410-153-0000: Purpose and Scope

(1) The Medicaid Division Certified Community Behavioral Health Clinic (CCBHC) rules are designed to assist CCBHCs in preparing claims for services provided to members with Medicaid Assistance Program coverage and rate setting procedures.
(2) It is the clinic's responsibility to understand and follow all Oregon Health Authority rules that are in effect on the date services are provided.
(3) Medical Assistance Programs (OAR 410-120) and the Oregon Health Plan (OHP) Administrative Rules (OARs 410-141-3820 and 410-141-3825) are intended to be used in conjunction with all program rules, including the CCBHC provider rules.

410-153-0005: Provider Enrollment and Eligibility

(1) To enroll with the Medicaid Division as a CCBHC, a health center must be certified by the Behavioral Health Division. CCBHCs must be enrolled with Medicaid as a mental health and substance use provider. Clinics are permitted to start Medicaid enrollment concurrently with CCBHC certification.
(2) Eligible CCBHCs who enroll with Medicaid Division as a CCBHC and receive reimbursement under the prospective payment system (PPS) encounter rate methodology, must submit the following information:
    (a) Completed authority provider enrollment forms with attachments as required in OAR 943-120-0300 through 943-120-0320;
    (b) National Provider Identification (NPI) number and associated taxonomy code(s) obtained for the CCBHC with the provider enrollment form;
    (c) Complete cost report.
    (d) Completed copy of the application proposal to the Behavioral Health Division detailing the clinic's capacity to meet criteria and provide required services;
    (e) A copy of the clinic's trial balance;
    (f) Audited financial statements;
    (g) Depreciation schedules;
    (h) Overhead cost allocation schedule;

(i) A list of all Coordinated Care Organization (CCO) contracts;

(j) A list includes names and NPI numbers of individual practitioners enrolled with the Medicaid Division and contracted with or employed by the CCBHC including any clinics that do not have CCBHC status; and

(k) A list including business names, addresses and facility NPI numbers for all Medicaid Division enrolled clinics affiliated or owned by the CCBHC including any clinics that do not have CCBHC status.

(3) The Medicaid Division, upon receipt of the required items as listed in section (2) of this rule for CCBHCs will review all documents for compliance with program rules, completeness, and accuracy.

(4) The Medicaid Division prohibits an established, enrolled CCBHC that adds or opens a new clinic site from submitting claims for services rendered to that new site under their CCBHC enrollment and according to the PPS encounter rate prior to the Medicaid Division's acknowledgement. A CCBHC is required to immediately submit to the attention of the Medicaid Division:

(a) A copy of the recent Behavioral Health Division certification including the new site under the main CCBHC site's scope;

(b) A recent list of all CCO contracts; and

(c) A recent list of names and NPI numbers for all individual practitioners enrolled with the Medicaid Division and contracted with or employed by the new CCBHC site.

(5) If an established and enrolled CCBHC changes ownership, the new owner must submit:

(a) A cost report within 30 days from the date of change of ownership to have a new PPS encounter rate calculated, or in writing, a letter advising adoption of the PPS encounter rate calculated under the former ownership;

(b) Notice of a change in tax identification number;

(c) A recent list of all CCO contracts;

(d) A recent list of names and NPI numbers of all individual practitioners enrolled with the Medicaid Division and contracted with or employed by the CCBHC; and

(e) A recent list including business names, addresses, NPI numbers and associated taxonomy codes for all Medicaid Division enrolled clinics affiliated or owned by the CCBHC including any clinics that do not have CCBHC status.

(6) CCBHCs that are involved with a designated collaborating organization must provide documentation. Designated collaborating organizations are entitled to financial payment from the CCBHC for rendering services on behalf of the CCBHC. Clinics are permitted to enter non-fiscal arrangements for mobile crisis services. Clinics must provide payment for all other service types provided by a DCO on behalf of the CCBHC.

410-153-0010: Certified Community Behavioral Health Clinic (CCBHC) Provider Numbers

(1) Pursuant to the National Provider Identifier (NPI) requirements in 45 CFR Part 162, providers must use an NPI and, in specific situations, associated taxonomy code(s) when billing the Medicaid Division

(2) A Certified Community Behavioral Health Clinic (CCBHC) shall register the NPI number and associated taxonomy code, obtained for the CCBHC at the time of enrollment. Multiple sites are not separately enrolled, unless each site has a different tax identification number.

(3) The Medicaid Division is permitted to grant an exception to section (2) of this rule upon written request to the Medicaid Division. The request must include a detailed explanation describing the:

(a) Need for separate enrollment of an additional site,

(b) Mechanisms in place to assure no duplication of billings, or

(c) Separate Behavioral Health Division certifications

(4) If the Medicaid Division finds evidence of duplicate or inappropriate billing resulting from provider misuse under multiple enrollments, the Medicaid Division is permitted to terminate the exception upon written notice to the clinic.

(5) If the Medicaid Division grants an exception to section (2) of this rule, the Medicaid Division shall separately enroll each clinic site. When granted multiple provider enrollments, clinics must register:

(a) A separate NPI number for each clinic, or

(b) One NPI number and separate taxonomy code for each clinic

(6) If a CCBHC has several clinic sites and one or more of the clinics are not designated as a CCBHC, the non-CCBHC (each individual clinic) must:
   (a) Enroll as a billing provider; and
   (b) Each practitioner must individually enroll.

(7) Upon enrollment and each October thereafter, CCBHCs must submit to the Medicaid Division:
   (a) A list including names and NPI numbers of individuals practitioners associated with the CCBHC, and
   (b) A list including business names, addresses, and facility NPI numbers for all Medicaid Division enrolled clinics affiliated or owned by the CCBHC, including any clinics that do not have CCBHC status

410-153-0015: Program Review

(1) Clinics are subject to program review by the Medicaid Division, Behavioral Health Division, the Department of Human Services' Audit Unit, and the Department of Justice Medicaid Fraud Unit for the purposes of assuring program integrity, and
   (a) Compliance with Oregon Revised Statutes, Oregon Administrative Rules, and Federal laws and regulations;
   (b) Use of accurate and complete encounter and fee-for-service claims data, and supporting clinical documentation for calculating coordinated care organization (CCO) supplemental payments; and
   (c) Adequate records maintenance for cost reimbursed services to thoroughly explain how the amounts reported on the cost report were determined. The records must be adequate and in sufficient detail to substantiate the data reported.

410-153-0020: Scope of Services

(1) Professional ambulatory services provided by Certified Community Behavioral Health Clinics (CCBHC) must include:

(a) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization;

(b) Screening, assessment, and diagnosis, including risk assessment;

(c) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning;

(d) Outpatient mental health and substance use services;

(e) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.

(f) Targeted case management;

(g) Psychiatric rehabilitation services;

(h) Peer support and counselor services and family supports; and

(i) 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.

(2) Clinics must use the following guidelines in conjunction with all individual program-specific Medicaid Division administrative rules to determine service coverage and limitations for Oregon Health Plan (OHP) members according to their benefit packages:
   (a) CCBHC 309 Division 09 Rules;
   (b) CCBHC Medicaid Division Rules;
   (c) General Rule (OAR 410 division 120); and
   (d) OHP Administrative Rules (OARs 410-141-3820 and 410-141-3825).
(3) Certified Community Behavioral Health Clinics (CCBHC) are eligible for reimbursement of covered professional services provided within the scope of the clinic and within the individual practitioner's scope of license or certification.
(4) The date of service determines the appropriate version of the CCBHC and Medical Assistance Programs (OAR 410-120) to determine coverage.

410-153-0025: ICD-10-CM Diagnosis and CPT/HCPCs Procedure Codes

(1) The Medicaid Division requires diagnosis codes on all claims, including those submitted by independent laboratories. A clinic must always provide the member's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.

(2) The appropriate ICD-10-CM diagnosis code(s) must be used to identify:

(a) Diagnosis,

(b) Symptoms,

(c) Conditions,

(d) Problems,

(e) Complaints, or

(f) Other reasons for the encounter/visit.

