Office of Mental Health | Office of Addiction Services and Supports

A new Subpart 600-1 is being added to Title 14 of the NYCRR to read as follows:

Subpart 600-1 Certified Community Behavioral Health Centers (CCBHC)

Section 600-1.1 Background and Intent.

(a) CCBHCs were originally established under the State's CCBHC demonstration pursuant to section 223 of the Protecting Access to Medicare Act (P.L. 113-93), as amended. Providers authorized to participate in the State's CCBHC demonstration operated integrated mental health and substance use disorder programs pursuant to federal demonstration requirements and integrated care regulations promulgated by the commissioners of the Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS). The purpose of this Subpart is to establish new standards for the certification, operation, and reimbursement of certified community behavioral health centers (CCBHCs).

(b) The purpose of CCBHCs is to provide coordinated, comprehensive integrated behavioral health care across the lifespan, including mental health and substance use services, primary care screening and monitoring, peer support services, psychiatric rehabilitation services, and targeted case management services, in accordance with standards established by the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration, or any successor agency, and the commissioners of OMH and OASAS.

(c) CCBHCs are developed under the authority of OMH and OASAS and, unless otherwise specified, all provisions of the Mental Hygiene Law (MHL) are accordingly integrated.

(d) This Subpart and all other standards of reimbursement applicable to CCBHC programs shall be contingent upon Federal financial participation.

Section 600-1.2 Legal Base

(a) Office of Mental Health (OMH):

(1) Section 7.09 of the Mental Hygiene Law (MHL) grants the Commissioner of Mental Health the power and responsibility to adopt regulations that are necessary and proper to implement matters under their jurisdiction.

(2) Section 7.15 of the MHL charges the Commissioner of Mental Health with the responsibility for planning, promoting, establishing, developing, coordinating, evaluating and conducting programs and services of prevention, diagnosis, examination, care, treatment, rehabilitation, training, and research for the benefit of persons with mental illness. Such law further authorizes the commissioner to take all actions that are necessary, desirable, or proper to carry out the statutory purposes and objectives of OMH, including undertaking activities in cooperation and agreement with other offices within the Department of Mental Hygiene, as well as with other departments or agencies of State government.

(3) Section 31.04 of the MHL authorizes the Commissioner of Mental Health to set standards of quality and adequacy of facilities, equipment, personnel, services, records and programs for the rendition of services for adults diagnosed with mental illness or children or youth diagnosed with serious emotional disturbance, pursuant to an operating certificate.

(4) Sections 31.05, 31.07, 31.09, 31.13, 31.19, and 31.27 of the MHL authorize the Commissioner of Mental Health or their representatives to examine and inspect CCBHCs to determine their suitability and proper operation.

(5) Section 31.06 of the MHL requires every holder of an operating certificate to develop and implement policies and training programs regarding reporting child abuse.

(6) Section 31.16 of the MHL authorizes the Commissioner of Mental Health to suspend, revoke or limit any operating certificate, under certain circumstances.

(7) Sections 43.01 and 43.02 of the MHL authorize the Commissioner of Mental Health to establish fees and rates for department services and services provided by facilities licensed by OMH subject to the approval of the director of the Division of the Budget.

(8) Section 43.02(b) of the MHL authorizes the Commissioner of Mental Health to request from operators of facilities licensed by OMH such financial, statistical, and program information as the commissioner may determine to be necessary.

(9) Section 364 and 364-a of the Social Services Law give OMH responsibility for establishing and maintaining standards for medical care, and services and facilities in accordance with cooperative arrangements with the Department of Health.

(10) Article 29-G of the Public Health Law authorizes the provision of and reimbursement for health care services provided via telehealth.

(b) Office of Addiction Services and Supports (OASAS):

(1) Section 19.07(a) of the MHL charges OASAS with assuring the development of comprehensive plans, programs and services for research, prevention, care, treatment, rehabilitation, education and training related to substance use disorder and compulsive gambling.

(2) Section 19.07(c) of the MHL charges the Commissioner of OASAS with the responsibility to ensure that persons who have a substance use disorder and their families are provided with care and treatment that is effective and of high quality.

(3) Section 19.07(e) of the MHL authorizes the Commissioner of OASAS to adopt standards including necessary rules and regulations pertaining to substance use disorder treatment services.

(4) Section 19.09(b) of the MHL authorizes the Commissioner of OASAS to adopt regulations necessary and proper to implement any matter under his/her jurisdiction.

(5) Section 19.20 of the MHL requires review of criminal history information review concerning certain prospective employees and volunteers of providers of services certified, operated or otherwise authorized by OASAS.

(6) Section 19.21(b) of the MHL requires the Commissioner of OASAS to establish and enforce regulations concerning the licensing, certification, and inspection of substance use disorder treatment services.

(7) Section 19.21(d) of the MHL requires OASAS to establish reasonable performance standards for providers of services certified by OASAS.

(8) Section 19.40 of the MHL authorizes the Commissioner of OASAS to issue operating certificates for the provision of substance use disorder treatment services.

(9) Section 22.11 of the MHL authorizes treatment for minors for substance use disorder without consent from a parent or guardian.

(10) Section 32.01 of the MHL authorizes the Commissioner of OASAS to adopt any regulation reasonably necessary to implement and effectively exercise the powers and perform the duties conferred by article 32 of the MHL.

(11) Section 32.05(b) of the MHL provides that a controlled substance designated by the Commissioner of Health as appropriate for such use, may be used by a physician to treat a chemically dependent individual pursuant to section 32.09(b) of the MHL.

(12) Section 32.07(a) of the MHL authorizes the Commissioner of OASAS to adopt regulations to effectuate the provisions and purposes of Article 32 of the MHL.

(13) Section 32.09(b) of the MHL provides that the Commissioner of OASAS may, once a controlled substance is approved by the Commissioner of Health as appropriate for such use, authorize the use of such controlled substance in treating a chemically dependent individual.

(14) Section 32.21 of the MHL provides the Commissioner of OASAS with the authority to suspend, revoke or limit operating certificates and imposition of fines.

(15) Part 2 of title 42 of the Code of Federal Regulation (CFR) relates to the confidentiality of substance use treatment records.

(c) Section 36.04 of the MHL authorizes the commissioners of OMH and OASAS to jointly certify community behavioral health centers, subject to the availability of State and Federal funding.

(d) Section 36.06 of the MHL provides authority for the shared criminal history information review and suitability determination for prospective employees and volunteers, providers, operators, and individuals seeking to be credentialed for entities that are licensed, certified, or otherwise authorized by OMH and OASAS.

Section 600-1.3 Applicability

This Subpart applies to any provider of services who operates or proposes to operate a New York State CCBHC, as permitted by section 600-1.5 of this Subpart.

Section 600-1.4 Definitions

(a) General Definitions

(1) Addiction means substance use disorder as defined in this Part and includes gambling disorder and problem gambling as defined in this Title.

(2) Addiction services mean examination, evaluation, diagnosis, care, treatment, or rehabilitation of persons with substance use disorder, gambling disorder, or problem gambling and their families or significant others.

(3) Approved medication means any medication approved by State or Federal authorities for the treatment of medical and psychiatric conditions, including those conditions caused by the use of such substances.

(4) Assessment or screening includes evaluations to determine immediate needs, risk, psychiatric needs, mental health disorders, addiction including substance use disorder, gambling disorder, or problem gambling, functional or rehabilitative deficits, and physical health needs, as well as gathering or updating information concerning the individual's behavioral and physical health history and status in order to determine the appropriate diagnosis(es) and assessing the individual's functional limitations, strengths and goals to inform the treatment planning process.

(5) Behavioral health care/services means care and treatment of mental health or substance use disorders.

(6) Behavioral health disorder means a mental health or addiction condition consistent or corresponding with the current edition of the Diagnostic and Statistical Manual (DSM) with the exception of:

(i) neurodevelopmental disorders in the absence of other mental health conditions defined in the Diagnostic and Statistical Manual or International Classification of Diseases except Attention-Deficit/Hyperactivity Disorder and Tic Disorders;

(ii) major neurocognitive disorder, traumatic brain injury, or mental disorders due to another medical condition; or

(iii) V-Codes. Other conditions that may be a focus of clinical attention (commonly described with Z codes), except for Parent-Child Relational Problem, relational problems related to the addiction disorder of a significant other, problem related to unspecified psychosocial circumstances and problem gambling as defined in this Subpart.

(7) Care coordination means the coordination of care between settings and providers, across the lifespan and spectrum of health services for participants, including behavioral health, physical health, as well as health related social needs to promote wellness and recovery of the whole person and family.

(8) Certified Community Behavioral Health Center or Clinic (CCBHC) means a program which provides coordinated, comprehensive integrated behavioral health care, including mental health and substance use services, primary care screening and monitoring, peer services, psychiatric rehabilitation services and targeted case management services,

across the lifespan, in accordance with CCBHC standards established by the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration, and any successor agency, and the commissioners of the Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS).

(9) Child or youth means an individual under the age of 21 years.

(10) Collateral means a person who is a member of the individual's family or household, or other person who regularly interacts with the individual and is directly affected by or has the capability of affecting their condition, and is identified in the treatment plan as having a role in treatment and/or is necessary for participation in the evaluation and assessment of the individual prior to enrollment.

(11) Commissioners means the commissioners of the Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS).

(12) Community needs assessment means a systematic approach to identifying current community and population needs, resources, and desired services across the lifespan within the identified service area based on data and input from community stakeholders.

(13) Co-occurring disorder means the diagnosis of at least one addiction and one mental health disorder occurring at the same time.

(14) Counseling or psychotherapy means individual, group, and family counseling or psychotherapy services, provided within scope, for the purposes of alleviating symptoms or dysfunction associated with an individual’s mental health disorder, or addiction including substance use disorder, gambling disorder, or problem gambling, reversing or changing maladaptive patterns of behavior, encouraging personal growth and development, and supporting the individual’s capacity to achieve age-appropriate developmental milestones. These services include tobacco use disorder treatment services.

(15) Crisis behavioral health services means the provision of emergency crisis intervention services, 24 hour mobile crisis services and crisis stabilization.

(16) Crisis intervention services identify the individual’s immediate needs, de-escalate the crisis and connect individuals to a safe and least restrictive setting for ongoing care including care provided by the CCBHC. This could include identifying triggers that would risk the individual not remaining in the community or that result in functional impairments, and assisting the individual, family members or other collaterals with identifying a behavioral health crisis, developing a crisis management plan or as appropriate, seeking other supports to restore stability and functioning.

(17) Designated Collaborating Organization (DCO) means 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 required services or elements of required services. This formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal, legal arrangements describing the parties' mutual expectations including that services provided shall conform to all relevant CCBHC criteria and establishing accountability for services to be provided and funding to be sought and utilized, including data sharing and consent to share Protected Health Information (PHI).

(18) Family means those members of the individual's natural family, family of choice, or identified caregivers.

(19) Family peer recovery support services means engagement, bridging support, parent skill development, and crisis support for families caring for a child or youth who is experiencing social, emotional, medical, developmental, substance use or other behavioral challenges in their home, school, placement, and/or community to promote recovery, self-advocacy, and the development of natural supports and community living skills.

(20) Individual means a person who is receiving services at a CCBHC.

(21) Integrated care services means the systematic coordination of services to treat co-occurring disorders concurrently, as well as screening for and monitoring primary care needs.

(22) Intensive, community-based behavioral health care for members of the armed forces and veterans means outpatient mental health and substance use and addiction services that comport with the standards for services set out in this Subpart and which are tailored to the meet the experience of members of the armed forces and veterans in that all services provided shall be integrated, coordinated, recovery-oriented, and incorporate the core recovery principles of privacy, security, and honor.

(23) Intensive Outpatient Services (IOS) is an outpatient treatment service provided by a team of clinical staff for individuals who require an intensive time-limited, multi-faceted, array of services, structure, and support to achieve and sustain treatment and recovery goals.

(24) Individuals with lived experience means individuals who self-identify as having personally experienced mental health, addiction, including substance use disorder, or co-occurring disorders or indirectly experienced mental health, addiction, including substance use disorder, or co-occurring disorders through family members.

