New York State (NYS)
Certified Community Behavioral Health Clinic (CCBHC)
Managed Care Organization (MCO) Operations Manual

The New York State (NYS) Certified Community Behavioral Health Clinic (CCBHC) Managed Care Organization (MCO) Operations Manual was created in an effort to provide MCOs with comprehensive information on NYS' implementation and management of the CCBHC national program demonstration.

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (H.R. 4302) was enacted, laying the groundwork for the establishment of CCBHCs. The purpose of a CCBHC is to improve health outcomes through increased access to quality care for all individuals, reduce avoidable hospital use & complications, foster diverse health system partnerships, and provide behavioral health care entities in underserved areas with more financial stability through enhanced Medicaid reimbursement. CCBHCs are responsible for directly providing (or contracting with partner organizations to provide) nine required types of services: crisis mental health services, screening assessment and diagnosis (including risk management), patient centered treatment planning, outpatient mental health and substance use services, physical health screening and health risk monitoring, care management, peer support and family supports, community-based mental health care for veterans and members of the armed forces, targeted case management and psychiatric rehabilitation. Section 223 of the law authorized the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS) - under the United States Department of Health and Human Services- to: administer one year planning grants to States, develop certification criteria for CCBHCs, provide guidance to States on developing a Prospective Payment System (PPS) for reimbursement, and report findings & recommendations to Congress on CCBHC data.

In October 2015, the State of New York was awarded a one year planning grant from SAMHSA & CMS to develop a proposal and program demonstration for the provision of CCBHC services. Under the planning grant, the State was charged with: collaborating with key stakeholders, certifying at least two clinics as CCBHCs based on the SAMHSA criteria, assisting clinics with meeting certification standards through training and technical assistance, developing a PPS methodology, and collecting & reporting data in preparation to participate in the National evaluation. In October 2016, NYS was selected as one of 8 States to implement a two-year demonstration program- with a requirement to begin services as of July 1st 2017. Of the behavioral health clinics who had initially applied to participate in the NYS federal demonstration, 13 providers were ultimately selected: BestSelf Behavioral Health Services, Bikur Cholim, Central Nassau Guidance & Counseling Services, Citizen Advocates, Endeavor Health Services, New Horizon Counseling Center, PROMESA, Samaritan Daytop Village, Services for the Underserved (SUS), Spectrum Human Services, Syracuse Brick House, University of Rochester Strong Memorial Hospital, and Vocational Instruction Project (VIP). Prior to beginning CCBHC services on July 1st 2017, NYS Department of Health (DOH) approved the demonstration services to be carved-out of managed care and billed to the State using rate code 1147. The State carve-out will apply throughout the course of the 2-year CCBHC demonstration, which is currently scheduled to conclude on July 1st 2019.

Questions or comments pertaining to the NYS CCBHC MCO Operations Manual may be directed to CCBHC@omh.ny.gov.

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I. New York State (NYS)
Certified Community Behavioral Health Clinic (CCBHC)
Scope of Services Provider Manual
(December 14, 2017)

New York State (NYS) is pleased to release the Certified Community Behavioral Health Clinic (CCBHC) Scope of Services Provider Manual to be used for participation in the National program demonstration of CCBHC. The Scope of Services required by NYS complies with the CCBHC Criteria published by the Substance Abuse and Mental Health Services Administration (SAMHSA), and will be available under the State Medicaid program, and reimbursed for under a Prospective Payment System (PPS) methodology for community behavioral health providers that are granted CCBHC certification by NYS.

As a part of a collaborative effort, the NYS Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse (OASAS), Department of Health (DOH), and community stakeholders developed the CCBHC Scope of Services Provider Manual to improve the State's behavioral health system, by:

- Addressing unmet needs identified though comprehensive community needs assessments;
- Increasing the accessibility and availability of person-centered, trauma-informed, culturally competent, and recovery-oriented services;
- Enhancing statewide care coordination efforts;
- Requiring nationally recognized evidence based practices.

The CCBHC Scope of Services Provider Manual describes the basic service provision requirements for all CCBHCs certified by NYS, and outlines the following:

- Service Definitions and Components Across the Lifespan
- Provider Qualifications and Training Requirements
- Required and Recommended Evidence Based Practices
- Allowable Modes and Settings for Service Delivery
- Admissions/Eligibility Criteria
- Limitations/Exclusions
- Billing Requirements

Questions or comments pertaining to the NYS CCBHC Scope of Services Provider Manual may be directed to CCBHC@omh.ny.gov.

Values/Core Principles

In an effort to enhance New York's behavioral health system and uphold the spirit of the Certified Community Behavioral Health Clinic program, the CCBHC Scope of Services Provider Manual has been developed based on the following values and core principles:

- **Person-Centered Care**: Person-centered care involves the individual seeking services to the maximum extent possible, reflecting the individual's goals, and emphasizing shared decision-making approaches that empowers, provide choice, and minimize stigma. Services should be self-directed, include family members and other key natural supports -based in the individual's wishes, emphasize wellness and attention to the person's overall well- being, and promote full community inclusion.
- **Recovery-Oriented:** Recovery oriented services should incorporate "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." Guiding principles of recovery include: • Hope • Person-driven • Many pathways • Holistic • Peer support • Relational • Culture • Addresses trauma • Strengths/responsibility • Respect (Substance Abuse and Mental Health Services Administration [2012]).
- **Culturally and Linguistically Competent:** Services should be respectful of and responsive to the values and needs of an individual, and contain a wide range of expertise in treating and assisting individuals with Serious Mental Illness (SMI) and Substance Use Disorder (SUD) in a manner responsive to cultural and linguistic diversity.
- **Evidence-Based:** Services should utilize evidence-based practices where appropriate and provide or enable continuing education activities to promote uptake of these practices.
- **Trauma-Informed:** Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives. (SAMHSA, 2014)
- **Coordination and Collaboration:** Care coordination activities should be the foundation of the CCBHC, along with efforts to foster individual responsibility for health awareness. These characteristics should guide all aspects of treatment and rehabilitation to support effective partnerships among the individual, family and other key natural supports and service providers. Services should be integrated- addressing both physical and behavioral health needs of individuals.
- **Accessible and Available:** Services should be flexible and mobile, and adapt to the specific and changing needs of each individual. CCBHCs should use a non-four walls service delivery model, along with therapeutic methods and recovery approaches which best suit each individual's needs.
- **Family-Centered Care**: Services that are family-focused emphasize~~s~~ the important role of family in the service planning and delivery process for children. Family-centered care promotes the wellbeing and developmental needs of the child, and supports relationships between the child, family, and service providers.
- **Data-Driven:** Providers should use data to define outcomes, monitor performance, and promote health and well-being. Performance metrics should reflect a broad range of health and recovery indicators beyond those related to acute care.

CCBHC State Needs Assessments

During the one year planning grant, NYS, in conjunction with the community behavioral health providers seeking CCBHC certification, developed nine geographic-specific community needs assessments in order to inform the CCBHC Scope of Service requirements, as well as other planning grant efforts.

The purpose of the needs assessment is to ensure that the behavioral health treatment needs in the community are identified and integrated into CCBHCs' strategic planning, and will ensure that their program designs and services are well suited to the populations they serve. The assessment provides information about cultural, linguistic, resource, treatment, and staffing needs of the areas to be served by the CCBHCs. It also addresses potential barriers to care including transportation, income, and cultural factors. Findings from this needs assessments are intended to provide information relevant to CCBHC staffing requirements, services and cost reports.

As the CCBHCs in NYS must participate in a Delivery System Reform Incentive Payment (DSRIP) Program Performing Provider System network, the needs assessments have been organized at the following DSRIP region levels: the Adirondacks, Capital, Central, Finger Lakes, Long Island, Mid-Hudson, New York City, Tug Hill Seaway, and Western NY regions. The needs assessments are comprehensive, data driven and compares results across the counties in each DSRIP region and across DSRIP regions.

The needs assessment includes the following sections:

- Section I. Description of Communities to Be Served ─ Describes the geographic service area and characteristics of the population to be served, including special populations.
- Section II. Physical and Behavioral Health Care Resources ─ Describes existing physical and behavioral health care resources including facilities, services and practitioners.
- Section III. Health Status ─ Describes the health status of the population to be served including disease prevalence, health behaviors and risk factors, and mortality and morbidity.
- Section IV. Behavioral Health Care Utilization ─ Describes current behavioral health care inpatient and emergency room utilization with a focus on Medicaid beneficiaries.

The CCBHC Scope of Services requirements outlined may be subject to change based on the periodic update of the community needs assessments.

Accessibility and Availability of Services

Per the criteria established by SAMHSA, CCBHCS shall offer services in a manner accessible and available to individuals in their community. Important considerations for accessible and available care includes:

- **Service times and settings that are convenient to the community served**: services that meet the needs of the community should be reasonably accessible. CCBHCs shall utilize the community needs assessment to ensure service settings and hours are appropriate.
- **Where the service recipient lives:** CCBHCs should consider acceptable travel times from the individual's home when ensuring accessibility of services.
- **Prompt intake and engagement in services:** CCBHCs will follow the prompt screening, assessment, and, diagnosis timeframes as outlined in this manual**.**
- **Access to adequate care, regardless of residency or ability to pay:** Statute establishing the CCBHC program requires that no individual will be denied behavioral health care services- including but not limited to crisis management services- because of their inability to pay for such services. Any fees or payments required by the clinic for such services will be reduced or waived to ensure appropriate accessibility and availability. Moreover, CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence. CCBHCs must have protocols in place to address the needs of individuals who do not live close to a CCBHC or within the CCBHC catchment area.
- **Person-centered treatment planning and service provision:** As a core principle for the Scope of Services Manual, CCBHCs should exercise person-centered care whenever possible to ensure accessibility and availability of services. Treatment planning and service provision should reflect an individual's goals and emphasize self- direction and choice.

- **Access to adequate crisis services:** because the emergency department (ED) is often a source of crisis care, CCBHCs must have clearly established relationships with local EDs to facilitate care coordination, discharge and follow-up, as well as relationships with other sources of crisis care.
- **Availability of community-based services and telehealth:** service provision should meet the needs of the community being served. Community-based peer, recovery, and clinical supports- as well as the use of telehealth/telemedicine shall be used to increase accessibility and availability of services.

Care Coordination

CCBHC care coordination is a non-billable, agency practice that facilitates a seamless transition of care in and out of the CCBHCs scope of practice. CCBHC care coordination facilitates integrated care by intentionally organizing patient care activities, information, and needs and preferences across all appropriate care settings. Care coordination activities are the foundation of the CCBHC program, and should guide all aspects of treatment to support effective partnerships among the individual, family and other key natural supports and service providers.

CCBHCs are required to maintain formal relationships with the following care settings for care coordination purposes:

1. Federally-Qualified Health Centers and/or Rural Health Clinics;
2. Inpatient psychiatric facilities, substance use detoxification, post-detoxification step-down services, and residential programs;
3. Other community supports such as:
    - schools, child welfare agencies,
    - juvenile and criminal justice agencies and facilities,
    - Indian Health Service youth regional treatment centers,
    - State licensed and nationally accredited child placing agencies for therapeutic foster care service, and
    - other social and human services;
4. The Department of Veterans Affairs medical centers;
5. Inpatient acute care hospitals and hospital outpatient clinics;
6. Health Homes.

CCBHC Care Coordination and Health Homes

Care Coordination as a billable service is currently provided by Health Homes separate from CCBHC. In order to prevent unnecessary service duplication and ensure an effective continuum of care, CCBHCs shall target their comprehensive care coordination efforts towards individuals who are not Health Home eligible or individuals who are Health Home eligible, but refuse Health Home services. The CCBHCs primary objective shall be to immediately link all individuals who are Health Home eligible to care coordination through a Health Home and maintain an effective coordination of care between the CCBHC and Health Home.

CCBHCs must provide all Health Home eligible individuals with the option to receive care coordination through a Health Home. If an individual is currently receiving or chooses to receive care coordination through the Health Home, the CCBHC must make the appropriate care linkage and conduct care coordination efforts solely with the Health Home.

CCBHC Provider Certification

A CCBHC Provider Implementation Monitoring Process and review tool will be developed within 3 months of initial operation of all CCBHCs.

CCBHC Scope of Services

Crisis behavioral health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization

Definition

CCBCH Crisis Behavioral Health Services refer to activities which are designed to provide a rapid response to address acute psychiatric and/or substance use crisis. CCBHC Crisis Behavioral Health Services are designed to:

a) Provide crisis management services that are accessible 24 hours a day, 365 days per year, and delivered within three hours.
b) Provide a continuum of crisis prevention, crisis response and post-intervention services to include suicide crisis response and services capable of addressing crisis related to substance abuse and intoxication, including ambulatory and medical detoxification.
c) Include an assessment that is culturally and linguistically sensitive, and incorporates the principles of trauma-informed care
d) Result in the development of a person-centered and family-centered crisis plan with the individual, child/youth and family/caregivers to prevent and de-escalate future crisis situations.

CCBHC crisis behavioral health services are intended to be provided based on a continuum of crisis response in effort to effectively address individual crisis needs. The continuum of crisis response includes:

1. **Early Intervention/Prevention:** Early intervention/prevention services are intended to help prevent individuals from experiencing future crisis and reduce the risk of repeated crisis. Individuals who may benefit from prevention services include, but are not limited to individuals who: are at risk or experiencing a crisis; received crisis response or stabilization service; are discharged from a hospital, emergency department, or psychiatric center following a behavioral health crisis.
2. **Crisis Response:** Crisis response services are designed to interrupt and/or ameliorate a crisis including a preliminary assessment, immediate crisis resolution and de-escalation. Mobile, telephonic and agency-based crisis response services must be available 24/7 with a three-hour response time. Individuals who may benefit from crisis response services are those who are at imminent risk of having a psychiatric or substance use-related crisis.
3. **Stabilization:** Crisis stabilization is a direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a mental health or substance use disorder. Individuals who may benefit from prevention services include, but are not limited to individuals who: received crisis response or are discharged from a hospital, emergency department, or psychiatric center following a behavioral health crisis.

Crisis behavioral health services must be provided directly by the CCBHC, unless there is an existing state-sanctioned crisis behavioral health services provider/network capable and willing to be a DCO for this service.

Service Components for Adults

At first point of contact, preliminary screening and assessment activities must be conducted consistent with the service requirements prescribed under CCBHC screening, assessment, and diagnosis.

Based on the assessed need, an individual may enter services at any point on the crisis response continuum. CCBHC crisis behavioral health service components shall be consistent with the following continuum of crisis response:

1. Early Intervention/Prevention: early intervention/prevention services are designed to assist an individual to prevent a crisis. Service components must include:

- Development of an individualized crisis prevention plan documented in the record.
- Referrals and appropriate linkages to ongoing CCBHC and other community-based behavioral health services
- Psychiatric consultation and urgent psychopharmacology intervention, as needed
- Access to 24-Hour Crisis Hotlines: Callers are connected to a crisis specialist that may provide assessment, screening, triage, preliminary counseling, and information and referral services.

2. Crisis Response Services: Emergency crisis intervention services are available 24 hours a day, 7 days a week, 365 days per year. The goal of this service is to offer face-to-face, mobile, agency-based and telephonic support to individuals who are experiencing a behavioral health crisis with the goal of ameliorating the crisis and linking to ongoing support services. Crisis Intervention services components must be available 24 hours a day, 7 days a week, to individuals of all ages who are experiencing a behavioral health crisis. Service components must include:

- Short-term counseling either in person or telephonically.
- Assistance in accessing inpatient care and/or short-term crisis respite services, if needed
- Assistance providing short-term case management and psychotropic medication management until individuals are connected to longer-term mental health services
- Referrals to diversionary levels of care, including psychiatric and/or substance abuse programs
- Linkages to ongoing CCBHC and other community-based behavioral health services
- Creation of Crisis Prevention Plans
- **Medically Managed Withdrawal and Stabilization:** Designed for patients who are acutely ill from alcohol-related and/or substance-related addictions or dependence, including the need for medical management of persons with severe withdrawal or risk of severe withdrawal symptoms, and may include individuals with or at risk of acute physical or psychiatric co-morbid conditions. This level of care includes the forty-eight (48) hour observation bed. It is required that CCBHCs have this service available and accessible to people experiencing a crisis at the time of the crisis. Please refer to Appendix E for further information.

  This service component must be provided in a hospital setting. It may be provided through a DCO relationship, or by referral.

- **Medically Supervised Withdrawal and Stabilization:** Appropriate for persons who are intoxicated by alcohol and/or substances, who are suffering from moderate withdrawal, coupled with situational crisis, or who are unable to abstain with an absence of past withdrawal complications. It is required that CCBHCs have this service available and accessible to people experiencing a crisis at the time of the crisis. Please refer to Appendix E for further information.

  This service component may be provided in a hospital or community based setting (an OASAS provider certified to deliver this service). It may also be provided through a DCO relationship or by referral.

- **Mobile crisis:** Upon notification, mobile crisis teams are dispatched to an individual's home or any setting where a crisis may be occurring to provide assessment, brief intervention and linkage/referral to other crisis/behavioral health services as appropriate. Mobile Crisis services must be available 24/7 with a three-hour response time. Mobile Crisis services must include:
  - A therapeutic response including short-term, solution-focused counseling.

- Referrals and linkages to necessary behavioral health community services and supports.
- Peer Support: Peers may provide support during and after a crisis and may assist with connecting an individual with natural supports and linkages to community services as soon as possible.
- Follow-up with the individual and the individual's family/support network to confirm linkage to Care Coordination, outpatient treatment or other community services.

3. Stabilization crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms. Crisis Stabilization Services may also follow an emergency room visit and psychiatric hospitalizations to provide services that may assist with preventing another inpatient visit. Service components include:

- 23-hour crisis observation**:** Services designed for individuals who may need short, intensive treatment in a safe environment that is less restrictive than a hospital. There is no continued stay associated with 23-hour observation. Individuals must be transferred to a more/less intensive level of care
- Individual and group counseling
- De-escalation strategies
- Medication management
- Peer Support
- WRAP planning
- Wellness activities
- Family support
- Conflict resolution
- **Ancillary Withdrawal Management**: Provide symptom relief and/or addiction medications for a person who is experiencing mild to moderate or persistent withdrawal, only after an accurate assessment of the level of withdrawal using a standardized assessment instrument.

This service component must be provided directly by the CCBHC. All CCBHC's must obtain designation through NYS OASAS for their integrated outpatient program(s) to provide Ancillary Withdrawal Management. **

- **Medically Supervised Outpatient Withdrawal and Stabilization:** Appropriate for persons who are intoxicated by alcohol and/or substances, who are suffering from moderate withdrawal, coupled with a stable environment and who are unable to abstain with an absence of past withdrawal complications. It is required that CCBHCs have this service available and accessible to people experiencing a crisis at the time of the crisis.

This service component may be provided directly by the CCBHC, or through a DCO relationship, or by referral. Please refer to Appendix E for further information.

- Transitional Support: integration/reintegration into community treatment
- Care linkage/referral: referral to higher level crisis stabilization services that are outside of the CCBHCs scope of practice, such as:
    - Crisis respite housing
    - OASAS Residential Stabilization Programs

Service Components for Children

Please refer to service components for adults.

Crisis behavioral health services are provided to a child under age 21, and his/her family/caregiver, who is experiencing a psychiatric or substance use (behavioral health) crisis.

Evidence Based Practices for Adults

Required:

- Motivational Interviewing
- Medication Assisted Treatment

Recommended:

- First episode early intervention for psychosis (OnTrackNY)
- Treatment for Post-Traumatic Stress Disorder (PTSD)
- Cognitive Therapy for Suicide Prevention
- Crisis Intervention Team (CIT) Model

Evidence Based Practices for Children

Required:

- Motivational Interviewing
- Medication Assisted Treatment

Recommended:

- Treatment for Post-Traumatic Stress Disorder (PTSD)
- First episode early intervention for psychosis (OnTrackNY)
- Crisis Intervention Team (CIT) Model

Modality

- Crisis behavioral health services are face-to-face interventions.
- Select service components for emergency crisis intervention services may be provided telephonically.

Setting

Crisis behavioral health services may occur in various settings, including emergency rooms when utilized as a diversion from emergency room admission, and community locations where a person lives, works, attends school and/or socializes.