(3) Clinics must list the principal diagnosis in the first position on the claim. Clinics must use the principal diagnosis code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Clinics are permitted to list up to three additional diagnosis codes on the claim for documented conditions that coexist at the time of the encounter/visit and require or affect member care, treatment, or management.

(4) Clinics must list the diagnosis codes using the highest degree of specificity available in the ICD-10-CM. Clinics must use a three-digit diagnosis code only if the diagnosis code is not further subdivided. Whenever fourth-digit or fifth-digit subcategories are provided, the provider must report the diagnosis at that specificity. Medicaid Division considers a diagnosis code invalid if it has not been coded to its highest specificity.

(5) Medicaid Division requires clinics to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers must accurately code claims according to the national standards in effect for the date the service(s) was provided.

410-153-0030: Prior Authorization

(1) It is the responsibility of the clinic to verify whether a coordinated care organization (CCO) or the Medicaid Division is responsible for reimbursement.

(2) If a member is enrolled in a CCO, the CCO is permitted to require prior authorization (PA) requirements for some services that are provided through the CCO. It is the Certified Community Behavioral Health Clinic's (CCBHC) responsibility to comply with the CCO's PA requirements or other policies necessary for reimbursement from the CCO before providing services to any OHP member enrolled in a CCO. The CCBHC must contact the member's CCO for specific instructions.

(3) If the CCBHC does not have a contract or other arrangements with a CCO, and the CCO denies payment, the Medicaid Division will reimburse for these services per a clinic's prospective payment system (PPS) rate.

(4) The Medicaid Division is permitted to require PA for certain covered services or items before the service is permitted to be provided or before payment will be made for fee-for-service (open card) members. A CCBHC assumes full financial risk in providing services to a fee-for-service (open card) member prior to receiving authorization, or in providing services that are not in compliance with OARs.

(5) If the service or item is subject to prior authorization, the CCBHC must follow and comply with PA requirements in these rules, the General Rules and applicable program rules, including but not limited to:

   (a) The service is adequately documented (see OAR 410-120-1360, Requirements for Financial, Clinical, and Other Records). Clinics must maintain documentation in the clinic's files to adequately determine the type, medical appropriateness, or quantity of services provided.

   (b) The services provided are consistent with the information submitted when authorization was requested.

   (c) The services billed are consistent with those provided.

410-153-0035: Oregon Health Plan Member Copayments

(1) The Oregon Health Plan member's Oregon Health ID will indicate which Oregon Health Plan (OHP) members are responsible for copayments for services.

(2) The Medicaid Division requires copayments from members with certain benefit packages as outlined in OAR in 410-200.

410-153-0040: Division Encounter and Recognized Practitioners

(1) The Medicaid Division reimburses Certified Community Behavioral Health Clinics (CCBHC) services according to the prospective payment system (PPS) as follows:
   (a) When the services meet the criteria of a valid encounter as defined by sections (2) through (4) of this rule
   (b) Reimbursement is limited to the Medicaid Division's covered services according to the Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act. Other services that are not defined in benefit package or the State Plan under Title XIX or Title XXI of the Social Security Act are not reimbursed by the Medicaid Division.

(2) For the provisions of services defined in Titles XIX and XXI and provided through a CCBHC, an encounter is defined as face-to-face or telephone contact between a behavioral health care professional and an eligible OHP member within a 24-hour period ending at midnight, as documented in the member's medical record. Section (4) of 410-153-0040 outlines limitations for telephone contacts that qualify as encounters. Face-to-face encounters include services provided via asynchronous two-way audiovisual link between a member and a provider.

(3) An encounter includes all services, items, and supplies provided to a member during the course of an office visit and those services considered "incident-to". The services are inclusive of the visit with the core provider meeting the criteria of a valid encounter and reimbursed at the PPS all-inclusive encounter rate. These services include:
   (a) Drugs or medication treatments provided during a clinic visit are inclusive of the encounter, with exception of contraception supplies and medications as costs for these items are excluded from the PPS encounter rate calculation;
   (b) Medical supplies, equipment, or other disposable products (e.g. gauze, band-aids, wrist brace) are inclusive of an office visit;
   (c) Laboratory and/or radiology services (even if performed on another day); and
   (d) Venipuncture for lab tests.

(4) Telephone encounters qualify as a valid encounter for services provided in accordance with OAR 410-130-0595 and OAR 410-130-0190. Except as set forth below, providers are not permitted to make telephone contacts at the exclusion of face-to-face visits:

(a) Telephone encounters must include all the same components of the service as if provided face-to-face, or

(b) During a state of emergency of an epidemic outbreak of an infectious disease impacting the safety of public health, in accordance with guidance notes and OAR 410-120-1990. Telephonic evaluation management services, assessment and management services, and psychotherapy are appropriate to ensure access to care while avoiding and preventing unnecessary potential infections exposure and are permitted to be made in place of a face-to-face visit.

(c) Some Medicaid covered services are not reimbursable when furnished according to the Oregon Health Plan (OHP) member's benefit package as a stand-alone service. Although costs incurred for furnishing these services are inclusive of the PPS all-inclusive rate calculation, visits where these services were furnished as stand-alone services were excluded from the denominator for the PPS rate calculation. When furnished as stand-alone services, sign language and oral interpreter services are not reimbursable.

(5) Member contact with more than one health professional for one or more diagnosis or multiple services with the same health professional that take place on the same day constitutes a single encounter.

(6) Providers are required to include all services provided within the encounter on the claim using the correct HIPAA procedure code set such as CPT, HCPCS, ICD-10-CM, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided. For claims that require the listing of a diagnosis or procedure code as a condition of payment, the code listed on the claim form must be the code that most accurately describes the member's condition, and the services provided. Providers must use the ICD-10-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual provider rules.

(7) CCBHCs are permitted to furnish services that are reimbursed outside of the PPS all-inclusive encounter rate and according to the fee schedule for services in which they are appropriately certified and approved to provide including but not limited to:
   (a) Services provided to Healthier Oregon (HOP) members
   (b) Services provided to Qualified Medicare Beneficiary (QMB) only members. Specific billing information is located in the CCBHC billing matrix, billing guide, and wraparound payment guide found on the Oregon CCBHC webpage.

(8) OHP benefit packages and delivery system are described in OAR 410-120-1210. Most OHP members have prepaid health services contracted for by OHA through enrollment in a CCO. Non-CCO enrolled members receive services on an open card basis.
   (a) The Medicaid Division is responsible for making payment for services provided to open card members. The provider will bill the Medicaid Division the clinic's encounter rate for Medicaid-covered services provided to these members according to their OHP benefit package.
   (b) A CCO is responsible to provide, arrange, and make reimbursement arrangements for covered services for their Oregon Health Plan members. The clinic must bill the CCO directly for services provided to an enrolled member. Clinics must not bill the Medicaid Division for CCO-covered services provided to eligible OHP members enrolled in CCOs.

(9) Clinics must make reasonable efforts to obtain payment first from other resources before billing the Medicaid Division.

(10) When a clinic receives payment from any source prior to the submission of a claim to the Medicaid Division, the amount of that must be shown as a credit on the claim submitted to the Medicaid Division in the appropriate field.

(11) Payment shall be limited to one payment per day per Oregon Health Plan member when an eligible CCBHC service is provided.

410-153-0045: Modifiers

(1) Certified Community Behavioral Health Clinics (CCBHC) must use HIPPA complaint modifiers for services provided within an prospective payment system encounter.

(2) Mobile Crisis services require the use of a modifier.

(3) When billing for services that are reimbursed outside a clinic's encounter rate, a clinic must use the required modifier(s) listed in the individual program administrative rules.