(25) Medication for addiction treatment (MAT) means the treatment of substance use disorder and co-occurring conditions, with medications requiring a prescription or order from an authorized prescribing professional and counseling and behavioral therapies, as clinically appropriate.

(26) Mental health disorder means a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation.

(27) On-call, for the purposes of this Subpart, shall mean the provider is not physically present at the center but can be contacted immediately for clinical consultation as needed and be on-site as necessary.

(28) Outpatient primary care screening and monitoring means screens for key health indicators and health risks in accordance with established protocols.

(29) Parent-child relational problem means a behavioral health condition for children or youth related to a parent-child conflict.

(30) Person or family centered treatment planning means an ongoing process directed by the individual in collaboration with the individual's family or other collaterals, to treat an individual's mental health condition, or addiction including substance use disorder, gambling disorder, or problem gambling in a manner consistent with the individual's preferences, phase of life and development. Treatment planning addresses treatment and rehabilitative goals, needs, preferences, capacities and desired outcomes for the provision of CCBHC services as well as monitoring of treatment of physical health conditions. Services are informed and determined by the preliminary triage screening, assessment, and diagnosis process and reflected in the treatment plan.

(31) Person-centered care means that an individual participates to every extent possible, in the planning of their services and makes choices about the services and supports that they receive.

(32) Preliminary triage and risk assessment means for individuals presenting for the first time to the CCBHC in person, by telephone, or using other remote communication the program shall determine acuity of needs. This includes using clinically appropriate screening tools to assess the need for emergency or crisis services related to Mental Health and Substance Use Disorder and ensuring all individuals requesting services will be provided with resources to prevent and respond to crisis situations.

(33) Problem gambling means gambling behavior meeting less than four of the DSM criteria for gambling disorder.

(34) Problem related to unspecified psychosocial circumstances means a behavioral health condition related to an individual's social, cultural or environmental influences.

(35)Psychiatric rehabilitation services means evidence-based rehabilitation services and recovery supports for both mental health and substance use disorders, that help individuals develop skills and enhance functioning to facilitate community living; support positive social, emotional, and educational development; facilitate inclusion and integration; and support pursuit of their goals in the community. These services include supported employment and education services designed to provide those receiving services with initial and on-going support to obtain and maintain competitive, integrated employment or meet education goals.

(36) Recovery-oriented means a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

(37) Relational problem due to the addiction disorder of a significant other means the psychological, behavioral, or emotional effects experienced by an individual due to the behaviors associated with another person's addiction disorder, regardless of whether the other individual is receiving treatment.

(38) Screening, assessment and diagnosis shall mean initial and comprehensive evaluations, and ongoing screenings and evaluations that occur while an individual receives services at the CCBHC.

(39) Substance use disorder (SUD) means presence of cognitive, behavioral, and physiological symptoms indicating that an individual continues using substances despite significant substance-related physical, psychological, and social problems as determined through assessment and diagnosis using the most recent version of the DSM as incorporated by reference in Part 800 of this Title.

(40) Targeted case management means a range of services to assist and support individuals in developing skills to gain access to needed medical, behavioral health, housing, employment, social, educational and other services essential to meeting basic human services; linkages to and training in the use of basic community resources; and monitoring of overall service delivery to assure that needed services and supports are received.

(41) Telehealth has the meaning set forth in section 2999-cc of the Public Health Law and includes audio-only visits.

(42) Treatment plan means a dynamic document that is current, reflects the unique strengths and needs of the individual and family, establishes the individual and family's goals and identifies the services and interventions needed to assist in accomplishing these goals. It also includes a means for determining when goals have been met, and the criteria for appropriate disenrollment or transition to other needed services.

(43) Youth or adult peer support services means services for adults or youth, including age-appropriate psychoeducation, counseling, person-centered goal planning, modeling effective coping skills, and facilitating community connections and crisis support to reduce symptomology and restore functionality.

(b) Staffing Definitions.

(1) Professional staff means an individual who is qualified by license, credentials, training and experience to provide supervision and direct service related to the treatment of physical health, mental health disorders, or addiction, including substance use disorders, gambling disorders, or problem gambling, or co-occurring disorders in a CCBHC and may include but not be limited to the following:

(i) Certified dietician/nutritionist: An individual who is currently licensed or possesses a permit to practice as a certified Dietician/Nutritionist issued by the New York State Education Department.

(ii) Creative arts therapist: An individual who is currently licensed or possesses a permit to practice as a creative arts therapist issued by the New York State Education Department.

(iii) Credentialed alcoholism and substance abuse counselor (CASAC): An individual who is currently credentialed by OASAS in accordance with the laws and rules of New York State.

(iv) Licensed practical nurse: An individual who is currently licensed or possesses a permit to practice as a licensed practical nurse issued by the New York State Education Department.

(v) Marriage and family therapist: An individual who is currently licensed or possesses a permit to practice as a marriage and family therapist issued by the New York State Education Department.

(vi) Mental health counselor: An individual who is currently licensed or possesses a permit to practice as a mental health counselor (LMHC) issued by the New York State Education Department.

(vii) Nurse practitioner: An individual who is currently certified or possesses a permit to practice as a nurse practitioner issued by the New York State Education Department.

(viii) Occupational therapist: An individual who is currently licensed or possesses a permit to practice as an occupational therapist issued by the New York State Education Department.

(ix) Physician: An individual who is currently licensed or possesses a permit to practice medicine issued by the New York State Education Department.

(x) Physician assistant: An individual who is currently licensed or possesses a permit to practice as a physician assistant issued by the New York State Education Department.

(xi) Psychiatric nurse practitioner: An individual who is currently certified or possesses a permit to practice as a nurse practitioner with an approved specialty area of psychiatry issued by the New York State Education Department.

(xii) Psychiatrist: An individual who is currently licensed or possesses a permit to

practice medicine issued by the New York State Education Department and who is either a diplomate of the American Board of Psychiatry and Neurology or is eligible to be certified by such Board or is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by such Board.

(xiii) Psychoanalyst: An individual who is currently licensed or possesses a permit to practice as a psychoanalyst issued by the New York State Education Department.

(xiv) Psychologist: An individual who is currently licensed or possesses a permit to practice as a psychologist issued by the New York State Education Department.

(xv) Registered nurse: An individual who is currently licensed or possesses a permit to practice as a registered professional nurse issued by the New York State Education Department.

(xvi) Social worker: An individual who is either currently licensed or possesses a permit to practice as a licensed master social worker (LMSW) or as a licensed clinical social worker (LCSW) issued by the New York State Education Department.

(xvii) Therapeutic recreation specialist: An individual who has either a master's degree in therapeutic recreation from a program approved by the New York State Education Department or certification as a therapeutic recreation specialist by the National Council for Therapeutic Recreation Certification.

(2) Licensed practitioner of the healing arts (LPHA) means the following professional staff, as defined in this Subpart:

(i) nurse practitioner;

(ii) physician;

(iii) physician assistant;

(iv) psychiatric nurse practitioner;

(v) psychiatrist;

(vi) psychologist;

(vii) registered nurse;

(viii) mental health counselor;

(ix) marriage and family therapist;

(x) creative arts therapist;

(xi) psychoanalyst;

(xii) occupational therapist;

(xiii) clinical social worker (LCSW); and

(xiv) master social worker (LMSW) if supervised by an LCSW, licensed psychologist, or psychiatrist employed by the agency/service provider.

(3) Peer support workers are individuals who are qualified by having personal experience and holding a standard or provisional certification, or credentialed, or provisionally credentialed as provided below:

(i) New York certified peer specialist (NYCPS): An individual who is over 18 years old who has been granted the status of a certified peer specialist by the New York Peer certification board and certifying authority recognized by the Commissioner of OMH.

(ii) Certified recovery peer advocate (CRPA): An individual who holds a certification issued by an entity approved and recognized by the Commissioner of OASAS.

(iii) Credentialed family peer advocate (FPA): An individual who is credentialed as a family peer support worker in New York State from a certifying authority recognized by OMH and OASAS.

(iv) Credentialed youth peer advocate (YPA): An individual who is credentialed as a youth peer support worker in New York State from a certifying authority recognized by OMH and OASAS.

(4) Other CCBHC staff means non-licensed or non-certified staff members who provide CCBHC services.

(5) Psychiatric rehabilitation services (PRS) staff means individuals who are at least 18 years of age and have a high school diploma or equivalent and one to three years of relevant work experience in a behavioral health setting or a bachelor's degree. The practice of PRS by unlicensed individuals does not include those activities that are restricted under title VIII of the Education Law.

(6) Targeted case management (TCM) case managers means individuals who are at least 18 years of age and have a high school diploma or equivalent. They may be unlicensed staff with appropriate training as determined by OMH and OASAS.

(7)Administrative staff means staff members who do not directly provide CCBHC services, but conduct vital functions of the CCBHC, including but not limited to data management, quality improvement, and other administrative tasks.

Section 600-1.5 Certification

(a) Prior Consultation

(1) The applicant shall participate in a prior consultation prior to submitting an application for certification in a form and format prescribed by the Offices. The applicant shall provide information to the LGU, and Offices regarding the program being planned to enable appropriate consultation and advice upon request.

(2) As part of the prior consultation, the applicant shall consult with the local governmental unit through its director of community services or designee in the counties or county to be served prior to submission of an application.

(b) Application and Approval Process.

(1) A CCBHC, previously established under the Federal CCBHC demonstration awarded by the State, that wishes to continue operating, or a provider seeking to obtain CCBHC certification, shall participate in a prior consultation and submit an application to OMH and OASAS seeking an operating certificate under this Subpart.

(i) CCBHCs previously established under the Federal demonstration shall have certification priority prior to reviews of new applicants for fifteen months from the date of promulgation of this Part.

(*a*) The Offices may establish a streamlined certification for CCBHCs who have demonstrated compliance with the federal demonstration and state requirements as determined by the Offices.

(2) Applications shall be submitted in a form and format prescribed for all applicants and reviewed by OMH and OASAS which shall be approved by the commissioners prior to the issuance of an operating certificate. The review of the application shall base approval upon consideration of the extent to which the applicant:

(i) Is licensed, certified or otherwise authorized by OMH and OASAS;

(ii)Is in compliance with all applicable requirements of OMH and OASAS, including but not limited to Parts 599 and 822 of this Title, unless as otherwise specified in this Subpart and applicable Federal, State and local requirements;

(iii) Is in good standing at the time of application approval;

(iv) Is in compliance with the physical plant requirements set forth in guidance issued by OMH and OASAS;

(v) Demonstrates in a form and format acceptable to the Offices, a public need for the program at the time and place and under the circumstances proposed; and

(vi) Demonstrates in a form and format acceptable to the Offices, geographic appropriateness including but not limited to inadequate or no facilities, programs and services available that may serve as alternatives or substitutes for the proposed

program;

(vii) can demonstrate compliance with all Federal and State CCBHC Requirements:

(*a*) a description of the CCBHC's character and competency to provide CCBHC services across the lifespan, including how the CCBHC will ensure access to crisis services at all times and accept all individuals regardless of location and ability to pay;

(*b*) a description of the CCBHC's service area;

(*c*) a statement indicating that the CCBHC has been included in an approved "local services plan" developed pursuant to article 41 of the MHL for each local government located within the CCBHC's service area;

(*d*) confirmation of required services being delivered at every site identified by the CCBHC;

(*e*) where executed, agreements establishing formal relationships with designated collaborating organizations (DCOs) to provide certain CCBHC services, consistent with guidance issued by the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration, or any successor agency, OMH, and OASAS;

(*f*) a staffing plan driven by a community needs assessment, reflecting appropriate credentials, and training to support service delivery;

(*g*) a description of the CCBHC's data-driven approach to quality improvement;

(*h*) a description of how individuals with lived experience are represented in governance of the CCBHC; and

(*i*) The commissioners may grant a waiver of a regulatory requirement requested pursuant to this section, in a form and format prescribed by the commissioners, if they determine that:

(*1)* the rights, health and safety of individuals would not be diminished;
(*2*) the best interests of recipients would be served;
(*3*) the benefits of waiving the requirement outweigh the public interest in meeting the requirement; and
(*4*) the purpose of the request is to implement/test innovative programs that may increase the efficiency or effectiveness of operations, to provide additional flexibility to better meet local service needs while maintaining program quality and integrity, or other purposes deemed appropriate by the commissioner.

