MT CCBHC Provider Manual

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Introduction

The Montana Department of Public Health and Human Services (DPHHS) Certified Community Behavioral Health Clinics (CCBHC) Planning Team has prepared this Provider Manual to provide operational guidance related to the implementation of the CCBHC core services in Montana.

We anticipate that this document will be updated and refined over the course of the initial CCBHC program at least quarterly to incorporate provider feedback and to accommodate any program modifications required by the Centers of Medicare and Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the State. Post CCBHC implementation, updated versions of the manual will be published at least 30 days prior to their effective date to allow sufficient time for review and implementation.

Version Number	Date	Summary of Content Changes and Updates
1	9/16/2026	Original publication of the Montana CCBHC Provider Manual
2	10/01/2026	• Updated guidance on CCBHC Provider Enrollment and CCBHC Billing • Updated Treatment Plan requirements for children/youth • Added additional references to applicable DPHHS Policies and Administrative Rules, to which CCBHCs must continue to adhere • Removed Mobile Crisis Services from the list of unallowable services (Service Duplication Restrictions) for individuals residing in an Adult Foster Care service setting • Updated the requirements related to the H.B. 574-required Quality Measure about Law Enforcement Involvement

This CCBHC Provider Manual is aligned with the certification requirements set forth by SAMHSA and CMS. Additionally, it reflects state-specific regulations and guidelines established by DPHHS, ensuring that all operational and clinical practices within Montana's CCBHCs are consistent with national standards while being tailored to meet local needs.

Montana's investment in the CCBHC model reflects a long-standing commitment to strengthening the state's behavioral health system. The initiatives described below build on years of planning, legislative action, and stakeholder engagement. All Montana CCBHCs are required to adhere to the federal CCBHC Certification Criteria and associated requirements, as well as the standards and expectations outlined in this Provider Manual.

Background of CCBHCs in Montana

Behavioral Health System for Future Generations Final Commission Report

In May of 2023, House Bill 872 was signed into law, establishing a major investment to strengthen Montana's behavioral health and developmental disabilities service systems. The legislation supports expanded access to intensive and community-based services statewide.

Beginning in July 2023, the Behavioral Health System for Future Generations Commission held public meetings across Montana to gather input from stakeholders and individuals with lived experience. This feedback informed a final report submitted to the Governor in September 2024, outlining recommended investments and near-term initiatives, including but not limited to expanding and sustaining CCBHCs in Montana. All proposals were funded by the Legislature, and DPHHS is now leading implementation.[1]

House Bill 574

House Bill 574,[2] passed by the Montana Legislature in 2025, authorizes the implementation of the CCBHC model statewide. It mandates the DPHHS to establish the program by October 1, 2026, including setting reimbursement rates, monitoring outcomes, and evaluating cost impacts. It also requires CCBHCs to provide the following services directly:

- targeted case management
- peer and caregiver support
- outreach and education

The bill outlines billing and non-duplication practices, performance metrics, and reporting requirements, and directs DPHHS to create an incentive program for clinics demonstrating exceptional outcomes. DPHHS is guided by the requirements set forth in HB 574 in establishing and implementing the CCBHC program in Montana.

[1] https://dphhs.mt.gov/FutureGenerations/Index
[2] https://legiscan.com/MT/text/HB574/2025

CCBHC Demonstration Program

In May of 2026, DPHHS was notified by CMS and SAMHSA that Montana was one of the ten states selected to join the CCBHC Demonstration Program. The Demonstration Program requires DPHHS and its state-certified CCBHCs to meet federal standards related to CCBHC service delivery and payment. It allows DPHHS to pilot implementation of the CCBHC model in Montana, including paying CCBHCs for the estimated cost of providing CCBHC services using a Medicaid prospective payment system (PPS) rate.

Based on this federal approval, Montana's CCBHC Demonstration program runs for four years, from July 1, 2026 – June 30, 2030. July 1, 2026 – September 30, 2026 served as a start up period, during which DPHHS and the initial cohort of CCBHC providers worked toward establishing the infrastructure necessary to implement CCBHC services. Implementation and payment of CCBHC services (for state-certified CCBHCs) began on October 1, 2026.

Federal CCBHC Requirements

SAMHSA CCBHC Criteria

In order to implement a Montana-based CCBHC initiative, DPHHS built upon the federal *CCBHC Certification Criteria*,[3] promulgated by SAMHSA.[4] SAMHSA's CCBHC Certification Criteria outlines national standards for staffing, access, care coordination, service delivery, quality, and governance to ensure high-quality, person-centered behavioral health care. These criteria provide guidance for clinics seeking certification and help establish consistency across states and providers.

All CCBHCs in Montana must adhere to the SAMHSA CCBHC Certification Criteria, in addition to the requirements outlined in this Provider Manual.

CMS Cost Report and Prospective Payment System Guidance

In addition to the federal CCBHC Certification standards, CMS has established two guidance documents related to the financial structure of the CCBHC initiative that Montana's CCBHCs should reference and utilize to support Cost Reporting and PPS implementation.

[3] https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria

[4] https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria

The federal *CCBHC Cost Report Instructions*[5] provide detailed guidance for clinics on how to complete CCBHC Cost Reports. These instructions cover reporting of direct and indirect costs, anticipated expenses, provider information, and patient visit day data to ensure compliance with federal requirements and accurate rate-setting. It includes information for CCBHCs who are completing their initial Cost Reports to establish their PPS rates (which include both actual (current) and anticipated costs and visit days), as well as guidance related to annual Cost Reports (which only include actual cost and visit days). DPHHS requires CCBHCs to use the CMS CCBHC Cost Report template (available on the same webpage[6]) as part of its initial and annual Cost Report submissions. Given this, the CMS CCBHC Cost Report guidance document is an essential reference for financial and administrative staff managing CCBHC cost reporting obligations.