410-153-0050: Drugs

(1) A valid Certified Community Behavioral Health Clinic (CCBHC) encounter excludes pharmaceutical, or biologicals not provided during a clinic visit. The Medicaid Division includes the costs of drugs or medication treatments administered by a clinic to treat a member during an office visit in the prospective payment system (PPS) all-inclusive encounter rate for the office visit, providers cannot bill separately for the costs of the drugs or treatments

410-153-0055: Fee-for-service (open card) Billing Requirements

(1) The Medicaid Division is responsible for making payment for services provided to fee-for-service (open card) members. The provider will bill the Medicaid Division the clinic's encounter rate for Medicaid-covered services provided to these members according to their OHP benefit package.
(2) Certified Community Behavioral Health Clinics must refer to CCBHC Billing guidance and the CCBHC Billing Matrix found on the Oregon CCBHC webpage for fee-for-service (open card) member billing procedures and eligible procedure codes.

410-153-0055: Coordinated Care Organizations

(1) Most Oregon Health Plan (OHP) members have prepaid health services, contracted for by the Oregon Health Authority (OHA) through enrollment in a coordinated care organization (CCO). Clinics serving OHP members who are enrolled in a CCO must secure authorization from the CCO prior to providing CCO-covered services or case management services. Certified Community Behavioral Health Clinics (CCBHC) must request an authorization or referral from the CCO before providing any services to members enrolled in a CCO unless the CCBHC has contracted with the CCO to provide CCO-covered services. If a CCBHC has an arrangement or contract with a CCO, the clinic is responsible to follow CCO rules and prior authorization requirements. See OAR 410 division 141 for OHP Program Rules.

(2) The Medicaid Division encourages CCBHCs to contact each CCO in their local service area for the purpose of requesting inclusion in their panel of providers.

(3) CCOs contracted with CCBHCs, for the provision of providing services to their members, are required to provide payment to the CCBHC that is no less than the level and amount of payment which the CCO would make for services furnished by a non-CCBHC provider.

(4) Payment for services provided to the CCO-enrolled members (CCO members) is a matter between the CCBHC and the CCO authorizing the services. The Medicaid Division requires CCBHCS to report payment received for CCBHC provided services through the supplemental payment process to ensure clinics are paid up to their prospective payment system (PPS) rates.

(5) CCOs are responsible to ensure the provision of qualified sign language and oral interpreter services for covered medical or behavioral health visits for their enrolled CCO members with a hearing impairment or who are non-English speaking. Services must be sufficient for the CCBHC provider to be able to understand the CCO member's complaint, to make a diagnosis, respond to the CCO member's questions and concerns, and to communicate instructions to the CCO member.

(6) The clinic assumes full financial risk in serving a person not confirmed by the Medicaid Division as eligible on the date(s) of service. It is the responsibility of the provider to verify a member's eligibility, including:

   (a) That the individual receiving medical services is eligible on the date of service for the service provided,

   (b) Whether an OHP member receives services on an open card basis or is enrolled with a CCO, and

   (c) Whether the service is covered by a third-party resource (TPR), a CCO, or if the Medicaid Division reimburses on an open card basis.

(7) The Medicaid Division requires the following of a CCBHC under contract with a CCO:

   (a) Clinics must maintain reimbursement and documentation records that will permit calculation of supplemental payments. According to OAR 410-141-3520, a CCO's participating providers shall maintain a clinical record keeping system with sufficient

detail and clarity to permit internal and external clinical audit to validate encounter submission and to assure medically appropriate services are provided consistent with the documented needs of the CCO members.

(b) Clinics are subject to ongoing performance review by the CCO. CCOs must maintain an effective process for monitoring, evaluating, and improving the access, quality, and appropriateness of services provided to OHP members. The Quality Improvement (QI) program must include QI projects that are designed to improve the access, quality, and utilization of services.

410-153-0060: Coordinated Care Organization (CCO) Supplemental Payments

(1) The Medicaid Division is required to ensure Certified Community Behavioral Health Clinics (CCBHC) are paid up to their prospective payment system (PPS) rate. To ensure claims paid by coordinated care organizations (CCO) are paid at the PPS rate, the Medicaid Division will pay clinics a CCO supplemental payment.

(2) The CCO supplemental payment represents the difference, if any, between the payment received by the CCBHC from the CCO for treating the CCO member to which the CCO would be entitled if they had billed the Medicaid Division directly for these encounters according to the clinics' Medicaid PPS encounter rate.

(3) In accordance with federal regulations, the clinic must take all reasonable measures to ensure that in most instances Medicaid will be the payer of last resort. Providers must make reasonable efforts to obtain payments first from other resources before submitting claims to the CCO.

(4) When any other coverage is known to the clinic, the clinic must bill the other resource(s) prior to billing the CCO. When a clinic receives a payment from any source prior to submission of a claim to the CCO, the amount of the payment must be shown as a credit on the claim in the appropriate field.

(5) Supplemental payment by the Medicaid Division for encounters submitted by the CCBHC for the purposes of this rule is reduced by any and all payments received by the CCBHC from outside resources, including Medicare, private insurance, or any other coverage. Therefore,

CCBHCs are required to report all payments received on the Wraparound Payment Template, including:

(a) Medicaid CCOs

(b) Medicare Advantage Managed Care Organizations (MCO)

(c) Medicare, including Medicare MCO supplemental payments

(d) Any Third-Party Resource(s) (TPR)

(6) The Medicaid Division will calculate the CCO supplemental payment in the aggregate of the difference between total payments received by the CCBHC, to include payments as listed in Section (5) of this rule and the payment to which the CCBHC would have been eligible to claim as an encounter if they had billed the Medicaid Division directly per their PPS encounter rate.

(7) To facilitate the Medicaid Division processing CCO supplemental payments, the CCBHC must submit the following:

(a) To the CCOs:

(A) Claims within the required timelines outlined in the contract with the CCO and related Oregon Administrative Rules.

(B) The approved CCBHC Medicaid ID(s), associated taxonomy code, registered by the CCBHC with the Medicaid Division must be used when submitting all claims to the CCO

(b) To the Medicaid Division:

(A) Report total payments for all services submitted to the CCO, excluding any bonus or incentive payments

(B) Report total payments for each category listed in the “Amounts Received During the Settlement Period” section of the Wraparound Payment Template

(C) Payments are to be reported at the detail line level on the Wraparound Payment Template except for capitation payments, or per member per month and risk pool payments received from the CCO.

(D) The total number of actual encounters. An encounter represents all services provided to an individual member on a single date of service within the CCBHC scope

of services. The total number of encounters is not the total number of members assigned to the CCBHC or the total detail lines submitted on the Wraparound Payment Template.

(E) All individual NPI numbers and taxonomy codes assigned to practitioners associated with the CCBHC. A practitioner associated with a CCBHC can only retain individual active enrollment with the Medicaid Division in limited situations.

(F) A current list of all CCO contracts. An updated list of all CCO contracts must be submitted annually to the Medicaid Division no later than October 31 of each year.

(8) CCO Supplemental Payment Process

(a) The Medicaid Division will process CCO supplemental payments on a quarterly basis:

(A) Quarterly processing of CCO supplemental payments includes a final reconciliation for the reported time period

(B) For a CCBHC approved by the Medicaid Division to participate in a pilot project, CCO supplemental payments will be processed at the discretion of the Medicaid Division in collaboration with clinics.