(3) CCBHCs are certified by New York State for up to three years before re-certification is required. OMH and OASAS may place a CCBHC on enhanced monitoring status or temporarily suspend or decertify CCBHCs if they fail to meet the criteria, if there are changes in the State CCBHC program, or as otherwise determined by the State.

(c) CCBHC applicants must operate and maintain documentation as:

(1) a non-profit organization, exempt from tax under section 501(c)(3) of the United States Internal Revenue Code;

(2) a part of a local government behavioral health authority;

(3) an entity that serves under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.); or

(4) an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(i) Where the CCBHC is not operated under the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, CCBHCs must establish relationships with the Indian Communities and enter into arrangements with those entities to facilitate the provision of services to tribal members, either jointly or independently with support from the Indian Communities.

(d) The applicant shall supply any additional documentation or information requested by OMH and OASAS which may include but is not limited to: requests for information regarding services to be added and the plan for implementation, staffing, environment, operating expenses and revenues, and utilization of services as they relate to CCBHC services as described in this Subpart. Such additional information shall be provided within a stated timeframe of such request, unless an extension is obtained. The granting of a request for an extension shall be at the discretion of OMH and OASAS. Failure to provide the additional documentation or information within the time prescribed shall constitute an abandonment or withdrawal of the application without any further action from OMH and OASAS.

(e) OMH and OASAS shall approve or disapprove an application in writing. Applicants may appeal the denial of an application with OMH and OASAS within 10 calendar days of receiving the denial.

(f) Each CCBHC site shall be issued an operating certificate that specifies the type of services CCBHC is authorized to operate. A program shall seek prior approval for any changes to services listed on the operating certificate.

(g) CCBHC sites.

(1) CCBHC programs are made up of an identified main site and satellites. CCBHC main sites, which are designated by the CCBHC as the primary address where all CCBHC required services are offered, is located within the service area defined in the community needs assessment and must serve the individual's full lifespan.

(i)CCBHC shall offer all required CCBHC services at the main site. This includes screening, assessment, and diagnosis; person-centered and family-centered treatment planning; outpatient mental health and substance use services; crisis behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation services; peer and family supports; and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans.

(ii) The determination of the appropriate setting and service modality shall include the individual and family's preferences and consider issues of safety and accessibility. The setting must be conducive to the provision of services in meeting treatment goals.

(iii) Individuals and families are not required to seek care at the main site if alternative settings or modalities are preferred, however, CCBHC programs must inform all individuals and families of their right to access in-person care at one location, regardless of their age or location of residence within the identified service area prior to program enrollment.

(2)CCBHC programs may provide services at satellite sites and such sites shall meet the following requirements:

(i) the CCBHC satellite site must be approved and certified by OMH and OASAS, in a form and format prescribed by OMH and OASAS, prior to operation;

(ii) there shall be an explicit clinical and administrative linkage between the CCBHC satellite site and the CCBHC main site which includes, but is not limited to, methods of staff supervision, treatment planning, review of treatment plans, maintenance of the records of individuals receiving services and utilization review;

(iii) there shall be adequate and sufficient staff to provide services at the CCBHC satellite site;

(iv) all required services should be made available as clinically appropriate to individuals who utilize the CCBHC satellite site(s), however, satellite sites must minimally provide the following services on-site and in person: screening, assessment, and diagnosis; outpatient mental health and substance use disorder services, and person-centered and family-centered treatment planning;

(v) The CCBHC satellites must offer all nine required services at the satellite site or ensure all nine services are accessible from another site within the CCBHC program, which may be a main or satellite site, within 30 minutes or 30 miles of such satellite; and

(iv) CCBHC satellite sites must meet the physical plant requirements for program space set forth in section 600-1.13 of this Subpart.

(h) A Community needs assessment (CNA) shall be conducted as part of an initial certification or recertification to determine staffing, services, community needs including but not limited to language and culture services, locations, service hours and program capacity. Such CNA shall be conducted in collaboration with community stakeholders. If a CNA has been completed in the past year by the community where the CCBHC is located, the CCBHC may decide to augment, or build upon the information already obtained; however, CCBHCs must ensure that the required components of the CCBHC CNA are collected.

(1) The CNA and related staffing plan will be updated regularly, but no less frequently than every three years. If community needs change during the three-year time period, CCBHCs must work with community stakeholders to amend the CNA accordingly.

(2) Community stakeholders, shall include but not be limited to:

(i) People and caregivers with lived experience of behavioral health and, crisis response partners such as hospital emergency departments, crisis stabilization settings, crisis call centers and warmlines.

(ii) Other behavioral health and physical health providers in the community.

(3) CCBHC required services must be reasonably accessible to communities identified in the CNA. Reasonable accessibility is defined as the lesser of either 30 miles or 30 minutes to access all nine required services. Any variations beyond this parameter of a reasonably accessible location of services must be approved by OMH and OASAS.

(i) Hearing Procedure.

(1) Applicability. This section applies to any action by OMH and OASAS to deny, suspend, revoke, or limit, a certification issued pursuant to this Subpart.

(2) Notice.

(i) When OMH and OASAS propose to take action under subdivision (a) of this section, they shall provide written notice to the provider, which shall include:

(*a*) the nature of the proposed action;

(*b*) the factual and legal basis for the proposed action;

(*c*) the proposed effective date of such action; and

(*d*) a statement of the provider's right to request an administrative hearing in accordance with this section.

(ii) The proposed action shall become effective 10 days after service of the notice unless, within that time period, the party files with the commissioners a written request for a hearing.

(3) Request for hearing. A provider may request a hearing by submitting a written request within 10 calendar days of receipt of the notice to the commissioners. Failure to submit a timely request shall be deemed a waiver of the right to a hearing.

(4) Hearing process. A hearing shall be conducted by a designated hearing officer in accordance with applicable law. There shall be no discovery, except as agreed upon by all parties. The provider may appear with or without counsel, present evidence, and respond to the stated reasons for the proposed action. The hearing officer shall issue a recommendation to OMH and OASAS, which shall render a final determination.

(5) Immediate action.

(i) Notwithstanding the provisions of subdivisions (b) through (d) of this section, OMH and OASAS may take immediate action to suspend a certification without prior notice if the continued operation of the program presents an imminent danger to the health or safety of individuals receiving services or the public.

(ii) In such cases, OMH and OASAS shall issue a written notice of emergency suspension and the reasons therefor.

(6) Record.

(i) A verbatim recording shall be made of the proceedings.

(ii) A transcription of the record shall be made available to any party upon request.

(7) Hearing officer's report.

(i) Unless otherwise agreed to by all parties, the hearing officer shall set forth their findings and recommendations for action by written report to the commissioners within 30 days of receipt of the entire transcript of the hearing. The hearing officer shall serve a copy of the report on all parties.

(ii) The record of the hearing and the hearing officer's report shall be transmitted to the

commissioners for final determination and order.

(8) Final determination.

(i) Within 10 days of the receipt of the record of the hearing, the commissioners shall make a final determination.

(ii) The commissioner's determination shall be in writing. In the event that the final determination includes findings of fact or conclusions of law that conflict with the findings, conclusions or recommended decision of the hearing officer, the reasons therefor shall be set forth in writing.

(iii) Copies of the commissioner's final determination shall be served upon all parties to the proceeding. At least one such copy shall be maintained on file in OMH and OASAS.

(9) Waiver of rules. Except as otherwise provided by law, any of the hearing process rules in this Part may be waived or modified by written agreement of the parties or, if a hearing has convened, by agreement of the parties with the consent of the hearing officer.

Section 600-1.6 Inspection

(a) OMH and OASAS shall have initial and ongoing inspection responsibility for all CCBHCs established pursuant to this Subpart. The purpose of the inspection is to ensure compliance with all applicable Federal, State, and local laws, rules and regulations, to determine the renewal term of the operating certificate.

(b) OMH and OASAS review shall be performed by staff with expertise as necessary to ensure individual health and safety. Any significant deficiencies will immediately be referred for enforcement. If at any point during the inspection, findings are identified that suggest imminent risk of serious harm or injury to individuals, OMH and OASAS reserve the right to request immediate corrective action or other activities to ensure the health and safety of individuals.

(c) Inspections shall be conducted utilizing a single oversight instrument. All deficiencies or corrective action will be overseen by OMH and OASAS. Each CCBHC shall undergo, at a minimum, one unannounced inspection which will occur prior to renewal of the Operating Certificate to ensure compliance with all applicable Federal, State and local laws and regulations.

(d) At the start of the inspection, the inspector(s) will meet with the CCBHC administrative staff to explain the purpose and scope of the inspection and request any documentation (e.g., policies; staffing information; etc.) that may be needed to facilitate the review.

(e) The inspection will include, but not be limited to, the following areas of review:

(1) on-site inspection of service appearance, conditions and general safety;

(2) evaluation of the sponsor, its management systems, and procedures;

(3) individual case record review;

(4) interviews of staff and individuals who receive services;

(5) examination of staffing patterns and staff qualifications;

(6) analysis of statistical information contained in reports required to be submitted by the service;

(7) compliance with the reporting requirements; and

(8) verification of staff credentials, and staff training.

Section 600-1.7 Organization and Administration

(a) The CCBHC shall identify a governing body which shall have overall responsibility for the operation of the CCBHC. The governing body may delegate responsibility for the day-to-day management of the CCBHC to appropriate staff pursuant to an organizational plan approved by OMH and OASAS. No person shall serve both as a member of the governing body and as paid CCBHC staff without prior approval of OMH and OASAS.

(b) Composition of Governing Body. Individuals with lived experience must be supported by CCBHC staff in their efforts to contribute to board decisions including but not limited to: community needs and goals, service development, quality improvement initiatives, and fiscal and budgetary decisions.

(1) 51 percent or more of the CCBHC governing board members shall be individuals with lived experience or with behavioral health experience; or

(2) the CCBHC may have an advisory board that represents individuals with lived experience with substance use disorders or mental health disorders, including youth and families.

(i) The governing board must establish written protocols for incorporating input from individuals with lived experiences and family members and the advisory board.

(ii) Advisory board members must receive copies of any board minutes or records.

(iii) Advisory board members must be invited to board meetings and have the opportunity to regularly address the board directly, share recommendations and have their comments and recommendations reflected in the board minutes.

(iv) The CCBHC staff must coordinate with the advisory board to ensure that a summary of advisory board recommendations are posted on the CCBHC website annually.

(c) Members of the governing body or advisory boards shall 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 concern or social service agencies within the communities served. No more than one half (50 percent) of the governing board members may derive more than ten percent of their annual income from the health care industry.