Admissions/Eligibility Criteria

- If a non-established/new recipient of the CCBHC receives a crisis demonstration service provided directly by the CCBHC rather than by a state-sanctioned crisis service acting as a DCO, the crisis service is a CCBHC covered service upon crisis assessment (which will include a screening and risk assessment).
- If a non-established/new consumer of the CCBHC receives crisis demonstration services provided by a state-sanctioned crisis service acting as a DCO, the crisis service is a CCBHC covered service upon receipt of:
  - Crisis assessment (which will include a screening and risk assessment) AND
  - Another of the 9 services that fall within the scope of CCBHC services delivered by the CCBHC.
- If an established/existing consumer of the CCBHC receives crisis services from the CCBHC, it is covered.

Limitations/Exclusions

N/A

Certification/Provider Qualifications

General Staffing Requirements: Staffing must be in accordance with all State laws, regulations, and approved protocols.

Staffing for Mobile Crisis:

- Mobile crisis visits to be conducted by a minimum of 2 staff persons – one of whom must be a licensed clinician.
- Services must be staffed by a multidisciplinary team including licensed, unlicensed and certified peer staff (see Appendix A).

Staffing Ratio/Case Limits

N/A

Staff Training Requirements

- Crisis intervention skills and training in serving as the first responders to individuals needing help on an emergency basis.
- All staff working on Mobile Crisis Teams must obtain training on the administration of Narcan (naloxone).

Billing Requirements

- (If a non-established/new recipient of the CCBHC receives a crisis demonstration service provided directly by the CCBHC rather than by a state-sanctioned crisis service acting as a DCO, the crisis service is a CCBHC covered service upon crisis assessment (which will include a screening and risk assessment).
- If a non-established/new consumer of the CCBHC receives crisis demonstration services provided by a state-sanctioned crisis service acting as a DCO, the crisis service is a CCBHC covered service upon receipt of:
  - Crisis assessment (which will include a screening and risk assessment) AND
  - Another of the 9 services that fall within the scope of CCBHC services delivered by the CCBHC.
- If an established/existing consumer of the CCBHC receives crisis services from the CCBHC, it is covered.

Screening, assessment, and diagnosis, including risk assessment

Definition

CCBHC screening, assessment, and diagnosis services are intended to determine the appropriateness of admission to the clinic, the appropriate behavioral health diagnoses and services to be provided, and to inform the development of a person-centered treatment plan for all new recipients. Screening, assessment, and diagnosis services are conducted in a timeframe responsive to the recipient's needs and can adequately assess the need for all services required to be provided by CCBHCs.

The CCBHC shall use standardized and validated screening and assessment tools as approved by the New York State Office of Mental Health and Office of Alcoholism and Substance Abuse Services. A complete list of recommended screening tools can be found in Appendix D. Where appropriate, this service shall incorporate brief motivational interviewing techniques. Service components under the

CCBHC screening, assessment, and diagnosis, including risk assessment are subject to more stringent state, federal or applicable accreditation standards.

Screening, assessment, and diagnosis services must be provided directly by the CCBHC.

Service Components for Adults

The preliminary screening, initial assessment, and comprehensive diagnostic and treatment planning evaluation are intended to be a unified process that establishes a comprehensive person-centered and family-centered evaluation to inform treatment planning and service provision. Each service component builds upon what came before it and may be completed separately or simultaneously.

Preliminary Screening
Preliminary screening activities are intended to be consistent with an initial intake process. At the first point of contact, all new recipients requesting or being referred for behavioral health services will receive a preliminary screening of presenting problems and risk assessment to determine acuity of needs. Preliminary screening activities shall also collect recipient demographic information.

The preliminary screening will be followed by: (1) an initial assessment, and (2) a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation.

Initial Assessment and Comprehensive Diagnostic and Treatment Planning Evaluation
If the preliminary screening identifies routine needs, an initial assessment shall be completed within 10 business days following the first point of contact- between a clinician and recipient and/or collaterals- to determine the appropriateness of the recipient for admission to a clinic. All new recipients will receive a more comprehensive person-centered and family-centered diagnostic and treatment planning evaluation to be completed within 60 calendar days of the first request for services or 30 days after admission- whichever timeframe is sooner. The first request for services is defined as the first point of contact with an individual seeking services. The prescribed timeframe for the comprehensive evaluation does not preclude either the initiation or completion of the comprehensive evaluation or the provision of treatment by an earlier date.

The combined initial assessment and comprehensive diagnostic and treatment planning evaluation shall inlude at minimum:

Assessment/Evaluation Components	Must be completed within 10 business days	Must be completed within 60 calendar days of the first request for services or 30 days after admission- whichever timeframe is sooner
1. Preliminary diagnoses.	X	
2. The source of referral	X	
3. The reason for seeking care, as stated by the recipient or other individuals who are significantly involved. This information may include: information regarding onset of symptoms, severity of symptoms, and circumstances leading to the recipient's presentation to the CCBHC.	X	
4. Identification of the recipient's immediate clinical care needs related to the diagnosis for mental and substance use disorders	X	

5. A drug profile including the recipient's prescriptions, over-the-counter medications, herbal remedies, and other treatments or substances that could affect drug therapy, as well as information on drug allergies	X	
6. An assessment of imminent risk (including suicide risk, danger to self or others, urgent or critical medical conditions, other immediate risks including threats from another person)	X	
7. An assessment of whether the recipient has other concerns for their safety	X	
8. An assessment of need for immediate medical care (with referral and follow-up as required)	X	
9. A determination of whether the recipient presently is or ever has been a member of the U.S. Armed Services	X	
10. LOCADTR (as deemed appropriate)	X	
11. Tobacco and other substance use/abuse in home (for children)		X
12. A psychosocial evaluation including housing, vocational and educational status, family/caregiver and social support, legal or forensic involvement, and insurance status		X
13. Behavioral health history (including trauma history and previous therapeutic interventions and hospitalizations)		X
14. Assessment of recipient's alcohol and other drug use (including tobacco) including previous SUD treatment history		X
15. Screening for problem gambling.		X
16. A diagnostic assessment, including current mental status, mental health and substance use disorders		X
17. Basic competency/cognitive impairment screening		X
18. A description of attitudes and behaviors, including cultural and environmental factors, that may affect the consumer's treatment plan		X
19. The recipient's strengths, goals, and other factors to be considered in recovery planning		X
20. Pregnancy and parenting status		X
21. Assessment of need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services, LEP or linguistic services)		X
22. An assessment of the social service needs of the consumer, with necessary referrals made to social services and, for pediatric consumers, to child welfare agencies as appropriate		X
23. Primary care screening and monitoring of key health indicators and health risk pursuant to the required Outpatient Clinic Primary Care		X

Screening and Monitoring of Key Health Indicators and Health Risk, either: (a) an assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the consumer's primary care provider (with appropriate referral and follow-up), or (b) a basic physical assessment. This provision is depending on whether the CCBHC directly provides Outpatient Clinic Primary Care Screening and Monitoring of Key Health Indicators and Health Risk		
24. The assessment results in a clinical formulation and reccommendations which inform the treatment plan		**X**

The comprehensive person-centered and family-centered diagnostic and treatment planning evaluation must be updated by the treatment team, in agreement with and endorsed by the consumer and in consultation with the primary care provider (if any), when changes in the consumer's status, responses to treatment, or goal achievement have occurred.

Service Components for Children

Please refer to Service Components for Adults.

Evidence Based Practices for Adults

Required:

- Motivational Interviewing
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)- where appropriate

Evidence Based Practices for Children

Required:

- Motivational Interviewing
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)- where appropriate

Modality

Screening, assessment, and diagnosis services, including risk assessment are delivered 1:1 between a clinician and recipient and/or collaterals

Setting

The Preliminary Screening may be done telephonically or face-to-face

- The Initial Assessment and Comprehensive Diagnostic and Treatment Planning Evaluation shall be face-to-face between a clinician and recipient and/or collaterals
- For recipients presenting with emergency or urgent needs, the initial evaluation may be conducted telephonically or by telehealth/telemedicine. An in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved the consumer must be seen in person at the next subsequent encounter and the initial evaluation reviewed

Admissions/Eligibility Criteria

- All new recipients requesting services or being referred for behavioral health will, at the time of first contact, receive a preliminary screening and risk assessment to determine acuity of needs.
- If the screening identifies an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent outpatient follow-up.
- If the screening identifies an urgent need, clinical services are provided and the initial evaluation completed within one business day of the time the request is made.
- If the screening identifies routine needs, services will be provided and the initial evaluation completed within 10 business days.

Limitations/Exclusions

N/A. CCBHCs must serve all individuals regardless of residency or ability to pay.

Certification/Provider Qualifications

- Preliminary Screening may be provided by Unlicensed staff as defined in Appendix A
- The Initial Assessment and Comprehensive Diagnostic and Treatment Planning Evaluation must be provided by Professional staff as defined in Appendix A
- Licensed Occupational Therapists and Occupational Therapy Assistants (See Appendix A) may participate in the screening, assessment, and diagnosis process.

Staffing Ratio/Case Limits

N/A

Staff Training Requirements

Staff providing screening, assessment, and diagnosis, including risk assessment shall be trained in Motivational Interviewing.

Billing Requirements

Must meet Threshold visit.

Person-centered treatment planning or similar processes, including risk assessment and crisis planning

Definition

Person and family-centered treatment planning is a collaborative process-directed by the individual receiving care- that results in the development of treatment goals and provision of services. Treatment plans should be strength-based and identify individual needs, goals, preferences, capacities, and desired outcomes. Effective person-centered care planning strengthens the voice of the individual, builds resiliency, and fosters recovery. The treatment goals and services should be designed to optimally treat illness, emphasize wellness and recovery, and attend to the person's overall well-being and full inclusion in the community of their choice.

Individuals and families are core participants in the development of the plans and goals of treatment. As such, the person and family-centered treatment plan is developed by the CCBHC treatment team, consisting of: the service recipient, the family/caregiver of child recipients, the adult recipient's family to the extent the recipient does not object, CCBHC clinical staff, and any other person the recipient chooses.

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

Person and family-centered treatment planning must be provided directly by the CCBHC.

Service Components for Adults

Treatment Planning Process:
Each CCBHC service recipient must have a written person and family-centered treatment plan developed by the responsible clinical staff member and individual. The person and family-centered treatment plan must be implemented in a manner that supports the individual and recognizes the individual as the expert on goals and needs. The treatment planning process is built upon a shared decision-making approach and should incorporate the following principles:

- The individual can direct who is included in the planning process, as well as maintain the ability to request meetings and revise the plan whenever necessary.
- The treatment planning process is timely and occurs at a time and location convenient to the individual and their family.
- The individual is provided the support necessary to ensure that they are able to understand the information and direct the process accordingly. In accordance with CCBHC Program Requirement 2, such accommodations should include auxiliary aids and services that are responsive to the needs of consumers with disabilities (e.g., sign language interpreters, teletype [TTY] lines).
- Personal preferences and a strengths-based approach must be used to develop goals, and to meet the individual's needs. Areas of personal preference may include-but are not limited to- the following supports and circumstances:
    - Family, friends, and other relationships
    - Housing
    - Employment
    - Community integration
    - Behavioral health
    - Culture and language
    - Social activities
    - Recreation
    - Education and vocational training
    - Other choices pertinent to community living
- The individual's cultural and linguistic preferences must be acknowledged in the treatment planning process. In accordance with CCBHC Program Requirement 2, service recipients and their family with limited English proficiency (LEP) should have meaningful access to low literacy materials and interpreters.
- There must be mechanisms in place for solving conflict or disagreement within the process, including clear conflict of interest guidelines.
- Individuals must be offered information on the full range of services available to support achievement of personally identified goals.
- In accordance with CCBHC Program Requirement 2, the individual must be able to choose between CCBHC providers or provider entities when choice is available.
- The treatment plan must be prepared in person-first singular language and be understandable to the service recipient.

In accordance with the person-centered and family-centered diagnostic and treatment planning evaluation, the treatment plan shall be completed within 60 calendar days of the first request for services, or 30 days after admission- whichever timeframe is sooner- and updated no less frequently than every 90 days.

Treatment Plan Components:

The treatment plan shall include identification and documentation of the following:

1. Documentation of the individual's strengths, abilities, and positive attributes.
2. Identification of risk, and measures available to reduce risk and ensure the health and safety of the individual. Such activities shall include an assessment of risk, and the development of a Crisis Prevention Plan that includes strategies to de-escalate crisis situations before they occur and the identification of triggers for substance use (if applicable). The individual/child/youth and family shall identify an advance plan for crisis management that promotes recovery, resilience, and includes natural supports.
3. Recipient-identified problem areas specified in the initial assessment and comprehensive person-centered and family-centered diagnostic and treatment planning evaluation.
4. Treatment goals for the identified problem areas (unless deferred).
5. Physical health, behavioral health, and social service needs.
6. Objectives that will be used to measure progress toward attainment of treatment goals and target dates for achieving completion of treatment goals.
7. Methods and treatment approaches that will be utilized to achieve the goals developed by the individual and CCBHC clinical staff and prevent unnecessary or inappropriate services and supports. The treatment plan shall include the amount and duration of the specific CCBHC services provided, as well as the specific provider(s) and provider agency responsible for monitoring treatment plan implementation and/or providing the documented services and supports.
8. Schedules of service provision.
9. Each diagnosis for which the individual is being treated at the program.
10. Descriptions of any additional services (outside of the CCBHC scope of services and provided by a care coordination entity) needed by the individual, as well as a plan for meeting those needs (Where appropriate, consultation shall be sought during treatment planning regarding specialty service needs).
11. Descriptions of any natural/non-paid supports, items, or other resources needed for goal achievement.
12. Documentation of an emergency plan that includes a range of circumstances such as: weather, housing, or staff-related issues.
13. Documentation of the consumer's advance wishes related to treatment and crisis management. If the consumer does not wish to share their preferences, that decision is documented.

The treatment plan must include signatures from all individuals responsible for treatment plan implementation, including the individual and a qualified health professional, or other licensed individual within his/her scope of practice, involved in the treatment and responsible for review of the treatment plan. A "qualified health professional" means an individual:

- who is in good standing with the appropriate licensing or certifying authority, as applicable;
- practicing within the scope of, and in accordance with, the terms and conditions of such licenses and certifications; and
- with a minimum of one year of experience and/or training in the treatment of behavioral health issues.

All individuals directly involved in the treatment planning process shall receive a copy of the plan, or a portion of the plan, as determined by the individual.

Any effort to restrict the right of the individual to realize preferences or goals must be justified by a specific and individualized assessed safety need and documented in the treatment plan. The following requirements must be documented in the plan when a safety need warrants such a restriction:

1. The specific and individualized assessed safety need.
2. The positive interventions and supports used prior to any modifications or additions to the treatment plan regarding safety needs.
3. Documentation of less intrusive methods of meeting the safety needs that have been tried, but were not successful.

4. A clear description of the condition that is directly proportionate to the specific assessed safety need.
5. A regular collection and review of data to measure the ongoing effectiveness of the safety modification.
6. Established time limits for periodic reviews to determine if the safety modification is still necessary or can be terminated.
7. Informed consent of the individual to the proposed safety modification.
8. An assurance that the modification itself will not cause harm to the person.

Treatment Plan Implementation:
Implementation of the person-centered treatment plan requires progress monitoring and notation to ensure goal achievement and appropriate action is taken when necessary. Progress monitoring shall ensure that:

- All services on the treatment plan are delivered
- The plan is reviewed according to the established timeline
- The individual can report on progress, issues, and problems
- Changes to the treatment plan can be made in an expedient manner

Progress notes shall be recorded by the clinical staff member(s) who provided services to the recipient upon each occasion of service. These notes must summarize the service(s) provided, update the recipient's progress toward his or her goals, and include any recommended changes to the elements of the recipient's treatment plan. The progress notes shall also document the date and duration of each service provided, the location where the service was provided, whether collaterals were seen, and the name and title of the staff member providing each service. The need for complex care management and the actions taken by the clinic in response to this need shall also be recorded in the progress notes.

Treatment Plan Review:
All treatment plans shall be reviewed and updated as clinically necessary based upon the individual's progress, changes in circumstances, the effectiveness of services, and/or other appropriate considerations. In accordance with the person-centered and family-centered diagnostic and treatment planning evaluation, such reviews shall occur no less frequently than every 90 days. Treatment plan reviews shall include the input of relevant staff, as well as the recipient, family members and collaterals, as appropriate.

The periodic review and update of the treatment plan shall fully involve the individual and include identification and documentation of the following:

(1) assessment of the progress of the patient regarding the mutually agreed upon goals in the treatment plan;
(2) adjustment of goals and treatment objectives, time periods for achievement, intervention strategies or initiation of discharge planning, as appropriate;
(3) an evaluation of physical health status; and
(4) Crisis Prevention Plan, to be reviewed at least annually or as clinically indicated;
(5) the signature of the qualified health professional, or other licensed individual within his/her scope of practice, involved in the treatment and responsible for review of the treatment plan.

Service Components for Children

- Please refer to Service Components for Adults
- If the patient is a minor, the treatment plan must also be developed in consultation with his/her parent or guardian unless the minor is being treated without parental consent

Evidence Based Practices for Adults

Required:

- Motivational Interviewing

Evidence Based Practices for Children

Required:

- Motivational Interviewing

Modality

Individual face-to face, inclusion of family/caregiver(s) if care recipient is a minor.

Setting

The treatment planning process occurs at a time and location convenient to the individual and their family.

Admissions/Eligibility Criteria

- If a non-established/new service recipient receives non- crisis demonstration services for the first time from a CCBHC, the service is covered for the first time following the preliminary screening and risk assessment defined under screening, assessment, and diagnosis.

- If an established/existing service recipient of an agency becoming a CCBHC receives any demonstration service from a CCBHC, the service is covered upon receipt of the first service at a CCBHC once the agency becomes a CCBHC.

Limitations/Exclusions

N/A. CCBHCs must serve all individuals regardless of residency or ability to pay.

Certification/Provider Qualifications

- Professional staff, Licensed Occupational Therapists, Occupational Therapy Assistants, and non-licensed staff (See Appendix A) may participate in the treatment planning process.
- A qualified health professional, or other licensed individual within his/her scope of practice must sign the treatment plan
- As appropriate for the individual's needs, the CCBHC shall designate an interdisciplinary treatment team- in collaboration with the service recipient, the family/caregiver of child recipients, the adult recipient's family to the extent the recipient does not object-that is responsible for directing, coordinating, and managing care and services for the individual. The interdisciplinary team may be composed of licensed and non-licensed staff who work together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of the individual.

Staffing Ratio/Case Limits

N/A

Staff Training Requirements

- Training in Motivational Interviewing – (e.g. Center for Practice Innovations).
- Training/Continuing Education as appropriate for Licensing and Scope of Practice.
- Staff should be trained on principles of person- and family-centered care, shared decision-making, and fostering individual self-direction in treatment planning.

- Training should cover awareness and sensitivity on issues of race, ethnicity, age, sexual orientation, and gender identity.

Billing Requirements

Must meet Threshold visit.

Outpatient mental health and substance use services

Definition

Outpatient mental health and substance use services are designed treat an individual's mental health and/or substance use disorder in a manner consistent with the individual's phase of life and development-specifically considering children, adolescents, transition age youth, and older adults as distinct groups for whom life stage and functioning may affect treatment. The provision of outpatient mental health and substance use services is informed and determined by the screening, assessment, and diagnosis process, as well as the person-centered treatment plan. Outpatient services shall incorporate evidence-based or best practices and maintain consistency with the needs of individuals, children/youth and family/caregivers.

CCBHCs shall provide outpatient mental health and substance use services consistent the regulations and standards of care required under the NYS Integrated Outpatient Services License for Mental Health (OMH) and Substance Use (OASAS) services. An "integrated services provider" is a provider holding multiple operating certificates or licenses to provide outpatient services, which has also been authorized by a Commissioner of a state licensing agency to deliver identified integrated care services at a specific site in accordance with the provisions of the regulations.

In the event specialized services outside the expertise of the CCBHC are required for purposes of outpatient mental and substance use disorder treatment (e.g., treatment of sexual trauma, eating disorders, specialized medications for substance use disorders), the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine services. The CCBHC also provides or makes available through formal arrangement traditional practices/treatment as appropriate for the consumers served in the CCBHC area.

Outpatient mental health and substance use services must be directly provided by the CCBHC.

Service Components for Adults

CCBHC outpatient mental health and substance use services components and provision must be consistent with the regulations and standards of care required under the NYS Integrated Outpatient Services License and shall include the following service categories:

Psychotropic Medication Treatment:
Psychotropic medication treatment means monitoring and evaluating target symptom response, ordering and reviewing diagnostic studies, writing prescriptions and consumer education as appropriate. This service must be provided by a psychiatrist or psychiatric nurse practitioner.