(b) Upon processing a clinic's data and the CCO supplemental payment, the Medicaid Division will:

(A) Send a check to the clinic for the CCO supplemental payment calculated from the clinic data the Medicaid Division was able to process

(B) Provide a cover letter and summary of the payment calculation, and

(C) Return data that is incomplete, unmatched, or cannot otherwise be processed by the Medicaid Division,

(c) The CCBHC is responsible for reviewing the data the Medicaid Division was unable to process for accuracy and completeness. The clinics has 30 days, from the date of the Medicaid Division's cover letter to make any corrections to the data and resubmit to the Medicaid Division for reprocessing. Documentation supporting any and all changes must accompany the resubmitted data. A request for extension must be received by the Medicaid Division prior to the expiration of the 30 days and must

(A) Be requested in writing

(B) Be accompanied by a cover letter fully explaining the reason for late submission, and

(C) Provide an anticipated date for providing the Medicaid Division the clinic's resubmitted data and supporting documentation

(d) Within 30 days of the Medicaid Division's receipt of the re-submitted data, the Medicaid Division will:

(A) Review the data and issue a check for all encounters the Medicaid Division verified to be valid, and

(B) For quarterly data submissions, send a letter outlining the final quarterly settlement including any other pertinent information to accompany the check,

(9) In order to be reimbursed at the clinic's PPS rate for services rendered to CCO members, providers must submit wrap reports within 12 months of close of the quarter being reported

(a) Exceptions to the 12-month requirement that are permitted to be submitted to the Division are as follows:

(A) When the Department, Division, or the member's branch office makes an error that causes the provider not to be able to bill within 12 months of the date of service, the report is permitted to be filed up to six months after the error is discovered. The Division must confirm the error.

(B) When a court or an Administrative Law Judge orders the Division to make payment.

(10) Clinics must carefully review in a timely fashion the data that the Medicaid Division was unable to process and returns to the CCBHC. If clinics do not bring any incomplete, inaccurate, or missing data to the Medicaid Division's attention within the timeframes outlined, the Medicaid Division will not process an adjustment.

(11) When the clinic does not have a contract or agreement with the CCO, clinics must exclude services provided to a CCO-enrolled member from their data submission for CCO supplemental payment.

(12) If a CCO denies payment to a CCBHC for all services, items and supplies provided to a member on a single data of service and meeting the definition of an "encounter", for the reason that all services, items, and supplies are non-covered by the plan, the Medicaid

Division is not required to make supplemental payment to the clinic. The following examples are excluded from the provision of this rule:

(a) Encounter that will later be billed to the CCO as a covered global procedure

(b) Had payment received by Medicare, and any other third-party resource have not exceeded the CCO would have made, the CCO would have made payment,

(c) At least one of the detail lines reported for all services, items, and supplies provided to a member on a single date of service and represents an "encounter", has reported payment amount by the CCO.

(13) If a CCBHC has been denied payment by a CCO because the clinic does not have a contract or agreement with the CCO, the Medicaid Division is not required to make a supplemental payment to the clinics. The Medicaid Division is only required to make a CCO payment when the CCBHC has a contract with a CCO.

(14) The Medicaid Division will not reimburse some Medicaid covered services that are only reimbursed by the CCOs and are not reimbursed by the Medicaid Division. The Medicaid Division will not make CCO supplemental payment for these services, as the Medicaid Division does not reimburse these services when billed directly to the Medicaid Division.

(15) It is the responsibility of the CCBHC to refer to CCO-enrolled members back to their CCO if the CCBHC does not have a contract with the CCO. The clinic assumes full financial risk in serving a person not confirmed by the Medicaid Division as eligible on the date(s) of service. It is the responsibility of the clinic to verify

(a) That the individual receiving medical services is eligible on the date of services for the service provided, and

(b) Whether a member is enrolled with a CCO or receives services on an fee-for-service (open card) basis.

410-153-0065: Encounter Rate Determination

(1) The Medicaid Division will coincide enrollment of a Certified Community Behavioral Health Clinic (CCBHC) with the calculation of the clinic's prospective payment system (PPS) encounter rate and Behavioral Health Division certification:

(a) The Medicaid Division will enroll a clinic as a CCBHC on the Behavioral Health Division certification effective date. The encounter rate will be used to bill CCBHC PPS-eligible services provided on or after the coinciding effective dates of certification, enrollment, and determination of the clinic's encounter rate.

(b) Consistent with OAR 410-120-1260, only enrolled providers can submit claims to the Medicaid Division for providing specific care, item(s), or service(s) to Oregon Health Plan members. A clinic or individual provider needs to bill fee-for service for services provided prior to enrollment as a CCBHC with the Medicaid Division, according to applicable service program's enrollment and billing Oregon Administrative Rules (OARs).

(2) To determine the PPS encounter rate, a CCBHC must submit all required financial documents for CCBHC services. CCBHCs will have one CCBHC PPS rate for mental health and substance use disorder services

(3) CCBHCs that have additional clinic site(s) under the main CCBHC designation must file the required financial documentation for each clinic site within a consolidated cost report.

(4) CCBHCs cannot include costs associated with non-CCBHC designated sites in the cost report.

(5) An out-of-state CCBHC will only include expenses associated with Medicaid covered services provided at the clinic sites serving Medicaid members when completing the cost report. Do not include costs associated with non-CCBHC designated sites, or clinic sites, that do not serve Oregon Health Plan members in the cost report.

(6) At any time, if the Medicaid Division determines that costs provided by the clinic for calculating the PPS encounter rate were inflated, the Medicaid Division is permitted to:

(a) Request corrected cost reports and any other financial documents in order to review and adjust the encounter rate, and

(b) Impose sanctions as defined in OAR 410-120-1400, 410-20-1460, and 943-120-0360.

(7) In general, the PPS encounter rate is calculated by dividing the total allowable costs of Medicaid covered services within the scope of the CCBHC within a 12-month period by the total number of clinic encounters during the same 12-month period

(8) CCBHC encounter rates will be increased by the Medicare Economic Index effective set by Centers for Medicare and Medicaid Services January 1 of each year

(9) Enrolled CCBHCs with a change of ownership must submit:

(a) A cost report within 30 days from the change of ownership for review by the Medicaid Division if a new PPS encounter rate will be calculated as otherwise described in this rule, or

(b) In writing, a letter advising adoption of the PPS encounter rate calculated under the former ownership, including notice there is a change to the clinic's tax identification number.

(c) Failure to submit a cost report within 30 days of the change of ownership will forfeit the opportunity for calculation of a PPS encounter rate. The PPS encounter rate calculated under the former ownership will be reassigned to the new ownership

(10) The Centers for Medicare and Medicaid Services (CMS) defines a change in scope of services as one that affects the type, intensity, duration, and number of services. Clinics must submit a request for change in scope to the Medicaid Division for review.

410-153-0070: Change in Scope of Services

(1) The Centers for Medicaid and Medicaid Services (CMS) defines a change in scope of services as one that affects the type, intensity, duration, and/or number of services provided by a health center. CMS' broad definition of change in scope of services allows the Medicaid Division the flexibility to develop a more precise definition of what qualified as a change in scope as it relates to the elements of "type", "intensity", "duration", and "amount" and procedures for implementing these adjustments. This rule defines the Medicaid Division's policy for implementing Certified Community Behavioral Health Clinic (CCBHC) rate adjustments based on a change in scope of services.

(2) A change in the scope of a CCBHC is permitted if the CCBHC has added, dropped, or expanded any service that fits within the scope of CCBHCs defined in OAR 309 division 009.

(3) A change in the cost of a service is not considered in and of itself a change in the scope of services. A CCBHC must demonstrate how a change in the scope of services impacts the overall picture of clinic's services rather than focus on the specific change alone. For example, while clinics might increase services to higher-need populations, this increase

might be offset by growth in the number of lower intensity visits. Clinics, therefore, need to demonstrate an overall change to the clinic's services.

(4) The following examples are offered as guidance to CCBHCs to facilitate understanding of the types of change that are recognized as part of the definition of change in scope of services. These examples should not be interpreted as a definitive nor comprehensive delineation of the definition of scope of service. Examples include:

(a) A change in the scope of services from what was initially reported and incorporated in the baseline prospective payment system (PPS) rate,

(b) A change in the scope of services resulting from a change in the types of health center providers. A change in providers without a corresponding change in scope of services does not constitute an eligible change,

(c) A change in service intensity or service delivery model attributable to a change in the types of members served including, but not limited to, homeless, elderly, migrant, or other special populations. A change in the types of patients served alone is not a valid change in scope of services. A change in the type of patients served must correspond with a change in scope of services provided by the clinic,

(d) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the clinic services, including new or expanded service facilities. A change in capital expenditures must correspond with a change in scope of services,

(e) A change in applicable technologies or medical practices, or

(f) A change in overall clinic costs due to changes in state or federal regulatory or statutory requirements

(5) The following changes do not qualify as a change in scope of service, unless there is a corresponding change in services as attributed in sections (2)-(4):

(a) A change in office hours,

(b) Adding staff for the same service-mix already provided,

(c) Adding a new site for the same service-mix provided,

(d) A change in location or office space, or

(e) A change in the number of patients served.