The *CCBHC Demonstration PPS Guidance Document*[7] provides states and providers with guidance to develop and implement a PPS structure (clinic-specific payment rates) for CCBHCs under the Section 223 Demonstration. This guidance outlines national requirements, including all four PPS methodologies (daily and monthly options), requirements for quality bonus payments, and periodic rebasing of rates. It also details federal match (eFMAP) provisions and cost reporting requirements to ensure that rates align with actual service delivery costs.

For Montana CCBHCs, please keep in mind:

- Montana has selected PPS-1, so references to other PPS methodologies are not relevant to our state CCBHC initiative
- HB 574 requires DPHHS to rebase CCBHC rates no less frequently than every two years, so each CCBHC's rates will be rebased at the following frequency*:

Demonstration Year (DY) 1	**DY 2**	**DY 3**	**DY 4**	**DY 5***	**DY 6***	**DY 7***
PPS rate based on Year 1 Cost Report (with Anticipated Costs/Visits)	DY 1 Rate + MEI	Re-based Rate using Actual DY 2 Costs/Visits	DY 3 Rate + MEI	Re-based Rate using Actual DY 4 Costs/Visits	DY 5 Rate + MEI	Re-based Rate using Actual DY 6 Costs/Visits

[5] https://www.medicaid.gov/medicaid/financial-management/certified-community-behavioral-health-clinic-ccbhc-demonstration/ccbhc-cost-reporting
[6] https://www.medicaid.gov/medicaid/financial-management/certified-community-behavioral-health-clinic-ccbhc-demonstration/ccbhc-cost-reporting
[7] https://www.medicaid.gov/medicaid/financial-management/certified-community-behavioral-health-clinic-ccbhc-demonstration/ccbhc-cost-reporting

** While the federal CCBHC Demonstration initiative is currently planned for four years, DPHHS hopes to sustain the capacity built via the Demonstration initiative through a State Plan Amendment (or other Medicaid vehicle). Therefore, we have included a period of time beyond the Demonstration program in the above table for ease of reference to the planned re-base frequency.*

CCBHC Application and Certification Process

Provider Eligibility

Organizations seeking certification as a CCBHC in Montana's CCBHC Demonstration must meet baseline eligibility requirements established in federal CCBHC statute and criteria, as implemented by the Montana DPHHS. Eligible entities include organizations that:

- Are a nonprofit organization exempt from tax under Section 501(c)(3), a unit of local or tribal government, or operated by or under the authority of a Tribal or Urban Indian organization.
- Are enrolled (or eligible to enroll) as a Montana Medicaid provider and licensed, certified, or accredited to provide both mental health and substance use disorder services, including services for children, youth, and families. CCBHCs are expected to maintain all existing state mental health and substance use service licenses, certifications, and accreditations, as well as adhere to the relevant Administrative Rules of Montana (ARMs) and state requirements, throughout the implementation of CCBHC services.
- Demonstrate the organizational authority, governance structure, and financial capacity to meet all CCBHC Certification Criteria, as validated by the Office of Inspector General (OIG) during the CCBHC Certification application process.
- Serve all individuals regardless of insurance status or ability to pay and adhere to federal requirements related to no refusal of services, sliding fee discounts, and nondiscriminatory access.

Providers must demonstrate the ability to meet the full scope of CCBHC requirements either directly or through formal Designated Collaborating Organization (DCO) agreements and must be prepared to operate in accordance with federal CCBHC Certification Criteria and the Montana CCBHC Provider Manual.

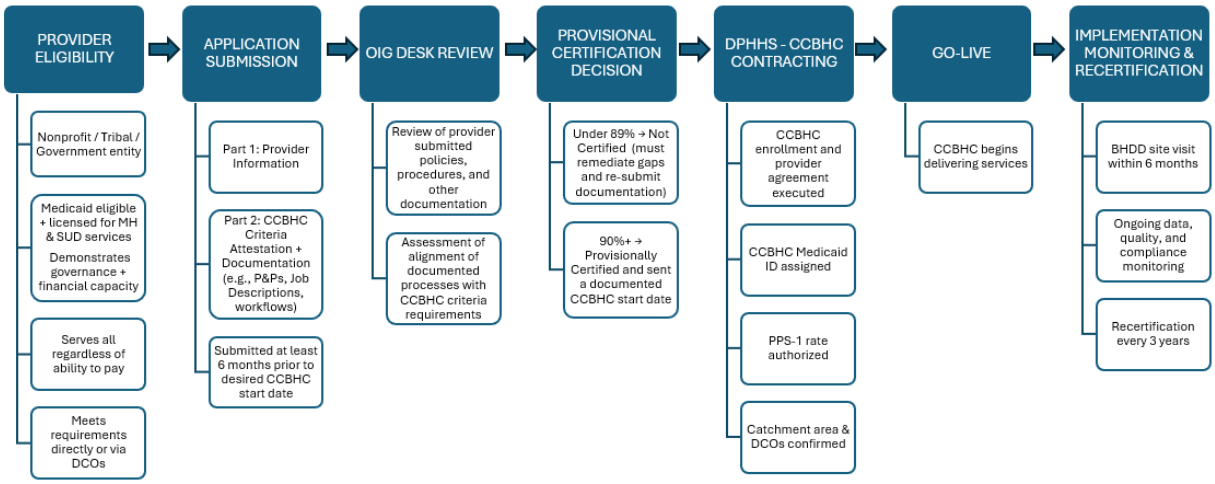
Provider Certification

Montana's CCBHC certification process is administered by OIG, in coordination with the Behavioral Health and Developmental Disabilities Division (BHDD). The process involves