Injectable Psychotropic Medication Administration:
Injectable psychotropic medication administration is the process of preparing, and administering the injection of intramuscular psychotropic medications. This service must be provided by an appropriate medical staff person with one of the following credentials: MD/NPP/RN/LPN/PA.

Injectable Psychotropic Medication administration with monitoring and Education:

Injectable Psychotropic Medication Administration with monitoring and education is the process of preparing, administering, managing and monitoring the injection of intramuscular psychotropic medications. It includes consumer education related to the use of the medication, as necessary. This service must be provided by an appropriate medical staff person with one of the following credentials: MD/NPP/RN/PA.

Medication Assisted Treatment:
Medication Assisted Treatment (MAT) uses medication, in combination with counseling and behavioral therapies, to treat people with severe addictions. Medications can reduce the cravings and other symptoms associated with withdrawal from a substance by occupying receptors in the brain associated with using that drug (agonists or partial agonists), block the rewarding sensation that comes with using a substance (antagonists), or induce negative feelings when a substance is taken. MAT has been primarily used for the treatment of opioid use disorder but is also used for alcohol use disorder and the treatment of some other substance use disorders.

Psychotherapy Services/Individual Counseling
Psychotherapy (including family/collateral or groups) means therapeutic communication and interaction for the purpose of alleviating symptoms or dysfunction associated with an individual's diagnosed mental illness or emotional disturbance, reversing or changing maladaptive patterns of behavior, encouraging personal growth and development, and supporting the individual's capacity to achieve age-appropriate developmental milestones.

Psychotherapy should promote community integration, and may encompass interventions to facilitate readiness for and engagement of the client and family in wellness self-management, school, and employment training services, which are provided by specialized programs and service providers.

Counseling
Consistent with and determined by the client's stage of change/treatment, counseling for those receiving integrated behavioral health services is largely based on motivational interviewing, cognitive-behavioral counseling, or some combination of both. Motivational interviewing involves helping a client identify his or her own goals and to recognize, through a systematic examination of the individual's ambivalence, that not managing one's illnesses interferes with attaining those goals. Clients in the action or relapse prevention stage receive cognitive-behavioral counseling that includes teaching how to manage cues to use and consequences of use, teaching relapse prevention strategies, teaching drug and alcohol refusal skills, problem solving skills training to avoid high risk situations, challenging client's beliefs about substance use, and coping skills and social skills training to deal with symptoms or negative mood states.

Group counseling for substance use disorder treatment is limited to 15 people, consistent with current OASAS requirements and best practices in substance use disorder treatment.

Peer Support Services:
Peer Support Services are face- to- face service provided by a peer advocate to an active patient for the purpose of connecting patients to community based recovery supports consistent with a patient's treatment plan.

Telepsychiatry Services-Effective August 31, 2016, NYS OMH repealed Part 599.17 and adopted a new Part 596 Telepsychiatry Services which expanded the use of Telepsychiatry beyond licensed Article 31 outpatient clinic settings. For the purpose of 14 NYCRR 596.4, Telepsychiatry is defined as the use of two-way real time-interactive audio and video equipment to provide and support clinical psychiatric care at a distance. Such services do not include a telephone conversation, electronic mail message or facsimile transmission between a clinic and a recipient, or a consultation between two professional or clinical staff, although these activities may support Telepsychiatry.

Approval to Utilize Telepsychiatry Services - Telepsychiatry services may be authorized by NYS OMH for assessment and treatment services provided by physicians or nurse practitioners, as defined in 14 NYCRR Section 596.4, from a site distant from the location of a patient, where the patient is physically located at an originating/spoke site licensed by the Office, and the physician or nurse practitioner is physically located at a distant/hub site that participates in the New York State Medicaid program.

Outreach:
"Outreach" is a face-to-face service with a patient provided by clinical staff or a peer advocate for the purpose of increasing motivation to participate in clinically indicated treatment for chemical dependence. Patients identified for this intervention must be current patients who have failed to appear for sessions at the program and are judged to be at risk for prematurely discontinuing treatment or persons transitioning from another Office-certified program.

Problem Gambling (Optional):
Problem gambling is a Chemical Dependence Outpatient program that has been granted a waiver to admit and treat individuals for problem gambling only (persons who do not have a co-occurring chemical dependency diagnosis) and/or a significant other who has been affected by problem gambling. Problem Gambling Treatment and Recovery Services assist individuals who are affected by problem gambling including family members and/or significant others. These services may be provided in free-standing settings or may be co-located in chemical dependency clinics or other mental health settings. Each problem gambling outpatient service shall provide the following: screening, assessments, crisis intervention groups, and individual counseling, education, orientation to and opportunity to participate in problem and pathological gambling awareness and relapse prevention, and financial counseling. Financial support and counseling and mutual support groups may be provided on site or by referral.

Service Components for Children

Please refer to Service Components for Adults

Early assessment and identification of childhood emotional disturbances, and engagement of the child and family in the development of a plan of care designed to minimize the symptoms and adverse effects of illness, maximize wellness, assist the child in developing a resilient and hopeful approach to school, family, and community, and maintain the child in his or her natural environment

Children and adolescents are treated using a family/caregiver-driven, youth guided and developmentally appropriate approach that comprehensively addresses family/caregiver, school, medical, mental health, substance abuse, psychosocial, and environmental issues.

Evidence Based Practices for Adults

Required:

- Integrated Treatment for Co-Occurring Disorders
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Cognitive Behavioral Therapy
- Medication Assisted Treatment (MAT)
- Motivational Interviewing
- Family Psychoeducation

Recommended:

- Dialectical Behavior Therapy (DBT)
- First episode early intervention for psychosis (OnTrackNY)
- Multi-Systemic Therapy
- Assertive Community Treatment (ACT)

- Motivational Enhancement Therapy
- Treatment for Post-Traumatic Stress Disorder (PTSD)
- Functional Family Therapy
- Multi-Systemic Therapy
- Twelve Step Facilitation Therapy
- Matrix Model
- Supported Housing
- Illness Management and Recovery
- Cognitive Management
- Behavioral Couples Therapy
- Cognitive Therapy for Suicide Prevention
- Seven Challenges
- Multi-Dimensional Family Therapy

Evidence Based Practices for Children

Required:

- Integrated Treatment for Co-Occurring Disorders
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Cognitive Behavioral Therapy
- Medication Assisted Treatment (MAT)
- Motivational Interviewing
- Family Psychoeducation

Recommended:

- Community wrap-around services for youth and children; and specialty clinical interventions to treat mental and substance use disorders experienced by youth (including youth in therapeutic foster care).
- Therapeutic Foster Care
- Multi-systemic Therapy
- Functional Family Therapy
- The Seven Challenges Program
- Motivational Enhancement Therapy and Cognitive Behavioral Therapy (MET-CBT)
- First episode early intervention for psychosis (OnTrackNY)

Modality

The service modality shall be consistent the regulations and standards of care required by the CCBHC's Host State Agency under the Integrated Outpatient Services License.

Setting

The service setting shall be consistent the regulations and standards of care required by the CCBHC's Host State Agency under the Integrated Outpatient Services License.

Admissions/Eligibility Criteria

- If a non-established/new service recipient receives non- crisis demonstration services for the first time from a CCBHC, the service IS covered for the first time following the preliminary screening and risk assessment defined under screening, assessment, and diagnosis.

- If an established/existing service recipient of an agency becoming a CCBHC receives any demonstration service from a CCBHC, the service IS covered upon receipt of the first service at a CCBHC once the agency becomes a CCBHC.

Limitations/Exclusions

N/A. CCBHCs must serve all individuals regardless of residency or ability to pay.

Certification/Provider Qualifications

CCBHCs must ensure that they have the staff and equipment necessary to provide services that are consistent with prevailing standards of care.

Staffing Ratio/Case Limits

Staffing ratios/case limits shall be consistent the regulations and standards of care required by the CCBHC's Host State Agency under the Integrated Outpatient Services License.

Staff Training Requirements

Treatments are delivered by staff with specific training in treating the segment of the population being served.

Billing Requirements

Must meet Threshold visit.

Outpatient clinic primary care screening and monitoring of key health indicators and health risk

Definition

Primary care screening is a basic physical assessment that measures specific health indicators and need for a physical exam or further evaluation by appropriate health care professionals. Health monitoring is the continued measuring of specific health indicators associated with increased risk of medical illness and early death. Prevention is a key component of the outpatient clinic primary care screening and monitoring of key health indicators and health risk services.

For children and adolescents, outpatient clinic primary care screening and monitoring of key health indicators and health risk services should include screening and preventive interventions such as: weight assessment and counseling for nutrition and physical activity, as well as an assessment of learning disabilities- where appropriate. For adults, these services should include preventive care and screening for Adult Body Mass Index (BMI), blood pressure, and tobacco use.

Whenever possible, the CCBHC or DCO should use standardized and validated screening and assessment tools and approaches that are culturally, linguistically and developmentally appropriate and accommodate disabilities (e.g., hearing disabilities, cognitive limitations, etc.). In addition, the CCBHC or DCO shall ensure that children receive age appropriate screening and preventive interventions including, where appropriate, assessment of learning disabilities, and older adults receive age appropriate screening and preventive interventions.

CCBHCs are not prohibited from providing other primary care services. This service may be provided directly by the CCBHCs, or through a Designated Collaborating Organization (DCO).

Service Components for Adults

Health indicators incorporated in primary care screening for adults and older adults should include, but are not limited to:

- Adult BMI screening
- Blood pressure
- Tobacco use screening

Monitoring should include:

- Generic Health Monitoring
- Smoking Cessation Counseling

CCBHCs and respective DCOs should ensure that adults and older adults receive age appropriate screening and preventive interventions. In addition, policies and procedures should be in place 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.
In conjunction with the recipient's Comprehensive Diagnostic and Treatment Planning Evaluation, an assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the consumer's primary care provider (with appropriate referral and follow-up), or a basic physical assessment shall be completed within 60 calendar days of the first request for services.

Service Components for Children

Health indicators incorporated in primary care screening for children and adolescents should include, but are not limited to:

- Body Mass Index (BMI) percentile
- Nutrition
- Activity/exercise level
- An assessment of learning disabilities, where appropriate
- Smoking status

Monitoring should include:

- Generic Health Monitoring
- Counseling for nutrition and physical activity
- Smoking Cessation Counseling

CCBHCs and respective DCOs should ensure that children and adolescents receive age appropriate screening and preventive interventions. In addition, policies and procedures should be in place 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.

In conjunction with the recipient's Comprehensive Diagnostic and Treatment Planning Evaluation, an assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the consumer's primary care provider (with appropriate referral and follow-up), or a basic physical assessment shall be completed within 60 calendar days of the first request for services.

Evidence Based Practices for Adults

Required:

- Motivational Interviewing

Evidence Based Practices for Children

Required:

- Motivational Interviewing

Modality

Primary care monitoring of key health indicators and health risk services may be provided individually or in group.

Setting

Outpatient clinic primary care screening and monitoring of key health indicators and health risk services are face-to-face services.

Admissions/Eligibility Criteria

Prior to admission, all programs must: conduct a communicable disease risk assessment to determine whether or not the individual appears to be free of serious communicable disease. For patients who have not had a physical exam within one year prior to admission, each patient must either be assessed face to face by a member of the medical staff to ascertain the need for a physical exam or referred for a physical exam; Any significant medical issues identified prior to or after admission must be addressed in the treatment recovery plan and documented in the patient case record.

Limitations/Exclusions

There is no annual limit to health monitoring services.

Screening and monitoring of behavioral health indicators shall be addressed through CCBHC Screening, Assessment, and Diagnosis services.

Certification/Provider Qualifications

This service must be provided by a physician, nurse or other medical professional acting within scope of practice (MD/NPP/NP/RN/LPN/PA). See Appendix A for further detail on staffing guidelines.

Staffing Ratio/Case Limits

Health monitoring services groups require documented face-to-face service with a minimum of two recipients and a maximum of 12 recipients for services of a minimum of either 30 or 60 minutes duration, or in the case of Smoking Cessation Counseling, greater than 10 minutes.

Staff Training Requirements

Billing Requirements

Must meet Threshold visit.

Targeted case management

Definition

CCBHC Targeted Case Management services are intended to support the wellness and recovery goals of individuals with complex and/or chronic behavioral health issues and needs by implementing targeted

interventions designed to provide timely, high-quality, and efficient care. CCBHC Targeted Case Management services are organized around goals aimed at providing access to services that encourage individuals to:

- Resolve problems that interfere with their attainment or maintenance of independence or self sufficiency
- Maintain themselves in the community

Case managers are an integral role CCBHC Targeted Case Management service provision. Case Managers shall:

- Promote hope and recovery by using strengths-based, culturally appropriate, and person-centered practices
- Maximize community integration and normalization
- Provide leadership in ensuring the coordination of resources for individuals eligible for behavioral health services

Target Populations

Since comprehensive care management services are currently provided by NYS Health Homes - separate from CCBHC - CCBHC Targeted Case Management services should target individuals who are not Health Home eligible or individuals who are Health Home eligible, but refuse Health Home services. Targeted populations include, but are not limited to:

- Adults diagnosed with severe mental illness
- Children and youth diagnosed with severe emotional disorders
- Adults or youth with two or more services in an inpatient/outpatient SUD detoxification program within a year
- Adults or youth with one inpatient or residential stay in an SUD program within a year
- Adults or youth with two or more emergency department (ED) visits with primary substance use diagnosis within a year
- Adults incarcerated for more than 30 consecutive days in the past 12 months

Services for Individuals who are Health Home Eligible

The CCBHC's primary objective shall be to link individuals who are Health Home eligible to a Health Home and maintain an effective coordination of care between the CCBHC and Health Home. CCBHCs must provide all Health Home eligible individuals with the option to receive care coordination and care management through a Health Home.

CCBHC Targeted Case Management services may be used to assist an individual in securing Medicaid benefits with the goal of subsequent Health Home enrollment. If an individual is currently receiving or chooses to receive care coordination or care management through the Health Home, the CCBHC must make the appropriate care linkage and conduct care coordination efforts solely with the Health Home. CCBHC Targeted Case Managements services cannot be provided to an individual enrolled in Health Home Care Management.

This service may be provided directly by the CCBHCs, or through a DCO.

Service Components for Adults

Targeted Case Management needs shall be identified in the individual's Comprehensive Diagnostic and Treatment Planning Evaluation, and will inform wellness and recovery goals developed through the Person-centered and Family-centered Treatment Planning process.

To achieve wellness and recovery goals, this service may include the following components:

- **Service Referral, Linkage, and Related Activities**

Service components shall support the individual obtain and maintain needed services and may include:

- Referral to community and social support services
- Providing support for improved community service linkages
- Transitional care, including appropriate follow-up from inpatient to other settings
- Support in navigating complex health care and social services systems
- Individual and family support
- Advocacy for needed services
- If the recipient is eligible, working to secure Medicaid benefits with the goal of subsequent Health Home enrollment
- Performing on-site crisis intervention and skills teaching when other services are not available

- **Monitoring and Follow-up:**
  - Monitoring and follow-up contact and other activities may be conducted as frequently as necessary-including at least one annual monitoring- and should ensure the following:
    - Services provision is consistent with the individual's treatment plan
    - Services in the treatment plan are adequately addressing individual's needs and wellness and recovery goals
  - Monitoring and follow-up activities may include contact with:
    - The service recipient,
    - The recipient's family and/or collaterals,
    - Service providers, and/or
    - Other entities or individuals.
  - Higher frequency of contacts and communication is necessary to effectively monitor and respond to the individual's changing needs; enhanced coordination with key community providers (including EDs and ambulatory services), and facilitation of a "warm hand-off" between ER/inpatient settings and community/aftercare services
  - If changes in the needs or status of the individual are identified, the appropriate treatment plan and/or service adjustments shall be made.

Service Components for Children

- Please refer to Service Components for Adults

Evidence Based Practices for Adults

Required:

- Motivational Interviewing

Evidence Based Practices for Children

Required:

- Motivational Interviewing

Modality

The minimum standard of contact per individual per month is four (4) telephonic contacts or one (1) face to face contact. For programs serving Children and Families, one contact may be collateral.

Setting

At the CCBHC or DCO site and in the community.

Admissions/Eligibility Criteria

- The target populations for CCBHC Targeted Case Management services shall include:
  - Individuals who are not Health Home eligible
  - Individuals who are Health Home eligible, but refuse Health Home services.
- The need for CCBHC Targeted Case Managements Services can be driven by a variety of situations such as (but not limited to):
  - Coordination required to treat co-occurring disorders;
  - Complex health status;
  - Risk to self or others;
  - Coordination necessary to break the cycle of multiple hospitalizations;
  - Loss of home;
  - Loss of Employment;
  - Children and adults with multiple other service providers in need of coordination;
  - Children at risk of school failure, expulsion or lack of school placement;
  - Children at risk of out of home placement;
  - Changes in custody status (from the parents' or child's perspective); and/or
  - AOT status and process.

Limitations/Exclusions

CCBHC Targeted Case Management Services cannot be provided to an individual receiving Health Home Care Management or any other Medicaid reimbursable case management service.

Certification/Provider Qualifications

- CCBHC Targeted Case Management Services can be provided by an individual or a team of case managers.
- Case managers may be unlicensed staff.

Staffing Ratio/Case Limits

Ratios of 1 case manager to 12-30 recipients or equivalent.

Staff Training Requirements

- Case Managers must be trained and demonstrate a basic knowledge and understanding of working with populations targeted by this service. Such populations include, but are not limited to:
  - Adults diagnosed with severe mental illness
  - Children and youth diagnosed with severe emotional disorders
  - Adults or youth with two or more services in an inpatient/outpatient SUD detoxification program within a year
  - Adults or youth with one inpatient or residential stay in an SUD program within a year
  - Adults or youth with two or more emergency department (ED) visits with primary substance use diagnosis within a year
  - Adults incarcerated for more than 30 consecutive days in the past 12 months
- Case Managers should also be trained in motivational interviewing and person-centered planning

Billing Requirements

The minimum standard of contact per individual per month is four (4) telephonic contacts or one (1) face to face contact. For programs serving Children and Families, one contact may be collateral.

Psychiatric Rehabilitation Services

Definition

Adults:
Psychiatric Rehabilitation Services (PRS) services are designed to assist the individual to overcome mental health barriers that may have interfered with the person's ability to function independently and perform normative adult roles in the community. The intent of PSR is to assist the individual to restore the individual's functional level to the fullest possible.

Children:
The intent of PRS is to restore, rehabilitate, and support a child/youth's functional level as much as possible and as necessary for the integration of the child/youth as an active and productive member of their community and family with minimal ongoing professional interventions.

** Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child (ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

This service may be provided directly by the CCBHCs, or through a DCO.

Service Components for Adults

This service may include the following components:

- Rehabilitation support, recovery oriented activities, interventions and skill development necessary for the individual to improve self-management of and reduce relapse to substance use, the negative effects of psychiatric, or emotional symptoms, that interfere with a person's daily living skills that are critical to remaining in home, school, work, and community.
- Rehabilitation support necessary for the individual to implement learned skills so the person can remain in a preferred natural community location including:
    - Assist individual to identify a meaningful life role goal and objectives through a person-centered assessment process and exploration of the individual's desired goals and desires.
    - Coping skills training which teaches strategies to address symptoms, manage stress and reduce exposure and vulnerability to stress. Identify trauma triggers and develop healthy alternatives to cope with anger and challenging situations.
    - Personal autonomy: Learning to manage stress, unexpected daily events and disruptions, mental health symptoms, relapse triggers and cravings with confidence; develop and pursue leisure and recreational interests, manage free time comfortably; transportation navigation
    - Holistic Health: Developing constructive and comfortable interactions with health-care professionals, Relapse Prevention Planning; managing chronic medical conditions, mental health symptoms and medications; establishing good health routines and practices
    - Social Skills: Engaging with people respectfully, appropriate eye contact, conversation skills, listening skills and advocacy skills
    - Dietary and Wellness Education: meal planning, healthy shopping and meal preparation, nutrition awareness, exercise options
    - Daily Living Skills and practices related to health that may include grooming, hygiene and sustaining living environment. May also include understanding and practicing routines related to managing medication, nutrition, medical care and navigating transportation.
    - Benefits and Financial Management which includes instruction on budgeting, income, benefits and personal finances.
    - Employment: assist in pursuing, securing and retaining paid or unpaid employment. Support the individual in sustaining employment through ongoing counseling, mentoring and advocacy.

- Ongoing assessment of the individual's progress toward recovery, functional skill and impairment levels by engaging the individual in an active, person-centered manner and partnership. Discuss and review selected PSR interventions and periodically assess their effectiveness in achieving goals.