(d) The governing body shall be responsible for the following duties:

(1) to retain an independent contractor to conduct a financial audit annually for the duration that the center is designated as a CCBHC in accordance with federal, state and local audit requirements, and, where indicated, a corrective action plan is submitted addressing all findings, questioned costs, reportable conditions, and material weakness cited in the Audit Report;

(2) to meet at least four times a year;

(3) to review, approve and maintain minutes of all official meetings;

(4) to develop an organizational plan which indicates lines of accountability and the qualifications required for staff positions. Such plan may include the delegation of the responsibility for the day-to-day management of the CCBHC to a designated professional who is qualified by training and experience to supervise CCBHC staff;

(5) to review the CCBHC's compliance with the terms and conditions of its operating certificate, applicable laws and regulations;

(6) to ensure that the design and operation of the CCBHC is consistent with and appropriate to the ethnic and cultural background of the population served. This can include ethnic representation on the staff and board and inclusion of culturally and ethnically relevant content in service programs;

(7) to develop, approve, and periodically review and revise as appropriate all programmatic and administrative policies and procedures. Such policies and procedures shall include, but are not limited to, the following:

(i) written criteria for enrollment, and disenrollment from the CCBHC program. Enrollment policies should include a mechanism for screening individuals at the time of referral to identify whether current needs should result in priority access;

(ii) the prescription and administration of medication, which shall be consistent with applicable Federal and State laws and regulations, and which includes procedures for ensuring that individuals are receiving prescribed medications and using them appropriately;

(iii) policies and procedures for conducting initial and ongoing risk assessments,

and for development of plans to address identified areas of elevated risk, including procedures to ensure that any physical or behavioral health issues identified are treated appropriately by the program or that an appropriate referral to a treatment provider and subsequent follow up is made;

(iv) policies and procedures addressing individual/family engagement and retention in treatment, including, at a minimum, plans for outreach and re-engagement efforts commensurate with an individual's assessed risk;

(v) policies to address personal safety of staff and provide appropriate training in de-escalation techniques;

(vi) policies and procedures for age-appropriate health monitoring, which describe whether such monitoring will be performed by the provider or, if not, how the provider will seek to ascertain relevant health information. Such policies and procedures must include a requirement that an individual's refusal to provide access to such information be documented in the case record;

(a) All necessary releases of information are obtained and included in the case record as a part of the development of the ~~initial~~ treatment plan. The person's health record documents any advance directives related to treatment and crisis planning. If the person receiving services does not wish to share their preferences, that decision is documented.

(vii) policies and procedures for screening for substance use or problem gambling;

(viii) policies and procedures ensuring that all required data regarding SUD treatment services is accurately and timely reported to OASAS Client Data Systems in a form and format prescribed by OMH and OASAS;

(ix) policies and procedures ensuring that a reasonable effort shall be made to obtain records from prior recent episodes of treatment;

(x) policies and procedures ensuring that a reasonable effort shall be made to communicate with family members, current service providers, and other collaterals, as appropriate;

(xi) written policies and procedures to ascertain whether individuals are currently receiving or are eligible to receive Medicare or Medicaid or other form of reimbursement for services provided. If it is determined that an individual is eligible for any such program but not currently enrolled, the policies and procedures shall include means of facilitating the enrollment of such individual in such program;

(xii) written policies and procedures ensuring compliance with applicable

provisions of Federal, and State law governing the use, disclosure, and access to patient records, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) Privacy, Security, and Notification Rule (45 CFR part 160 and 45 CFR part 164, subparts A and E) as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), 42 CFR part 2, article 27-F of the New York State Public Health Law, article 33 of the New York State Mental Hygiene Law, and the New York Stop Hacks and Improve Electronic Data Security Act (SHIELD Act) as defined in article 39-F of the New York General Business Law and section 208 of the New York State Technology Law;

(xiii) written policies and procedures describing an individual grievance process which ensures the timely review and resolution of individual complaints and which provides a process enabling recipients to request review by OMH and OASAS when resolution is not satisfactory;

(xiv) written policies which guide efforts to reduce disparities in access, quality of care and treatment outcomes;

(xv) written personnel policies which shall prohibit discrimination in accordance with State and Federal law;

(xvi) written policies for the availability of crisis intervention services at all times. After-hours coverage shall include, at a minimum, the ability to provide brief crisis intervention services provided pursuant to a plan approved by the local governmental unit or OMH and OASAS. Such services shall be provided either directly or pursuant to a DCO agreement. Such contract shall include, at a minimum, provisions assuring that, in the event of a crisis, the nature of the crisis and any measures taken to address such crisis are communicated to the primary clinician or other designated clinician involved in the individual's treatment at the program or the individual's primary care or other mental health care provider, if known, or as soon as practicable;

(xvii) written policies regarding the selection, supervision, and conduct of students accepted for training in fulfillment of a written agreement between the program and a State Education Department accredited higher education institution, as well as requesting OMH and OASAS to perform criminal history record checks in accordance with article 36 of the Mental Hygiene Law;

(xviii) written policies regarding the employment, supervision, and qualification of all program staff including initial verification and ongoing maintenance of required licensure, certification and training. Policies must include the supervision and privileging of nurse practitioners and physician assistants;

(xix) written policies which shall establish that contracts with third party

contractors that are not subject to the criminal history background check requirements established in article 36 of the Mental Hygiene Law include reasonable due diligence requirements to ensure that any persons performing services under such contract that will have regular and substantial unsupervised or unrestricted contact with individuals of the program do not have a criminal history that could represent a threat to the health, safety, or welfare of the individuals of the program including, but not limited to, the provision of a signed, sworn statement whether, to the best of their knowledge, such person has ever been convicted of a crime in this State or any other jurisdiction; and

(xx) written policies and procedures regarding the mandatory reporting of child abuse or neglect, reporting procedures and obligations of persons required to report, provisions for taking a child or youth into protective custody, mandatory reporting of deaths, immunity from liability, penalties for failure to report, and obligations for the provision of services and procedures necessary to safeguard the life or health of the child or youth. Such policies and procedures shall address the requirements for the identification and reporting of abuse or neglect regarding recipients who are children or youth, or who are the parents or guardians of children or youth;

(xxi) to ensure the establishment and implementation of an ongoing training program for current and new employees and volunteers that addresses the policies and procedures regarding child abuse and neglect described in this subdivision.

(e) A provider shall ensure that no individual who is appropriate for enrollment is denied access to services and shall ensure that CCBHC services are available for individuals across the lifespan for mental health disorders and substance use disorders as well as co-occurring disorders.

(f) A provider shall ensure that any CCBHC subject to this Subpart does not:

(1) utilize restraint or seclusion for any purpose, including, but not limited to, as a response to a crisis situation, provided, however nothing in this section shall be construed to prohibit the use of reasonable physical force when necessary to protect the life and limb of any person where alternative procedures and methods have failed; and

(2) perform electroconvulsive therapy or aversive conditioning therapy for any purpose, including, but not limited to, as a treatment intervention.

(g) A provider of service shall ensure the development, implementation and ongoing monitoring of a Risk Management Program that includes the requirements for identification, documentation, reporting, investigation, review, and monitoring of incidents pursuant to the Mental Hygiene Law and Part 524 of this Title.

(1) The CCBHC shall utilize New York Incident Management Reporting System reports or other available incident/data analysis reports to assist in risk management activities

and compile and analyze incident data for the purpose of identifying and addressing possible patterns and trends to improve service delivery.

(2) All new staff shall receive training which must include at a minimum, the definition of incidents, reporting procedures, an overview of the review process, and the role of risk management. Refresher incident reporting training shall be conducted at least annually for all staff and evidence of such training must be recorded in the staff personnel file.

(h) There shall be emergency procedures including but not limited to an emergency evacuation plan and staff shall be knowledgeable about such procedures.

(i) There shall be a written utilization review policy and procedure to ensure that all recipients are receiving appropriate services and are being served at an appropriate level of care.

(j) A provider shall ensure that no individual who is otherwise appropriate for enrollment is denied access to services solely because the individual does not have creditable coverage or the means to pay the provider's private pay rates or sliding fee scale.

(1) The CCBHC must publish a sliding fee discount schedule(s) that includes all services the CCBHC offers on the CCBHC website, and post in the waiting room of all CCBHC locations. This shall be communicated in languages/formats appropriate for individuals seeking services who have Limited English Proficiency (LEP), literacy barriers, or disabilities.

(2) The fee schedule(s) must be submitted and approved by OMH and OASAS.

(k) CCBHCs and DCOs shall obtain from each Individual, prior to treatment, a release permitting the CCBHC to disclose individual's clinical records to DCOs, other providers and payers and permitting CCBHC and payers to re-disclose patient information to related organizations to the extent necessary for referral and treatment, payment for services, and support with health related social needs and quality assurance. CCBHC shall immediately notify other parties if the individual revokes or modifies any consent to disclosure of health information. Such release does not preclude authorized disclosure permitted by State or Federal law.

(l) The CCBHC shall be enrolled as a Medicaid provider and certified as a CCBHC provider, jointly by OMH and OASAS. Further, the CCBHC is required to participate in Substance Abuse and Mental Health Services Administration (SAMHSA) Behavioral Health Treatment Locator or its successor survey.

(m) The CCBHC must have an Electronic Health Record (EHR) that has the capacity to collect, report, and track encounter, outcome, and quality data. CCBHCs must collect and report the Clinic-Collected and State-Collected quality measures identified as required by OMH and OASAS.

(n) CCBHCs shall continue to develop, implement, and maintain a Continuous Quality Improvement (CQI) plan for provided services that is effective throughout the life of the

CCBHC. The Medical Director must be involved in areas of the CQI plan surrounding quality of medical care, including primary care coordination and integration.

Section 600-1.8 CCBHC Services

(a) General Requirements of Access and Availability

(1) Required activities.

(i) Care Coordination.

(*a*) Care coordination activities are the foundation of the CCBHC ensuring services are integrated and address both physical and behavioral needs of individuals. Care coordination activities foster and promote clear and timely communication, deliberate coordination, and seamless care with a goal of individual responsibility for health awareness. Such activities shall take into account the individual's preferences and shall to the extent possible be provided in collaboration with the family or caregiver of the individual receiving services. These characteristics guide all aspects of treatment and rehabilitation to support effective partnerships among the individual, family, and other natural supports and service providers. (ii) CCBHCs shall secure partnerships to provide services for individuals across the lifespan. Such partnership agreements must minimally include:

(*1*) the 988 Suicide and Crisis Lifeline call center for the service area(s) in which the CCBHC serves, as determined by their CNA;

(*2*) federally qualified health centers and, as applicable, rural health clinics;

(3) residential services;

(*4*) residential rehabilitation services for youth;

(*5*) Department of Veterans Affairs' medical centers, clinics, drop-in centers, or other facility of the Department of Veterans Affairs';

(*6*) schools;

(*7*) child welfare agencies;

(*8*) juvenile and adult justice agencies and facilities;

(*9*) Indian health services where locally applicable;

(*10*) State licensed and accredited child placing agencies for therapeutic foster care service; and

(*11*) other social and human services as appropriate.

(*b*) CCBHCs are required to track when individuals receiving CCBHC services are admitted to the facilities listed below and when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity.

(*1*) The CCBHC shall coordinate with the discharging facility prior to discharge and will contact individuals receiving CCBHC services who are discharged from these settings within 24 hours of discharge.

(*i*) inpatient acute care hospitals in the service area and the associated services/facilities;

(*ii*) inpatient psychiatric treatment and their associated services/facilities;

(*iii*) opioid treatment programs;

(*iv*) OASAS Certified Crisis Detoxification Services; and

(*v*) OASAS Certified Inpatient Rehabilitation Services;

(*c*) The CCBHC must receive service notifications through the Admission-Discharge-Transfer (ADT) system of relevant inpatient and outpatient facilities, for people receiving CCBHC services.

(*d*) Care coordination partnerships shall be supported by formal signed agreements detailing the roles of each party. If unable to enter into formal agreements, the CCBHCs will work with the partner to develop unsigned written joint protocols and document all efforts.

(ii) Preliminary triage and risk assessment screening.

(*a*) Individuals presenting for the first time to the CCBHC in person, by telephone, or using other remote communication, shall receive a preliminary triage, including risk assessment, to determine acuity of needs. If the triage identifies an emergency or crisis need, appropriate action shall be taken immediately to reduce or remove risk of harm and to facilitate any necessary subsequent follow-up.

(*b*) The provider shall use clinically appropriate screening tools to assess the need for emergency or crisis services related to Mental Health and Substance Use Disorder.

(*1*) Where the individual is utilizing a call center for after hours and crisis response, the call center shall align with the National Suicide Prevention Lifeline (NSPL) suicide risk assessment standards.

(2) There shall be protocols established to track referrals made from such call

center to the CCBHC or its DCO crisis care provider to ensure the timely delivery of mobile crisis team response, crisis stabilization, and post crisis follow-up care.