submitting a two-part application for CCBHC Certification, along with supporting documents demonstrating adherence to each CCBHC criteria component, which are reviewed by OIG. If OIG confirms the CCBHC meets 90% or more of the CCBHC criteria, they are provisionally certified and may begin operations at their assigned CCBHC start date. Within six months of initial CCBHC implementation, BHDD will conduct a site visit (along with ongoing data monitoring) to assure the provider is meeting 100% of the CCBHC criteria in practice, after which the provider will receive full certification. Full certification is valid for three years, at which point the provider will seek recertification.

This process is illustrated in Figure 1 and described in more detail in the sections below.

Figure 1: CCBHC Certification Process



Initial Application for CCBHC Certification

Providers seeking CCBHC certification must complete and submit a two-part CCBHC Application. The application consists of:

- **Part 1 - Provider Information**, including organizational, licensing, site, and service delivery details; and
- **Part 2 - Provider Attestation**, in which the provider attests to compliance with the federal CCBHC Certification Criteria and submits required supporting documentation for OIG's review.

Following the launch of Montana's CCBHC Demonstration in October 2026, DPHHS will open an annual CCBHC Certification application cycle during the third quarter of each calendar year (July 1st - October 1st). Applications will be due by October 1st of each year, beginning October 1, 2027. This deadline is set six months before the provider's desired

start date; therefore, providers submitting applications by October 1, 2027, would be eligible for an April 1, 2028 start date.

All submitted applications are reviewed by OIG through a desk review process, which focuses on written policies, procedures, and documentation demonstrating how the provider will operate under the CCBHC model.

Provisional Certification Thresholds

Certification determinations are based on each provider's demonstrated level of compliance with the CCBHC Certification Criteria, as determined by OIG's desk audit of the provider's submitted materials:

OIG Assessment of the Provider's Compliance with the CCBHC Certification Criteria	**Certification Determination**
Under 90% compliance	Providers must address identified gaps and resubmit their application within a defined timeframe. If Providers do not reach 90% compliance (based on OIG's assessment) within 45 days of the planned April 1st CCBHC start date for new providers after Cohort 1, they will not be approved to participate and may reapply in a future Demonstration Year.
90% or greater compliance	Providers are approved for provisional certification and initial participation in the CCBHC Demonstration

Provider CCBHC Enrollment and Contracting

Upon confirmation of provisional CCBHC certification based on OIG's review of the CCBHC certification, DPHHS will enter into a supplemental agreement with each certified CCBHC during provider enrollment. The DPHHS - CCBHC agreement will:

- Require adherence to all provisions of the Montana CCBHC Provider Manual, including service delivery standards, access requirements, quality reporting, and data submission.
- Authorize reimbursement for CCBHC services through Montana's selected PPS-1 methodology.
- Include provisions allowing the Department to impose corrective actions or terminate CCBHC certification and participation if the provider fails to maintain compliance with CCBHC requirements.

- Define the provider's CCBHC start date when they can begin delivering (and billing for) CCBHC services

Each provider must also enroll as a CCBHC (Provider Type 80) in Optum. Please see this site with instructions about how to enroll as a specific provider type in Montana: https://medicaidprovider.mt.gov/providerenrollment. For CCBHCs, this includes going through the following process:

- Initiate an update to the provider's existing record, validating they have the "Type of Provider" Ambulatory Health Care Facility. If not, the provider will select that from the drop-down menu.
- Select taxonomy code 261QC1500X from the drop-down, and under state program select "Certified Community Behavioral Health Clinics (CCBHC)." This will place the details on the National Provider Identifier (NPI) level of the application.
- After this, the provider will navigate to the location tile on the left menu and select the check box of each site location(s) where CCBHC services will be provided and they will provide the PT80 services.

Implementation Monitoring and Recertification

Following each provider's provisional CCBHC certification and initial implementation, BHDD will conduct a site visit within six months of implementation to assess each CCBHC's service quality, operational fidelity, and compliance with CCBHC requirements. During the site visit, BHDD will confirm the CCBHC's adherence to 100% of the CCBHC Criteria, which (if confirmed) will result in full CCBHC Certification. In addition to the site visit, ongoing monitoring will include review of claims data, quality measure reporting, and regular technical assistance check-ins with BHDD. Failure to maintain full compliance with CCBHC Certification criteria may result in corrective action, sanctions, or loss of certification. Corrective action is used for minor and fixable issues; sanctions are applied for serious, repeated, or unresolved issues; and certification may be terminated when non-compliance is substantial, persistent, or poses risk to clients or program integrity.

In addition, CCBHCs must be recertified at least every three years. The recertification process will include:

- An updated application and desk review conducted by OIG; and
- Review of site visit findings and performance data by BHDD.

CCBHC Site Types

As part of CCBHC Certification, a CCBHC must designate each proposed physical location as either a Main Site, Satellite Site, or Access Point, consistent with the definitions below.