Service Components for Children

Service Components for PSR are defined broadly so that they may be provided to children within the context of each child's treatment plan.

Personal and Community Integration Services– Using rehabilitation interventions and individualized, collaborative, hands-on training to build developmentally appropriate skills. The intent is to promote personal independence, autonomy, and mutual supports by developing and strengthening the individual's independent community living skills and support community integration in the domains of employment, housing, education, in both personal and community life. This includes:

- **Psychoeducation**, with the goal to restore, and support:
  - Increasing community tenure and avoiding more restrictive placements
  - Enhancing personal relationships
  - Establishing support networks
  - Increasing community awareness
  - Developing coping strategies and effective functioning in the individual's social environment, including home, work, and school locations.
- **Daily Living Skills**, with the goal to restore, rehabilitate and support:
  - Improving self-management of the negative effects of psychiatric, emotional, physical health, developmental, or substance use symptoms that interfere with a person's daily living
  - Support the individual with the development and implementation of daily living skills and daily routines necessary to remain in the home, school, work and community.
  - Wellness skills, such as:
    - Meal planning
    - Healthy shopping and meal preparation
    - Nutrition awareness
    - Exercise options
  - Personal autonomy skills, such as:
    - Learning to manage stress, unexpected daily events, and disruptions, behavioral health and physical health symptoms with confidence
    - Learning self-care
    - Developing and pursuing leisure and recreational interests
    - Managing free time comfortably
    - Transportation navigation
    - Managing money
    - Developing daily living skills specific to managing their own medications and learning self-care consistent with the directions of prescribers (e.g., setting an alarm to remind the child/youth when it is time to take a medication, developing reminders to take certain medications with food, writing reminders on a calendar when it is time to refill a medication)
    - Managing medications consistent with the directions of prescribers
    - Developing methods of communication with prescribers about medication side effects or medication issues (e.g., help the child/youth prepare for an upcoming appointment by encouraging them to write down questions or concerns to discuss with the prescribing clinician)
    - Gaining and/or regaining the ability to make independent choices and to take a proactive role in treatment, including discussing questions or concerns about medications, diagnoses, or treatment approaches with their treatment provider.
    - Using community resources

- **Intervention Implementation**
  - Implementing learned skills so the child/youth can remain in a natural community location and achieve developmentally appropriate functioning in the following areas
    - Social skills, such as:
      - Positive recreational/leisure activities
      - Developing interpersonal skills when interacting with peers, establishing and maintaining friendships/a supportive social network while engaged in recovery plan.
      - Developing conversation skills and a positive sense of self to result in more positive peer interactions
      - Coaching on interpersonal skills and communication
      - Training on social etiquette
      - Developing self-regulation skills including anger management
      - Engendering civic duty and volunteerism
    - Health skills, such as:
      - Developing constructive and comfortable interactions with health-care professionals
      - Relapse prevention planning strategies
      - Managing symptoms and medications
      - Re-Establishing good health routines and practices
    - Assisting the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments
  - Supporting the identification and pursuit of personal interests and hobbies
    - e.g., creative arts, reading, exercise, faith-based pursuits, cultural exploration
    - identify resources where interests can be enhanced and shared with others in the community
    - identify and connect to natural supports and resources, including family, community networks, and faith-based communities

Evidence Based Practices for Adults

Required:

- Individual Placement and Support (IPS) Model

Evidence Based Practices for Children

Required:

- Individual Placement and Support (IPS) Model- as applicable

Recommended:

- Multi-Systemic Therapy

Setting

PSR can occur in a variety of settings including community locations where the individual lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes.

Admissions/Eligibility Criteria

An individual can qualify to receive this service from a CCBHC if the comprehensive, person-centered and family-centered diagnostic and treatment plan indicates that an individual could benefit from PSR and if the individual wishes to receive it.

Limitations/Exclusions

The service duration and intensity should be reviewed by the CCBHC or DCO provider at least quarterly to assess the need for modification.

Certification/Provider Qualifications

Individual Staff Qualifications for Children:

- Must be 18 years old and have a high school diploma, high school equivalency preferred, or a State Education Commencement Credential (e.g. SACC or CDOS); with a minimum of three years' experience in children's mental health, addiction and/or foster care.
- The practice of PSR by unlicensed individuals does not include those activities that are restricted under Title VIII.

Individual Staff Qualifications for Adults:

- Must be 18 years old and have a high school diploma, high school equivalency preferred, or a State Education Commencement Credential (e.g. SACC or CDOS); and 1-3 years of relevant experience working with individuals with Substance Use Disorders (SUD) and/or Serious Mental Illness (SMI) or a Bachelor's degree and 1-3 years relevant experience.

Supervisor Qualifications for both Children and Adults:

- The PSR provider must receive regularly scheduled supervision from Professional staff as defined in Appendix A.

Licensed Occupational Therapists & Occupational Therapy Assistants may provide this service.

Staffing Ratio/Case Limits

Groups should not exceed more than 8 members. Consideration may be given to a smaller limit of members if participants are younger than eight years of age.

The caseload size must be based on the needs of the individual an emphasis on successful outcomes and individual satisfaction. Staffing ratio maximums: 1:20 staff to individuals serves; Supervisory ratio: 1:10 (1 supervisor to 10 Direct Care Staff) and 1:16 for groups with family members.

Staff Training Requirements

Recommended Training Topics:
Domestic Violence
Motivational Interviewing

Billing Requirements

Must meet Threshold visit.

Peer support and counselor services and family supports

Definition

Adults:
Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self-efficacy, and community living skills). Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from a behavioral health disorder.

Activities included must be intended to achieve the identified goals or objectives as set forth in the individuals individualized service plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist individuals in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery.

***Children**:*
Family Peer Support Services (FPSS) are an array of formal and informal services and supports provided to families caring for/raising a child who is experiencing social, emotional, developmental, medical, substance use, and/or behavioral challenges in their home, school, placement, and/or community. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth.

The service is needed to allow the child the best opportunity to remain in the community. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth's treatment plan.

Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home

Youth:

Youth Peer Support and Training (YPST) services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills.

Youth Peer Support and Training activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth's individualized treatment plan.

The structured, scheduled activities provided by this service emphasize the opportunity for the youth to expand the skills and strategies necessary to move forward in meeting their personal, individualized life goals, develop self-advocacy skills, and to support their transition into adulthood.

This service may be provided directly by the CCBHCs, or through a DCO.

Service Components for Adults

There are 6 categories of peer-support components for adults. Any of the below services can be provided either individually or combined as the care/service plan indicates their need. They include:

1. **Advocacy**
    - Assistance seeking and obtaining benefits and entitlements, food, shelter, permanent housing
    - Assisting recipients in participating in shared decision making
    - Use Peer Bridgers to assist with linkages to and systems navigation within behavioral health and allied human services systems to access appropriate care
    - Benefits advisement and planning
    - Development of psychiatric advance directives (PAD)

- Assistance advocating for self-directed services

2. **Outreach and Engagement**:
   - Companionship and modeling of recovery lifestyle, including participation in recovery activities that might be beyond the scope of treatment providers (e.g., coffee/tea at a coffee shop, attending a court date, attending an appointment, attending or participating in a recovery celebration event or wellness activity)
   - Raising the awareness of existing services, pathways to recovery and helping a person to remove barriers that exist for access to them
   - Interim visits with individuals after discharge from Hospital Emergency Rooms, Detox Units or Inpatient Psychiatric Units to facilitate community tenure and increased readiness while waiting for the first post-discharge visit with a community-based mental health provider, treatment provider or appropriate system of care
   - "Outreach" is a face-to-face service with a patient provided by clinical staff or a peer advocate for the purpose of increasing motivation to participate in clinically indicated treatment for chemical dependence. Patients identified for this intervention must be current patients who have failed to appear for sessions at the program and are judged to be at risk for prematurely discontinuing treatment or persons transitioning from another Office-certified program.
3. **Self-help tools:**
   - Assist selecting and utilizing self-directed recovery tools such as Relapse Prevention Planning
   - Assist selecting and utilizing the things that bring a sense of passion, purpose and meaning into his/her life and coaching the person as they identify barriers to engaging in these activities
   - Assist individuals to help connect to natural supports that enhance the quality and security of life
   - Connecting individuals to "warm lines"
   - Connections to self-help groups in the community
4. **Peer Recovery Supports and Peer Counseling:**
   - Recovery education and counseling for individuals and their family members
   - One to one peer support. Person centered goal planning that incorporates life areas such as community connectedness, physical wellness, spirituality, employment, self-help
   - Assisting with skills development that guides people towards a more independent life
   - Individuals in continuing care may receive counseling or peer services once per month.
   - Learning and practicing new skills
   - Helping peers self-monitor their progress
   - Modeling effective coping skills
5. **Transitional Supports:**
   - Bridging from Jail or prison to an individual's home (note: that peer supports while in Jail are not Medicaid reimbursable)
   - Bridging from institutions (e.g. inpatient or residential facilities) to an individual's home (note: that peer supports while in an institution are not Medicaid reimbursable)
   - Bridging from general hospitals to an individual's home
   - Bridging from an individual's home to the community
   - Arrangements for appropriate services (appointment dates, contact names, and numbers, etc.) are discussed and made with the individual and their significant others prior to the planned discharge date. Documentation of this information will be included in the individual's case record. Where an individual is going from a bedded service to another service, a warm hand-off or peer service is considered where possible.
6. **Pre-crisis and Crisis Support Services:**
   - Providing companionship when an individual in an emergency room or crisis unit or preparing to be admitted to detox, residential or other service to deal with crisis
   - Providing peer support in the individual's home or in the community to support them before (or in) a crisis or relapse
   - Developing crisis diversion plans or relapse prevention plans

Service Components for Children

There are 4 categories of peer support components for Children. Any of the below services can be provided either individually or combined as the care/service plan indicates their need. They include:

1. **Engagement, Peer Bridge Services, and Services to Assist Individuals transitioning between service systems or between residential or Inpatient Settings to the Community.**
   - Based on the strengths and needs of the youth and family, connect them with appropriate services and supports. Accompany the family when visiting programs.
   - Facilitate meetings between families and service providers.
   - Assist the family to gather, organize and prepare documents needed for specific services.
   - Address any concrete or subjective barriers that may prevent full participation in services.
   - Serve as a bridge between families and service providers, supporting a productive and respectful partnership by assisting the families to express their strengths, needs and goals.
   - Support and assist families during stages of transition which may be unfamiliar (e.g. placements, in crisis, and between service systems etc.).
   - Arrangements for appropriate services (appointment dates, contact names, and numbers, etc.) are discussed and made with the individual and their significant others prior to the planned discharge date. Documentation of this information will be included in the individual's case record. Where an individual is going from a bedded service to another service, a warm hand-off or peer service is considered where possible.
   - Promote continuity of engagement and supports as families' needs and services change.
   - "Outreach" is a face-to-face service with a patient provided by clinical staff or a peer advocate for the purpose of increasing motivation to participate in clinically indicated treatment for chemical dependence. Patients identified for this intervention must be current patients who have failed to appear for sessions at the program and are judged to be at risk for prematurely discontinuing treatment or persons transitioning from another Office-certified program.
   - Individuals in continuing care may receive counseling or peer services once per month.

2. **Self-Advocacy, Self-Efficacy, and Empowerment**:
   - Train families to advocate on behalf of themselves to promote shared decision-making.
   - Regularly consult with families and providers to ensure that the family's perspectives are included in all planning and decision-making.
   - Coach and model shared decision-making and skills that support collaboration, in addition to providing opportunities for families to self-advocate.
   - Model strengths-based interactions by accentuating the positive.
   - Support the families in discovering their strengths and concerns. Assist families to identify and set goals and short term objectives.
   - Prepare families for meetings and accompany them when needed.
   - Empower families to express their fears, expectations and anxieties to promote positive effective communication.
   - Assist families to frame questions to ask providers.
   - Provide opportunities for families to connect to and support one another.
   - Support and encourage family participation in community, regional, state, national activities to develop their leadership skills and expand their circles of support.
   - Provide leadership opportunities for families who are receiving Family Peer Support Services.
   - Empower families to make informed decisions regarding the nature of supports for themselves and their child through:
     - Sharing information about resources, services and supports and exploring what might be appropriate for their child and family
     - Exploring the needs and preferences of the family and locating relevant resources.
     - Helping families understand eligibility rules
     - Helping families understand the assessment process and identify their child's strengths, needs and diagnosis.

- Learning and practicing new skills
- Helping peers self-monitor their progress
- Modeling effective coping skills

3. **Parent Skill Development and Training, Family/caregiver Psychoeducation**
   - Supports the efforts of families in caring for and strengthening their children's mental, and physical health, development and well-being of their children.
   - Helps the family learn and practice strategies to support their child's positive behavior.
   - Assist the family to implement strategies recommended by clinicians.
   - Assist families in talking with clinicians about their comfort with their treatment plans.
   - Provide emotional support for the family on their parenting journey to reduce isolation, feelings of stigma, blame and hopelessness.
   - Provide individual or group parent skill development related to the behavioral and medical health needs of the child (i.e., training on special needs parenting skills).
   - Support families as children transition from out of home placement.
   - Assist families on how to access transportation.
   - Support the parent in their role as their child's educational advocate by providing: information, modeling, coaching in how to build effective partnerships, and exploring educational options with families and school staff.

4. **Community Connections and Natural Supports**:
   - Enhance the quality of life by integration and supports for families in their own communities
   - Help the family to rediscover and reconnect to natural supports already present in their lives.
   - Utilize the families' knowledge of their community in developing new supportive relationships.
   - Help the family identify and become involved in leisure and recreational activities in their community.
   - In partnership with community leaders, encourage families who express an interest to become more involved in faith or cultural organizations.
   - Arrange support and training as needed to facilitate participation in community activities.
   - Conduct groups with families to strengthen social skills, decrease isolation, provide emotional support and create opportunities for ongoing natural support.
   - Work collaboratively with schools to promote family engagement.

Service Components for Youth

Skill Building:

- Develop skills for coping with and managing psychiatric symptoms, trauma, and substance use disorders
- Develop skills for wellness, resiliency and recovery support
- Develop skills to independently navigate the service system
- Develop goal-setting skills
- Build community living skills

Coaching: Enhance resiliency/recovery oriented attitudes, i.e., hope, confidence, and self-efficacy

- Promote wellness through modeling.
- Provide mutual support, hope, reassurance and advocacy that include sharing one's own "personal recovery/resiliency story" as the Youth Peer Advocate (YPA) deems appropriate as beneficial to both the youth and themselves. YPA's may also share their recovery with parents as a means to engage parents and help them "see" youth possibilities for future in a new light.

Engagement, Bridging, and Transition Support:

- Act as a peer partner in transitioning to different levels of care and into adulthood. Help youth understand what to expect and how and why they should be active in developing their treatment plan and natural supports.

Self-Advocacy, Self-Efficacy, & Empowerment:

- Help youth develop self-advocacy skills (e.g., may attend a Committee on Preschool or Special Education meeting with the youth and parent, coaching the youth to articulate his educational goals).
- Assist youth with gaining and regaining the ability to make independent choices and assist youth in playing a proactive role in their own treatment (assisting/mentoring them in discussing questions or concerns about medications, diagnoses or treatment approaches with their treating clinician). The YPA will guide the youth to effectively communicate their individual perspective to providers and families.
- Develop, link, and facilitate the use of formal and informal services, including connection to peer support groups in the community
- Serve as an advocate, mentor, or facilitator for resolution of issues
- Assist in navigating the service system
- Assist youth in developing skills to advocate for needed services and benefits and seeking to effectively resolve unmet needs.
- Assist youth in understanding their treatment plan and help to ensure the plan is person/family centered

Community Connections and Natural Supports:

- Connect youth to community resources and services. The YPA may accompany youth to appointments and meetings for the purpose of mentoring and support but not for the sole purpose of providing transportation for the youth.
- Help youth develop a network for information and support from others who have been through similar experiences, including locating similar interest programs, peer-run programs, and support groups.
- Facilitate or arrange youth peer resiliency/recovery support groups.

Evidence Based Practices for Adults

- Motivational Interviewing
- Wellness Management and Recovery (WMR)

Evidence Based Practices for Children and Youth

- Motivational Interviewing
- Cognitive Behavioral Motivational Enhancement Therapy (CBMET)
- Seven Challenges
- Multi-Dimensional Family Therapy

Modality

Individual face-to-face intervention

Group face-to-face intervention. (For Kids and Youth: Composition of members should share common characteristics, such as related experiences, developmental age, chronological age, challenges or treatment goals).

To allow for continuous connection to treatment over time, OASAS has included continuing care in the new PART 822 regulations http://www.oasas.ny.gov/regs/index.cfm. This will allow programs to discharge an individual from an outpatient episode of active care in an outpatient setting (outpatient clinic or Opioid Treatment Program) into continuing care. The person will be able to access counseling, peer services, medication assisted treatment and recovery supports following treatment for an indefinite period of time. For some, this may be for only a few months as they transition to recovery supports in the community for others it may be for many years. See below for patient examples of appropriate use of continuing care.

Setting

Peer supports may be provided in a variety of settings including outpatient and community settings. The majority of the contacts with the individual should be offsite in the community. Community locations may include: an individual's home, family or caregiver's home, homeless shelters and soup kitchens, where an individual works, attends school, engages in services (e.g. provider office sites), and/or socializes.

Admissions/Eligibility Criteria

Peer Supports is voluntary. An individual can qualify to receive this service from a CCBHC 1. If the comprehensive, person-centered and family-centered diagnostic and treatment plan indicates that an individual could benefit from peer supports and 2. If the individual wishes to receive peer supports.

Limitations/Exclusions

If the admissions/eligibility criteria are met, there are no limits/exclusions.

Certification/Provider Qualifications

***Children*:**
Individual Staff Qualifications:

- Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA). To be eligible for the FPA Credential, the individual must:
  - Demonstrate 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
  - Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS)
  - Complete Level One and Level Two of the Family Peer Advocate Core Training/ Parent Empowerment Program (PEP) training or approved comparable training.
  - Submit three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from FPAs supervisor.
  - Agree to practice according to the Family Peer Advocate Code of Ethics.
  - Complete 20 hours of continuing education and renew their FPA credential every two years.

Youth:
Individual Staff Qualifications:
Youth Peer Support and Training is delivered by a New York State credentialed Youth Peer Advocate.

Supervisor Qualifications:
YPAs will be supervised by:

1) A credentialed YPA with four years of direct YPST service experience with access to clinical consultation as needed. The clinical supervision may be provided by a staff member or through a contract with another organization.
   OR

2) A credentialed FPA with four years of experience providing FPSS that has been trained in YPST services and the role of YPAs, and efforts are made as the YPST service gains maturity in NYS to transition to supervision by experienced credentialed YPAs within the organization.
OR

3) A "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595 that has training in YPST services and the role of YPAs and efforts are made as the YPST service gains maturity to transition to supervision by an experienced credentialed YPA within the organization.

***Adults**:*
Peer support providers must have a certification as one of the following:

- OMH established Certified Peer Specialist
- OASAS Certified Recovery Peer Advocate

Supervision of peer support must be provided by Professional Staff**.**

Peer Advocates. Peer advocates, as defined in Part 800 of this Title, must be supervised by a clinical staff member who is credentialed or licensed and participate in a training plan appropriate to their needs. Peer advocates may provide peer support and outreach services based on clinical needs as identified in the patient's treatment/recovery plan.

Staffing Ratio/Case Limits

Maximum 1 FTE to 20 consumers.

A group is composed of two or more families and cannot exceed more than six families composed of no more than 12 individuals in total.

Staff Training

The below trainings are required for all peer/family support service personnel:

- Personal Safety in the Community
- Ethics
- Crisis Intervention

The below trainings are recommended to improve service delivery by peer support personnel:

- Domestic Violence: Signs and Intervention
- Motivational Interviewing
- Principles and concepts of recovery
- coping skills
- advocacy
- Medication Assisted Treatment (Opiate Overdose Prevention for those applicable)
- Trauma Informed Care
- Mental Health/Substance Use 101

The below trainings are recommended for Youth Peer Advocates:

- Level One and Level Two Youth Peer Advocate Training approved by the Youth Peer Support Services Council which include the following training components: Role of the Youth Peer Advocate in the Managed Care System, Peer Mentoring and Support, Small Group Facilitation Skills, Professional Expectations, Self-care and Support.

Billing Requirements

Must meet Threshold visit.