(*c*) Where the preliminary triage and risk assessment screening identifies an urgent need, defined as non-life threatening but evidence of distress, the program shall ensure that clinical services and the initial evaluation are to be provided within one business day.

(*d*) Where the preliminary triage and risk assessment screening identifies a routine need, the program shall ensure that services are provided, and the initial evaluation completed within 10 business days.

(*e*) All individuals requesting services will be provided with, at minimum, resources to prevent and respond to crisis situations including 988/Lifeline, overdose response and prevention, warmlines, crisis stabilization and other resources as appropriate.

(2) Required Services.

(i) The CCBHC must provide and deliver integrated, comprehensive, person- and family-centered mental health and substance use services across the lifespan.

(*a)* CCBHCs must offer the following nine required services:

(*1*) screening, assessment, and diagnosis;

(2) person-centered and family-centered treatment planning;

(*3*) outpatient mental health and substance use services;

(*4*) crisis behavioral health services;

(*5*) outpatient primary care screening and monitoring;

(*6*) targeted case management;

(*7)* psychiatric rehabilitation services;

(*8*) peer and family supports; and

(*9*) intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans.

(b)The following services must be provided directly by the CCBHC: screening, assessment, and diagnosis; person-centered and family-centered treatment planning; and outpatient mental health and substance use services.

(c) The remaining six services may be delivered directly by the CCBHC or via DCO: crisis behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation services; peer and family supports; and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans.

(d) CCBHC services shall be made available and accessible to all community members with or at risk for developing a behavioral health diagnosis regardless of residence, ability to pay or the severity of their condition, unless a higher level of care is clinically indicated. If a higher level of care is indicated, CCBHC shall communicate this to the individual and their collaterals, and collaborate with community partners to ensure the individual is referred to a program that can meet their needs.

(e) Telehealth cannot be the only method for individuals to obtain a CCBHC service. All CCBHC services must be available in the modality the individuals prefer. The individual's preferences must be documented in the case record.

(ii) Screening, Assessment, and Diagnosis

(*a)* Initial evaluations

(*1*) An initial evaluation must be completed within 10 business days following the preliminary triage and risk assessment screening. The date of enrollment is defined as the date of the first CCBHC service.

(*i*) An enrollment note must be completed immediately following the date of first service. The enrollment note must include:

(*A*) Brief description of the presenting problem, critical needs and overall condition;

(*B*) Preliminary diagnosis, service initiation, and initial treatment goals;

(*C*) Notation that the individual received a copy of the program's rules and regulations, including patient's rights and a summary of the federal confidentiality requirements;

(*D*) Date of preliminary triage and risk assessment and

(*E*) Signature from LPHA.

(*2*) Initial evaluations shall include the preliminary diagnosis, consent forms, assessment of risk and any other items as defined by the Offices.

(b) Comprehensive evaluation.

(*1*) A comprehensive evaluation shall be completed within 60 business days from date of preliminary triage and risk assessment.

(*2*) A comprehensive evaluation addresses all of the items in the initial evaluation, description of social support needs, relevant cultural and environmental factors, examination of current mental health and substance use disorders and symptoms, assessment for the need of services outside the CCBHC and additional items as determined by the Offices.

(iii) Person-centered and Family-centered Treatment Planning

(*a*) The CCBHC shall directly provide person-centered and family-centered treatment planning which includes crisis planning. The treatment plan shall be based on information obtained through the initial and comprehensive evaluation(s) and be developed in collaboration with, and endorsed by, the individual receiving services and collaterals and shall reflect the unique strengths and needs of the individual and family, establish the individual and family's goals and identify the services and interventions needed to assist in accomplishing these goals. CCBHCs offer nine core services in support of an integrated treatment plan tailored to address all the goals and objectives of the individual and family needs.

(*b*) A treatment plan is a document that must be completed for every enrolled individual. The treatment plan must be completed upon the conclusion of the comprehensive evaluation and no later than 60 business days from the date of the preliminary triage and risk assessment.

(*c*) The treatment plan shall include the following:

(*1*) an individual's goals and objectives and the specific services or activities necessary to accomplish these goals and objectives;

(*2*) modality, frequency, and duration for each service;

(*3*) staff or external providers who are involved in the treatment plan; and

(*4*) signature of a psychiatrist, other physician, or nurse practitioner in psychiatry.

(*d*) Treatment plan reviews shall occur at a minimum of every six months. Such reviews shall occur more frequently based upon the needs of the enrolled individual and when clinically indicated. A review of treatment goals shall occur following significant events, including but not limited to hospitalization, and changes in level of care. Identification of the need for additional services, an increase in intensity or frequency of service, or when goals have been achieved or are no longer applicable shall be documented in the enrolled individual's record.

(*e*) All individuals will be provided with the opportunity to develop wellness or crisis plans, including Psychiatric Advance Directives, to identify the preferences of the person in the event of psychiatric or substance use crisis based on their assessed level of need.

(iv) Outpatient mental health and substance use services

(*a*) The CCBHC shall have the capacity for directly providing integrated outpatient mental

health and substance use services designed to treat an individual's mental health or substance use disorder in a manner consistent with the individual's preferences, phase of life and development.

(*b*) The provision of outpatient mental health and substance use services is informed and determined by the preliminary triage screening, assessment, and diagnosis process, as identified within the treatment plan. outpatient services shall:

(*1*) utilize a trauma informed and recovery-oriented approach;

(*2*) incorporate evidence-based or best practices and maintain consistency with the needs of individuals, children/youth and family/caregivers.

(*c*) For individuals with a substance use and/or problem gambling disorder diagnosis, the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR)is a required web-based tool to assist providers in determining the most appropriate level of care.

(*d*) For individuals receiving services with potentially harmful substance use, the CCBHC shall make all efforts to engage the individual receiving services with motivational techniques and harm reduction strategies to promote safety or reduce substance use.

(*e*) CCBHCs shall provide the following outpatient mental health and substance use services consistent with the individual's conditions and needs:

(*1*) Psychotherapy, to include individual, group, family, and collateral; provided by or supervised by a licensed practitioner of the healing arts working within their scope of practice.

(*2*) Addiction counseling, including individual, group, family, and collateral.

(*3*) Medication management.

(*4*) Medication administration and observation.

(*5*) Psychotropic medications and medications for addiction treatment, including injectable medications.

(*f*) Toxicology testing:

(*1*) Each program must conduct toxicology tests to be determined by the provider as clinically appropriate for each individual dispensed medication to treat opioid use disorder.

(*2*) Each program must review and discuss toxicology test results with the individual and document the discussion in their chart.

(*3*) Laboratories used for toxicology testing must be approved by the New York State Department of Health or, in the City of New York, the New York City Department of Health and Mental Hygiene.

(*4*) Each program must use toxicology testing methods approved by the Food and Drug Administration (FDA) and Center for Substance Abuse Treatment (CSAT).

(*5*) Overdose prevention and naloxone education and training.

(*6*) Safety plan development based on the results of the screening, assessment, and diagnosis.

(*g*) CCBHCs shall offer Intensive Outpatient Services (IOS) as an additional outpatient mental health and substance use service.
(*h*) CCBHCs shall also offer medications approved by the FDA for the treatment of opioid use disorder upon obtaining all required Federal and State approvals, including by OASAS.
(*i*) CCBHCs may offer the following additional outpatient mental health and substance use services, which require prior approval from OMH and OASAS:

(*1*) Testing Services, including Developmental Testing, Neurobehavioral Status Examination, and Psychological Testing.
(*2*) Ancillary Withdrawal:

(*i*) Programs that are intending to manage withdrawal through tapering medications will need to have the service identified as designated on the program's operating certificate and an approved protocol by OASAS' Medical Director.
(ii) The Ancillary Withdrawal designation is required to provide medication to taper individuals from opioid, alcohol, or benzodiazepine.
(*iii*) A program does not need an Ancillary Withdrawal designation to provide an induction to buprenorphine to initiate maintenance with buprenorphine or to utilize injectable naltrexone.

(*3*) Problem gambling. CCBHCs that wish to meet additional criteria to obtain the Problem Gambling Treatment and Recovery Designation Standards from OASAS must meet the designation criteria in Part 830 of this Title.

(v) Crisis Behavioral Health Services

(*a*) The CCBHC shall make crisis services available through DCO agreements required with existing state sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services or provide them directly as identified in these criteria and to supplement any gaps in crisis coverage.

(*b*) The CCBHC shall provide or coordinate with telephonic, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. The CCBHC shall coordinate crisis care with protocols between the 988 Suicide and Crisis Lifeline and CCBHC or DCO crisis provider to ensure the timely delivery of mobile crisis team response, crisis stabilization, and post crisis follow-up care.

(*c*) The CCBHC shall provide community-based behavioral health crisis intervention services using existing State-sanctioned mobile crisis teams, and then supplementing with DCO agreements with other providers or utilizing their own staff for mobile crisis services or on an on call basis to ensure 24 hours per day, seven days per week to adults, children, youth, and families anywhere within the service area including at home, work, or anywhere else where the crisis is experienced.

(*1*) Mobile crisis response is required to arrive in person within one hour (two hours

in rural settings) and not to exceed arrival within three hours. Such services may be provided via telehealth with prior approval from OMH and OASAS, where remote travel distances make the two hour response time unachievable. However, an in-person response must be available when it is necessary to assure safety.

(*d*) The CCBHC shall provide crisis stabilization services that includes at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals. These services identify the individual's immediate needs, de-escalate the crisis and connect individuals to a safe and least restrictive setting for ongoing care.

(*e*) The CCBHC shall provide suicide prevention and intervention and services capable of addressing crises related to substance use including the risk of drug and alcohol related overdose and support following a non-fatal overdose after the individual is medically stable. Overdose prevention activities shall include the availability of naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to collaterals.

(vi) Outpatient primary care screening and monitoring

(*a*) The CCBHC is responsible for ensuring outpatient primary care screening and monitoring of key health indicators and health risks are received timely, whether provided directly or through a DCO.

(*b*) The CCBHC's medical director shall establish protocols and ensure ongoing primary care monitoring as clinically indicated for the individual. Monitoring shall include:

(*1*) ensuring individuals have access to primary care services;

(*2*) ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions;

(*3*) coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and

(*4*) promoting a healthy behavior lifestyle.

(vii) Targeted Case Management (TCM)

(*a*) CCBHC TCM services provide an intensive level of support that goes beyond the basic level of care coordination available to all individuals and families served by the CCBHC. TCM may be used as clinically indicated, for individuals with complex or serious mental health or substance use conditions and for individuals who have a short-term need for support during critical periods such as an acute episode or during times of care transitions such as from a residential treatment, hospital emergency department,

incarceration, or psychiatric hospitalization.

(*b*) TCM also includes supports for people deemed at high risk of suicide or overdose, including but not limited to times of transition from residential treatment, hospital emergency department, or psychiatric hospitalization, episodes of homelessness or transitions to the community from jails or prisons.

(*c*) TCM services shall connect individuals with necessary medical, social, legal, educational, housing, vocational, and other services and supports.

(*d*) Where an individual is enrolled in a Health Home the CCBHC must make the appropriate care linkage and conduct care coordination activities solely with the Health Home. Individuals cannot receive TCM through the CCBHC and receive Health Home Care Management services at the same time.

(viii) Psychiatric rehabilitation services (PRS)

(*a*) CCBHCs shall provide directly, or through a DCO, evidence-based rehabilitation services for both mental health and substance use disorders.

(*b*) Rehabilitative services include services and recovery supports that help individuals develop skills and enhance functioning to facilitate community living; support positive social, emotional, and educational development; facilitate inclusion and integration; and support pursuit of their goals in the community. These services may be provided or enhanced by peer providers.

(*c*) PRS shall include supported employment services designed to provide those receiving services with initial and on-going support to obtain and maintain competitive, integrated employment and shall follow the evidence-based Individual Placement and Support (IPS) model.

(ix) Peer and family supports

(*a*) CCBHCs shall provide directly, or through a DCO, peer supports, which shall include peer specialist and recovery coaches, peer services, and family/caregiver supports.