(6) Threshold change in cost per visit: To qualify for a rate adjustment, changes must result in a minimum 5% change in cost per visit. This minimum threshold is permitted to be met by changes that occur over the course of several years. A change in the cost per visit is not considered in and of itself a change in the scope of services. The 5% change in cost per visit must be a result of one or more of the changes in the scope of services provided by a clinic, as defined in sections (2)-(4) of this rule. The intent of this threshold is to avoid administrative burden caused by minor change in scope adjustments.

(7) If a CCBHC has experienced an increase or decrease in the clinic's scope of services, as described in sections (2)-(4) of this rule and that meets the threshold requirement of section (6) of this rule, the CCBHC must submit to the Medicaid Division a written application as outlined below. The application must include:

(a) A written narrative describing the specific changes in the clinic's service and how these changes related to a change in the clinics' overall picture of services;

(b) An estimate of billable encounters for the forthcoming 12-month period so the financial impact to the Medicaid Division can be accounted for;

(c) A cost report. All costs and expenses reported must agree with the principles of reasonable reimbursement as found at 42 CFR 413 and any other regulations mandated by the Federal government. Any situations not covered will be based on Generally Accepted Accounting Principles;

(d) Certification and a letter of licensure by the Behavioral Health Division of a clinic's program is required; and

(e) The clinic is responsible for providing complete and accurate copies of the above documentation. Clinics are permitted to submit a maximum of one change in scope application per year.

(8) The Medicaid Division is permitted to initiate review of whether a change in scope of services has occurred at a clinic

(9) Upon receipt of a clinic's written change in scope of services request, the Medicaid Division will:

(a) Review all documents for completeness, accuracy, and compliance with program rules. An incomplete application will result in a delay in the Medicaid Division's review until the complete application is received, and

(b) Respond to the clinic with a decision within 90 days of receipt of a complete application.

(10) Providers are permitted to appeal these decisions in accordance with the provider appeal rules set forth in OAR 410-120-1560.

(11) The new rate will be effective beginning the first day of the quarter immediately following the date the Medicaid Division approves the change in scope of services

(a) The Medicaid Division will not implement adjusted PPS rates (for qualifying change in scope of service requests) retroactive to the date of a change in scope of services was implemented by the clinic.

(b) It is the clinic's responsibility to request a timely change in scope of service rate adjustment.

(12) Inclusion of anticipated costs:

(a) For anticipated changes, clinics should submit anticipated costs for the Medicaid Division to calculate a new per visit rate. These costs will be based on reasonable cost projections and reviewed by the Medicaid Division. Clinics will be rebased on actual costs after a 12-month period.

(b) For gradual or unanticipated changes, clinics must provide at least six months of actual costs beginning the date on which the change in the cost per visit threshold is met or beginning in the calendar year of the CCBHC's fiscal year in which the changes were implemented and the cost threshold was met.

(c) Clinics are permitted to submit both actual costs for prior changes as well as anticipated costs for anticipated changes. Prior to submitting both actual and anticipated costs, clinics should work with the Medicaid Division to confirm the appropriate time period of costs to submit.

(13) Change in scope rates will be adjusted by Medicare Economic Index (MEI) as set by the Centers for Medicaid and Medicare Services.

410-153-0075: Rebasing

(1) The Medicaid Division shall rebase Certified Community Behavioral Health Clinic (CCBHC) prospective payment system (PPS) encounter rates once every two years following the last rebasing and no less than 12 months following an initial rate, or a rate change due to a change in scope.
(2) Medicaid Division shall provide for a 60-day appeals process after the notice of the rebasing
(3) A CCBHC that receives a PPS rate that overlaps with another federal Medicaid rate is not eligible for the CCBHC rate methodology.

410-153-0080: Medicare Economic Index (MEI)

Certified Community Behavioral Health Clinic (CCBHC) prospective payment system (PPS) encounter rates shall be updated annually by trending each clinic's PPS rate by the Medicare Economic Index (MEI). This shall occur each year in December with an effective date of January 1st of the current year.

410-153-0085: Cost Report Instructions

(1) The Medicaid Division requires Certified Community Behavioral Health Clinics (CCBHC) to submit cost reports. The following rules should be used in conjunction with the CCBHC Cost Report Guidance document.
(2) The Medicaid Division reimburses certain services, items, and supplies fee-for-service, outside of the CCBHC prospective payment system (PPS) encounter rate. For this reason, clinics must exclude costs for the following items from the cost report:
    (a) Residential behavioral health and substance use disorder services, and
    (b) Behavioral health and substance use disorder services outside of the defined CCBHC scope
(3) Payment for services provided by CCBHCs is in accordance with guidance from the Centers for Medicare and Medicaid Services (CMS). A PPS encounter rate is calculated on a per visit basis that is equal to the average of reasonable and allowable costs incurred by a clinic for furnishing services included in the State Plan under Title XIX and XXI of the Social Security Act. The rate is calculated by dividing the total costs incurred by the CCBHC for furnishing services by the total number of clinic encounters.

(4) A clinic must submit a cost report to the Medicaid Division at the following times:
   (a) For new clinics to establish initial PPS rate
   (b) No less than 12 months following an initial rate, or a rate change due to a change in scope
   (c) For established clinics during an adjustment to the clinic's rate based on a change in scope of clinical services
   (d) For established clinics, every 2 years for rebasing
   (e) If there is a change of ownership, the new owner can submit the cost report within 30 days from the date of change of ownership to have a new PPS encounter rate calculated
   (f) Upon request of OHA.
(5) The cost report must include all documents required in Oregon Administrative Rules

410-153-0090: Total Encounters for Cost Report

(1) Certified Community Behavioral Health Clinics (CCBHC) are required to report the total number of encounters for furnishing services regardless of payer of individual receiving services. Encounters should encompass services provided to both Medicaid and non-Medicaid members.
(2) OAR 410-153-0090 provides guidance for cost reporting of all encounters. It is the responsibility of the CCBHC to report all encounters including:
   (a) Encounters for all members regardless of payer, and
   (b) Encounters for CCBHC services that are not covered by Medicaid, Medicare, Third Party Payer, or other party, but otherwise have an associated cost for providing the service whether billed to the member or absorbed by the clinic. Examples include uninsured, signed waiver on file, etc.
(3) CCBHCs must report all encounters furnished to all member populations irrespective of coverage or payer source.
(4) CCBHCs must exclude from the total number of reported encounters:
   (a) Encounters attributed to non-allowable costs:
      (A) Services performed and reimbursed under separate enrollment

(B) Provider participation in a community meeting or group session that is not designed to provide clinical services. This includes, but is not limited to, information sessions for prospective Medicaid members, and information presentations about available services at the CCBHC

(C) Health services provided as part of a large-scale "free to the public" or "nominal fee" effort, such as a mass screening program, community-wide service programs, etc.

(b) Encounters for specific services that do not meet the criteria of a valid encounter when furnished as a stand-alone service. Costs for furnishing these services are allowed administrative program costs and should not be reported as an encounter in the cost report.

