their outpatient services that is designed to keep these young people engaged in the community and avoid (when possible/clinically appropriate) residential and/or acute service utilization/incidents

See below for the Evidence Based Practices required for 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 in accordance with the Federal Criteria. 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 individual 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 individual 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 evidence-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 individual 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.

4. Outpatient Clinic Primary Care Screening and Monitoring

CCBHCs are 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.^{12, 13}

The CCBHC must also coordinate with each individual's primary care provider to ensure that screenings occur for the identified conditions. If the individual 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. If the individual refuses screening or refuses to sign a release of information to coordinate with the primary care provider, this should be noted in the record of the person served. *Attempts to obtain all documentation should be documented in the record of the individual 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. Each CCBHC's Medical Director should include in the primary care screening and monitoring protocols the required laboratory tests that must be completed. CCBHCs must include in their required laboratory tests:

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

¹² <https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf>

¹³ <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-brecommendations>.

Note: 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.

Documentation of all screening and monitoring must be present in the primary record of the individual receiving services.

5. Targeted Case Management Services

CCBHC targeted case management (TCM) provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all individuals served by the CCBHC.

CCBHC targeted case management should include support for individuals deemed at high risk of suicide or overdose, particularly during times of transitions such as discharge from:

- Residential treatment
- Hospital emergency department
- Psychiatric hospitalization
- Incarceration

In addition to SAMHSA's requirements, CCBHCs must adhere to Chapter 106 guidelines when implementing TCM services. In addition to 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.). CCBHCs should consider the following individuals as being able to possibly benefit from TCM services:

- Individuals transitioning from carceral settings.
- Individuals transitioning from residential treatment.
- Individuals transitioning from inpatient treatment.
- Individuals transitioning from a hospital emergency department.
- Individuals screening high on social determinants of health screening.
- Individuals who have a short-term need for support in a critical period, such as an acute episode or care transition.
- Individuals 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 Individuals 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).

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 and/or Stimulant Use Disorder 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.

CCBHCs are responsible for providing directly, or through a DCO, evidence-based rehabilitation services for both mental health and substance use disorders. In addition to the above, CCBHCs are required to provide the following services:

- Supported Employment
 - If the agency operates an Individual Placement and Support (IPS) team outside of the CCBHC, the CCBHC should have a standard process for making connections to IPS when an individual is eligible for this evidence-based service.
 - CCBHCs should also have referral relationships and linkages with other entities offering employment supports, including connection to Supportive Housing Program
- Connection to Supportive Housing Program

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.

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 individuals 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
- Connect to Supportive Housing Program

These services may be provided or enhanced by Certified Peer Support Specialists.

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

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

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

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 individuals receiving CCBHC services in the acquisition and exercise of skills needed to support recovery.
- Services may include activities that assist individuals receiving CCBHC services 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 support and basic daily living skills

Peer Support Services provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural support, 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 support in leading and directing the design of the service plan and thereby ensures that the plan reflects the needs and preferences of the individual receiving services (and family when appropriate) with the goal of active participation in this process. Additionally, this service provides support and coaching interventions to (individuals receiving services (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 support provides 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

In addition to federal CCBHC Criteria, 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

Individuals 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 Clinics¹⁴).

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.

CCBHCs should refer to the SAMHSA CCBHC Criteria and VHA Handbook for additional guidance.

9. Crisis Services

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, including a mobile response to crisis.

In addition to the above requirements, CCBHCs will be required to:

¹⁴ <https://www.va.gov/vhapublications/publications.cfm?pub=1>

- 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 receiving services/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 individual receiving services crisis state, when known
- Identifying the maladaptive reactions exhibited by the individual receiving services
- Evaluating the potential for rapid regression
- Resolving the crisis
- Referring the individual receiving services for treatment at an alternative setting, when indicated

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.

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.

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.

Other Crisis Service Requirements

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.

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.

The CCBHC develops a crisis prevention/safety plan with each individual 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 individual receiving services. Psychiatric Advance Directives, if developed, are entered in the electronic health record of the individual receiving services so that the information is available to providers in emergency care settings where those electronic health records are accessible.

If the individual 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).