(*1*) The CCBHC shall clearly define peer specialist's roles and responsibilities and distribute this information to relevant staff. Training should be required of all relevant agency staff and supervisors regarding peer roles and their work as a member of an integrated care team.

(*b*) Adult peer services may include but is not limited to: recovery coaching; staffing of a non-emergency phone line offering emotional support and resources; peer-led crisis planning; peer navigators to assist individuals transitioning between different treatment programs or levels of care; peer-led support to assist individuals with community connections and natural supports; mutual support and self-help groups; mentoring, self-advocacy and self-efficacy; peer support for older adults; peer education and leadership development; peer recovery services; engagement, bridging and transition supports; or

pre-crisis and crisis support services.

(*c*) Family and caregiver support services may include but is not limited to: community resources education; community connections and natural supports; navigation support; behavioral health and crisis support; parent/caregiver recovery support and education; family-to-family caregiver support; engagement, bridging and transition supports; self-advocacy, self -efficacy and personal empowerment; or parent skill development.

(*d*) Youth peer services may include but is not limited to: skill building; coaching; engagement, bridging and transition support; mentoring self-advocacy, self-efficacy and empowerment; or facilitating community connections and natural supports.

(x) Intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans.

(*a*) CCBHC's are responsible for providing directly, or through a DCO, intensive, community based behavioral health care for certain members of the U.S. Armed Forces and veterans, particularly those Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility (MTF) and veterans living 40 miles or more (driving distance) from a Veteran's Affairs (VA) medical facility, or as otherwise required by Federal law. Such services shall be recovery-oriented.

(*b*) Care provided to veterans is required to be consistent with minimum clinical mental health guidelines issued by the Veterans Health Administration (VHA).

(*c*) All individuals shall be asked whether they have ever served in the U.S. military. Veterans: persons affirming former military service (veterans) are offered assistance to enroll in VHA for the delivery of health and behavioral health services.

(*1*) Veterans who decline or are ineligible for VHA services shall be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA, including but not limited to clinical guidelines contained in the Uniform Mental Health Services Handbook.

(*d*) The CCBHC shall ensure there is integration or coordination for individuals with co-occurring disorders including ensuring any care management or coordination with the individual's existing Veterans Health Administration care team.

Section 600-1.9 Medication for Addiction Treatment (MAT) for Substance Use Disorder (SUD)

(a) CCBHCs must have the capacity to prescribe medication for addiction treatment (MAT), as defined in this Subpart. The treatment of SUD with MAT must be offered to recipients who are entering a CCBHC.

(b) CCBHC's providing MAT must also meet the following requirements:

(1) The CCBHC shall comply with all State and Federal rules, including prescribing rules, for the provision of MAT.

(2) The prescribing provider must determine the appropriateness of medication with collaboration and consent from the patient. If the patient entering the CCBHC is being treated with MAT outside of the CCBHC, then the provider must collaborate with the existing provider or practitioner to maintain MAT through the course of treatment.

(3) Where the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder (OUD) directly, it shall provide referral to an Opioid Treatment Program (OTP) with care coordination to ensure access to methadone and coordination with other services.

(4) MAT may be offered to minors entering the CCBHC with consent from the minor and their parent or guardian before the initiation of any medications. If parental consent cannot be obtained, the CCBHC shall act in accordance with Mental Hygiene Law section 22.11.

Section 600-1.10 Staffing

(a) A CCBHC shall continuously have an adequate number and appropriate mix of staff to carry out the objectives of the CCBHC program, as informed by the CNA, and to assure the outcomes of the program including any Designated Collaborating Organizations (DCOs) that deliver services under arrangement with the CCBHC. The provider shall have a staffing plan that documents the staff qualifications, including training, clinical experience with providing behavioral health care across the lifespan, and supervisory experience in a clinical setting, the assignment of staff to the CCBHC Main site and any approved CCBHC additional sites, and the supervisory relationships among the staff. The plan shall also detail any proposed use of students, non-licensed staff, or other CCBHC staff and their supervision and oversight. The staffing plan shall be subject to review and approval by OMH and OASAS at the time of issuance or renewal of the program's operating certificate, and shall demonstrate sufficient coverage by qualified psychiatrists and medical staff to meet the needs of the individuals enrolled in the CCBHC.

(b) The following staff may provide CCBHC services:

(1) Professional staff within their defined scopes of practice or as otherwise permitted by law.

(2) Licensed practitioners of the healing arts (LPHA) within their defined scopes of practice or as otherwise permitted by law.

(3) Certified or provisionally certified peer specialists, credentialed or provisionally credentialed family peer advocates, and credentialed or provisionally credentialed youth peer advocates, certified or provisionally certified recovery peer advocates (CRPA).

(4) Students, provided they are participating in a program approved by the New York State Education Department that leads to a degree or license in one of the CCBHC program's professional disciplines, including professional staff as defined in this Subpart, and in accordance with the following:

(i) students must be supervised and evaluated according to a signed agreement between the CCBHC program provider and a New York State Education Department-approved educational program, and pursuant to the CCBHC program provider's policies and procedures for student placements and clinical supervision; and

(ii) students must be part of a staffing plan that is approved by OMH and OASAS.

(5) Other CCBHC staff supervised by professional staff.

(c) All prospective employees, contractors and volunteers of CCBHCs certified pursuant to article 36 of the Mental Hygiene Law and this Subpart who have the potential for, or may be permitted to have, regular and substantial unsupervised or unrestricted contact with individuals receiving services shall submit to a criminal history information review. Criminal history information reviews required pursuant to sections 19.20, 19.20a and 31.35 of the Mental Hygiene Law, sections 424-a and 495 of the Social Services Law, and Parts 550 and 805 of this Title, shall be conducted in accordance with such laws and regulations and any guidance issued by OMH and OASAS. All staff with the potential for regular and substantial contact with individuals receiving services in performance of their duties shall submit to clearance by the New York Statewide Central Register of Child Abuse and Maltreatment. Staff who have not been screened by the New York Statewide Central Register of Child Abuse and Maltreatment shall not perform duties requiring contact with individuals receiving services unless there is another staff member present.

(d) OMH and OASAS may approve other qualified staff, as appropriate including but not limited to targeted case management (TCM) case managers, psychiatric rehabilitation services (PRS) staff, and staff trained in Intensive Community-Based Behavioral Health Care for members of the Armed Forces and veterans.

(e) OMH and OASAS may approve the transition of CCBHCs to heightened licensure requirements set by the New York State Education Department or other licensing or credentialing authority to the extent permitted by law.

(f) CCBHCs operated by hospitals, including psychiatric centers operated by the State, or hospitals licensed pursuant to article 31 of the Mental Hygiene Law or article 28 of the Public Health Law, which are Medicare certified and provide outpatient services reimbursed by Medicare, shall ensure services are provided under the supervision and direction of a physician, consistent with applicable Medicare certification and coverage standards and policies.

(g) Required Staffing. A CCBHC as approved pursuant to this section, shall be staffed with a team capable of delivering the CCBHC services and meeting the needs of presenting individuals

which shall also include, but not be limited to:

(1) A management team comprised of a Chief executive officer (CEO) or equivalent program director and a medical director. These positions may be fulfilled by one individual.

(i) CEO. The CEO shall maintain a fully staffed management team, as appropriate for the size and needs of the CCBHC, as determined by the CNA and staffing plan.

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

(a) The medical director shall be: a psychiatrist, internist (internal medicine), or family medicine physician with experience in: the assessment, diagnosis and treatment of mental health disorders and addiction disorders;

(1) substance intoxication and withdrawal;
(2) pharmacological management of intoxication, withdrawal, and SUDs;
(3) ambulatory withdrawal management;
(4) outpatient addiction treatment;
(5) toxicology testing; and
(6) pharmacodynamics of commonly used substances.

(b) If the medical director is not experienced with the treatment of SUDs, the CCBHC shall have experienced addiction medicine physicians or specialists on staff, or enter into arrangements which ensure access to consultation on addiction medicine for the medical director and clinical staff.

(c) If the medical director is not experienced with the treatment of mental health disorders, the CCBHC shall have experienced psychiatrists or specialists on staff, or enter into arrangements which ensure access to consultation on mental health disorders for the medical director and clinical staff.

(d) The medical director shall also have experience in pediatric psychiatry. If the medical director is not experienced with the assessment and treatment of children or youth, the CCBHC shall have experienced physicians or specialists on staff, or enter into arrangements which ensure access to consultation on pediatric psychiatry for the medical director and clinical staff.

(e) The medical director need not be a full-time employee of the CCBHC.

(f) OMH and OASAS must be notified of any change in medical director or any change that reduces access to consultation on addiction medicine or pediatric psychiatry. Such notification shall also provide a plan for coverage.

(2) At least one full-time CASAC.

(3) At least one full time licensed practitioner of the healing arts (LPHA).

(4) CCBHCs are required to provide peer support services across the lifespan based on the needs of their service area. This may include a combination of Peer staff with the following credentials:

(i) New York certified peer specialist (NYCPS);

(ii) OASAS certified recovery peer advocate (CRPA);

(iii) Credentialed family peer advocate (FPA-C); and

(iv) Credentialed youth peer advocate (YPA-C).

(5) Primary care staff. These staff can be comprised of medical doctors, nurse practitioners, physician assistants, registered nurses, psychiatric registered nurses, and licensed practical nurses who are under the supervision of any of the aforementioned medical staff.

(6) Targeted Case Management (TCM) Case Managers. Case managers must be at least 18 years of age and have a high school diploma or equivalent. They may be unlicensed staff. Case managers must be trained and demonstrate a basic knowledge and understanding of working with populations targeted by this service.

(7) Psychiatric rehabilitation services (PRS) staff. PRS staff must be at least 18 years of age and have a high school diploma, high school equivalency preferred, or a State Education Commencement Credential (e.g., SACC or CDOS); and one to three years of relevant work experience in a behavioral health setting or a bachelor's degree. The practice of PSR by unlicensed individuals does not include those activities that are restricted under title VIII of the Education Law.

(h) Staff Training Requirements

(1) At orientation and at reasonable intervals thereafter, the CCBHC must provide training to staff as appropriate to their job responsibilities on:

(i) evidence-based practices;

(ii) cultural competency aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS);

(iii) person-centered and family-centered, recovery-oriented planning and

services;
(iv) trauma-informed care;
(v) the clinic's policy and procedures for continuity of operations/disasters;
(vi) the clinic's policy and procedures for integration and coordination with primary care;
(vii) military and veterans' culture; and
(viii) care for co-occurring mental health and substance use disorders.

(2) At orientation and annually thereafter, the CCBHC must provide training to staff as appropriate to their job responsibilities on:
(i) risk assessment;
(ii) suicide and overdose prevention and response; and
(iii) the roles of both family and peer staff.

Section 600-1.11 Case Records

(a) There shall be a complete case record maintained for each person enrolled to a CCBHC. Such case records shall be maintained in accordance with recognized and accepted principles of recordkeeping as follows:

(1) hard copy case record entries shall be made in non-erasable ink or typed, and shall be legible;

(2) electronic records which use accepted mechanisms for clinician signatures and are maintained in a secure manner, may be utilized. Such records may be kept in lieu of a hard copy case record; and

(3) all entries in case records shall be dated and signed by appropriate staff.

(b) The case record shall be available to all staff of the CCBHC who are participating in the treatment of the individual and shall include the following information:

(1) individual demographics, identifying information, and history;

(2) source of referral, if applicable;

(3) pre-enrollment screening notes, as appropriate;

(4) enrollment note;

(5) diagnosis;

(6) assessment of the individual's needs;

(7) reports of all mental and physical diagnostic exams, mental health assessments, screenings, tests, and consultations, including risk assessments, health monitoring, and evaluative reports concerning co- occurring developmental, medical, substance use or educational issues performed by the program;

(8) treatment plans;

(9) dated progress notes that relate to goals and objectives of treatment, signed by the provider who performed the service;

(10) dated progress notes that relate to significant events and/or incidents, signed by the provider who documents the information;

(11) treatment plan reviews;

(12) dated and signed records of all medications prescribed by the CCBHC; and other medications, prescription and non-prescription, being used by the individual if known;

(13) transition plan; and referrals to other programs and services, if applicable;

(14) consent forms, as applicable;

(15) record of contacts with collaterals if applicable; and

(16) disenrollment summary.