(5) CCBHCs are required to include encounters for services furnished by practitioners recognized by the Medicaid Division. Examples include but are not limited to:

(a) Telephone contacts as provided within the scope of CCBHC services

(b) Encounters by Registered and Licensed Practical Nurses within the CCBHC scope

(6) When two or more services are provided on the same date of service, it is considered one encounter and should only be reported once

(7) Clinics must maintain, for no less than five years, all documentation relied upon by the clinic to calculate the number of encounters reported on the cost report. All documentation supporting the number of encounters reported on the cost report by be sufficient to withstand an audit

(8) The total number of encounters calculated from all sources of documentation must reconcile to the total number of encounters reported on the cost report and subtotaled encounters must reconcile to each documentation source relied upon

410-153-0100: Satellite Facilities

(1) A satellite facility is a Certified Community Behavioral Health Clinic (CCBHC) facility that:

(a) Was established by a behavioral health agency that is certified by the Behavioral Health Division as a CCBHC

(b) Operates under the governance and financial control of that CCBHC, and

(c) Provides crisis services; screening, diagnosis, and risk assessment; person and family centered treatment planning; and outpatient mental health and substance use services within the scope of the CCBHC.

(2) Facilities meeting the definition of a satellite facility established after April 1, 2014 cannot receive CCBHC payment.

(a) Costs associated with such satellite facilities are not be included in the cost report

(b) Encounters at these satellite facilities are not be included the cost report

(c) Services provided by staff working from these facilities do not generate PPS encounter rates even if services are provided in the community

410-153-0105: Designated Collaborating Organization (DCO)

(1) CCBHCs must provide the following services directly: outpatient mental health and substance use services; crisis services except for mobile crisis; screening, assessment, and diagnosis; and service planning. The remaining core services are permitted to be provided through a designated collaborating organization (DCO).

(2) DCOs are entities that are not under the direct supervision of a CCBHC but engage in a contractual agreement with a CCBHC to provide CCBHC services under the same requirements as the CCBHC.

(a) DCOs furnishing services on behalf of the CCBHC must be appropriately licensed and certified to provide services they are contracted to provide.

(b) Services provided by the DCO must meet the same standards as the CCBHC as outlined in OARs 309 division 009 for the services they are providing.

(c) The relationship must be evidenced by a legally binding document.

(3) The CCBHC must pay for the services provided by the DCO at the prospective payment system (PPS) rate with exception to state-sanctioned mobile crisis services. As such:

(a) Costs associated with the provision of the services for the DCO must be reported in the cost report.

(b) Encounters from the DCO must be reported in the cost report.

(c) The CCBHC and DCO must have policies and procedures outlining how the DCO will avoid duplication of payment.

(4) DCOs are required to provide CCBHCs with the data needed to calculate encounters, cost of services, and any related data reporting and quality metrics.

(5) DCOs are required to provide services on behalf of the CCBHC in accordance with CCBHC rules and regulations and defined in OARs 309-009.

410-153-0110: Accounting and Record Keeping

(1) General Requirements

  (a) The following rules and regulations apply to clinics reimbursed as a Certified Community Behavioral Health Clinic (CCBHC)

  (b) In cases of conflict between the rules contained in section (2) and (3) of this rules, section (2) will prevail over section (3).

  (c) Must adhere to acceptable accounting standards

(2) Each CCBHC shall:

  (a) Maintain internal control over and accountability for all funds, property, and other assets;

  (b) Maintain complete member documentation;

  (c) Adequately safeguard from duplicate billings or other routine billing errors;

  (d) Adequately safeguard all such assets and assure that they are used solely for authorized purposes;

  (e) Prepare cost reports in conformance with:

    (A) Generally accepted accounting principles

    (B) The provision of the CCBHC administrative rules

  (f) Maintain for a period of no less than 5 years from the end of the fiscal year;

    (A) Cost report;

    (B) A copy of the clinic's trial balance;

    (C) Audited financial statements;

    (D) Overhead cost allocation schedules; and

    (E) Financial and clinical records for the period covered by the cost report

(g) Maintain adequate records to thoroughly explain how the amounts reported on the cost report were determined. If there are unresolved audit questions at the end of the five-year period, the records must be maintained until the questions are resolved;

(h) Adequately document expenses reported as allowable costs in the records of the clinic, or they will be disallowed. Documentation for travel and education expenses must include a summary of costs for each employee stating the purpose of the trio or activity, the dates, name of the employee, and a detailed breakdown of expenses. Receipts must be attached for expenses over $25; and

(i) Prepare special work papers or reports to support or explain data reported on the cost report for current or previous periods at the Medicaid Division's request. These work papers/reports must be completed with 30 days of the Medicaid Division's request. An extension of up to 30 Dys will be granted if the request is made before the end of the original 30-day period. Extensions must be requested in writing.

(3) CCBHCs shall not submit financial documentation to the Medicaid Division for CCBHC sites that:

(A) Are not designated as a CCBHC and/or

(B) Do not serve Oregon Health Plan members

410-153-0115: Sanctions

(1) Providers are directed by the Medicaid Division's General rules, OARs 410-120-1400, OARs 410-120-1460, and OARs 410-120-0360.

(2) The Oregon Health Authority is authorized to take the actions necessary to investigate and respond to substantiated allegations of fraud and abuse, including but not limited to suspending or terminating the provider from participating in the medical assistance programs.

Oregon Health Authority

~~Health Systems Division:~~ Behavioral Health Services – Chapter 309

Division 9

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICs (CCBHC) ~~PROGRAM~~

309-009-0000: Purpose and Scope

~~These rules establish the Certified Community Behavioral Health Clinic (CCBHC) program and define the criteria and process that the Authority shall use to recognize and verify status as CCBHCs. These rules specify the standards for the CCBHC application and certification process. In addition to meeting all state and federal criteria, only organizations certified under OAR 309-019-0100 to 309-019-0220 (Outpatient Addictions and Mental Health Services) and OAR 309-008-0100 to 309-008-1600 (Standards for Certification of Behavioral Health Treatment Services) may become certified.~~

(1) Organizations certified under OAR 309-019-0100 to 309-019-0220 (Outpatient Addictions and Mental Health Services) and OAR 309-008-0100 to 309-008-1600 (Standards for Certification of Behavioral Health Treatment Services) are eligible to be certified as Certified Community Behavioral Health Clinics (CCBHC).

(2) Organizations must be enrolled as a Medicaid provider and licensed, certified, or accredited provider of both mental health and substance use disorder services, including developmentally appropriate services to children, youth, and their families.

(3) A CCBHC must conform to at least one of the following criteria for organizational authority:

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

(b) Is part of a local government behavioral health authority. A CCBHC is considered part of a local government behavioral health authority when a locality, county, region or state

maintains authority to oversee behavioral health services at the local level and utilizes the clinic to provide those services;

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

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

(4) CCBHCs must be certified in accordance with all rules in OAR Chapter 309, Division 008.

309-009-0005: Definitions

Commented [RR1]: In progress

The following definitions apply to OAR 309-009-0000 to 309-009-0060 ~~409-062-0000 to 409-062-0060~~:

(1) "Authority" means the Oregon Health Authority.

(2) "CCBHC" means the Certified Community Behavioral Health Clinic.

(3) "CCBHC application" means the survey link that is posted on the CCBHC program website.

(4) "Certification" means the process which the Authority uses to determine if a practice has met the criteria in the document titled "Oregon CCBHC Program Requirements."

(5) "Certified" means that the Authority has affirmed that a practice substantially meets the Oregon requirements for certification ~~federal and Oregon CCBHC standards.~~

(6) "Practice" means an individual, facility, institution, corporate entity, or other organization which provides direct health care services or bills, obligates, and receives reimbursement on behalf of a performing provider of services, also termed a billing provider (BP). The term provider refers to both performing providers and BPs unless otherwise specified.

~~(7) "Program" means activities associated with the CCBHC planning grant.~~

~~(8) "Program website" means http://www.oregon.gov/oha/HPA/CSI-BHP/Pages/Community-BH-Clinics.aspx.~~

(9) "Verification" means the process that the Authority shall conduct to ensure that a practice has submitted accurate information to the Authority for purposes of CCBHC certification.