- **Main CCBHC Site:** Main sites must provide all nine required CCBHC services physically at the site through in-person service delivery. Telehealth alone is not sufficient to meet the main site requirement. A CCBHC must operate a main site in any county within its catchment area with a population exceeding 50,000 residents. If no county within the catchment area exceeds this population threshold, the CCBHC must operate at least one main site within the catchment area.
- **CCBHC Satellite Site:** Satellite sites must, at a minimum, provide the following core services physically at the site:
    - 24/7 crisis services;
    - Screening, diagnosis, and risk assessment;
    - Person- and family-centered treatment planning; and
    - Outpatient mental health and substance use disorder services.

  A CCBHC must operate a satellite site in any county within its catchment area with a population between 10,001-50,000 residents. In addition, satellite sites must be operated under the governance and financial control of the CCBHC, must have been established prior to April 1, 2014, and must be reasonably accessible to one or more Main CCBHC sites to assure access to all CCBHC services when needed.
- **CCBHC Access Points:** Access points must provide, at a minimum the following services physically at the site location:
    - Screening, diagnosis, and risk assessment;
    - Person- and family-centered treatment planning; and
    - Outpatient mental health and substance use disorder services.

  In addition, CCBHC crisis services must be available across the entire catchment area, even if they are not physically delivered at the access point. access points must promote access to crisis services provided through a main or satellite site, or through a DCO when needed.

  A CCBHC provider should consider an access point in counties with less than 10,000 residents. Access points must be reasonably accessible to a main site to assure access to all CCBHC services.

Regardless of site type, all CCBHC locations within the CCBHC's catchment area must comply with the CCBHC certification criteria applicable to the services provided at that site, as well as other access and related requirements defined in state law and federal

CCBHC criteria. This includes requirements related to staffing, quality reporting, care coordination, and continuity of care.

In addition to the above, all CCBHC staff, regardless of site, must:

- Have access to and document within the CCBHC's electronic health record (EHR);
- Be integrated into CCBHC interdisciplinary team meetings, training, and quality improvement activities; and
- Participate in the CCBHC's population health and integrated care workflows, including processes for identifying and monitoring individuals at higher risk.

Reasonable Accessibility Standards

To ensure timely access to services, all CCBHC satellite sites and access points must be reasonably accessible to a main CCBHC site. Reasonable accessibility in Montana is defined as being within a 120-minute drive time.

Requesting Approval for a New CCBHC Site Location Within Existing Catchment Area

A CCBHC in Montana can request to add a new site location to their existing catchment area after one year of full certification as a CCBHC. When a Montana CCBHC seeks to establish a new site location within its existing approved catchment area, the CCBHC should notify DPHHS as early as possible in the planning process. The request should describe the proposed location, the services to be offered, and how the site will support access to CCBHC services while maintaining compliance with CCBHC requirements.

To facilitate review, CCBHCs should submit the following information:

- Proposed site address and anticipated opening date
- Type of site (e.g., main, satellite, or access point)
- Counties, communities, or ZIP codes to be served
- Description of services that will be provided at the site, including those offered on site and any planned telehealth services
- Anticipated hours of operation
- Brief explanation of how the new site will improve access to care, address identified community needs, or reduce barriers to services
- Description of how individuals served at the new location will have access to the full array of CCBHC services, either directly or through established referral and care coordination processes

- Confirmation that the site will operate under the CCBHC's governance, quality improvement, EHR, and compliance structures

DPHHS may request additional information as needed to evaluate the proposed site and ensure continued compliance with state and federal CCBHC requirements. CCBHCs should not begin billing services under the CCBHC program at the new location until receiving written approval from DPHHS.

Defining Your CCBHC Catchment Area

Each CCBHC's catchment area is the geographic scope within which a CCBHC operates. A CCBHC catchment area in Montana is defined as a single county or a contiguous set of counties that a CCBHC is approved to serve. A provider may propose to serve non-contiguous counties as a CCBHC; however, non-contiguous counties are considered separate catchment areas and must independently meet all applicable CCBHC certification criteria as confirmed through a separate CCBHC application and certification process. If successful, this will result in the provider having two independently operating CCBHC programs.

Defining the catchment area for your CCBHC is essential, as it frames the population whose needs will drive the CCBHC's programming and services. During certification and the Community Needs Assessment, each CCBHC will be asked to specify:

- The geographic boundaries and size of its selected service area. In Montana, CCBHCs should define their catchment areas based on full county boundaries. Partial county coverage will not be permitted.
- Service delivery sites, including both CCBHC locations (main, satellite, and access point sites) and those of any DCO partners.
- Population characteristics, including cultural and linguistic diversity, age distribution, and priority populations (e.g., veterans, children, individuals with serious mental illness or substance use disorders).
- Health and social indicators, such as prevalence of behavioral health conditions, suicide and overdose data, poverty rates, housing instability, and transportation challenges.

A well-defined catchment area allows the CCBHC to ground its staffing model, service design, and outreach strategies in the lived realities of the community. By doing so, CCBHCs ensure equitable access, tailor care delivery, and strengthen partnerships with other local organizations serving the same population.