Intensive, community-based behavioral health care for members of the armed forces and veterans

Definition

CCBHCs are responsible for providing intensive, community-based behavioral health care for members of the U.S. Armed Forces and veterans with inadequate access to, or chooses not to receive services from a Military Treatment Facility (MTF), or VA Medical Facility. Such services are to be consistent with the Uniform Mental Health Services Handbook and clinic guidelines established by the Veterans Health Administration (VHA), in effort to maintain consistent and high-quality care for all members of the U.S. Armed Forces and veterans.

Intensive, community-based behavioral health care for members of the armed forces and veterans shall be inclusive of the individual's perspective, and thoroughly meet their care needs. In addition, services shall be integrated, coordinated, and recovery-oriented-incorporating the core recovery principles of privacy, security, and honor.

Military Service: Service as an active duty, reserve, or national guard member of the United States Army, Navy, Marine Corps, Air Force or Coast Guard.

Current Military Personnel: Persons affirming current military service.

Veterans: Persons affirming former military service.

This service may be provided directly by the CCBHCs, or through a DCO.

Service Components for Adults

Service components are to be consistent with the VHA Uniform Mental Health Services Handbook (VHA HANDBOOK 1160.01) and the VA/DoD Clinical Practice Guidelines (http://www.healthquality.va.gov/index.asp).

Identification of Current or Former Military Service
At the initial point of contact (see Screening, Assessment, and Diagnosis), individuals shall be asked whether they have ever served in the U.S. military. If current or former military service is identified, CCBHCs shall adhere to the following protocol:

*Current Military Personnel***:** Persons affirming current military service will be offered assistance in the following manner:

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

Veterans: Persons affirming former military service (veterans) are offered assistance to enroll in VHA for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC.

Members of the U.S. Armed Forces and Veterans-specific Treatment Plan Components:
Per the CCBHC criteria established by SAMHSA, the behavioral health treatment plan for all members of the U.S. Armed Forces and veterans receiving services shall include the following:

(1) The treatment plan includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis.
(2) The treatment plan includes approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself.
(3) As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness.
(4) The plan is recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments.
(5) The treatment plan is developed with input from the veteran, and when the veteran consents, appropriate family members. The veteran's verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1.

Scope of Services under Intensive, Community-Based Behavioral Health Care for Members of the Armed Forces and Veterans
CCBHCs shall provide services within the VHA Handbook under their scope of practice. CCBHCs shall ensure all services included in the VHA Handbook that are outside the CCBHC scope of practice (such as inpatient care or residential and treatment programs) be reasonably accessible via a care coordination agreement.

Principal Behavioral Health Providers
Per the CCBHC criteria established by SAMHSA, all members of the U.S. Armed Forces and veterans receiving services shall be assigned a Principal Behavioral Health Provider. When veterans are seeing more than one behavioral health provider and when they are involved in more than one program, the identity of the Principal Behavioral Health Provider is made clear to the veteran and identified in the medical record. The Principal Behavioral Health Provider is identified on a consumer tracking database for those veterans who need case management. The Principal Behavioral Health Provider ensures the following requirements are fulfilled:

(1) Regular contact is maintained with the veteran as clinically indicated as long as ongoing care is required.
(2) A psychiatrist, or such other independent prescriber as satisfies the current requirements of the VHA Uniform Mental Health Services Handbook, reviews and reconciles each veteran's psychiatric medications on a regular basis.
(3) Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision-maker's consent when the veteran does not have adequate decision-making capacity).
(4) Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained.
(5) The treatment plan is revised, when necessary.
(6) The principal therapist or Principal Behavioral Health Provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision-making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2).

(7) The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the Principal Behavioral Health Provider suspects the veteran lacks the capacity to decide about the mental health treatment plan, the provider must ensure the veteran's decision-making capacity is formally assessed and documented. For veterans who are determined to lack capacity, the provider must identify the authorized surrogate and document the surrogate's verbal consent to the treatment plan.

Service Components for Children

Please refer to Service Components for Adults.

Evidence Based Practices for Adults

Per the VHA Handbook, required evidence based practices include:

- Evidence-based Psychotherapy for PTSD (Cognitive Processing Therapy (CPT) or Prolonged Exposure Therapy)
- Evidence-based Psychotherapy for Depression and Anxiety Disorders (Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), or Interpersonal Therapy)
- Evidence-based Somatic Therapies (evidence-based pharmacotherapy)

Please refer to the VA/DoD Clinical Practice Guidelines (http://www.healthquality.va.gov/index.asp) for additional recommended evidence based practices

Evidence Based Practices for Children

See Evidence Based Practices for Adults.

Modality

Intensive, community-based behavioral health care for members of the armed forces and veterans may be provided individually or in group.

Setting

Service settings shall be consistent with the VHA Uniform Mental Health Services Handbook.

Admissions/Eligibility Criteria

The CCBHC is responsible for providing intensive, community-based behavioral health care for certain members of the U.S. Armed Forces and veterans under the following circumstances:

- Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility
- veterans living 40 miles or more (driving distance) from a VA medical facility
- veterans who decline VHA services
- veterans who are ineligible for VHA services
- as otherwise required by CCBHC certification criteria, or federal law

Limitations/Exclusions

N/A

Certification/Provider Qualifications

Based on the service needs of the individual, provider qualifications for this service shall be consistent with the other services in the CCBHC Scope of Services Provider Manual. In addition, providers must adhere to the service-specific training requirements.

Staffing Ratio/Case Limits

N/A

Staff Training Requirements

(1) Any staff who is not a veteran has training about military and veterans' culture in order to understand the unique experiences and contributions of those who have served their country.
(2) All staff receives cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity.
(3) Staff must be trained in trauma-informed care.

Billing Requirements

Must meet Threshold visit.

Appendix

A. Staffing Guidelines:

I. **Professional staff** means practitioners possessing a license or a permit from the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness and substance use disorders and shall include the following:

a. ***Certified Rehabilitation Counselor (CRC)*** is certified with a national Certified Rehabilitation Counselor (CRC) designation by The Commission on Rehabilitation Counselor Certification (CRCC) that sets the standard for quality rehabilitation counseling services in the United States and Canada. All VR staff within the OASAS treatment provider system must adhere to the Code of Ethics set forth by the NYS Ethics Commission (http://www.nyintegrity.org/) and/ or the Commission on Rehabilitation Counselor Certification (CRCC) (www.crccertification.com)

b. ***Creative arts therapist*** is an individual who is currently licensed as a creative arts therapist by the New York State Education Department or possesses a creative arts therapist permit from the New York State Education Department.

c. ***Licensed practical nurse*** is an individual who is currently licensed as a licensed practical nurse by the New York State Education Department or possesses a licensed practical nurse permit from the New York State Education Department.

d. ***Licensed psychoanalyst*** is an individual who is currently licensed as a psychoanalyst by the New York State Education Department or possesses a permit from the New York State Education Department.

e. ***Licensed psychologist*** is an individual who is currently licensed as a psychologist by the New York State Education Department or possesses a permit from the New York State Education Department and who possesses a doctoral degree in psychology, or an individual who has obtained at least a master's degree in psychology who works in a federal, state, county or municipally operated clinic. Such master's degree level psychologists may use the title "psychologist," may be considered professional staff, but may not be assigned supervisory responsibility.

f. ***Marriage and family therapist*** is an individual who is currently licensed as a marriage and family therapist by the New York State Education Department or possesses a permit from the New York State Education Department.
g. ***Mental health counselor*** is an individual who is currently licensed as a mental health counselor by the New York State Education Department or possesses a permit from the New York State Education Department.
h. ***Nurse practitioner*** is an individual who is currently certified as a nurse practitioner by the New York State Education Department or possesses a permit from the New York State Education Department.
i. ***Nurse practitioner in psychiatry*** is an individual who is currently certified as a nurse practitioner with an approved specialty area of psychiatry (NPP) by the New York State Education Department or possesses a permit from the New York State Education Department.
j. ***Physician*** is an individual who is currently licensed as a physician by the New York State Education Department or possesses a permit from the New York State Education Department.
k. ***Physician assistant*** is an individual who is currently registered as a physician assistant by the New York State Education Department or possesses a permit from the New York State Education Department.
l. ***Psychiatrist*** is an individual who is currently licensed to practice medicine in New York State, who (i) is a diplomate of the American Board of Psychiatry and Neurology or is eligible to be certified by that Board, or (ii) is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that Board.
m. ***Registered professional nurse*** is an individual who is currently licensed as a registered professional nurse by the New York State Education Department or possesses a permit from the New York State Education Department.
n. ***Social worker*** is an individual who is either currently licensed as a licensed master social worker or as a licensed clinical social worker (LCSW) by the New York State Education Department, or possesses a permit from the New York State Education Department to practice and use the title of either licensed master social worker or licensed clinical social worker.

II. Unlicensed Staff:

a. Unlicensed staff must be at least 18 years of age and have a high school diploma or equivalent, and 1-3 years of relevant experience working with individuals with SUD disorders and/or SMI or a BA degree.
b. A Certified Peer Specialist/Certified Recovery Peer Advocate, or equivalently qualified by education in the human services field or a combination of work experience and education, with one year of education substituting for one year of experience. A LMHP or QHP shall be available at all times to provide supervision, back up, support and/or consultation.
c. Case manager/care coordinator staff that meet the qualifications and experience identified under unlicensed staff.

Direct service staff should be appropriately licensed or credentialed, trained and experienced practitioners with appropriate skills for engaging family members; providing education about substance use disorder/mental illness and its treatment; possessing information on community resources; guidance on how to manage or cope with substance use disorder relapse, maladaptive behaviors; emotional support and counseling; crisis planning/intervention; and problem solving skills training.

III. Certified Peer:

a. OMH-certified Peer Specialist
b. OASAS-certified Recovery Peer Advocate

OMH and OASAS certification programs are separate. Though OMH uses the Academy of Peer Support for training that is NOT the certification program. OMH peers must be certified by The New York Peer Specialist Certification Board (http://nypeerspecialist.org/) The OMH certification has minimal training on SUD issues. Likewise, the OASAS process has minimal training on mental health issues. For this reason,

best practice would be for a peer specialist to have the certification that aligns with the type of program that are working in. If the program is an SUD program, then they should have the OASAS certification. If it is a mental health program, then they should have the OMH certification. For those working with the dually diagnosed population, it is recommended that they have both certifications to be fully prepared to serve the populations of that program.

OASAS Requirements:
Certified Recovery Peer Advocate
The Alcoholism and Substance Abuse Providers of New York State (ASAP) New York Certification Board Requirements:

- 46 hours of training specific to the Peer Recovery (PR) domains:
  - Advocacy – 10 hours
  - Mentoring & Education – 10 hours
  - Recovery & Wellness – 10 hours
  - Ethical Responsibility – 16 hours
- Hold a high school diploma or jurisdictionally certified high school equivalency
- 500 hours of volunteer or paid work experience specific to the PR domains
- 25 hours of supervision specific to the PR domains. Supervision must be provided by a qualified supervisor
- Pass the NYCB/IC&RC Peer Recovery Exam

Additional New York Certification Association (NYCA) Requirements:

- Lived Experience-Lived experience as a peer and/or an individual in recovery is critical to the role of a Certified Recovery Peer Advocate.
- All training must have been completed within the last 5-years.
- Related Work Experience
  - 500 hours of related experience for the following applicants: Individual's holding a bachelor's degree or credentialed as a CASAC, CASAC-T, CASAC-G, Prevention Professional, Prevention Specialist, or Recovery Coach Academy graduates.
  - 1,000 hours of related experience for all other applicants.
  - All experience must have been gained within the last 5-years.
  - On-the-Job Supervision-25 hour's total, A minimum of 4 hours of supervision per performance domain must be documented. Remaining hours may be allocated across any performance domain. All supervision must have been received within the last 5-years.
- Recommendations:
  - 1 professional letter of recommendation for certification.
  - 1 character reference letter of recommendation for certification.
- Certified Recovery Peer Advocate Certification Exam (required)
- Criminal Background: Must have a clean criminal history for a minimum of 3-years prior to application for certification, including release from all sanctions.
- Must read and sign an attestation agreeing to comply with the NYCA Code of Ethical & Professional Conduct.

IV. State Credentialed Staff:

a. ***CASAC:*** Staff person who holds a credential by the Office of Alcohol and Substance Abuse as a Credentialed Alcohol and Substance Abuse Counselor.
b. ***CASAC-T:*** Staff person who holds a credential by the Office of Alcohol and Substance Abuse as a Credentialed Alcohol and Substance Abuse Counselor-in-training.

V. Other Credentialed Staff:

Certified Psychiatric Rehabilitation Practitioner (CPRP): Staff person who holds a credential from the Psychiatric Rehabilitation Association as a practitioner working within the adult mental health system.

VI. **Licensed Occupational Therapist & Occupational Therapy Assistant**

a. **Occupational Therapist** is an individual who is currently licensed as an occupational therapist by the New York State Education Department.
b. **An Occupational Therapy Assistant** is an individual who is currently licensed by the New York State Education Department.

B. CCBHC Evidence Based Practices

Required EBPs:

1. **Integrated Treatment for Co-Occurring Disorders**
   Integrated Treatment is an evidence-based practice in which the same clinician or team of clinicians, working in one setting, provide appropriate mental health and substance use interventions in a coordinated fashion. Treatment planning considers stages of change/treatment and client choice in developing an individualized treatment plan. Services include screening, assessment, assertive outreach, health promotion, pharmacological treatment, counseling, group treatment, family psycho-education, and self-help groups. The benefits of treating both disorders together are well documented, with most individuals receiving Integrated Treatment achieving abstinence or substantially reducing harm from substance use and reporting improvements in independent living, control of symptoms, and competitive employment.

2. **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**
   SBIRT is an evidence-based practice used to identify individuals who use alcohol and other drugs at risky levels with the goal of reducing and preventing related negative health consequences, disease, accidents, and injuries. Using valid and reliable instruments that are easy to score, Screening provides specific information about an individual's substance use. Brief Intervention is a time limited, client-centered discussion that aims to change an individual's behavior by increasing insight and awareness of his or her substance use. Referral to Treatment, a more advanced treatment option, involves referring an individual to a higher level of care that is most often provided at specialized substance use treatment programs.

3. **Cognitive Behavioral Therapy**
   Cognitive Behavioral Therapy (CBT) focuses on connections between thoughts, feelings and beliefs and teaches techniques to reduce behavioral symptoms including: depression, anxiety, and urges and cravings to use substances. Evidence supports the effectiveness of cognitive behavioral therapies across the broad range of behavioral health disorders that CCBHCs are expected to treat.

4. **Medication Assisted Treatment (MAT)**
   Medication Assisted Treatment (MAT) uses medication, in combination with counseling and behavioral therapies, to treat people with severe addictions. Medications can reduce the cravings and other symptoms associated with withdrawal from a substance by occupying receptors in the brain associated with using that drug (agonists or partial agonists), block the rewarding sensation that comes with using a substance (antagonists), or induce negative feelings when a substance is taken. MAT has been primarily used for the treatment of opioid use disorder but is also used for alcohol use disorder and the treatment of some other substance use disorders.

5. **Motivational Interviewing**
   Motivational Interviewing is a clinical approach that helps people with mental health and substance use disorders and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health. The approach upholds four principles— expressing empathy, developing discrepancy, rolling with resistance, and supporting

self-efficacy. Motivational Interviewing is an effective approach for integrated settings as it can target a broad range of behaviors.

6. **Individual Placement and Support (IPS)**
   IPS is an evidence based practice of supported employment. It consists of intensive employment supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting.

7. **Family Psychoeducation**
   Family Psychoeducation fosters a partnership between the service recipient, their family, and clinician to support mental health treatment and recovery. Evidence shows that individuals who participate in Family Psychoeducation experience fewer relapses and hospital readmissions. Moreover, families report greater knowledge of serious mental illnesses and less stress, confusion, and isolation.

8. **Evidence-based Psychotherapy for PTSD**
   According to the VHA Handbook, all veterans with PTSD must have access to evidence-based Psychotherapy for PTSD. Therapies include Cognitive Processing Therapy (CPT) or Prolonged Exposure Therapy.

9. **Evidence-based Psychotherapy for Depression and Anxiety Disorders**
   According to the VHA Handbook, all veterans with depression or anxiety disorders must have access to evidence-based psychotherapy for depression and anxiety disorders. Therapies include Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), or Interpersonal Therapy.

10. **Evidence-based Somatic Therapies (evidence-based pharmacotherapy)**
    According to the VHA Handbook, all veterans with depression or anxiety disorders must have access to evidence-based psychotherapy for depression and anxiety disorders. Therapies include Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), or Interpersonal Therapy.

Additional Recommended EBPs Include:

1. **Crisis Intervention Team (CIT) Model**
2. **Dialectical Behavior Therapy (DBT)**
3. **First episode early intervention for psychosis (OnTrackNY)**
4. **Multi-Systemic Therapy**
5. **Assertive Community Treatment (ACT)**
6. **Therapeutic foster care**
7. **Motivational Enhancement Therapy**
8. **Treatment for Post-Traumatic Stress Disorder (PTSD)**
9. **Functional Family Therapy**
10. **Multi-Systemic Therapy**
11. **Twelve Step Facilitation Therapy**
12. **Matrix Model**
13. **Supported Employment**
14. **Supported Housing**
15. **Illness Management and Recovery**
16. **Cognitive Management**
17. **Behavioral Couples Therapy**
18. **Cognitive Therapy for Suicide Prevention**
19. **Seven Challenges**
20. **Multi-Dimensional Family Therapy**

21. **Wellness Management and Recovery (WMR)**
22. **Community Wrap around Services for Children and Youth; and specialty clinical interventions to treat mental health and substance use disorders experienced by youth (including youth in foster care placement).**

C. Guidance on State Sanctioned Crisis Behavioral Health Programs

Definition

A Certified Community Behavioral Health Clinic (CCBHC) State Sanctioned Crisis Behavioral Health Program is defined as a Crisis Behavioral Health provider given official designation by New York State. All programs entering into a Designated Collaborating Organization (DCO) agreement with a CCBHC to provide all or part of the CCBHC Crisis Behavioral Health Service components must seek designation as a CCBHC State Sanctioned Crisis Behavioral Health Program.

Designation Process

To qualify for CCBHC State Sanctioned Designation, a Crisis Behavioral Health program must be established by State law, regulation, or otherwise authorized by a state agency. Potential examples include: programs that are a part of a Local Government Unit Crisis Plan, Comprehensive Psychiatric Emergency Program (CPEP), and approved Delivery System Reform Incentive Payment (DSRIP) crisis services.

Potential DCOs will apply for CCBHC State Sanctioned Designation through the submission of the respective CCBHC's plan to provide CCBHC Crisis Behavioral Health Services. The CCBHC Crisis Behavioral Health Services Plan will be part of the CCBHC certification process and designed by the CCBHC and the DCOs they are contracting with to demonstrate that they have the organizational capacity and culture to provide one or more of the required CCBHC Crisis Behavioral Health Service components. CCBHC Crisis Behavioral Health Services Plans will be reviewed based on staff qualifications, organizational experience, capacity to provide services to identified CCBHC coverage area and ability to meet the criteria.

DCO Agreements with Designated State Sanctioned Crisis Behavioral Health Programs

CCBHCs have the option to contract with multiple designated State Sanctioned Crisis Behavioral Health programs –also known as a State Sanctioned Crisis Behavioral Health Network- to ensure an appropriate level and continuum of care. State Sanctioned Crisis Behavioral Health Networks may be appropriate to ensure appropriate coverage across a CCBHCs catchment area or for providing population-specific crisis services such as: adults, children, mental health, substance use, etc.

In the event that the Designated State Sanctioned Crisis Behavioral Health Programs do not provide all service components, the contracting CCBHC must build capacity to meet the remaining components to provide 24 hour, 365 day per year coverage, delivered within three hours. Please note that NYS requires all CCBHC's to directly provide Ancillary Withdrawal Management services. The CCBHC may utilize DCO agreements for all other levels of care related to Withdrawal Management/Detoxification services in their Crisis plan.

If CCBHC crisis behavioral health service provision is divided among multiple entities (Designated State Sanctioned Crisis Behavioral Health program and/or CCBHC) the roles and responsibilities for meeting all CCBHC crisis behavioral health service criteria must be thoroughly outlined in the CCBHC Crisis Behavioral Health Services Plan and DCO contract(s). Moreover, if multiple CCBHCs are utilizing the same Designated State Sanctioned Crisis Behavioral Health Program for service provision, it is the responsibility of the CCBHCs and Designated State Sanctioned Crisis Behavioral Health Program to negotiate an appropriate referral process and to determine appropriate coverage capacity needs.