(c) Health Information Systems

(1) Programs shall maintain a secure and functional electronic health record system that supports the management of health information, and demographic data.

(2) Programs shall use technology that has been certified to current criteria under the Office of the National Coordinator for Health Information Technology Certification Program for the following required core set of certified health Information Technology capabilities:

(i) capture health information, including demographic information;

(ii) support care coordination by sending and receiving summary of care records;

(iii) provide individuals with electronic access to view, download, or transmit their health information or to access their health information via an Application Programming Interface (API) using a personal health app of their choice;

(iv) conduct electronic prescribing;

(v) ensure that treatment records generated by DCOs for individuals receiving services are incorporated into the CCBHC health record; and

(vi) ensure that treatment records maintained by the CCBHC are accessible to DCOs, consistent with appropriate Federal and State laws and regulations governing the sharing of health records.

(3) Develop methods to improve the transition of care to and from the CCBHC, utilizing the existing or planned health IT systems for smooth data exchange.

Section 600-1.12 Premises

(a) A provider of service shall maintain premises that are adequate and appropriate for the safe and effective operation of a CCBHC in accordance with the following:

(1) CCBHCs shall provide for sufficient private and group rooms consistent with the number of people served and activities offered. There shall also be a sufficient number of restroom facilities to accommodate the population utilizing CCBHC services.

(2) CCBHCs shall provide for controlled access to and maintenance of medications and supplies in accordance with all applicable Federal and State laws and regulations.

(3) CCBHCs shall provide for controlled access to and maintenance of records.

(4) CCBHCs shall ensure accessibility for persons with disabilities to program and bathroom facilities. Programs shall adjust service environments, as needed, for recipients who are vision impaired, deaf or otherwise disabled.

(5) CCBHCs shall have sufficient and appropriate furnishings maintained in good condition and appropriate program related equipment and material for the population served.

(6) CCBHC space shall be sufficient to provide safety, and to allow for a reasonable degree of privacy consistent with the effective delivery of services. CCBHC space may be shared with other programs, pursuant to a plan approved by OMH and OASAS. Non-program space may be shared with other programs without such approval.

(7) There should be sufficient separation and supervision of various treatment groups and waiting areas, including adults and children or youth, to ensure the safety of the population receiving CCBHC services.

(b) The provider of service shall ensure life safety on the premises by possession of a certificate of occupancy in accordance with the Building Code of New York State and the Property Maintenance Code of New York State (19 NYCRR Chapter XXXIII, Subchapter A, Parts 1221 and 1226) or comparable local codes.

(c) Off-site services shall be provided in settings that are conducive to meeting treatment goals and objectives, be accommodating to the conditions and needs of those being served, be safe and accessible for all, shall provide sufficient separation and supervision of various treatment populations, including adults and children or youth, and assure privacy for the delivery of services.

Section 600-1.13 Approval for the use of telehealth

(a) For purposes of this section the following definitions apply:

(1) *Telehealth* means the use of two-way real-time interactive telecommunication system for the purpose of providing mental health or substance use disorder services at a distance. Such

services do not include an electronic mail message, text message, or facsimile transmission between a provider and a recipient, services provided where the originating site and distant sites are the same location, or a consultation between two physicians or nurse practitioners, or other staff, although these activities may support telehealth services.

(2) *Distant site* means the site at which the practitioner delivering the service is located at the time the service is provided via the interactive telecommunication system, which may include the practitioner's place of residence, office, or other identified space within the United States.

(3) *Originating site* means the site at which the recipient is located at the time the service is being provided via the interactive telecommunication system, which may include a recipient's place of residence, other identified location or other temporary location out-of-state.

(4) *Telehealth practitioner* means licensed or credentialed staff providing mental health or substance use disorder services consistent with their scope of practice and as authorized pursuant to this section and article 29G of the Public Health Law and Other CCBHC staff.

(5) *Recipient* means a person who is receiving CCBHC services via telehealth.

(6) *Encounter* means a recipient or collateral contact in which services are provided using telehealth and whereby the care of the recipient is the direct responsibility of the CCBHC in which the recipient is enrolled at the time of the encounter and the distant telehealth practitioner.

(7) *Encryption* means a system of encoding electronic data where the information can only be retrieved and decoded by the person or computer system authorized to access it.

(b) Approval to Use Telehealth Services

(1) Telehealth services may be authorized by OMH and OASAS for CCBHCs for services provided by telehealth practitioners, from distant site from the location of the recipient, where the recipient is located at the originating site. OMH and OASAS support the use of telehealth as an appropriate component of delivery of CCBHC services to the extent that it is in the best interests of the recipient of services; is performed in compliance with applicable State and Federal laws and regulations, the provisions of this section, and any guidelines issued by OMH and OASAS. All services may be delivered via telehealth unless otherwise specified by guidelines established by OMH and OASAS.

(c) Approval shall be based on receipt by OMH and OASAS of the following:

(1) Sufficient written demonstration that telehealth services will be used for assessment and treatment services provided by CCBHCs consistent with the requirements of this Subpart, guidelines established by OMH and OASAS, and that the services are being requested not to fulfill regulatory staffing requirements but because they are necessary to improve access and the quality of care of individuals receiving services or because they are necessary to address workforce shortages.

(2) Submission to OMH and OASAS of policies and procedures and an attestation to provide telehealth services that satisfies the provisions of this section and includes:

(i) confidentiality protections for persons who receive telehealth services, including measures to ensure the security of the electronic transmission;

(ii) procedures for assessing recipients to determine whether a recipient may be properly treated via telehealth services;

(iii) informed consent of persons who receive telehealth services and procedures for the withdrawal of such consent;

(iv) procedures for handling emergencies with persons who receive telehealth services; and

(v) contingency procedures to use when the delivery of telehealth service is interrupted, or when the transmission of the two-way interactions is deemed inadequate for the purposes of service provision.

(3) Requests for approval to deliver telehealth services shall be submitted in writing by the CCBHC in a form and format prescribed by OMH and OASAS.

(4) Approval by OMH and OASAS shall be based on review of the policies and procedures addressing the requirements for telehealth services in this section.

(5) OMH and OASAS shall provide approval to utilize telehealth services in writing. The CCBHC must retain a copy of the approval document and shall make it available for inspection upon request of OMH and OASAS.

(6) Failure to adhere to the requirements set forth in this section may be grounds for revocation of approval to utilize telehealth services. CCBHCs will be notified of such revocation in writing, and the CCBHC may request an informal administrative review of such decision. The request for review must be made in writing within 15 business days of the date it receives notice of revocation. Such request shall be made to the commissioners. The commissioners shall notify the CCBHC, in writing, of the results of the informal administrative review within 20 business days of receipt of the request for review. The commissioners' determination shall be final and not subject to further review.

(d) In order to provide telehealth services, the distant site telehealth practitioner must:

(1) possess a current, valid license, permit, limited permit, or credential to practice in New York State, or is designated or approved by OMH and OASAS to provide services and be in good standing with the appropriate licensing/credentialing authority;
(2) directly render the telehealth service;
(3) abide by the laws and regulations of the State of New York including the New York State Mental Hygiene Law and any other law, regulation, or policy that governs the assessment or treatment service being provided;

(4) adhere to the same laws, rules, and regulations and exercise the same standards of care and competencies required for services delivered in-person;
(5) utilize evidence-based telehealth practice guidelines and standards of practice, to the degree they are available, to ensure recipient safety, quality of care, and positive outcomes; and
(6) deliver services from a secure location which ensures the minimum standards for privacy for recipient-telehealth practitioner interaction are met.

(e) Telehealth practitioners are permitted to deliver services from a site located within the United States or its territories, which shall include the practitioner's place of residence, office, or other identified space approved by OMH and OASAS and in accordance with guidelines established by OMH and OASAS.

(1) The telehealth practitioner must not be terminated, suspended, barred from the Medicaid or Medicare program or on the staff exclusion list.
(2) If the originating site is a hospital, the telehealth practitioner at the distant site must be credentialed and privileged by such hospital, as required by applicable accreditation standards.
(3) Telehealth services must be rendered using telehealth technologies. A provider of CCBHC services approved to offer telehealth services shall adopt and implement technology in a manner that supports the standard of care to deliver the services, the features of which include at least:

(i) Telehealth practitioners must verify the identity of the recipient before beginning each telehealth encounter.
(ii) The technology and equipment utilized in the provision of telehealth services must be of sufficient quality, size, resolution, and clarity where applicable such that the provider of services can safely and effectively provide the telehealth services.
(iii) The technology and equipment utilized in the provision of telehealth services or the use of audio or video telephone communication must be compliant with the Health Insurance Portability and Accountability Act (HIPAA).

(4) A notation must be made in the clinical record that indicates that the service was provided via telehealth and indicating whether audio only services were provided which specifies the time the service was started and the time it ended.
(5) Telehealth services provided to recipients under age 18 may include staff members of the originating site in the room with the recipient. Such determinations shall be clinically based, consistent with guidelines issued by OMH and OASAS.
(6) For purpose of billing, telehealth services shall be considered face-to-face contacts when the service is delivered in accordance with the provisions of the plan approved by OMH and OASAS pursuant to this section. Providers should refer to the CCBHC specific guidelines established by OMH and OASAS to determine authorized use of telehealth services.

(7) Culturally competent interpreter services shall be provided in the recipient's preferred language when the recipient and telehealth practitioners do not speak the same language.
(8) The telehealth practitioner providing telehealth services at a distant site shall be considered an active part of the recipient's treatment team and shall be available for discussion of the case or for interviewing family members and others, as the case may require. Such telehealth practitioner shall prepare appropriate progress notes and securely forward them or directly enter them into the originating provider health record as a condition of reimbursement.
(9) Telehealth services shall not be used:

(i) for purposes of seeking a court order for treatment over objection; or
(ii) restraint or seclusion, as defined in Part 526.4 of this Title.

(f) Policies and Procedures. A CCBHC approved to utilize telehealth services must have written policies and procedures that address, at a minimum the following:

(1) Each recipient must be evaluated to determine if telehealth is appropriate and documented in the case record; additional evaluations may be required for medication for addiction treatment using controlled substances.

(i) Audio only modalities are not permitted for youth aged five and under.

(2) Informed consent: persons receiving telehealth services must provide informed consent to participate in such services.

(i) The recipient must be provided with basic information about telehealth including alternatives, possible delays in services, possible need to travel to an approved originating site to receive services, risks associated with not having the services provided, and be apprised of alternatives to telehealth services.
(ii) For recipients under age 18 for whom informed consent cannot be obtained pursuant to Mental Hygiene law section 33.21, such information shall be shared with and informed consent obtained from the recipient's parent or guardian.
(iii) The recipient has the right to refuse to participate in telehealth services, in which case services must be conducted in-person by appropriate clinicians.
(iv) Telehealth services shall not be recorded without the recipient's consent, which shall be documented in the clinical record.

(3) Confidentiality, at a minimum: policies and procedures must be maintained as required by OMH and OASAS, HIPAA at 45 CFR parts 160 and 164, and 42 CFR part 2 and shall apply to both the originating site and the distant site.

(i) All telehealth services must be conducted via telehealth technologies that meet minimum Federal and State requirements, including but not limited to 45 CFR parts 160 and 164, and 42 CFR part 2. Transmissions must employ acceptable authentication and identification procedures by both the sender and the recipient.

(4) Emergency situations: All CCBHC sites must have a written procedure detailing the availability of in-person services/assessments in emergency situations.
(5) Prescribing medications via telehealth. Procedures for prescribing medications through telehealth must be identified and must be in accordance with all applicable New

York State and Federal laws. The provision of buprenorphine prescribing and monitoring via telehealth must comply with all applicable State and Federal laws and regulations.