Multiple CCBHCs Serving a Single County

In Montana, DPHHS will allow multiple CCBHCs to serve the same county on a case-by-case basis. However, if a provider proposes to serve a county that is already part of an existing CCBHC's catchment area, the following additional requirements apply:

- The provider must submit data clearly demonstrating unmet service needs across the full scope of the CCBHC service continuum that their proposed CCBHC will address. This could include (but is not limited to) data related to:
    - Wait times for services
    - Geographic access barriers
    - Underserved populations and the disparities in service access/outcomes they experience
    - Emergency Department utilization, hospitalization, overdose, suicide, and crisis-service data
- The provider must submit written documentation about their plans for coordination and collaboration with the existing CCBHC (e.g., to ensure non-duplication of services), Local Government Units, and other community partners
    - If multiple CCBHCs are serving a single county, a Care Coordination agreement will be required between the two CCBHCs that clearly defines how the CCBHCs will coordinate and ensure non-duplication of client services (will be a condition of certification/recertification).
    - The incoming CCBHC will be responsible for reaching out to the existing CCBHC to define care coordination protocols and assess community needs.
- The provider requesting new CCBHC certification must meet with BHDD prior to submitting their CCBHC certification application to discuss operational considerations, including:
    - Anticipated client volume based on identified unmet needs
    - Staffing capacity and approach
    - Their plans for coordination and collaboration with the existing CCBHC (e.g., to ensure non-duplication of services), Local Government Units, and other community partners

Expanding Your CCBHC Catchment Area to Contiguous Counties

CCBHCs are expected to use their Community Needs Assessments to identify unmet behavioral health needs and to inform decisions about adding counties or service locations. Regardless of geography, CCBHCs must assure access to the full scope of required CCBHC services for all individuals residing in or receiving services within the catchment area.

CCBHCs seeking to expand their catchment area to a contiguous county or set of contiguous counties may submit a Catchment Area Expansion Request Form to DPHHS after completing at least one year of CCBHC operations following full CCBHC Certification (received after a successful site visit with BHDD).

At a minimum, the request must be submitted 60 days prior to the desired expansion date and include:

- The additional county or counties proposed for inclusion in the catchment area
- The name, address, and type (main, satellite, or access point) of each proposed site located in the expanded catchment area
- The date each site was established
- The CCBHC services that will be provided at each site
- A narrative describing the community needs the expansion is intended to address, with a direct tie to your CCBHC Community Needs Assessment or updated Community Needs Assessment to incorporate the new county/ies
- A staffing plan for the expanded catchment area
- A description of how individuals served in the expanded area will be screened for, offered, and connected to all required CCBHC services
- A description of how staff at additional sites located in the expanded catchment area will be integrated into overall CCBHC operations
- Confirmation that the site will operate under the CCBHC's governance, quality improvement, EHR, and compliance structures

In addition to reviewing the written request, DPHHS will review the quality and effectiveness of the CCBHC's existing operations to determine whether the agency demonstrates the capacity to successfully expand its catchment area. This review will include an assessment of the CCBHC's current service delivery model, access to required services, staffing capacity, care coordination practices, and overall compliance with CCBHC program requirements. In addition, DPHHS will analyze service utilization and outcome data from the CCBHC's current operations to evaluate performance, quality of care, and client outcomes. DPHHS may request additional documentation or data related to current operations, performance metrics, or outcomes as needed to inform its determination.

Based on this review, DPHHS will jointly determine whether the CCBHC has the capacity necessary to support services in the new county and if so, will issue written approval, including an approved start date. Approved expansions may take effect at the beginning of any CCBHC Demonstration quarter (Oct. 1st, Jan. 1st, Apr. 1st, Jul. 1st).

CCBHC Staffing

CCBHC staffing plans must be informed by the Community Needs Assessment and support the full scope of services delivered within the CCBHC service area. Staffing plans are a required component of CCBHC certification and recertification and apply to services delivered directly by the CCBHC, as well as those provided through formal arrangements with DCOs. All staffing must comply with applicable Montana licensure, credentialing, and administrative requirements, as well as any relevant accreditation standards.

Staffing levels and composition must be sufficient to meet behavioral health needs of individuals across the lifespan and reflect the size, geographic coverage, and service array of the CCBHC. Staffing plans must be reviewed and updated regularly, and no less than once every three years, or more frequently as community needs change.

At a minimum, CCBHC staffing, inclusive of both CCBHC and contracted DCO staff, must include the following roles:

- A Leadership and Management team appropriate for the size and needs of the CCBHC, which must include:
    - Chief Executive Officer (CEO) or Equivalent, who is responsible for overall organizational leadership and ensuring that the CCBHC maintains adequate staffing to meet program and certification requirements. This individual oversees a management structure appropriate to the size and complexity of the organization, as informed by the Community Needs Assessment.
    - Medical Director, who provides clinical leadership and oversight of behavioral health service delivery and is responsible for the quality and integration of medical and behavioral health care. This role is preferably filled by a psychiatrist and may be part-time or contracted. If a psychiatrist is not available, another qualified prescriber with appropriate education, licensure, and authority under Montana law may serve in this role. The Medical Director should have experience in supporting Medications for Addiction Treatment. When the Medical Director lacks this experience, the CCBHC must ensure access to consultation from addiction medicine specialists.
- Staff to provide all required CCBHC services, including but not limited to:
    - Medically Trained Behavioral Health Prescribers, who are authorized to prescribe and manage medications, including FDA-approved Medications for Addiction Treatment for individuals with opioid, alcohol, and tobacco use disorders, in accordance with Montana law. Consultation must be available when specialized expertise is required.