Required Evidence Based Practices

Based upon the findings of the CCBHC's CNA, 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
- Cognitive Behavioral Therapy
- Integrated Treatment for Co-occurring Disorders (COD)
- Medications for Addiction Treatment (MAT)
- Trauma-Focused CBT
- Peer and Family Support

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

- While Alabama Assertive Community Treatment (A-ACT) services are carved-out services and are not included in the AL CCBHC Scope, ADMH recognizes that A-ACT are critical services for individuals living with SMI. Therefore, Alabama CCBHCs are expected to establish formal written processes to connect individuals to A-ACT, in order to promote opportunities to access this level of care and step-down to outpatient CCBHC services when an individual is ready to be discharged from A-ACT.
- Similarly, if the CMHC operates an Individual Placement and Support (IPS) team outside of the CCBHC, the CCBHC should have a standard process for making connections to IPS when an individual is eligible for this evidence-based service. The CCBHC should also have processes to support linkages to Supportive Housing services. CCBHCs must establish processes that address employment, and housing needs specific to their catchment area. These processes are subject to ADMH's review and approval.
- In addition, CCBHCs are expected to provide services in the community outside of their clinic sites' four walls, in order to promote accessible services. This can include in-home team services within the scope of the 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.
- 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

Based on the CCBHC Certification Criteria, 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 in a full-time position.

In addition to the above requirements, all CCBHCs must designate a Medical Director, listed as Key Staff with the Office of CCBHC and on all CCBHC documents. If the CCBHC is unable to designate a Medical Director as referenced above, the CCBHC must inform the Office of CCBHC 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 Medical Director. This information must be made available to the Office of CCBHC at site visits or upon request.

The Medical Director will establish organizational screening protocols for primary care screening and monitoring. The protocols must include how to identify individuals 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 the Office of CCBHC at site visits or upon request.

The Medical Director will establish measures and monitor the ongoing quality improvement efforts related to medical care. The Medical Director, or designee, will co-chair the CQI committee. CQI policies and minutes will be made available to the Office of CCBHC 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)

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. In addition to the Criteria requirements, CCBHCs must meet the following requirements related to establishing agreements with DCOs:

- 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 (contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal, legal arrangements) 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 team meetings
 - Mechanisms for the CCBHC to ensure adherence to all CCBHC criteria

- Specific actions to reduce administrative burden on the individual 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 the Office of CCBHC 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 DCOs must submit to the Office of CCBHC a plan to improve data sharing and coordination within 2 years of certification as a CCBHC.

Regardless of the CCBHC's DCO relationships, the CCBHC maintains responsibility for assuring that individuals receiving services from the DCO receive services as needed and in a manner that meets the same quality standards and requirements of the 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 an individual 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 individuals receiving CCBHC services. Payment for those referred services is not through the PPS but is made through traditional mechanisms within Medicaid or other funding sources.

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

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 individual.

Care Coordination Activities

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. In addition to the requirements above, 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
 - Federally Qualified Health Centers (FQHCs)
 - FQHC Look-Alikes and Community Health Centers
 - As applicable, Rural Health Clinics (RHCs)
 - The nearest Veterans Affairs institutions
 - 988 Suicide & Crisis Lifeline Call Center (serving the area in which the CCBHC is located)
 - 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 the Office of CCBHC 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 individuals receiving CCBHC services
- 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).

Note: CCBHCs must make every attempt to contact individuals being served by the CCBHC once they are discharged (within 24 hours) from an acute inpatient setting, ED or other levels of care. These attempts must be documented.

All required care coordination agreements must be signed by agency leadership and reviewed at 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 individuals receiving CCBHC services served. Annual review of care coordination agreements should be conducted and documented in a standardized tracker that includes at minimum the following elements:

- Care Coordination Partner/Entity's Name
- Review Date
- Reviewer's Name
- Status (No changes/ Updated/ Follow Up Needed/ Pending Revision)
- Comments
- Signature Line (for leadership) and Date

All elements listed above are required for documentation and must be present; however, the elements are not required to be listed or recorded in any specific order.

Whenever a care coordination agreement is updated or awaiting a revision, a final copy must be provided to the Office of CCBHC.

All other care coordination agreements must be signed by agency leadership and reviewed no less than every 3 years and updated as necessary.

Access and Availability of Services

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 individuals receiving services.

Transportation or transportation vouchers for individuals 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 individual 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, individuals 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 individuals 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 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.

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 an individual 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 individuals receiving same/next day access services.

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

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

CCBHC Service Enrollment

Any individual with a mental health or substance use disorder diagnosis is eligible to receive CCBHC services regardless of their inability to pay or place of residence, homelessness, or lack of a permanent address. Individuals eligible for CCBHC services should be identified by the CCBHC using a multifaceted outreach and engagement approach for both Medicaid and non-Medicaid beneficiaries.

Note: Receipt of duplicative services (e.g., **outpatient** co-enrollment between CCBHCs and/or **another** CMHC) should not occur. Programs should contact the Office of CCBHC 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 be enrolled in the CCBHC program through the below initial and comprehensive evaluation processes.