10 +) Additional definitions as necessary and appropriate per complete rules text

~~309-009-0030~~

~~Application and Certification Process~~

~~(1) To be certified as a CCBHC, practices or their designee shall submit a CCBHC application electronically to the Authority using the Program's online application system found on the program website or by mail to the address posted on the program website which shall be open for 30 days. The Authority may choose to extend the application period beyond 30 days.~~

~~(2) The Authority shall review the application within 30 days of its submission to determine whether it is accurate, complete, and meets the certified requirements. If the application is incomplete the Authority shall notify the applicant in writing of the information that is missing and when it must be submitted.~~

~~(3) The Authority shall review a complete application within 45 days of submission. If the Authority determines that the applicant has met the requirements of these rules the Authority shall:~~

~~(a) Inform the applicant in writing that the application has been approved as a potential CCBHC;~~

~~(b) Assign a preliminary level of readiness for certification; and~~

~~(c) Include information regarding site visit planning, including, but not limited to, needs assessment requests, an anticipated agenda, schedule, and materials required for site visit.~~

~~(4) The Program shall post instructions and criteria for submitting a CCBHC application on the Program website.~~

~~(5) The Authority may deny CCBHC certification if an applicant does not meet the requirements of these rules.~~

~~(6) A practice may request that the Authority reconsider the denial of CCBHC recognition or reconsider the assigned level of readiness.~~

~~(a) A request for reconsideration must be submitted in writing to the Authority within 30 days of the date of the denial or approval letter and must include a detailed explanation of why the practice believes the Authority's decision is in error along with any supporting documentation.~~

~~(b) The Authority shall inform the practice in writing whether it has reconsidered its decision.~~

~~**309-009-0040**~~

~~**Certification Criteria**~~

~~A practice seeking CCBHC certification must meet the following criteria:~~

~~(1) Complete CCBHC application process, meeting the "ready to certify" or "mostly ready to certify" designation;~~

~~(2) Meet all federal criteria stated in the document titled "Criteria for the Demonstration program to Improve Community mental health Centers and to Establish Certified Community Behavioral Health Clinics";~~

~~(3) Meet all Oregon criteria stated in the Oregon CCBHC standards;~~

~~(4) Agree to a verification site visit and follow up activities with the CCBHC site review team; and~~

~~(5) Agree to contributing to and participating in the statewide needs assessment process.~~

309-009-0010: Certification

(1) CCBHCs must meet all program requirements described in the Oregon CCBHC Provider Manual. When updates are made to the manual, the Authority will release the proposed

changes on its website and provide a 60-day public comment period on the proposed changes.

(2) Prior to certification, any organization that is not a community mental health program (CMHP) must enter into a written agreement with the CMHP in its service area regarding the coordination of services that are provided by both entities.

(a) If the non-CMHP and CMHP are unable to reach a mutual agreement on the coordination of services, either entity may request an arbitration meeting with the Authority.

309-009-0050: Level of Readiness Designation

(1) The Authority shall award three levels of readiness designations to practices implementing multiple advanced CCBHC measures, including:

(a) Ready to certify: Currently meets the required criteria.

(b) Mostly ready to certify: Currently meets the majority of required criteria and has plans and a timeline in place to meet remaining required criteria.

(c) Mostly ready to certify with assistance: Currently meets the majority of required criteria with needs for significant technical assistance to meet required criteria and develop a plan and timeline to meet remaining required criteria.

(2) Not ready to certify: Does not meet all certification criteria.

~~**309-009-0020: Program Administration**~~

~~(1) The Program shall develop and implement a uniform application and process for certifying CCBHCs throughout the state of Oregon.~~

~~(2) The Authority shall recognize practices as certified CCBHCs upon meeting criteria set forth in OAR 409-062-0040.~~

~~(3) The Authority shall administer the Program, including data collection and analysis, recognition, and verification that a practice meets the defined CCBHC criteria.~~

~~(4) The Authority may also provide technical assistance.~~

309-009-0015: Community Needs Assessment & Staffing

(1) The clinic's CCBHC model must be informed by the community needs assessment.

(2) The community needs assessment must be completed in conjunction with the Certification of Approval (COA).

(3) The clinic must maintain a staffing plan that is informed by the community needs assessment and approved by the medical director.

(4) CCBHCs must have a psychiatrist or psychiatric nurse practitioner as a medical director. The medical director does not have to be a full-time employee but must be employed or contracted by the clinic.

309-009-0020: Availability and Accessibility of Services

(1) Services are provided at locations and times that facilitate accessibility and meet the needs of the population, including evening hours and weekend hours.
(2) CCBHCs must provide transportation or transportation vouchers to facilitate access to services.
(3) CCBHCs must have the capability to utilize telehealth video conferencing, remote patient monitoring, asynchronous intervention, and other technologies to facilitate access to services.
(4) The CCBHC conducts outreach, engagement, and retention activities to support inclusion and access for individuals and populations affected by health inequities.
(5) The CCBHC must have a continuity of operations plan in the event of an emergency that disrupts services.
    (a) The plan will ensure the CCBHC is able to effectively notify staff, people receiving services, and community partners when a disaster/emergency occurs, or services are disrupted.

(b) The CCBHC, to the extent feasible, has identified alternative locations and methods to sustain service delivery and access to behavioral health medications during emergencies and disasters.

(c) The plan addresses health IT systems security/ransomware protection and backup and access to these IT systems, including health records, in case of disaster.

(6) All people requesting or referred for services receive, at the time of first contact, a preliminary triage to determine acuity of needs.

(7) CCBHCs ensure no individual is denied behavioral health care services because of an individual's inability for pay for such services, place of residence, houselessness, or a lack of a permanent address.

309-009-0025: Care Coordination

(1) The CCBHC must establish care coordination partnerships with community partners, including inpatient and outpatient physical and behavioral health care providers and non-medical services and supports.

(2) When an individual is referred to an external provider for services outside of the scope of the CCBHC, the CCBHC shall assist the person or their guardian in obtaining an appointment, track participation in and receipt of services, and ensure ongoing coordination of care.

(3) When a CCBHC is unable to serve an individual, due to a need for specialized or intensive care outside of the CCBHC's scope or capability or by the individual's choice, a closed-loop referral must be provided. Coordination of care remains the responsibility of the CCBHC until the individual has established care and received services from the referred provider.

(4) Before prescribing medications, the CCBHC must document attempts to determine any medications prescribed by other providers, including consulting the Prescription Drug Monitoring Program. With consent, the CCBHC must provide this information to external providers to the extent necessary for safe and quality care.

(5) The CCBHC must assist individuals and families in gaining access to and maintaining resources, including but not limited to: Medicaid, Social Security benefits, general assistance, food stamps, vocational rehabilitation, and housing.

(6) The CCBHC has written protocols describing care coordination procedures and roles in care coordination with Federally Qualified Health Centers, Rural Health Centers, other primary care, inpatient psychiatric treatment, opioid treatment program services, medical withdrawal management, residential substance use disorder treatment (if existing within the service area), tribally operated mental health and substance use disorder services, schools, child welfare, criminal justice, Indian Health Service youth regional treatment centers, and agencies for therapeutic foster care.

(7) The CCBHC designates an interdisciplinary team responsible for cooperatively supporting the needs of the individual, as appropriate and desired, in a culturally and linguistically appropriate manner.

309-009-0030: Scope of Services

(1) CCBHCs are responsible for ensuring access to nine required services areas: crisis services; screening, assessment and diagnosis; person-centered and family-centered treatment planning; outpatient behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer and family supports; and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans.

(a) CCBHCs must provide the following services directly: outpatient mental health and substance use services; crisis services except for mobile crisis; screening, assessment, and diagnosis; and service planning. The remaining core services may be provided through a designated collaborating organization (DCO).

(b) All CCBHC services must be provided in a manner aligned with the requirements of Section 2401(a) of the Affordable Care Act, including, but not limited to, being person

and family-centered, developmentally appropriate, and culturally and linguistically responsive.