- Licensed Clinical Treatment Staff, including individuals with expertise in mental health and substance use disorder treatment as part of an integrated care model. The clinical team should include individuals with experience in trauma-informed, recovery-oriented care for children, adolescents, adults, and older adults. Staff may include licensed behavioral health professionals and supervised unlicensed practitioners working toward licensure, consistent with Montana requirements.
- Staff to deliver primary care screening and monitoring services, who support integrated care and may include physicians, nurse practitioners, physician assistants, registered nurses, and other licensed nursing staff operating within their scope of practice.
- Certified Peer Support Staff, which may include adult and family peers with lived experience. Peer staff must receive appropriate training, supervision, and support. Peer staff may be hired directly or through formal arrangements, consistent with Montana standards.
- Targeted Case Management Staff, who will support care coordination, targeted case management, and service navigation. Minimum qualifications for a staff member providing Targeted Case Management services are a bachelor's degree in a human services field with at least one year of full-time experience serving people with mental illnesses and/or substance use needs. Individuals with other educational backgrounds who, as providers, consumers, or advocates of mental health/substance use services have developed the necessary skills, may also be employed as targeted case managers. The CCBHC's targeted case management staff position description must contain equivalency provisions.
- Psychiatric Rehabilitation and Skills Support Staff, who provide rehabilitation and recovery-oriented services under the supervision of a licensed mental health professional and according to the individual's rehabilitation goals.
- Staff with Specialized Population Training Capacity: CCBHCs are required to serve veterans, active duty service members, and other specialized populations as identified by their Community Needs Assessment. CCBHCs must ensure staff have training appropriate to the cultural and service needs of those populations.

Staff Training Requirements

CCBHCs must maintain a staff training plan that aligns with Montana requirements, applicable accreditation standards, and the SAMHSA CCBHC Certification Criteria.[8] Training requirements apply to all employed and contracted staff and must be appropriate to staff roles and responsibilities.

At orientation and at regular intervals thereafter, CCBHC staff must receive training on the following topics, at a minimum:

- Evidence-based and best-practice behavioral health interventions
- Cultural competency
- Person-centered, family-centered, and recovery-oriented care
- Trauma-informed care
- The CCBHC's policy and procedures related to continuity of operations and emergency response
- Coordination and integration with primary care, including the services a CCBHC offers via primary care screening and monitoring and processes for supporting connections to primary care providers and/or specialists when needs outside of the scope of the CCBHC are identified
- Treatment of co-occurring mental health and substance use disorders

At orientation and annually thereafter, CCBHC staff must receive training on:

- Risk assessment
- Suicide prevention and response
- Overdose prevention and response
- The roles and integration of family members and peer support staff
- Military culture to support staff serving active-duty military members or veterans

CCBHCs must also provide additional training opportunities to support staff competency based on community need and service delivery requirements. These may include, but are not limited to, trainings related to child- and adult-serving systems, developmental and family-focused care, community safety, and specialized population needs.

CCBHCs are responsible for routinely assessing staff competencies and providing ongoing education and in-service training to ensure high-quality, compliant, and responsive care.

[8] https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

Designated Collaborating Organizations

A Designated Collaborating Organization (DCO) is a partner agency or provider that a CCBHC formally contracts with to carry out certain CCBHC service(s) (or a portion of a CCBHC service) the lead CCBHC is unable to deliver on its own, or to broaden the scope of CCBHC services available to clients. These agreements allow CCBHCs to expand service access while ensuring individuals still receive care that is coordinated, high quality, person-centered, and aligned with the CCBHC criteria requirements.

Lead CCBHCs are expected to remain at the center of care delivery, even when DCOs are engaged. Federal rules require that each lead CCBHC deliver at least 51% of required service encounters directly. This threshold is designed to keep most of the care within the lead CCBHC's oversight, ensuring that clients maintain a strong and consistent relationship with their CCBHC provider. At certification, each CCBHC that proposes to use one or more DCOs will be required to share their documented processes for monitoring service encounters to ensure compliance with this requirement.

When services are delivered through DCOs, they must be seamlessly integrated into the CCBHC's overall operations. This includes shared treatment planning, timely and secure exchange of client information, and coordinated service delivery so that clients experience care as continuous and unified.

All CCBHCs that partner with a DCO must have a formal written agreement that:

- Specifies the roles, responsibilities, and expectations of both organizations
- Requires compliance with all state and federal laws and regulations, as well as the SAMHSA CCBHC Criteria relevant to the service(s) being provided
- Establishes processes for regular communication and coordination between the CCBHC and the DCO, both related to shared client care and overall partnership arrangements

Whenever possible, compatible EHR systems or connectors should be used to support secure data sharing and coordination of services. However, if this is not feasible, secure, manual information exchange (e.g., via a Secure File Transfer Protocol) between partners is acceptable.

Additionally, CCBHCs must routinely review DCO performance to ensure that services follow CCBHC criteria requirements. Corrective action must be taken if quality concerns arise.

DCOs are held to the same reporting and confidentiality requirements as the CCBHC, including compliance with HIPAA, 42 CFR Part 2, and CCBHC and state Medicaid reporting

standards. CCBHCs are responsible for supporting DCO partners in meeting these obligations, and DCOs should report all relevant data to the CCBHC, for submission to the state as applicable.

DCOs must maintain appropriate staffing, deliver services in a timely manner, and ensure that care is culturally and linguistically appropriate for the populations served.

Clients must be informed when services are provided through a DCO, how those services fit into their overall treatment plan, and who they can contact with questions or for support.

The CCBHC is ultimately responsible for the quality and coordination of all care, whether delivered directly or through a DCO. Strong oversight, integration, and transparency are essential to ensuring that these collaborations enhance, rather than fragment, the system of care available to Montana communities.