Individuals Engaged in Services Prior to CCBHC Certification

No later than 90 days from the date of CCBHC certification, CCBHCs must conduct all required screenings and gather, and document updated assessment information from each individual who was already engaged in CMHC services at the time of CCBHC certification. This is intended to ensure all of the required initial and comprehensive evaluation information is collected in alignment with the CCBHC criteria. Within 180 days of certification, or prior to the expiration of the current treatment plan, whichever occurs first, the CCBHC must engage the individual to update the treatment plan. The updated plan must incorporate all CCBHC services appropriate to the individual's needs and preferences, include assignment of an interdisciplinary team, and document the individual's risk level. CCBHCs should also review each Treatment Plan to ensure 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>.

Note: 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/or audit reviews, the Office of CCBHC will randomly select charts for individuals receiving CCBHC services to ensure 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 Service Enrollment section of this Manual have not been completed within the specified timeline.*

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

Individuals Whose First CCBHC Service is a Crisis Service

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 enrollment processes referenced above) 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).

Enrollment of Individuals Regardless of Their Ability to Pay or Place of Residence

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 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 receiving services 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 individual receiving services to inform the treatment plan and services provided.

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:

- Individuals 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 population¹⁵
 - 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 areas 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; individuals who identify as LGBTQ+,
- Individuals identified by federal data as being at risk of gun violence, which include but are not limited to:^{16, 17}
 - Minority youth living in poverty
 - African American individuals, including children and adolescents
 - White individuals ages 45 and older
 - Male children ages 19 and under

Agencies may use the following resources to determine whether a particular geography is rural.¹⁸

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 ADMH. Any disparities noted will be addressed through the agency's formal CQI process.

CCBHCs must complete a CNA at a 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 the Office of CCBHC to update communications with SAMHSA and demonstration priorities.

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 the individuals 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.

¹⁵ <https://www.hrsa.gov/rural-health/about-us/what-is-rural>

¹⁶ <https://www.hhs.gov/sites/default/files/firearm-violence-advisory.pdf>

¹⁷ <https://www.apa.org/pubs/reports/gun-violence-prevention>

¹⁸ <https://data.hrsa.gov/tools/rural-health>

Staffing plans should also align with the needs of the 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 Manual and outlined in the table below:

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

Note: 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 individual. 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.

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

Demographic and Social Data Collection for Measure Stratification: With the exception of the state-collected Patient Experience of Care Survey (PEC) and Youth/Family Experience of Care Survey (YFEC) 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 is standardizing the collection and reporting of demographic and social determinants data across state and clinic-level databases. Required data, collected through Medicaid enrollment, includes individual receiving CCBHC services' race, ethnicity, sex, age, language, marital status, pregnancy status, and veteran status. For individuals receiving CCBHC services that are not Medicaid eligible, 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 the Office of CCBHC and other CCBHCs to promote a culture of learning and improvement.

CQI Plan: CCBHCs must also develop and maintain a CQI Plan that is approved by the agency's Medical Director and the Clinical Director. CQI Plans are to be submitted to the Office of CCBHC on an annual basis. Please refer to the CCBHC Quality Manual for detailed requirements regarding what should be included in the CQI Plan and the timelines for submission.

Please see the CCBHC Quality Manual for more information about these data-related requirements.

CCBHC 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 90 days after the end of each Demonstration Year (DY) (by September 30th of each year).

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 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 the CCBHC Cost Report Instructions

here: <https://www.medicaid.gov/medicaid/financial-management/certified-community-behavioral-health-clinic-ccbhc-demonstration/ccbhc-cost-reporting>. As Alabama is utilizing the daily Prospective Payment System Option 1 (PPS-1) rate structure, providers should follow the instructions pertinent to PPS-1 when completing their annual Cost Reports.

Note: 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.

Cost Report, Required/Allowable Services, and Triggering Events Relationship & Distinctions



Changes to the Provision of the CCBHC Core Services

Failure to provide any of the CCBHC 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 ADMH:**

- Any changes to the provision of any of the 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 PPS-1 daily rate payment model that supports clinics' costs of expanding services and increasing the number of individuals receiving services, while also 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 are not reimbursable.

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 individual receiving services by the CCBHC. For more details about Triggering Events, see the “Triggering Events” spreadsheet linked here: [Certified Community Behavioral Health Clinics – Alabama Department of Mental Health](#) A visit is defined as a “billable event” when an individual receives at least one face-to-face or telehealth encounter with a qualified CCBHC staff member in an approved setting, during which one or more triggering services are provided and appropriately documented, consistent with the guidance in this manual.
- **Non-Triggering Events**– an allowable service under the CCBHC program that does not trigger a daily PPS-1 payment (e.g., 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 that 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 (e.g., an inpatient service setting).

For more information about allowable/unallowable service settings and other billing considerations, please see the CCBHC Billing Manual.