D. Recommended Screening Tools

Children	Adults
Patient Health Questionnaire (PHQ-9): modified is a common, validated screening tool to identify depression, that was modified for adolescents **AUDIT** is a validated screening tool used to identify unsafe alcohol consumption. It is available in a modified three item questionnaire: **AUDIT-C**. **CAGE AID** is a screening tool validated to screen for drug and alcohol use. **The Columbia-Suicide Severity Rating Scale (C-SSRS)** is a screening tool used for suicide assessment. It is available in 114 different languages. **Child and Adolescent Needs and Strengths (CANS)** is a comprehensive multisystem assessment used for children and adolescents. **Beck Anxiety Inventory** is a self-report tool used to evaluate anxiety symptoms. **Beck Depression Inventory** is a self-report tool used to evaluate depression symptoms. **The CRAFFT** is an alcohol and drugs screening tool recommended for youth ages of 14-21. **Screening to Brief Intervention (S2BI)** is an alcohol and drugs screening tool recommended for youth ages of 12-17. **NIAAA Alcohol Screening and Brief Intervention for Youth** is an intervention recommended for youth ages of 9-18. **Adverse Childhood Experiences (ACE)** screens for a history of trauma.	**Patient Health Questionnaire (PHQ-9)** is a common, validated screening tool to identify depression. It is available in Spanish, as well as in a modified two item questionnaire: PHQ-2. **Generalized Anxiety Disorder 7- Item (GAD-7)** is a common, validated screening tool used in the assessment for anxiety. **AUDIT** is a validated screening tool used to identify unsafe alcohol consumption. It is available in a modified three item questionnaire: **AUDIT-C**. **Patient Stress Questionnaire** is a tool adapted from the PHQ-9, GAD-7, PC-PTSD, and AUDIT and used to screen for behavioral health symptoms. **CAGE AID** is a screening tool validated to screen for drug and alcohol use. **DAST-10** is a self-report tool used to evaluate drug use. **The Columbia-Suicide Severity Rating Scale (C-SSRS)** is a screening tool used for suicide assessment. It is available in 114 different languages. **Primary Care PTSD Screen (PC-PTSD)** is screening tool currently used by the VA to identify PTSD in veterans. **PTSD Checklist (PCL-C)** is checklist used to screen for PTSD in civilians (non-military). **Disability Assessment Schedule (WHODAS)** is an assessment instrument for functioning, disability, and health. It is available in 60 different languages. **NYS Community Mental Health (CMH) Assessment** **Beck Anxiety Inventory** is a self-report tool used to evaluate anxiety symptoms. **Beck Depression Inventory** is a self-report tool used to evaluate depression symptoms. **Adverse Childhood Experiences (ACE)** screens for a history of trauma.

E. American Society of Addiction Medicine (ASAM) and NYS LOCADTR Crosswalk and Justification

The criteria for Ambulatory and Medical Detoxification set forth by SAMHSA (criteria 4.c.1) refers to the revised American Society of Addiction Medicine (ASAM) criteria and levels of Withdrawal Management for Adults, however, since the ASAM criteria did not align with New York State specific levels of care, the LOCADTR 3.0 was developed and must be utilized in New York State when making LOC determinations for Substance Use Disorder services.

Below is a brief description of the LOCADTR, which includes a crosswalk with ASAM levels of Withdrawal Management. Although there is not complete alignment with the recommended ASAM levels of care, NYS feels that the Withdrawal Management services that are currently available and accessible meet the requirements of CCBHCs and respond to the needs of individuals in our state.

What is the LOCADTR 3.0?
LOCADTR is a clinical tool, used in conjunction with a full assessment of an individual presenting for Substance Use Disorder treatment. The purpose of the LOCADTR is to determine the most appropriate recommended level of care based on the clinician's answers to the individual's risks and resources. No tool can replace clinical judgment and there is an option within the tool to override the recommended level of care based on clinical judgment.

Why was the LOCADTR 3.0 developed?
The Office of Alcoholism and Substance Abuse Services (OASAS) recognizes the value in using a common assessment tool across all regions and entities so that all decision making is based on the best clinical evidence for level of care available. The goal should always be to provide care at the right time, in the right setting, and for the right duration and intensity. To address these goals, a process was undertaken to ensure that such tool is available to all NYS substance abuse treatment providers and referring entities.
OASAS convened a Clinical Advisory Panel in 2012. The purpose of this panel was to provide recommendations for implementing a standard level of care tool. The Panel acknowledged that accessing the most clinically appropriate level of care in substance use disorder (SUD) services was essential in providing safe and effective SUD treatment. The Panel also recognized that it was crucial to identify one tool that utilized a client-centered approach to assessing level of care need to ensure the use of consistent standards across the state. The Panel explored all level of care assessment tools that were available at the time. After examination of these tools, the Panel determined that OASAS should revise the LOCADTR 2.0 to include two things:
1) New York specific levels of care; and,
2) The New York State recovery vision that was based on both risk of harm from substance use and individual resources that support recovery goals in the community

As a result, a workgroup was formed to create a tool that met the following goals:

- **User-friendly**: The ability to be completed in minutes using a modern, intuitive web-based platform;
- **Patient-centered**: Based on an individualized clinical assessment
- **Recovery-oriented**: Inclusion of recovery concepts and encourage the use of community and family supports
- **Least restrictive**: Logic supports the principle of treating as close to the individual's community as is clinically appropriate
- **Relevance**: Include Levels of Care known and understood in New York
- **Reliability**: Predictably and accurately recommends the best level of care
- **Credibility**: Managed care plans and SUD treatment providers accept the tool and agree that there is evidence to support the tool
- **Clinical Support**: Provides information to clinicians to support the level of care decisions which are understood by payers and auditors.

Who can use the LOCADTR?
The LOCADTR requires the clinical staff person to complete an assessment of an individual's presenting issues, history, medical, mental health, risk and resource information, and to make clinically informed decisions in order to answer the questions. Staff who are working in an SUD setting with appropriate supervision within the scope of their practice can use the LOCADTR to make level of care recommendations. Medical staff is required to complete the crisis decision tree where there is a potential

for serious or life threatening withdrawal to occur. **The recommendation for clinical detoxification should always be made by medical staff working within their scope of practice.** Where the history includes frequent use of a substance, in large amounts over a significant period of time including the past several days that is likely to cause serious withdrawal (e.g. alcohol, benzodiazepines, barbiturates), the patient should be evaluated by a program medical staff person, or be referred to a medical staff person or emergency room to assess the need for medical withdrawal management.

ASAM Crosswalk with OASAS Levels of Care

The standard instrument used in NYS is LOCADTR 3.0 which defines appropriate placement of clients into approved NYS LOCs. These LOCs are consistent with ASAM LOCs. However, there are New York State specific level of care attributes. Entities insuring patients in NYS will need to comply with NYS specific LOCs. This table provides a listing of OASAS certified programs; the applicable authorizing New York State program regulation; and where appropriate, a cross walk to an ASAM level of care.

OASAS Program Type	New York State Regulation	ASAM
Outpatient		
Outpatient Clinic	Title 14 NYCRR Part 822	**Level I** (also **Level 1-WM**, contingent on program designation to provide ancillary withdrawal services)
Outpatient Day Rehabilitation	Title 14 NYCRR Part 822	**Level 2.5**
Intensive Outpatient	Title 14 NYCRR Part 822	**Level 2.I**
Opioid Treatment Programs	Title 14 NYCRR Part 822	**Level I**
Medically Supervised Outpatient Withdrawal	Title 14 NYCRR Part 822	**Level 2-WM**
Clinical Services in a Residential Setting		
Stabilization Services in a Residential Setting	Title 14 NYCRR Part 820	**Level 3.5**
Rehabilitation Services in a Residential Setting	Title 14 NYCRR Part 820	**Level 3.3**
Reintegration in a Residential Setting.	Title 14 NYCRR Part 820	**Level 3.1**
Inpatient		
Medically Managed Inpatient Detoxification	Title 14 NYCRR Part 816	**Level 4-WM**
Medically Supervised Inpatient Detoxification	Title 14 NYCRR Part 816	**Level 3.7-WM**
Inpatient Treatment and Residential Rehabilitation for Youth	Title 14 NYCRR Part 818	**Level 3.7**

II. CCBHC Claims Processing Clarification

The following contains clarification/guidance regarding appropriate claims processing for the thirteen (13) providers that are providing CCBHC Demonstration services under rate code 1147. This information was previously shared by e-mail to the MCO/CCBHC Workgroup on August 11th 2017. Please review your procedures to ensure the following points are being properly addressed within your processes. Medicaid Managed Care Organizations (MCOs) should be aware of the following:

- Providers must bill the eMedNY system for all Medicaid claims for services covered by the CCBHC demonstration using rate code 1147.

- All claims for services delivered Child Health Plus (CHP) plans are not impacted by the CCBHC Demonstration. Services provided to individuals enrolled in CHP must be paid in accordance with the "routine" processes used prior to July 1, 2017. Several providers have advised that MCOs have rejected their claims, and advised "to bill the service to Medicaid", which is not possible as the individuals enrolled in CHP are not covered by Medicaid. Only Medicaid (MMC, HARP, FIDA and PACE are impacted by the "carve-out" of CCBHC from Medicaid Managed Care.

- MCOs should not disallow claims solely based on the provider/location previously identified as part of the CCBHC Demonstration. Some providers may still bill the MCO for non-CCBHC Demonstration services from these locations, which the MCO would be responsible to adjudicate for payment.

- MCOs should not disallow claims solely based on the CPT/HCPCS Codes contained in the CCBHC CPT Crosswalk, as these codes may be used for billing non-CCBHC services, which the MCO would be responsible to adjudicate for payment.

- The administration of Methadone and buprenorphine in OTPS is not included in the CCBHC demonstration, and is not "carved-out" of Medicaid Managed Care, even if provided by an organization that is a CCBHC. Any claims received by the MCO using H0020; H0033 and Rate Codes 1564 or 1567 are not carved out, and the MCO remains responsible for adjudication of the claim for payment.

III. Allowable Co-Enrollment of CCBHC Services and SPA / HCBS Grids

Allowable Co-enrollment of CCBHC Services and OASAS/OMH State Plan Services									
SPA SERVICES	**CCBHC 9 Core Services**								
	Screening, Assessment, Diagnosis & Risk Assess.	Crisis Services	Outpt. MH/SU Services	Person Centered Tx. Planning	Psych. Rehab Services	Targeted Case Management	Outpt. Primary Care Screen & Monitor	Peer/Family Support & Counselor Services	Community-Based MH tx. For Veterans
OMH Part 599 Clinic	NO	NO	NO	NO	NO	NO	NO	NO	NO
OASAS Article 32 Clinic	NO	NO	NO	NO	NO	NO	NO	NO	NO
OASAS OTP	YES	YES	YES	YES	YES	YES	YES	YES	YES
OMH ACT	NO	NO	NO	NO	NO	NO	NO	NO	NO
OMH PROS	NO	NO	NO	NO	NO	NO	NO	NO	NO
OMH IPRT/CDT	NO	NO	NO	NO	NO	NO	NO	NO	NO
OMH Partial Hospital Program	NO	NO	NO	NO	NO	NO	NO	NO	NO
Health Home	YES	YES	YES	YES	YES	NO	YES	YES	YES
OASAS Outpt. Rehab	NO	NO	NO	NO	NO	NO	NO	NO	NO

Allowable Co-enrollment of CCBHC Services and HCBS									
HCBS SERVICES	**CCBHC 9 CORE SERVICES**								
	Screening, Assessment, Diagnosis & Risk Assess.	Crisis Services	Outpt. MH/SU Services	Person Centered Tx. Planning	Psych. Rehab Services	Targeted Case Management	Outpt. Primary Care Screen & Monitor	Peer/Family Support & Counselor Services	Community-Based MH tx. For Veterans
Psychosocial Rehab	YES	YES	YES	YES	NO	YES	YES	YES	YES
Community Psych. Support & Treatment	YES	YES	NO	YES	NO	YES	YES	YES	YES
Habilitation Services	YES	YES	YES	YES	YES	YES	YES	YES	YES
Education Support Services	YES	YES	YES	YES	YES	YES	YES	YES	YES
Family Support & Training	YES	YES	YES	YES	YES	YES	YES	Peer YES Family NO	YES
Employment Services	YES	YES	YES	YES	NO	YES	YES	YES	YES
Peer Supports	YES	YES	YES	YES	YES	YES	YES	NO	YES
Crisis Respite	YES	YES	YES	YES	YES	YES	YES	YES	YES

IV. Medicaid Procedure Codes for CCBHC Demonstration Services

PURPOSE:
To inform clinics selected for participation in the CCBHC demonstration grant of the procedure codes that are eligible for reimbursement under the Prospective Payment System (PPS) methodology. This crosswalk will inform clinics of the Demonstration Service category that each procedure code falls under, and the specifications for providing and billing the service.

Primary Care (**PCSM**) evaluation and management (E/M) codes for CCBHC Demonstration include **99201-99220; 99224-99226; 99304-99310; 99341-99350**
Providers utilizing E/M codes may also bill mental health procedure codes as listed in the Current Procedural Terminology (CPT) Code List and contained in this Demonstration Service listing

DEMONSTRATION CORE SERVICES KEY:

CRISIS = Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization*
SADRA = Screening, assessment, and diagnosis, including risk assessment*
PCTP = Patient-centered treatment planning or similar processes, including risk assessment and crisis planning*
OMHSUS = Outpatient mental health and substance use services*
PCSM = Outpatient clinic primary care screening and monitoring of key health indicators and health risk
TCM = Targeted case management
PRS = Psychiatric rehabilitation services
PEER = Peer support and counselor services and family supports
VETS = Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration

* Demonstration services that must be provided directly by the CCBHC and **not** through a Designated Collaborating Organization (DCO) to receive the PPS encounter rate; Crisis services may be delivered through a **state-sanctioned** DCO.

CODE	Demonstration Service Category (VETS may receive any category of service - see note in Service Key)	Reimbursement Method	NY OMH or OASAS CPT codes/description
H2011	CRISIS	PPS Cost-Based Rate	NY OMH - Crisis Intervention - 15 min
S9484	CRISIS	PPS Cost-Based Rate	NY OMH - Crisis Intervention - Complex - minimum 1 hr.
S9485	CRISIS	PPS Cost-Based Rate	NY OMH - Crisis Intervention - Per Diem
90785	OMHSUS	PPS Cost-Based Rate	Interactive Complexity (in addition to the primary procedure code) - ADD ON
90832	OMHSUS	PPS Cost-Based Rate	NY OMH - Psychotherapy Individual - 30 min
90832	OMHSUS	PPS Cost-Based Rate	NY OASAS - Individual Therapy - brief - 25 min
90833	OMHSUS	PPS Cost-Based Rate	NY OMH - Psychiatric Assessment - 30 min - ADD ON
90834	OMHSUS	PPS Cost-Based Rate	NY OMH - Psychotherapy - Individual - 45 min
90834	OMHSUS	PPS Cost-Based Rate	NY OASAS - Individual Therapy - normative - 45 min
90836	OMHSUS	PPS Cost-Based Rate	NY OMH - Psychiatric Assessment - 45 min - ADD ON
90837	OMHSUS	PPS Cost-Based Rate	NY OMH - Psychotherapy - 60 min
90838	OMHSUS	PPS Cost-Based Rate	NY OMH - Psychotherapy performed with eval - 60 min - ADD ON
90846	OMHSUS	PPS Cost-Based Rate	NY OMH - Family Psychotherapy (without patient present)
90846	OMHSUS	PPS Cost-Based Rate	NY OASAS - Family / Couple Counseling - 30 min
90847	OMHSUS	PPS Cost-Based Rate	NY OMH - Psychotherapy Family and Client - 1 hr.
90849	OMHSUS	PPS Cost-Based Rate	NY OMH - Family Group - 1 hr.
90849	OMHSUS	PPS Cost-Based Rate	NY OASAS - Multi-Family Group (adolescents) - 60 min
90853	OMHSUS	PPS Cost-Based Rate	NY OMH - Psychotherapy Group - 1 hr.
90882	OMHSUS	PPS Cost-Based Rate	NY OMH - Complex Care Management
90882	OMHSUS	PPS Cost-Based Rate	NY-OASAS - Complex Care Coordination - 45 min (combined) on same visit date - within 5 days of another clinical service
96372	OMHSUS	PPS Cost-Based Rate	NY OMH - Injection Only
99201-99205	OMHSUS	PPS Cost-Based Rate	Medication Management & Monitoring, New Pt
99211-99215	OMHSUS	PPS Cost-Based Rate	Medication Management & Monitoring, Established Pt
99241-99245	OMHSUS	PPS Cost-Based Rate	Outpatient Consultation, New or Established Pt
H0004	OMHSUS	PPS Cost-Based Rate	NY OASAS - Brief Treatment - 15 min
H0005	OMHSUS	PPS Cost-Based Rate	NY OASAS - SUD Group Counseling Services - 60 min
H0014	OMHSUS	PPS Cost-Based Rate	NY OASAS - Addiction Medication Induction / Ancillary Withdrawal Management - 30 min
H0020 KP	OMHSUS	PPS Cost-Based Rate	NY OASAS - Medication Administration & Observation. Use KP modifier for 1st visit of week.
H0020	OMHSUS	PPS Cost-Based Rate	NY OASAS - Medication Administration & Observation. Additional visits during week.
H0033	OMHSUS	PPS Cost-Based Rate	NY OASAS - Oral Medication Administration, direct observation
H0049	OMHSUS	PPS Cost-Based Rate	NY OMH - Alcohol and/or Drug Screening
H0049	OMHSUS	PPS Cost-Based Rate	NY OASAS - SUD Screening - assessment tool - 15 min
H0050	OMHSUS	PPS Cost-Based Rate	NY OMH - Alcohol and/or Drug, brief intervention - 15 min
H0050	OMHSUS	PPS Cost-Based Rate	NY OASAS - SUD Intervention - 15 min
S9480	OMHSUS	PPS Cost-Based Rate	Intensive Outpatient Services
T1502	OMHSUS	PPS Cost-Based Rate	Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit
T1006	OMHSUS	PPS Cost-Based Rate	NY OASAS - Family / Couple Counseling - 30 min