CCBHC Access Requirements

Under Section 223(a)(2)(B) of the Protecting Access to Medicare Act (PAMA), CCBHCs are required to make services available and accessible to all individuals. This includes ensuring crisis management services are available 24 hours a day, applying a sliding fee scale so no one is denied care due to inability to pay, and prohibiting the rejection or limitation of services based on a person's place of residence.

Building on this federal requirement, CCBHCs in Montana must ensure timely and equitable access to the full array of required services. Access standards are designed to remove barriers, uphold person-centered principles, and ensure that individuals and families can receive behavioral health care when and where it is needed.

Key Access Requirements for Montana CCBHCs include:

- Individuals cannot be turned away based on diagnosis, age, level of need (as long as they are appropriate for the outpatient/intensive outpatient level of care), geographic location, or ability to pay. Crisis services must be provided regardless of residence or insurance status
- Timeliness of Services, including for individuals with:
    - Crisis needs, for whom services must be available immediately and 24/7
    - Urgent needs, for whom an initial evaluation (and initial clinical services) must occur within one business day
    - Routine needs, for whom the first appointment for an initial evaluation (and initial clinical services) must occur within 10 business days

- In alignment with House Bill 574, the CCBHC comprehensive diagnostic evaluation must be completed with each client within 30 calendar days of the individual's first request for services
- Clinics must define and serve their designated catchment area, as further described in the above sections, ensuring that individuals have access to all CCBHC services regardless of where they live in the CCBHC's catchment area
- Consistent with federal law, no individual may be denied services due to inability to pay or insurance status. CCBHCs must maintain a sliding fee scale related to CCBHC service provision, with the ability to reduce or waive fees in accordance with federal poverty levels
- Services must be delivered in ways that accommodate cultural, linguistic, and disability-related needs. This includes providing interpreters, accessible locations, and telehealth options when necessary to support access
- CCBHCs are responsible for coordinating care across settings and with external providers to ensure individuals experience a seamless continuum of services

CCBHC Scope of Services

Behavioral Health Crisis Services

To support consistent, statewide access to behavioral health crisis services while accounting for Montana's rural and frontier geography, the State has established a tiered crisis response framework for CCBHCs. This approach ensures that all counties have access to 24/7 crisis response, with a service model based on county population size and available infrastructure.

All CCBHCs are responsible for ensuring that individuals experiencing a behavioral health crisis receive timely, person-centered, and clinically appropriate intervention at any time, 24 hours per day, 7 days per week, either directly or through formal agreements with DCOs.

24/7 Mobile Crisis Service Requirements

Tier 1: Crisis De-Escalation (Counties with Less than 10,000 Population)

In counties with less than 10,000 residents, where there is often limited workforce and infrastructure capacity, crisis response will be primarily delivered through telehealth-supported de-escalation and coordination. Key requirements of CCBHC Crisis Services in these counties include:

- 24/7 crisis service availability through contracted or shared service models that ensure consistent access to clinical support across the catchment area

- Execution of agreements with existing 988 Suicide & Crisis Lifeline providers to ensure coordination of crisis call response and follow-up
- Use of existing, trained[9] first responders (e.g., law enforcement, EMS) to support in-person response when needed, all of whom will have (at minimum) access to a licensed behavioral health professional (e.g., Licensed Clinical Social Worker [LCSW], Licensed Clinical Professional Counselor [LCPC], Licensed Addiction Counselor [LAC], Psychologist, or equivalent) via telehealth to provide real-time clinical consultation, risk assessment, and de-escalation support*

**If a CCBHC is unable to enter into an agreement with existing first responders to support in-person response, they should document their outreach efforts and continue conducting outreach, at minimum biannually, to build and strengthen the partnership.*

Tier 2: On-Call Co-Response (Counties 10,001–50,000 Population)

In mid-sized counties with between 10,001 and 50,000 residents, crisis response capacity is expanded to include on-call co-response services available 24/7/365.

Key requirements for these counties include:

- Availability of on-call paraprofessional co-responders (qualifications and training requirements at the discretion of the CCBHC) who can respond in person in coordination with first responders
- Access to a licensed behavioral health professional (e.g., LCSW, LCPC, LAC, Psychologist, or equivalent) on-call at all times, who can support crisis assessment and stabilization services. The licensed professional may provide clinical oversight and consultation either in person or via telehealth
- Integration with local crisis system partners, including 988 call centers and emergency responders, to support coordinated dispatch and response

Tier 3: Full Mobile Crisis Response (Counties Greater than 50,000 Population)

In larger counties with more than 50,000 residents, CCBHCs are expected to operate or partner to provide a comprehensive 24/7 mobile crisis program. Key requirements of this tier include:

- Deployment of mobile crisis teams operating 24/7, with:
    - Two-person response teams available for a minimum of 16 hours per day, and
    - At least one qualified responder available during remaining hours

[9] Specific training is up to the discretion of each CCBHC/local partner. If a training resource is needed, the University of Montana offers a Montana Crisis Now Training, available at no cost to interested stakeholders: https://www.umt.edu/ccfwd/training/crisis/

- A CCBHC mobile crisis staffing model that includes:
    - A licensed behavioral health professional (e.g., LCSW, LCPC, LAC, Psychologist, or equivalent) to conduct crisis assessment and stabilization services, and
    - Clinical supervision and oversight, including a designated supervisor role
- Integration with local crisis system partners, including 988 call centers and emergency responders, to support coordinated dispatch and response

Additional Requirements, Regardless of County Size/Tier

For all counties in their catchment area, BHDD strongly encourages CCBHCs to establish DCO agreements with existing state-sanctioned mobile crisis providers to leverage established infrastructure and enhance service capacity.