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 individual 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 actions¹⁹ (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.²⁰
 - They are not conflicted from providing services through Medicare, Medicaid, or other federal funding.²¹
- 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
 - 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

Note: 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 meets 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

¹⁹ 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.

²⁰ https://medicaid.alabama.gov/content/8.0_Fraud/8.7_Suspended_Providers.aspx

²¹ <https://exclusions.oig.hhs.gov/>

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 provide effective, efficient, and coordinated care to individuals receiving services 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 individuals 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 individual being served, including:

- Regular audits of the records of the individual receiving services 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 payment conditions, 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 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 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 are defined as:

Item	Description
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that 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 reflects 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.²² 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

²² [Certified Community Behavioral Health Clinics – Alabama Department of Mental Health](#)

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, Gainwell²³.

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.

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 supports 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.

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)).

²³ 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.

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)²⁴ - Licensed Marriage and Family Therapist	1. State License 2. Malpractice History	1. Primary Verification Sources (see Appendix B) 2. NPDB Query

²⁴ 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 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

Paraprofessionals	• Certified Recovery Support Specialist (CRSS) • Medical Assistant (MA) or Certified Medical Assistant (CMA) • Qualified Mental Health Professional (QMHP) • Qualified Practitioner of Psychology (QPP)²⁵ • Certified Peer Specialists (CPS) or Peer Support Specialist (PSS)²⁶ • Targeted Case Management (TCM)²⁷	1. State Certification	1. Primary Verification Sources (see Appendix B)
Nursing	• Certified Nursing Assistant (CAN) • Licensed Practical Nurse (LPN) • Registered Nurse (RN) • Psychiatric Clinical Nurse Specialist (PCNS)	1. State License	1. Primary Verification Sources (see Appendix B)

²⁵ 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](#).

²⁶ 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](#).

²⁷ 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](#).

Advanced Practice Clinicians	- Physicians Assistants (PA) - Psychiatric Certified Registered Nurse Practitioners (Psych CRNP)	- State License - Collaborative Agreement with Physician (CRNP only)²⁸ - DEA Number²⁹ - Malpractice History	- Primary Verification Sources (see Appendix B) Alabama Board of Nursing DEA NPDB Query
Pharmacist	Registered Pharmacist (RPH)	- State License - DEA Number²⁹ - Malpractice History	- Primary Verification Sources (see Appendix B) DEA NPDB Query
Physicians	- Medical Doctors (MD) - Psychiatrist (MD) - Doctor of Osteopathic Medicine (DO)	- State License & Board Certifications - DEA Number²⁹ - Malpractice History	- Primary Verification Sources (see Appendix B) DEA NPDB Query

²⁸ 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.

²⁹ 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

Licensed Behavioral Health Professionals

Provider Profession	Verification Source
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) - Qualified Substance Abuse Professional (QSAP I³⁰ II³¹ and III³²)	Alabama Board of Examiners in Counseling
Licensed Marriage and Family Therapist	Alabama Board of Examiners in Marriage and Family Therapy

³⁰ 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

³¹ 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.

³² 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.

Paraprofessionals

Provider Profession	Verification Source
• Certified Recovery Support Specialist (CRSS) • Medical Assistant (MA) or Certified Medical Assistant (CMA) • Certified Peer Specialists (CPS) OR Peer Support Specialist (PSS)³³ or Certified Peer Recovery Specialist (CPRS) • Targeted Case Management (TCM)³⁴	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.
• Qualified Mental Health Professional (QMHP)	Licensee Search – Alabama Board of Examiners in Counseling
• Qualified Practitioner of Psychology (QPP)³⁵	Licensee Search – Alabama Board of Examiners in Psychology

Nursing

Provider Profession	Verification Source
• Certified Nursing Assistant (CAN) • Licensed Practical Nurse (LPN) • Registered Nurse (RN) • Psychiatric Clinical Nurse Specialist (PCNS)	Alabama Board of Nursing

³³ 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](#).

³⁴ 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](#).

³⁵ 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](#).

Advanced Practice Clinicians

Provider Profession	Verification Source
Physicians Assistants (PA)	Licensee Search Alabama Board of Medical Examiners & Medical Licensure Commission
- Psychiatric Certified Registered Nurse Practitioners (Psych CRNP)	Alabama Board of Nursing

Pharmacists

Provider Profession	Verification Source
Registered Pharmacist (RPH)	Alabama Board of Pharmacy

Physicians

Provider Profession	Verification Source
- Medical Doctors (MD) - Psychiatrist (MD) - Doctor of Osteopathic Medicine (DO)	Alabama Board of Medical Examiners and Medical Licensure Commission

Appendix C – Provider Checklist for Enrolling Individuals Already Receiving Services at the Time of Certification)

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 receiving services 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 screenings and 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

Within 90 days thereafter, the CCBHC must:

- 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)