99381-99387	PCSM	PPS Cost-Based Rate	Health Physicals, New Patient
99391-99397	PCSM	PPS Cost-Based Rate	Health Physicals, Established Patient
99401	PCSM	PPS Cost-Based Rate	NY OMH - Health Monitoring - 15 min
99402	PCSM	PPS Cost-Based Rate	NY OMH - Health Monitoring - 30 min
99403	PCSM	PPS Cost-Based Rate	NY OMH - Health Monitoring - 45 min
99404	PCSM	PPS Cost-Based Rate	NY OMH - Health Monitoring - 60 min
99411	PCSM	PPS Cost-Based Rate	NY OMH - Health Monitoring Group - 30 min
99412	PCSM	PPS Cost-Based Rate	NY OMH - Health Monitoring Group - 60 min
99406	PCSM	PPS Cost-Based Rate	NY OMH - Smoking Cessation Treatment - 3-10 min
99406	PCSM	PPS Cost-Based Rate	NY OASAS - Smoking Cessation, Individual - 3-10 min
99407	PCSM	PPS Cost-Based Rate	NY OMH - Smoking Cessation Treatment > 10 min
99407	PCSM	PPS Cost-Based Rate	NY OASAS - Smoking Cessation, Individual - 11+ minutes
99407HQ	PCSM	PPS Cost-Based Rate	NY OMH - Smoking Cessation Treatment (Group) > 10 min
H0038	PEER	PPS Cost-Based Rate	Self-Help / Peer Advocate Services - per 15 min - on-site or off-site
H0038HQ	PEER	PPS Cost-Based Rate	Peer-Led Group Services
H2014	PEER	PPS Cost-Based Rate	Skills Training and Development - per 15 min
G0176	PRS	PPS Cost-Based Rate	Activity Therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session - 45 min
H2017	PRS	PPS Cost-Based Rate	NY OMH - Psychosocial Rehab Services - per 15 min
H2017	PRS	PPS Cost-Based Rate	NY OMH - Psychosocial Rehab Services - Ind. - on-site; Modifier U1
H2017	PRS	PPS Cost-Based Rate	NY OMH - Psychosocial Rehab Services - Ind. - off-site; Modifier U2
H2017	PRS	PPS Cost-Based Rate	NY OMH - Psychosocial Rehab Services- Group 2-3;Modifier UN or UP
H2017	PRS	PPS Cost-Based Rate	NY OMH - Psychosocial Rehab Services- Group 4-5;Modifier UQ or UR
H2017	PRS	PPS Cost-Based Rate	NY OMH - Psychosocial Rehab Services - Group 6-10; Modifier US
H2018	PRS	PPS Cost-Based Rate	NY OMH - Psychosocial Rehab Services - Ind. - Per Diem
H2023	PRS	PPS Cost-Based Rate	Intensive Supported Employment Services
H2025	PRS	PPS Cost-Based Rate	Ongoing Supported Employment Services - per 15 min.
T2015	PRS	PPS Cost-Based Rate	Pre-Vocational Services
90791	SADRA	PPS Cost-Based Rate	NY OMH - Initial Assessment Diagnostic & Treatment Plan
90792	SADRA	PPS Cost-Based Rate	NY OMH - Initial Assessment Diagnostic & Treatment Plan with Medical Services
96101	SADRA	PPS Cost-Based Rate	NY OMH - Psychological Testing - various
96110	SADRA	PPS Cost-Based Rate	NY OMH - Developmental Screening, with Scoring and Documentation, per Standardized Instrument
96111	SADRA	PPS Cost-Based Rate	NY OMH - Developmental Testing, with Interpretation and Report
96116	SADRA	PPS Cost-Based Rate	NY OMH - Psychological Testing - neurobehavioral
96118	SADRA	PPS Cost-Based Rate	NY OMH - Psychological Testing - various
99341	SADRA	PPS Cost-Based Rate	NY OMH - Home Visit, New Pt, low severity problem - 20 min
99342	SADRA	PPS Cost-Based Rate	NY OMH - Home Visit, New Pt, moderate severity problem - 30 min
99347	SADRA	PPS Cost-Based Rate	NY OMH - Home Visit, Established Pt, self-limited or minor problem - 15 min
99348	SADRA	PPS Cost-Based Rate	NY OMH - Home Visit, Established Pt, low to moderate problem - 25 min
H0001	SADRA	PPS Cost-Based Rate	NY OASAS - Assessment Normative - Pre-Admission - 30 min
H0002	SADRA	PPS Cost-Based Rate	NY OASAS - Assessment Extended - Pre-Admission - 75 min
H2000	SADRA	PPS Cost-Based Rate	Child and Adolescent Needs Survey (CANS)
T1023	SADRA	PPS Cost-Based Rate	NY OASAS - Assessment Brief, Pre-Admission - 15 min
H0006	TCM	PPS Cost-Based Rate	Alcohol and/or Drug Services; Case Management
T1016	TCM	PPS Cost-Based Rate	Case Management - per 15 min

V. CCBHC / MCO Care Coordination Workflow

- The managed care organization (MCO) receives notification from the inpatient facility of an admission.
    - Emergent admission 24 hours
    - Elective admission 48 hours
    - SUD detox 48 hours
        - Note plan time frames may vary slightly

- Inpatient provider creates s a treatment plan for inpatient stay
    - Current issue leading to admission
    - Other issues to address while in the program
    - Begin a discharge plan which is focused on current needs and prior treatment/social support experiences
    - Provide LOCADTR for SUD admission

- Concurrent review continues throughout the stay
    - Time between reviews is based on clinical need and expectation
    - Refining discharge plan a core part of each review
    - Relevant clinical information is shared ie. history of diagnoses (medical and BH), history of treatment, outpatient provider(s), treatment in CCBHC, Health Home eligibility/enrollment status/contact info

- On day of discharge facility is expected to notify MCO of discharge
    - Including but not limited to updated demographics, detailed information on the follow appointment(s) (BH and PH), dc meds

- MCO Case management is a part of all initial post hospital follow up
    - Focuses on engaging in ongoing outpatient care
    - Addresses gaps in care both general medical and behavioral
    - Coordinates with community based care management if applicable (HH)
    - Care management areas of focus
        - Ensuring member engages with behavioral health provider
        - Works to connect member with PCP for general medical follow up (At least 50-60% of these members have unmet needs) – this may also involve engaging an MCO general medical case manager
        - Promotes connectivity to community and social service agencies

- Post discharge outreach
    - Member of the MCO case management team outreaches member in order to
        - Ensure member know about their first follow up appointment and can get there
        - Work to ensure providers are updated as to status of member

- Post discharge MCO case management
    - Length of involvement will depend on ongoing need, risk stratification of member and level of their engagement with community providers
    - There is no specific time frame but MCOs should have criteria for continuation or discontinuation of case management

- CCBHC specific items
    - The above to management of all inpatient admissions
    - Key goal for members seen in CCBHC is that they re-connect with CCBHCMCOs and CCBHCs along with OMH support need to maintain as up to date as possible rosters of members being treated in CCBHC

- CCBHC member admitted
    - Processes above are the same
    - MCO will notify IP facility of member's connection to CCBHC
      MCO will work with IP facility and CCBHC to connect the 2 groups to jointly develop a discharge plan
    - Coordination of plan and ensuring care gaps are a part of the plan is a function of the MCO
    - Working alongside the CCBHC MCO and CCBHC will decide how case management will be done (CCBHC will provide or MCO)
    - MCO CM will remain engaged until there is evidence of member's reconnection to CCBHC
    - MCO may choose to have processes in place within or outside CCBHC to ensure a clinical visit occurs within 7 days and 30 days of discharge
    - If Health Home Care manager is involved, MCO will include HHCM in all coordination activities

VI. CCBHC OASAS / OMH Joint Consent to Release Information Form

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES
OFFICE OF MENTAL HEALTH

CONSENT TO RELEASE INFORMATION
Certified Community Behavioral Health Clinic
Alcoholism/Substance Use or Mental Health Patient

Revoked On:_____ Staff Initials:_____

Patient's Last Name	First	M.I.
Case Number		
CCBHC Facility	Unit	

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED

Information to be exchanged among and between my Certified Community Behavioral Health Clinic (CCBHC), as named above, my Designated Collaborating Organization(s) (DCOs) _____ _____ (if applicable) and my Managed Care Organization (MCO) _____, which might include, (if applicable) information related to crisis intervention/stabilization; outpatient mental health and/or substance use services; HIV/AIDS status and treatment; screening, assessment and diagnosis; treatment planning; physical health screening; care management; psychiatric rehabilitation services; peer and family support; community based mental health care for veterans and members of the armed forces.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION.

Information may be exchanged among my CCBHC, DCOs and MCO for the purpose of treatment, payment and care coordination.

Information will be disclosed to NYS Department of Health (DOH), Office of Alcoholism and Substance Abuse Services (OASAS) and Office of Mental Health (OMH) for purposes of payment and statistical reporting requirements.

I, the undersigned, have read the above and authorize my CCBHC, DCO and MCO named above to disclose and obtain such information as herein specified.

I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within twelve (12) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164 and New York mental Hygiene Law § 33.13 ; and that redisclosure of this information to a party other than those designated above is forbidden without additional written authorization on my part.

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form.

_____ (Signature of Patient)

_____ (Print Name of Patient)

_____ (Date)

_____ (Signature of Parent/Guardian)

_____ (Print Name of Parent/Guardian)

_____ (Date)

VII. CCBHC Fee for Service Complaints Workflow

- A member writes a letter or calls a managed care plan's member services hotline to advise they would like to initiate a complaint. The complaint is initiated and pertinent member information is gathered.

- The plan assesses if the complaint is 'access to care,' 'quality of care,' or 'administrative' in nature.

- If the member's complaint is related to 'access to care' then the plan should offer information on referrals to alternative in-network providers to access the requested services.

- If the member's complaint relates to a service covered by the plan then the complaint should be transferred to the plan's internal quality or complaints divisions to be further investigated.

- If the member's complaint relates to a non-covered service (which the CCBHC services currently are under the 1147 rate code) then the misdirected FFS complaint should be re-directed to the DOH Consumer Helpline (1-800-541-2831). The plan will then document the complaint was re-directed to DOH and that no further action is required on behalf of the plan.

- Once DOH receives the complaint, either via a warm call transfer from the plan or the client calling the Helpline directly, the Helpline associate should follow standard procedures to initiate the complaint.

- The Helpline associate should assess if the complaint is primarily regarding a substance abuse service or a mental health service then warm transfer the call to the respective governing agency (OASAS at 518-473-3460 or OMH at 1-800-597-8481). Since the CCBHC clinics are IOS licensed if the Helpline associate is not able to determine the nature of the complaint then the call should be transferred to OMH to further investigate. The Helpline associate will then document the complaint was re-directed to OASAS or OMH and that no further action is required on behalf of DOH.

- Once the OASAS or OMH customer service unit receives the complaint, either via a warm call transfer from DOH or the client calling the customer service unit directly, the customer service associate should follow standard procedures to initiate and process the complaint.

- If the complaint is relevant to the CCBHC, either due to the client identifying the service as a CCBHC service or because the service was provided at a CCBHC demonstration site, the OASAS or OMH customer service representative should inform the CCBHC

OMH staff (led by Don Zalucki) as the complaint information may need to be included into the CCBHC demonstration data reporting.

- If the client advises they were directed to call OASAS or OMH by their managed care plan then the OASAS or OMH customer service associate should also communicate the resolution of the complaint to the client's managed care plan in order to complete the chain of communication.

VIII. Specifications for DOH Fee-for-Service Claims Data Report

Description of Claim File Sharing Initiative

Population	• New and existing Medicaid managed care enrollees identified using the NYS DOH Managed Care Organization (MCO) enrollee roster data file.
Health Plans Types	• HMO/PHSP • HIV SNP • MLTC
Time Frames / Periodicity	• Extracted on the 1st of each month and transmitted routinely pending the completion of an attestation by a plan representative on behalf of the health plan. • New enrollees: six months of claim history, including pharmacy • Existing enrollees: previous month of claims, including pharmacy
Method of Transmission	• Secure File Transfer Utility located on the MEDS III Home Page on the Health Commerce System (HCS) • Text (.txt) file format
Data Elements (File format and descriptions on next page)	• Claim Transaction ID • Original Claim Reference Number • Recipient Identification Number • Eligibility Description • New Enrollee Indicator • Health Plan MMIS Identification Number • Plan Name • Claim Service Date • Claim Payment Date • Claim Admission Date • Inpatient Discharge Date • Billing Provider ID • Billing Provider NPI • Billing Provider Name • Category of Service • Provider Specialty Code • Rate Code • Unit Quantity • DRG Code • Place of Service • Procedure Code • Sequence Identification Number • Diagnosis Codes (up to 25) • National Drug Code / Product • Pharmacy Quantity Dispensed • Drug Days Supply Count • Tooth Number • Procedure Modifier Code • ICD Version Code (up to 25)
Reference Files Available for Download	• Category of Service • Place of Service • Provider Specialty Code • Rate Code
Excluded Data	• Paid Supplemental Services (e.g., GME and FQHC Supplemental Payments) • Capitation Claims • COPS Payments

Contact Information	Provider Network and MEDS Data Compliance Unit Bureau of Managed Care Fiscal Oversight Division of Health Plan Contracting and Oversight Email: omcmeds@health.ny.gov Phone: (518)474-5050 Fax: (518)486-7899 MEDS III Home Page on the Health Commerce System (HCS): https://commerce.health.state.ny.us/hpn/ctrldocs/medsrpts/index.html

Variable Name	Data Element	Record Position	Variable Type and Length	Description
Claim Transaction ID	CLAIM_TRANS_ID	1-15	Num 15	Claim Transaction Identifier is a New York State generated ID used to identify a unique claim Transaction record.
Original Claim Reference Number	ORIG_CRN	26-41	Char 16	This element specifies the Claim Reference Number (CRN) of the original claim replaced due to an adjustment. Found on Paid Claims only.
Recipient Identification Number	CIN	43-50	Char 8	Unique Medicaid recipient identification number.
Eligibility Description	MEG_DESC	52-71	Char 20	Description of the Medicaid eligibility category of the recipient.
New Indicator	NEW_IND	73	Num 1	NEW_IND indicates whether an enrollee is a new managed care enrollee (1) or an existing managed care enrollee (0).
Health Plan MMIS Identification Number	PLAN_ID	75-82	Char 8	The eight digit MMIS Identification Number for the Health Plan.
Health Plan Name	PLANNAME	84-111	Char 28	Name of the Medicaid Managed Care health plan the recipient is enrolled in.
Claim Service Date	SERVICE_DATE	113-121	Date9	Claim Service Date is the first date that a service on a claim or claim line was rendered.
Claim Payment Date	PAYMENT_DATE	123-131	Date9	Claim Payment Date is the date upon which a payment instrument (Electronic Funds Transfer (EFT) or check) was generated for a claim transaction.
Claim Admission Date	ADMIT_DATE	133-141	Date9	Claim Admission Date is the date that a recipient was admitted to a medical institution for inpatient, outpatient or residential care.
Inpatient Discharge Date	DISCH_DATE	143-151	Date9	Date on which recipient was released from hospital.
Billing Provider MMIS Identification Number	BILLING_PROV_ID	153-160	Char 8	Provider Identification Number is a unique number assigned to each provider enrolled to provide services to clients of the Medicaid program.
Provider NPI	BILLING_PROV_NPI	162-171	Char 10	National Provider Identifier (NPI) is a standard unique identifier for health care providers.

Variable Name	Data Element	Record Position	Variable Type and Length	Description
Billing Provider Name	BILLING_PROV_NAME	173-207	Char 35	Provider Name is the name of a provider of Medicaid services as used on official State records.
Category of Service	SURS_COS_CODE	209-210	Char 2	Category of Service code derived from billing data (Claim Type and Provider Category of Service) in a claim or encounter record.
Provider Specialty Code	SPECIALTY_CODE	212-214	Char 3	Provider Specialty Code identifies the medical specialty for which a provider is certified.
Rate Code	RATE_CODE	216-219	Char 4	Rate Code specifies a medical service or product that utilizes a rate reimbursement technique under eMedNY.
Unit Quantity	UNIT_QUANTITY	221-235	Num 15.3	The units (e.g. days, visits, miles, injections) of a procedure rendered to a recipient.
DRG Code	DRG_CONTROL_CODE	237-240	Char 4	Diagnosis Related Group (DRG) Code specifies the group of services received by a recipient during an inpatient stay.
Place of Service	PLACE_OF_SERVICE	242-243	Char 2	Claim Place of Service Code identifies the places where a service was or may be rendered by a provider.
Procedure Code	PROC_CODE	245-251	Char 7	Procedure Code uniquely identifies a service rendered by a provider.
Sequence Identification Number	SEQ_ID	253-255	Num 3	SEQ_ID is a New York State assigned data element that determines the incremental number of procedures within a unique VISIT_ID.
Diagnosis Code, Sequence 1	DX_CODE_1	257-266	Char 10	Claim Diagnosis Code indicates any significant condition which affects treatment and/or length of stay.
Diagnosis Code, Sequence 2	DX_CODE_2	268-277	Char 10	
Diagnosis Code, Sequence 3	DX_CODE_3	279-288	Char 10	
Diagnosis Code, Sequence 4	DX_CODE_4	290-299	Char 10	
Diagnosis Code, Sequence 5	DX_CODE_5	301-310	Char 10	
Diagnosis Code, Sequence 6	DX_CODE_6	312-321	Char 10	
Diagnosis Code, Sequence 7	DX_CODE_7	323-332	Char 10	
Diagnosis Code, Sequence 8	DX_CODE_8	334-343	Char 10	
Diagnosis Code, Sequence 9	DX_CODE_9	345-354	Char 10	
Diagnosis Code, Sequence 10	DX_CODE_10	356-365	Char 10	
Diagnosis Code, Sequence 11	DX_CODE_11	367-376	Char 10	
Diagnosis Code, Sequence 12	DX_CODE_12	378-387	Char 10	
Diagnosis Code, Sequence 13	DX_CODE_13	389-398	Char 10	
Diagnosis Code, Sequence 14	DX_CODE_14	400-409	Char 10	
Diagnosis Code, Sequence 15	DX_CODE_15	411-420	Char 10	
Diagnosis Code, Sequence 16	DX_CODE_16	422-431	Char 10	
Diagnosis Code, Sequence 17	DX_CODE_17	433-442	Char 10	
Diagnosis Code, Sequence 18	DX_CODE_18	444-453	Char 10	
Diagnosis Code, Sequence 19	DX_CODE_19	455-464	Char 10	
Diagnosis Code, Sequence 20	DX_CODE_20	466-475	Char 10	
Diagnosis Code, Sequence 21	DX_CODE_21	477-486	Char 10	

Variable Name	Data Element	Record Position	Variable Type and Length	Description
Diagnosis Code, Sequence 22	DX_CODE_22	488-497	Char 10	
Diagnosis Code, Sequence 23	DX_CODE_23	499-508	Char 10	
Diagnosis Code, Sequence 24	DX_CODE_24	510-519	Char 10	
Diagnosis Code, Sequence 25	DX_CODE_25	521-530	Char 10	
National Drug Code/Product Code	NDC	532-542	Char 11	An 11-digit national drug identification number assigned by the Federal Drug Administration (or the HCPCS code) used to identify Durable Medical Equipment, Hearing Aids, OTC medications or other pharmacy products without an NDC code.
Pharmacy Quantity Dispensed	Quantity_Dispensed	544-556	Num 13.3	Quantity Dispensed is the quantity of a drug as submitted on a claim form. The dispensing quantity is based upon the unit of measure as defined by the National Drug Code (formerly called NDC Units).
Drug Days Supply Count	Days_Supply	558-567	Num 10	Drug Days Supply Count specifies the number of days supply dispensed with the prescription service.
Tooth Number	Tooth	569-570	Char 2	Dental Site Code specifies a tooth, oral cavity, quadrant, or arch.
Procedure Modifier Code	Proc_Modifier_Code	572-573	Char 2	Procedure Modifier Code is used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider.
ICD Version Code, Sequence 1	ICD_VER_CD_1	575	Char 1	The ICD Version code of the respective diagnosis code. 0 = ICD Version 9 1 = ICD Version 10
ICD Version Code, Sequence 2	ICD_VER_CD_2	577	Char 1	
ICD Version Code, Sequence 3	ICD_VER_CD_3	579	Char 1	
ICD Version Code, Sequence 4	ICD_VER_CD_4	581	Char 1	
ICD Version Code, Sequence 5	ICD_VER_CD_5	583	Char 1	
ICD Version Code, Sequence 6	ICD_VER_CD_6	585	Char 1	
ICD Version Code, Sequence 7	ICD_VER_CD_7	587	Char 1	
ICD Version Code, Sequence 8	ICD_VER_CD_8	589	Char 1	
ICD Version Code, Sequence 9	ICD_VER_CD_9	591	Char 1	
ICD Version Code, Sequence 10	ICD_VER_CD_10	593	Char 1	
ICD Version Code, Sequence 11	ICD_VER_CD_11	595	Char 1	
ICD Version Code, Sequence 12	ICD_VER_CD_12	597	Char 1	
ICD Version Code, Sequence 13	ICD_VER_CD_13	599	Char 1	
ICD Version Code, Sequence 14	ICD_VER_CD_14	601	Char 1	
ICD Version Code, Sequence 15	ICD_VER_CD_15	603	Char 1	
ICD Version Code, Sequence 16	ICD_VER_CD_16	605	Char 1	
ICD Version Code, Sequence 17	ICD_VER_CD_17	607	Char 1	
ICD Version Code, Sequence 18	ICD_VER_CD_18	609	Char 1	
ICD Version Code, Sequence 19	ICD_VER_CD_19	611	Char 1	
ICD Version Code, Sequence 20	ICD_VER_CD_20	613	Char 1	
ICD Version Code, Sequence 21	ICD_VER_CD_21	615	Char 1	
ICD Version Code, Sequence 22	ICD_VER_CD_22	617	Char 1	
ICD Version Code, Sequence 23	ICD_VER_CD_23	619	Char 1	
ICD Version Code, Sequence 24	ICD_VER_CD_24	621	Char 1	
ICD Version Code, Sequence 25	ICD_VER_CD_25	623	Char 1	