(c) CCBHCs must practice measurement-based care.

(2) The relationship between a CCBHC and its designated collaborating organization (DCO) must be established through a contract or other formal, legal written agreement.

(a) CCBHCs must have a fiscal arrangement with the designated collaborating organization in accordance with Chapter 410, Division [CCBHC]. A designated collaborating organization may provide mobile crisis through a non-fiscal arrangement with the CCBHC.

(b) The CCBHC retains responsibility for care coordination and is responsible for ensuring access to all required CCBHC services.

(c) Designated collaborating organization-provided services must adhere to all CCBHC requirements for those services and meet the same quality standards as those provided directly by the CCBHC.

(d) The CCBHC's health IT system must support coordinated care between the CCBHC and its designated collaborating organizations, including but not limited to, integrating treatment records generated by the DCO into the CCBHC health record.

(e) Designated collaborating organizations must be legally authorized in accordance with federal, state, and local laws and act within the scope of their respective state licenses, certifications, or registrations.

(f) People receiving services from a designated collaborating organization will be informed of and have access to the CCBHC's existing grievance procedures.

(3) The CCBHC shall provide crisis services, including emergency crisis intervention services, 24-hour mobile crisis, and crisis receiving/stabilization.

(g) The CCBHC provides or coordinates with telephonic, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide.

(h) The CCBHC must directly provide onsite crisis receiving and stabilization services, which must include, at minimum, walk-in behavioral health services.

(3) The CCBHC provides screening, assessment, and diagnosis, including risk assessment for behavioral health conditions.

(a) When specialized screening, assessment, or diagnostic services outside of the scope of the CCBHC are required, the CCBHC shall refer the person receiving services to an appropriate provider to receive these services.

(b) All individuals pursuing CCBHC services must be asked whether they have ever served in the US military.

(4) The CCBHC develops an individualized service plan that shall address the person's prevention, medical, and behavioral health needs.

(5) The CCBHC provides outpatient behavioral health care, including mental health care, substance use disorder services, including psychopharmacological treatment.

(a) The CCBHC must provide promising or evidence-based practices for treating behavioral health conditions.

(b) Substance use disorder treatment and services shall be provided as described in ASAM Level 1 and 2.1.

(c) Outpatient substance use disorder services must include treatment of tobacco use disorders.

(6) The CCBHC is responsible for outpatient primary care screening and monitoring of key health indicators and health risk.

(a) The medical director shall establish organizational protocols to ensure that screenings for common physical health conditions are provided.

(b) The CCBHC must have the ability to collect biologic samples directly and conduct laboratory analyses directly, through a DCO, or through an arrangement with independent organizations.

(c) The CCBHC must provide ongoing monitoring of health conditions as clinically indicated for the person receiving services, including but not limited to: Ensuring that people receiving services have access to primary care services; ensuring ongoing period laboratory testing and measurement of physical health status indicators and changes in the status of chronic health conditions; coordination of care with primary care and

specialty health providers, including tracking attendance at needed physical health care appointments; and promoting a health behavior lifestyle.

(7) The CCBHC must provide targeted case management services in accordance with Oregon Administrative Rules Chapter 410, Division 138.

(8) The CCBHC must provide rehabilitation services for mental health and substance use disorders.

(a) Psychiatric rehabilitation services must include supported employment programs.

(b) Psychiatric rehabilitation services must support people receiving services in participating in supported education or other educational services; achieving social inclusion and community connectedness; participating in medication education, self-management, and/or individual and family psychoeducation; and finding and maintaining safe and stable housing.

(9) The CCBHC is responsible for providing peer services, including peer counseling and family supports, through a peer support specialist or a peer wellness specialist.

(a) The CCBHC must that ensure peer services are supervised by a peer-delivered services supervisor.

(10) The CCBHC is responsible for providing intensive, community-based behavioral health care for U.S Armed Forces located more than 50 miles or one hour's drive time from a Military Treatment Facility and veterans living more than 40 miles from a VA medical facility or as otherwise required by federal law.

(a) Care provided to veterans is required to be consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including those contained in the Uniform Mental Health Services Handbook.

(b) Every veteran seen for behavioral health services is 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 health record.

309-009-0035: Quality and Other Reporting

(1) The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records.
   (a) The CCBHC uses its secure health IT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct quality improvement, quality measurement, and reporting.
   (b) The CCBHC uses technology that has been certified to current criteria under the ONC Health IT Certification Program.

(2) The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including but not limited to:
   (a) characteristics of people receiving services;
   (b) staffing;
   (c) access to services;
   (d) use of services;
   (e) screening, prevention, and treatment;
   (f) care coordination;
   (g) other processes of care;
   (h) costs; and
   (i) outcomes of people receiving services.

(3) CCBHCs must report encounter, clinical outcome, quality data and any other such data as the Authority requires.

(4) The CCBHC develops, implements, and maintains a continuous quality improvement (CQI) plan for the services provided. The CQI plan must include explicit actions to identify, track and improve outcomes for populations facing health inequities.

309-009-0040: Organizational Authority, Governance, and Accreditation

(1) An independent financial audit is performed annually in accordance with federal audit requirements. Where applicable, a corrective action plan is submitted addressing all

findings, questioned costs, reportable conditions, and material weakness cited in the Audit Report.

(2) The CCBHC must have a governance board that is informed by the individuals and communities they serve.

(a) The governance board must reflect the demographics of the individuals and communities they serve with respect to race, ethnicity, language, disability, immigration status, age, gender, gender identity, sexual orientation, geography, social class, and health and behavioral health needs.

(b) Individuals, including youth, with lived experience of mental health conditions and/or substance use disorders and their families must have a meaningful opportunity to participate in the governance board. CCBHCs must ensure meaningful participation through one of two options:

(A) Option 1: At least fifty-one percent of the CCBHC governing board is comprised of individuals with lived experience of mental and/or substance use disorders and families.

(B) Option 2: Individuals with lived experience of mental and/or substance use disorders and family members of people receiving services must have representation in governance that assures input into:

(i) Identifying community needs and goals and objectives of the CCBHC;

(ii) Service development, quality improvement, and the activities of the CCBHC;

(iii) Fiscal and budgetary decisions; and

(iv) Governance (human resource planning, leadership recruitment and selection, etc.).

(3) If the CCBHC is unable to meet the governing board requirements in (2), it must develop an alternative approach for individuals with lived experience and their families to meaningfully participate in governance. This approach must be reviewed and approved by the Oregon Health Authority.

309-009-0060: Variances

~~(1) The Authority may grant a variance to a CCBHC applicant or provider if:~~
~~(a) There is a lack of resources to meet the criteria required in these rules; or~~
~~(b) Implementation of the proposed alternative services, methods, concepts or procedures would result of improved outcomes for the individual.~~
~~(2) CCBHC applicants must submit the variance request directly to the CCBHC project team.~~
~~(3) The request must be in writing and must contain the following:~~
~~(a) Criteria from which the variance is sought;~~
~~(a) The reason for the proposed variance;~~
~~(c) The alternative practice, service, method, concept, or procedure proposed, and;~~
~~(d) A plan and timetable for compliance with the section of criteria for which the variance applies.~~
~~(4) The CCBHC principal investigator must approve or deny the request for a variance and must notify~~
~~the provider in writing of the decision to approve or deny the requested variance, within 30 days of~~
~~receipt of the variance. The written notification must include the specific alternative practice, service,~~
~~method, concept, or procedure that is approved and the duration of the approval.~~

(1) Requirements and standards for requesting and granting variances or exceptions are found in OAR 309-008-1600.
(2) The Division's chief officer or designee shall approve or deny the request for a variance to these rules. The request shall be made in writing using the Division approved variance request form and following the variance request procedure pursuant to OAR 309-008-1600.
(3) Granting a variance for one request does not set a precedent that must be followed by the Authority when evaluating subsequent requests for variance.