(6) Recipient rights policies must ensure that each individual receiving telehealth services:

(i) is informed and made aware of the role and license information of the telehealth practitioner at the distant/hub site, as well as staff at the originating/spoke site, where non-residential, who are responsible for follow-up or on going care;

(ii) is informed and made aware of the location of the distant/hub site and all questions regarding the equipment, the technology, etc., are addressed;

(iii) has the right to have appropriately trained staff immediately available to them while receiving the telehealth service to attend to emergencies or other needs;

(iv) has the right to be informed of all parties who will be present at each end of the telehealth transmission; and

(v) if the recipient is a minor, the recipient and their parent or guardian shall be given the opportunity to provide input regarding who will be in the room with the recipient when telehealth services are provided.

(7) Quality of care. All CCBHCs must have a written procedure detailing the contingency plan when there is a failure of transmission or other technical difficulties that render the service undeliverable.

(8) Ownership and maintenance of records:

(i) The CCBHC in which the recipient is enrolled shall be responsible for obtaining and maintaining a complete clinical record as if the recipient were seen in-person.

(ii) The telehealth practitioner must have immediate access to the recipient health record.

(iii) The distant site shall maintain copies of all documentation completed by the distant site telehealth practitioner unless the telehealth practitioner records the information directly within the originating sites electronic medical record system.

(g) Guidelines of the Offices: OMH and OASAS shall develop guidelines to assist CCBHC providers in complying with the provisions of this section and in achieving treatment goals through the use of telehealth services. OMH and OASAS shall post such guidelines on their public websites.

(h) Medication for Addiction Treatment. Initiation and prescribing of medications for addiction treatment must be done in accordance with any and all applicable State and Federal rules and regulations.

(i) Reimbursement for Telehealth Services.

(1) The CCBHC where the recipient is enrolled is authorized to bill Medicaid for

telehealth services.

(2) Under the Medicaid program, telehealth services are covered when medically necessary and under the following circumstances:

(i) the person receiving services is located at the originating/spoke site;

(ii) the telehealth practitioner is located at the distant/hub site and is employed by or contracted with a program licensed or designated by OMH and OASAS;

(iii) the person or collateral receiving services is present during the encounter;

(iv) the request for telehealth services and the rationale for the request are documented in the individual's clinical record;

(v) the clinical record includes documentation that the encounter occurred; and

(vi) the telehealth practitioner at the distant/hub site is:

(*a*) authorized in New York State;

(*b*) practicing within his/her scope of specialty practice; and

(*c*) if the originating or spoke site is a hospital, credentialed and privileged at the originating/spoke site facility.

(3) Audio-only or audio-video communication is covered by Medicaid and the Child Health Insurance Plan to the extent consistent with regulations promulgated by the New York State Commissioner of Health pursuant to section 2999-cc of the Public Health laws.

(4) The following interactions do not constitute reimbursable telehealth services: E-mail messages, text messages; or Facsimile transmission.

(5) Reimbursement for services provided via telehealth must be in accordance with the rates and fees established by OMH and OASAS, subject to the approval of the Director of the Division of the Budget and the availability of State and Federal funding. Such rates or fees shall be the same for identical procedures provided by practitioners in-person, in the same location as the recipient unless otherwise established by OMH and OASAS.

(i) If telehealth service is undeliverable due to a failure of transmission or other technical difficulty, reimbursement shall not be provided.

Section 600.-1.14 Medical Assistance Billing Standards

(a) Medicaid claims for individuals who have been enrolled in a CCBHC shall include, at a minimum, the Medicaid identification number of the recipient, the diagnosed behavioral health conditions, the procedure code or codes corresponding to all allowable services provided on that day, the location of the service or services, specifically the licensed location where the service

was provided or the clinician's regularly assigned licensed location from which the clinician departed for an off-site procedure, and the national provider identification or equivalent Department of Health approved alternative as appropriate of the attending clinician. The provider must also comply with the requirements associated with any procedure code being billed.

(b) To receive reimbursement for CCBHC services pursuant to this Subpart, each program operated by a provider of service shall:

(1) have a valid operating certificate issued by OMH and OASAS;

(2) comply with all applicable Medicaid requirements of title XIX of the Social Security Act and regulations promulgated thereunder and title 11 of article 5 of the New York State Social Services Law and regulations promulgated thereunder; and

(3) comply with all the requirements of this Subpart.

(c) Services may be provided by a CCBHC directly or through a formal relationship with a Designated Collaborating Organization ("DCO"). DCOs may only provide required services specified under section 600-1.8 of this Subpart.

(d) To receive reimbursement for services, a provider must demonstrate that they have provided at least one of the following services:

(1) screening, diagnosis and risk assessment;

(2) person- and family-centered treatment planning;

(3) outpatient mental health and substance use services;

(4) crisis services;

(5) outpatient primary care screening and monitoring;

(6) targeted case management;

(7) psychiatric rehabilitation services;

(8) peer family support and counselor services; or

(9) community-based behavioral health care for veterans.

(e) Reimbursement for such services provided by CCBHC shall be based upon provider-specific cost-based rates with a bundled daily rate for all CCBHC services provided on any given day by a CCBHC directly or through a formal relationship with a DCO.

(f) The CCBHC will be responsible for any reimbursement paid to the DCO and the DCO will not bill Medicaid payors directly for services provided on behalf of the CCBHC.

(g) In the case that the same individual is seen by multiple providers on the same day, the provider who holds the treatment plan for that individual will be the only provider eligible to receive payment for that day, for that individual.

600-1.15 Medical Assistance Certified Community Behavioral Health Center program reimbursement system

(a) Providers will be required to produce and submit cost reports specifically for the CCBHC program and supplemental documentation to OMH and OASAS in a form and format to be determined by both agencies. Such cost reports and supplemental documentation will form the basis of each provider's provider-specific cost-based rates. CCBHCs must comply with OMH and OASAS directed timelines for submitting cost reports and supplemental documentation. Medicaid payments may be reduced or suspended and CCBHCs may be required to pay back State Medicaid program payments received during the period for which a complete cost report was not provided.

(b) For newly approved CCBHC providers, OMH and OASAS will recognize the use of anticipated, allowable costs to establish the provider-specific rate.

(1) The anticipated allowable costs reported within the CCBHC cost report will be subject to review for reasonableness, necessity, and prudence in accordance with Medicaid cost principles. The allowance of anticipated costs and corresponding anticipated visits are at the discretion of OMH and OASAS.

(2) The State will recalculate the rate once sufficient cost data is available within a timeframe to be determined by OMH and OASAS and within the first three years for which there is a completed annual cost report. Once the rebased rate is calculated using a year of actual costs, the State will have the discretion to reconcile previous payments made with the initial payment rate to cost if actual costs are determined to be significantly less than total payments.

(3) If the State determines there are sufficient providers to establish a representative regional average CCBHC rate, OMH and OASAS may elect to reimburse newly certified CCBHC providers such regional average rate, as an alternative to establishing rates based upon anticipated costs, until such time as the provider is rebased.

(c) For existing providers, rates will be calculated based upon cost and visit data supplied annually.

(1) Reimbursement rates will be updated to the applicable rate year utilizing the Medicare Economic Index (MEI) for primary care services as defined in section 1842(i)(3) of the Social Security Act or an inflationary index to be determined by the State.

(2) Services and costs related to services provided by DCOs will be included in the rate computation.

(3) Reimbursement for dispensed medication will be covered under the Medicaid pharmacy benefit and will not be included in allowable CCBHC costs.

(d) The cost-based rate will be calculated in accordance with the following formula:

(Total annual allowable CCBHC costs X applicable inflationary index) / Total number of approved/allowable CCBHC annual daily visits

(1) "Allowable costs" shall include, but not be limited to, direct costs necessary to support the provision of CCBHC services plus indirect costs applicable to CCBHC services to be prorated based on the share of CCBHC program costs to non-CCBHC program costs.

(i) Allowable costs include salaries and benefits of Medicaid qualified providers which will be generally consistent with market data or Bureau of Labor Statistics salary data, cost of services provided under agreement, and other direct CCBHC costs.

(ii) Allowable costs must comply with all appropriate New York State and Federal laws.

(2) "Applicable inflationary index" shall refer to an established inflationary index as determined by the Center for Medicaid and Medicare Services, or established by OMH and OASAS, subject to the approval of the Director of the Budget.

(3) "Total annual daily visits" shall include all visits for CCBHC services, including both Medicaid and non-Medicaid visits.

(i) The daily visit will consist of all services provided to the consumer on a single day whether provided by the CCBHC or a DCO and will be limited to one daily CCBHC visit per beneficiary per day. A CCBHC or DCO must provide at least one qualifying service,

as described in section 600.-1.9(a)(1) of this Subpart to an individual to be eligible for reimbursement.

(e) Provider-specific cost-based rates will be rebased to more accurately reflect actual costs at least once every three years, with rebased rates taking effect prospectively, for rates effective July 1st following final State certification. Provider-specific cost-based rates may also be rebased in the event of significant changes in scope of services or costs that are the result of circumstances, including, but not limited to, public health, natural or environmental emergencies or other factors as determined by the commissioners of OMH and OASAS.

(f) Provider-specific cost-based rates established by OMH and OASAS shall be subject to the approval of the director of the Division of the Budget and the availability of State and Federal funding and shall not be eligible for revision based on the request of the provider.

Section 600-1.16 Quality Bonus Payments (QBP)

(a) CCBHC providers will be eligible for participation in the Quality Bonus Payments (QBP) program based on achieving specific thresholds on State mandated performance measures. The performance period will be based on a calendar year and CCBHC providers must have one full calendar year of complete operational data from which designated quality measures will be calculated to qualify for the QBP program.

(b) The State mandated performance measures and technical specifications shall be made public electronically on OMH website.

(c) A CCBHC must meet or exceed the thresholds for established performance measures to receive funds under the program. CCBHC providers that do not report measurement data to the State timely will not be eligible for participation in the QBP program.

(d) Payments under the QBP program will be based on multiplying the total CCBHC specific Medicaid payments made during the performance period by a percentage based upon the achieved respective CCBHC specific thresholds on State mandated performance measures. Payments will be made as an annual lump sum payment and not through adjustment of provider-specific cost-based rates.

(e) The State will establish the minimum volume of individuals served in each performance measure denominator necessary for the performance measure to be valid. Measures that do not meet the minimum threshold of individuals served will not be eligible for payment under the QBP and no proportioned payment of that measure will be made. Measures that do not meet the minimum threshold of individuals served will reduce the overall QBP percentage achievable by that provider.

(f) Total annual payments under the CCBHC QBP program shall not exceed 8.5 percent of statewide aggregate CCBHC Medicaid expenditures. In the event the sum of individual

CCBHC QBP each year exceed this measure; all such awards shall be reduced in proportion to this aggregate limit.

(g) CCBHC QBP payments will be contingent upon the availability of State and Federal funding.

Section 600-1.17 Application and Approval Process for CCBHC Established under Federal Demonstration

(a) A CCBHC, previously established under the Federal CCBHC demonstration awarded by the State, that wishes to continue operating, or such provider seeking to obtain a CCBHC license, shall submit an application to OMH and OASAS seeking an operating certificate under this Subpart.

(b) In order to prevent treatment and services disruption and provide for a seamless transition for CCBHCs previously established under the Federal demonstration to certification under this section, effective upon adoption of this section, OMH and OASAS jointly designate CCBHCs previously established under the Federal demonstration to continue to operate as a CCBHC and be reimbursed a cost-based Medicaid rate, subject to continued provider compliance with the New York State CCBHC Provider Manual and SAMHSA CCBHC Certification Criteria available for public inspection at https://omh.ny.gov/omhweb/bho/ccbhc.html.

(c) Such designation is provisional and will expire on the 90th calendar day after the date that the Notice of Adoption of final OMH and OASAS CCBHC regulations is published in the New York State Register. Such designation shall be extended, as necessary, for any CCBHCs previously established under the Federal demonstration that apply, on or before such 90th calendar day, for certification as a CCBHC under this Subpart, until such certification application is approved or disapproved.