IX. CCBHC Site Locations

Taxpayer_ID	CCBHC_NAME	SITE_NAME	ST_ADDRESS	CITY_NY	MMI	NPI	ZIPCODE	LOC_CODE
133211807	BIKUR CHOLIM	Bikur Cholim Center for Behavioral Health	25 Robert Pitt Drive Suite 101	Monsey	2497721	1386705119	10952-3366	003
133211807	BIKUR CHOLIM	Bikur Cholim Center for Behavioral Health - 59	404 Route 59	Airmont	2497721	1386705119	10952-3429	004
112438388	CENTRAL NASSAU GUIDANCE AND COUNSELING SERVICES	Central Nassau Guidance and Counseling Services, Inc.	950 South Oyster Bay Road	Hicksville	00383477	1114928462	11801-3510	
112438388	CENTRAL NASSAU GUIDANCE AND COUNSELING SERVICES	Central Nassau Guidance and Counseling Services, Inc.	55 West Ames Court, Suite 100	Plainview	00383477	1114928462	11801-3510	
141577715	CITIZEN ADVOCATES	Malone Behavioral Health Center	209 Park Street	Malone	01111260	1780619064	12953-1228	
141577715	CITIZEN ADVOCATES	Saranac Lake Behavioral Health Center	70 Edgewood Rd.	Saranac Lake	01111260	1780619064	12983-1537	
141577715	CITIZEN ADVOCATES	Tupper Lake Satellite	114 Wawbeek Ave	Tupper Lake	01111260	1780619064	12986-2038	
141577715	CITIZEN ADVOCATES	Tupper Lake Middle/High School Satellite	25 Chaney Ave	Tupper Lake	01111260	1780619064	12986-1837	
141577715	CITIZEN ADVOCATES	LP Quinn Elementary School Satellite	294 Hosley Ave	Tupper Lake	01111260	1780619064	12986-1555	
141577715	CITIZEN ADVOCATES	Saranac Lake School Satellite	79 Canaras Ave	Saranac Lake	01111260	1780619064	12983-1537	
141577715	CITIZEN ADVOCATES	Malone Middle School Satellite	15 Francis St	Malone	01111260	1780619064	12953-1807	
141577715	CITIZEN ADVOCATES	Davis Elementary School Satellite	183 Webster St	Malone	01111260	1780619064	12953-2226	
141577715	CITIZEN ADVOCATES	Flanders Elementary School Satellite	524 E Main St	Malone	01111260	1780619064	12953-2029	
141577715	CITIZEN ADVOCATES	St Joseph's Elementary School Satellite	99 Elm St	Malone	01111260	1780619064	12953-1519	
141577715	CITIZEN ADVOCATES	Franklin Academy School Satellite	42 Huskie Lane	Malone	01111260	1780619064	12953-2451	
141577715	CITIZEN ADVOCATES	Chateaugay School Satellite	42 River St	Chateugay	01111260	1780619064	12920-2002	
141577715	CITIZEN ADVOCATES	Brushton Moira School Satellite	758 County Rt 7	Brushton	01111260	1780619064	12916-3916	
161004090	LAKE SHORE BEHAVIORAL HEALTH	Lake Shore Behavioral Health, Inc.; Lower West Side Counseling	951 Niagara Street	Buffalo	00671765	1023230695	14213-2116	003
161004090	LAKE SHORE BEHAVIORAL HEALTH	Lake Shore Behavioral Health, Inc.; Abbott Corners Counseling	3176 Abbott Road	Orchard Park	00671765	1023230695	14127-1069	008

161004090	LAKE SHORE BEHAVIORAL HEALTH	Lake Shore Behavioral Health, Inc.; Linwood Community Services	625 Delaware Avenue, Suite 204	Buffalo	00671765	1023230695	14202-1007	011
161004090	LAKE SHORE BEHAVIORAL HEALTH	Lake Shore Behavioral Health, Inc.; Franklin Counseling	254 Franklin Street, 2nd Floor	Buffalo	00671765	1023230695	14202-1954	019
161004090	LAKE SHORE BEHAVIORAL HEALTH	Lake Shore Behavioral Health, Inc.; North Collins Counseling	2107 Spruce Street	North Collins	00671765	1023230695	14111-9701	009
161004090	LAKE SHORE BEHAVIORAL HEALTH	Lake Shore Behavioral Health, Inc.; Health Mall Counseling	1500 Broadway Street	Buffalo	00671765	1023230695	14212-1845	020
161004090	LAKE SHORE BEHAVIORAL HEALTH	Lake Shore Behavioral Health, Inc.; Delaware Park Community Counseling	95 W. Humboldt Parkway	Buffalo	00671765	1023230695	14214-2604	024
161004090	LAKE SHORE BEHAVIORAL HEALTH	Lake Shore Behavioral Health, Inc.; OnTrack@LSBH	255 Delaware Avenue, Suite 400	Buffalo	00671765	1023230695	14202-2016	021
161017709	MID-ERIE MENTAL HEALTH SERVICES	Walden Avenue Clinic, AMH, CMH,CD	1526 Walden Avenue	Cheektowaga	2994796	1225095201	14225-4985	
161017709	MID-ERIE MENTAL HEALTH SERVICES	Center for Self Development, Forensic Services	1131 Broadway	Buffalo	2994796	1225095201	14212-1501	
161017709	MID-ERIE MENTAL HEALTH SERVICES	Towne Garden Clinic	463 William Street	Buffalo	2994796	1225095201	14202-1181	
161017709	MID-ERIE MENTAL HEALTH SERVICES	Lancaster Satellite	5360 Genesee Street, Suite 200	Bowmansville	2994796	1225095201	14026-1044	
161017709	MID-ERIE MENTAL HEALTH SERVICES	Health Mall Children's Clinic	1500 Broadway	Buffalo	2994796	1225095201	14212-1845	
161017709	MID-ERIE MENTAL HEALTH SERVICES	Baker Victory Residential Satellite	125 Martin Road	Lackawanna	2994796	1225095201	14218-2707	
161017709	MID-ERIE MENTAL HEALTH SERVICES	Baker Victory Outpatient satellite	650 Ridge Road	Lackawanna	2994796	1225095201	14218-1435	
161017709	MID-ERIE MENTAL HEALTH SERVICES	Gateway-Longview Residential Satellite	6350 Main Street	Williamsville	2994796	1225095201	14221-5821	
161017709	MID-ERIE MENTAL HEALTH SERVICES	Main Pediatrics Satellite	2924 Main Street	Buffalo	2994796	1225095201	14214-1720	
161017709	MID-ERIE MENTAL HEALTH SERVICES	Cleveland Hill Family Resource Center	3660 Harlem Road, Room 2	Cheektowaga	2994796	1225095201	14215-2014	
161017709	MID-ERIE MENTAL HEALTH SERVICES	Bennett park Montessori #32 Satellite	342 Clinton Street, Room 111	Buffalo	2994796	1225095201	14204-1755	
161017709	MID-ERIE MENTAL HEALTH SERVICES	School 82 Satellite; aka Early Childhood Center #82	230 Easton Avenue, Room 102C	Buffalo	2994796	1225095201	14215-1845	
161017709	MID-ERIE MENTAL HEALTH SERVICES	School 74, Hamlin Park Satellite	126 Donalson Road, Room 209	Buffalo	2994796	1225095201	14208-1629	

112593090	NEW HORIZON COUNSELING CENTER, INC.	Ozone Park Clinic	108-19 Rockaway Blvd.	South Ozone Par	00688220	1366430563	11420-1034	
112593090	NEW HORIZON COUNSELING CENTER, INC.	Far Rockaway Clinic	718-720 Beach 20th Street	Far Rockaway	00688220	1366430563	11691-3502	
112593090	NEW HORIZON COUNSELING CENTER, INC.	West Rockaway Clinic	88-02 Rockaway Beach Blvd.	Rockaway Beach	00688220	1366430563	11693-1608	
132663328	PROMESA	Westchester Center of Excellence	915 Westchester Avenue	Bronx	2892868	1295911063	10459-3009	
112635374	SAMARITAN DAYTOP VILLAGE	Independence Outpatient	2776-2778 3rd Avenue	Bronx	00245309	1396282839	10455-4029	
112635374	SAMARITAN DAYTOP VILLAGE	New Beginnings Mental Health	2780 3rd Avenue	Bronx	00245309	1396822839	10455-4029	
161019944	SPECTRUM	City Center Counseling	1280 Main Street	Buffalo	3005176	1487601837	14209-1912	
161019944	SPECTRUM	South Buffalo Counseling Center	2040 Seneca Street	Buffalo	3005176	1487601837	14210-2339	
161019944	SPECTRUM	South Towns Counseling Center	326 Orchard Park Road	West Seneca	3005176	1487601837	14224-2635	
161019944	SPECTRUM	Springville Counseling Center	27 Franklin	Springville	3005176	1487601837	14141-1314	
161019944	SPECTRUM	Spectrum's WyCo Counseling Center	34 North Main Street	Warsaw	3005176	1487601837	14569-1209	
161019944	SPECTRUM	Spectrum's Allentown Ped Counseling	560 Franklin Avenue	Buffalo	3005176	1487601837	14202-1309	
161019944	SPECTRUM	Spectrum's Southgate Counseling	1026 Union Road	West Seneca	3005176	1487601837	14224-3445	
161019944	SPECTRUM	Oak Orchard	81 South Main Street	Warsaw	3005176	1487601837	14569-1326	
160743209	STRONG MEMORIAL HOSPITAL, UNIVERSITY OF ROCH	SR Chemical Dependency Clinic	2613 West Henrietta Road	Rochester	00279034	1346285657	14623-2327	
160743209	STRONG MEMORIAL HOSPITAL, UNIVERSITY OF ROCH	Crisis Therapy Services Clinic	2613 West Henrietta Road	Rochester	00279034	1346285657	14623-2327	
160743209	STRONG MEMORIAL HOSPITAL, UNIVERSITY OF ROCH	Strong Ties	2613 West Henrietta Road	Rochester	00279034	1346285657	14623-2327	
160743209	STRONG MEMORIAL HOSPITAL, UNIVERSITY OF ROCH	SR Opiate Treatment Program	2613 West Henrietta Road	Rochester	00279034	1346285657	14623-2327	
160743209	STRONG MEMORIAL HOSPITAL, UNIVERSITY OF ROCH	Child & Adolescent Outpatient Clinic	315 Science Parkway	Rochester	00279034	1346285657	14620-4257	
112540650	SERVICES FOR THE UNDERSERVED (SUS)	Wellness Works CCBHC- Recovery Center	1125 Fulton Street, 2 & 3 floors	Brooklyn	3422626	1053696195	11238-2669	
150532288	SYRACUSE BEHAVIORAL HEALTH CARE	SBH Behavioral Healthcare, Integrated Outpatient Services	329 N. Salina Street	Syracuse	0689712	1609892280	13203-1755	
150532288	SYRACUSE BEHAVIORAL HEALTH CARE	SBH Behavioral Healthcare	329 N. Salina Street	Syracuse	0689712	1609892280	13203-1755	
133224700	VIP (VOCATIONAL INSTRUCTION PROJECT SERVICES, INC.)	VIP Community Services	1910 Arthur Ave	Bronx	0828919	1881733830	10457-6305	

X. MCO FAQ Document

Topic	Priority	Question	OMH/OASAS Response
Implementation Timeframe	**High**	Need additional details and answers to questions below to make a determination on the timeframe of implementation. With no information, plans cannot determine how long it will take to reconfigure systems – or even whether they will be able to at all.	As indicated below, plan system reconfigurations will be very minimal, and plans should have no trouble configuring their systems on time.
Plan Reimbursement	**High**	1. Would the MCO rate be adjusted to reflect the additional administrative expense of dealing with this carve-out and the additional burden of trying to integrate and manage care for members when multiple BH services are now carved out?	No.
Reimbursement Model	**High**	2. We need clarification as to whether the identified 13 providers will have separate NPIs? Should MCOs deny claims by NPI or deny by those specific 9 core CCBHS services?	Plans should deny services based on the CCBHC Rate Code (1147). The NPI numbers associated with these providers will (in most instances) continue to be associated with services for which the plans will remain responsible.
		3. Please confirm that all members receiving any of the 9 core services will be billed FFS claims (not submit claims to MCO).	Plans will continue to receive claims for members receiving services from providers who are not designated as a CCBHC. Plans will continue to be financially responsible for these services and should compensate providers for providing them. Plans should pay any appropriate bill that does not include the CCBHC Rate Code (1147).
		4. OMH needs to identify specific service codes that will be impacted. Please provide additional information related to CCBHC billing requirements from MCO perspective.	The only requirement for MCOs will be to deny the bills they receive with the CCBHC Rate Code (1147).
		5. There are certain services listed as services that need to be offered by the provider. We need the rate codes and CPT codes for these services. Screening, assessment and diagnosis are supposed to be covered by the CCBHC. Does this mean SBIRT services billed by these providers are carved out? Are all outpatient MH and SUD services, ACT, PROS, etc. carved out?	ONLY CCHBC services (Rate Code 1147) are carved out. Plans remain financially responsible for all MH and SUD services that are not included in the CCBHC demonstration. Other services provided by the CCBHC providers (regardless where those services are provided) that are medically necessary (including ACT, PROS, SBIRT, etc.) remain the financial responsibility of the plan. Plans are financially responsible for services provided by their network providers to their members **unless** those services are provided under a CCBHC Rate Code (1147).
		6. Are all services offered by the provider listed as a CCBHC provider carved out of Managed Care? For example: If Provider XXXX offers ACT and is part of CCBHC, is ACT then carved out?	No. ONLY CCBHC services (Rate Code 1147) are carved out. All other medical, surgical and behavioral health services remain the financial responsibility of the plan.
		7. If all services or services at a particular location are carved out, how soon can we get this list from the providers? We will need this to start our configuration process.	Only CCBHC services will be carved out. There may be other services provided by the provider at the same location for which the plan will remain financially responsible. Plans will know that the bill is for a carved-out service because it will have the CCBHC Rate Code (1147) on it.
		8. We need each facility to list their affiliated organizations or Designated Collaborating Organizations (DCOs), if any. Please include the NPI and services that will be provided by DCOs. Please clarify who is responsible for payment of DCOs services (CCBHC or MCO). If DCO services are billed to the MCO, we need to clarify if any require prior authorization.	Whether the service is provided directly by the CCBHC or by the DCO, the CCBHC will submit the bill for the service. Plans will know that the service is carved out because the bill will have the CCBHC Rate Code. Prior authorization from the plan will not be necessary because the plan will not be financially responsible for the services provided by the DCO. A DCO would never directly bill a plan or MMIS for any CCBHC services provided. The DCO would bill the CCBHC for reimbursement, and the CCBHC will bill MMIS. There are a limited number of DCO arrangements.

		9. If MCOs are not responsible for payment of DCOs claims, plans would need to set up the DCOs in their systems to deny services. How do plans ensure that CCBHC/DCO do not bill MCO and State for the same claim?	A DCO would never directly bill a plan or MMIS for any CCBHC services provided. The DCO would bill the CCBHC for reimbursement. Plans will remain financially responsible for non-CCBHC services provided to their members by providers under contract that may also serve as a CCBHC DCO. These bills will not have the CCBHC Rate Code, so plans will know that they are financially responsible for them. The state will establish a robust post audit to identify any duplicate claims. If a duplicate claim is identified the recovery will be from a the CCBHC for the PPS rate paid. The MCO claim payment will not be recovered if it is appropriate.
		10. If the CCBHC will be offering these services directly or through a DCO, will plans need to pay Health Homes for Care Management or pay for peer services if a member is HARP, HCBS eligible?	CCBHCs do not provide Health Home services. Plans will remain financially responsible for Health Home services. Plans will also remain financially responsible for any HCBS provided outside the context of a CCBHC. HCBS provided via a CCBHC will be billed under the CCBHC Rate Code (1147), and should be denied by plans.
		11. How will inpatient stays for members receiving outpatient services at the CCBHC be handled? Are plans responsible? Is it possible that CCBHCs enter into some kind of DCO relationship with a hospital and if so, are plans responsible for payment?	Plans will remain responsible for all inpatient stays for their members regardless whether the member receives services from a CCBHC or not. Inpatient is not a CCBHC service.
		12. If plans are unable to reconfigure systems, can they deny all outpatient services for these providers and then pay claims after they receive clarification from the state?	No.
		13. If plans mistakenly pay for services that are carved out, how long will they have to go back to recoup payment?	24 months.
		14. How does the carve-out of these providers/services impact plan progress toward VBP for behavioral health?	It does not. Similar to other services that are carved out (e.g., residential) a CCBHC could add value and potentially share upside savings.
Member's Benefit	**High**	15. Please confirm that this impacts members in Medicaid (MMC, HARP), Medicare (and integrated products including FIDA, MAP and PACE), Child Health Plus, the Essential Plan and Commercial products.	This impacts only Medicaid (MMC, HARP), FIDA, and PACE.
		16. The memo states that eligible plan enrollees are not required to participate in the demonstration program. Can the state advise how MMCs/HARPs will become aware of their members who are enrolled in the demonstration program?	Plans will be made aware that their members are being served by a CCBHC through a data feed/report that will be periodically provided by the state. Participating CCBHC providers will be required to communicate with MCOs concerning members' service utilization at the CCBHC. There is no specific enrollment into a CCBHC.
		17. We assume that there is no impact to members' benefits. Please confirm.	Correct.
		18. How does the State want us to refer if someone calls for authorization for these services?	CCBHC services require no prior authorization. Plans can instruct callers of this.
		19. Are eligible enrollees who reside out of the demonstration program service areas not eligible to enroll in the demonstration program? Once the services are carved out, will it only impact the regions that participated in the demonstration program?	Demonstration programs serve all members regardless the region of NYS in which they live. There is no formal enrollment in the CCBHC demonstration for individuals. Individuals requesting services will be assessed and provided care.
		20. Since plans cover inpatient services and in order to support care transitions, will plans need to have a BAA with the CCBHCs or will plans need to have their legal teams review to see if the current clinic contract is enough to share information?	Plans should have their legal teams review to ascertain if the current clinic contract is sufficient to enable information sharing.

		21. Does the carve-out extend to other services if the CCBHC refers the member to a specialist and/or approves a hospitalization?	No
		22. How would the MCO avoid/know of duplicate services if the member is in care of CCBHC provider. Please outline the notification process, if any. What's the mechanism to contact MCOs (fax, call, etc.)?	Plans will know because they will receive a data feed/report that will be periodically provided by the state.
		23. MCOs need clarifications on directory impact/changes and network adequacy measures since those services are carved-out (should they be listed, where members call if looking for referral? MCO or Provider?)	CCBHCs should be listed in plan directories.
Case Management	Medium	24. MCO needs clarification on exchange and notification on members that receive Case Management by CCBHCs to avoid duplication of Case Management by the MCO.	Plans will be made aware that their members are being served by a CCBHC through a data feed/report that will be provided by the state. Participating CCBHC providers will be required to communicate with MCOs concerning members' service utilization at the CCBHC. The state is drafting a model consent to be used by CCBHC providers to facilitate this exchange.
Complaints	Medium	25. Who is responsible to manage complaints? Since services are carved-out, we expect that complaints will be managed by the state and will not impact a plan's member satisfaction score.	It depends on the nature of the complaint. If the complaint is about the CCBHC, the state will handle it. If the complaint is about the plan or a non-CCBHC service, the plan will be responsible for it and it will impact the plan's member satisfaction score.
		26. Please provide workflow/process for misdirected complaints.	Process should be the same as other FFS Medicaid services.
Credentialing/ Contracting	Medium	27. We need clarification on credentialing requirements.	Plans are not responsible for credentialing CCBHC providers.
		28. How should a plan handle OON providers?	CCBHC services are carved out, so members can access them whether the CCBHC provider is in-network or not.
Encounter Data	Medium	29. Will there be data sharing between MCOs and the State (eg. high utilizers)? How is encounter information will be shared?	Yes. Plans will be made aware that their members are being served by a CCBHC through a data feed/report that will be periodically provided by the state.

		30. Will the utilization information be included within PSYCKES (also see question below)? If so, will plans be able to see services utilized given the 42 CFR Part 2 regulations as well?	Yes, utilization information will be included within PSYCKES. Consumer consent will be needed to share certain information. The state will be drafting a model consent to be used by CCBHC providers so that information can be shared with plans.
HEDIS follow-up after hospitalization for mental illness (FUH) reporting	Medium	31. MCOs need clarification on the process for FUH reporting to the plans. This change will also impact other BH HEDIS measures. As plans move to value based payment and new BH measures are implemented, the impact of CCBHC on those measurements for plans needs to be clarified.	Plans will be made aware that their members are being served by a CCBHC through a data feed/report that will be periodically provided by the state. Participating CCBHC providers will be required to communicate with MCOs concerning members' service utilization at the CCBHC.
		32. As carve out FFS, FUH aftercare claims will be invisible to MCOs until it's posted in PSYCKES, at which time plans have to manually follow up. a. Manually ID members who went to the CCBHC for aftercare b. Pull the page from PSYCKES member by member c. Submit the PSYCKES info manually as supplemental HEDIS data internal system	Not correct. The state will provide plans with this information.