Criteria FAQs

Use this document as a supplement to Criteria for the Demonstration Program manual.

Table of contents

Criteria FAQs 1
Table of contents 1
General Questions 1
Questions Regarding Scope of Services 2
Questions Regarding Screening and Assessment 4

General Questions

Q: We currently have a sliding fee schedule in place for our uninsured/underinsured population. How should this practice change in light of the CCBHC? Should we set up the prospective payment system (PPS) rate on a sliding fee schedule or continue to set up the individual services (IT, CM, etc.) on sliding fees? Are we allowed to collect sliding fees from individuals for CCBHC services?

CCBHCS are allowed to collect sliding fees from individuals seen for CCBHC services. The sliding fee scale must be consistent with locally prevailing rates or charges and designed to cover the site's reasonable costs of operation. In this case, it would not be permissible to have a separate fee schedule with higher rates than the clinic would charge other payers for the same services, for this population.

Clinics may use current sliding fee scales to the extent they meet all relevant CCBHC criteria.

Q: I am not seeing a specific frequency requirement regarding military cultural training (one time, annually, etc.). Is there a minimum requirement we need to meet?

There is not a specific frequency provided in the federal criteria or in state regulations. Staff who specifically work with veterans as part of internal programming to meet the needs of veterans within the community should have frequent and regular training. For all other staff, the expectation is for clinics to stay up to date with new and relevant trainings to ensure staff have the most up to date training.

Please visit the Veteran and Military Behavioral Health webpage to keep up to date with OHA resources.

Questions Regarding Scope of Services

Q: Are the primary care services associated with Oregon Standard 4 required to be provided by an RN or MD?

No. Primary care services are not required by an RN or MD; however, the provider must be operating within their scope and licensure.

Q: Does the Health Evidence Review Commission (HERC) prioritized list criteria (regarding diagnoses) apply to uninsured/underinsured individuals receiving CCBHC services?

No. The Prioritized List of Health Services only applies to coverage for Oregon Health Plan members.

Q: If we were to use CCBHC clinicians to provide services, and triage either to the community or refer to the CCBHC once stabilized, would the clinic as a whole need to follow all CCBHC guidelines? Or would these clinicians be able to operate similar to when we have therapists provide services in the community patient's home, or at school?

All CCBHC services must be provided to the standards and requirements outlined for CCBHCs whether the service is provided in the community or within the facility. These

standards and requirements do NOT replace existing standards; thus, clinics should provide services in accordance with the most stringent requirements applicable.

Q: 2.a.3 "Informed by the community needs assessment, the CCBHC provides services at locations that ensure accessibility and meet the needs of the population to be served, such as settings in the community (e.g., schools, social service agencies, partner organizations, community centers) and, as appropriate and feasible, in the homes of people receiving services." To clarify if the program is oriented from the main location, there is an expectation for community-based service delivery?

CCBCHCs are required and expected to offer services "outside of the four walls". While only staff tied to certified CCBHC locations may provide community-based services to trigger the prospective payment system (PPS) rate, services may be provided within community settings such as homes, schools, shelters, streets, nursing homes, etc.

Q: 4.f.1 "Certifying states are free to determine whether these or other evidence-based treatments may be appropriate as a condition of certification." Can you provide any direction at this juncture which EBPs the state may require?

OHA has identified the following EBPs:

1. Early Assessment Support Alliance (EASA)
2. Cognitive Behavioral Therapy (CBT)
3. Dialectical Behavioral Therapy (DBT)
4. American Society of Addition Medicine (ASAM) Criteria
5. Relapse Prevention
6. Motivational Interviewing
7. Supported Employment

Clinics are strongly encouraged to provide these EBPs directly; however, clinics may partner with other agencies who are providing these services. CCBHCs who are not providing these EBPs directly must have documentation outlining their designated collaborating organization (DCO) agreement with the agency providing the EBP

detailing coordination and collaboration of services. Please review the OHA Memo on CCBHC EBPs.

Q: 4.f.1 "The CCBHC or the DCO must provide evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for adults, children, and families. SUD treatment and services shall be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 and include treatment of tobacco use disorders" We are currently an enhanced level 1 (with ICOD), but we do not offer SUDs IOP. Based on the above criteria, do we need to DCO with a Level 2.1 or would securing a memorandum of understanding with an agency, or agencies, that already offer Level 2.1 meet the criteria? If we do choose to offer and certify as a level 2.1, are the SUD IOP billing codes eligible for the wrap payment?

ASAM 2.1 must be provided directly by a CCBHC or through a DCO. While a memorandum of understanding (MOU) is accepted legal documentation for a DCO, the relationship must meet the requirements for a DCO, including a financial relationship to cover services provided on behalf of the CCBHC.

Covered services can be found on the CCBHC Services Billing Matrix.

Q: 1.b.2 "CCBHC staff must include a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other FDA approved medications used to treat opioid, alcohol, and tobacco use disorders." To clarify, this element of this item is referring to MAT, although the language has changed?

Correct. Criteria 1.b.2 refers to medication assisted treatment (MAT) services. CCBHCs must provide MAT services directly or through a DCO relationship.

Questions Regarding Screening and Assessment

Q: 4.d.8 "If screening identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the person receiving services is provided a full assessment and treatment, if appropriate within the level of care of the CCBHC or referred to a more appropriate level of care. If the screening identifies more immediate threats to

the safety of the person receiving services, the CCBHC will take appropriate action as described in 2.b.1." What is unsafe use? What is full assessment?

As part of metric reporting, CCBHCs are required to use the AUDIT, AUDIT-C, or the one question screener. These screeners outline what unsafe use is:

- For the AUDIT: scores over 8 are considered unsafe with a score over 15 indicating alcohol dependence.
- For the AUDIT-C: for men, a score over 4 is considered unsafe. For women, a score over 3 is considered unsafe.
- For the one question screening, any score over 1 is unsafe.

There are no specifically required screeners for substance use. Clinics may choose their own methods for screening for substance use following best practices and state and federal regulations.

Full assessment is considered to be diagnostic assessment meeting state and federal criteria for the assessment of alcohol and drug use.

Q: 4.d.4 "A comprehensive evaluation is required for all people receiving CCBHC services. Subject to applicable state, federal, or other accreditation standards, clinicians should use their clinical judgment with respect to the depth of questioning within the assessment so that the assessment actively engages the person receiving services around their presenting concern(s)." Does this ever mean ASAM, or ASAM with expanded questions performed by a CADC staff?

Clinics must use ASAM or ASAM with expanded questions performed by a CADC staff as is appropriate to meet the needs and preferences of the individual and as is applicable to state and federal laws outside of CCBHC criteria.

Q: 2.b.2 "The treatment plan must be reviewed and updated no less frequently than every 6 months, unless the state, federal, or applicable accreditation standards are more stringent." The criteria does not mention assessments. Are there expectations clinics will conduct assessments at the treatment plan

update? If so, what assessments are expected? Additionally, is there expectation for an updated diagnosis to occur?

Although criteria does not outline minimum assessment and diagnostic requirements around treatment planning, clinics are expected to follow state and federal screening and assessment requirements around frequency of assessment. Additionally, some CCBHC metrics, specifically the Depression Remission at 6 months (DEP-REM-6), requires screening to be done every 6 months.

You can get this document in other languages, large print, braille, or a format you prefer free of charge. Contact the CCBHC team at CCBHC Inbox.

Behavioral Health Division
Certified Community Behavioral Health Centers
Oregon CCBHC Webpage