Following all mobile crisis service encounters, CCBHCs are required to provide follow-up support to the individual within 72 hours. If the follow-up involves a distinct CCBHC service that rises to the level of a billable service (e.g., peer support services, a clinical session), that service may be billed accordingly. However, CCBHCs should not bill H2011 U1/U2/U3 again for a follow-up contact involving only care coordination and monitoring tied to the mobile crisis encounter. These care coordination activities are carried costs, meaning they do not trigger the PPS payment and should not be billed outside of the CCBHC model for these activities when they are provided to a Medicaid enrollee.

CCBHC Crisis Receiving and Stabilization Services

In addition to virtual and mobile crisis response services, CCBHCs must ensure reasonable access to crisis receiving and stabilization services appropriate to the population and geographic characteristics of each county within their service area. CCBHCs in Montana must meet the below requirements within 18 months of their certification. Across all counties, CCBHCs are responsible for ensuring that individuals experiencing a behavioral health crisis can be safely transported to, received and engaged in, and stabilized within the least restrictive clinically appropriate setting, with established protocols for warm handoffs, care coordination, and follow-up services. Services should operate within a "no wrong door" framework and provide clear pathways for escalation and step-down across levels of care.

Tier 1: Crisis Living Room or Peer-run Crisis Diversion Program (Counties with Less than 10,000 Population)

CCBHCs in counties with less than 10,000 residents must ensure access, either directly or through a formal DCO partnership, to a Living Room Model or comparable peer-operated crisis diversion setting within a three-hour drive. These crisis diversion programs are not required to be 24/7; however, hours should reflect local demand patterns (e.g., evenings,

weekends). These settings should provide a low-barrier, voluntary, non-clinical environment for ongoing recovery support, early crisis intervention, and diversion from emergency departments and inpatient care. Formal protocols must exist for referral and transportation to higher-acuity crisis stabilization services when needed.

Tier 2: Crisis Drop-In Center (Counties 10,001-50,000 Population)

CCBHCs in counties with 10,001-50,000 residents must ensure access to a Crisis Drop-In Center, provided either directly or via DCO partnership, with a three-hour drive. Crisis Drop-In Centers should provide voluntary, low-barrier crisis stabilization services staffed by licensed clinicians and peer specialists, offering assessment, triage, safety planning, crisis intervention, and brief stabilization as an alternative to hospital emergency departments. Crisis Drop-In Centers are recommended to be open for a minimum of 12 hours per day, with the goal of 24/7/365 coverage as regional capacity allows. Hours should reflect local demand patterns (e.g., evenings, weekends). Formal agreements must support step-up access to higher-acuity crisis receiving services when clinically indicated.

Tier 3: In-County Crisis Receiving Center (Counties >50,000 Population)

CCBHCs in counties with more than 50,000 residents must ensure access to an in-county crisis stabilization resource, which may include a Crisis Receiving Center or comparable crisis receiving and stabilization program. Communities serving larger populations should work toward development of a dedicated Crisis Receiving Center capable of providing 24/7/365 crisis receiving, assessment, stabilization, law enforcement and EMS drop-off, and coordination with mobile crisis and 988 services.

Post-Crisis Continuity of Care, Regardless of County Size/Tier

Regardless of the specific crisis receiving or stabilization service provided, the goal of the CCBHC is to de-escalate and stabilize the immediate crisis, then engage the individual and, when appropriate, their family in clinically appropriate ongoing services based on their unique needs, strengths, and preferences. To support this transition, CCBHCs must establish formal warm handoff, care coordination, and engagement processes that promote timely connection to ongoing treatment and recovery supports. These processes should include active follow-up, direct communication between providers, and procedures to address barriers to engagement so that individuals do not lose connection to care after the immediate crisis has resolved. This continuity of care is intended to support recovery, improve long-term outcomes, and, whenever possible, prevent future crises.

Screening, Assessment, and Diagnosis

CCBHCs must provide timely, comprehensive, and developmentally appropriate screening, assessment, and diagnostic services for individuals across the lifespan. These

services are foundational for person-centered care, treatment planning, and care coordination. All procedures must adhere to SAMHSA CCBHC Certification Criteria[10] and use evidence-based practices and standardized instruments.

Screening identifies behavioral health risks, SDOH, and other factors that may influence treatment planning. All individuals served should be engaged to complete an initial evaluation that includes, at a minimum gathering information on their:

- Preliminary diagnoses, reason for seeking care, and referral source
- Immediate clinical needs and safety concerns
- Current medications and history of treatment
- Substance use and risk to self or others
- Social service involvement (for children/youth, child welfare or juvenile justice)
- An assessment of need for medical care
- A determination of whether the person presently is or has ever been a member of the U.S. Armed Services

For individuals already receiving behavioral health services from a clinic prior to that clinic's CCBHC certification, CCBHCs should do the following at the individual's next treatment plan review session (which must occur within six months of CCBHC certification at the latest):

- Gather and document updated assessment information from each individual as needed to ensure all of the required initial and comprehensive evaluation information is collected in alignment with the CCBHC criteria
- Engage the individual to update their treatment plan as needed, to include all CCBHC services that are appropriate based on their needs and preferences

In alignment with the above, CCBHCs are required to use the following validated tools appropriate to age, clinical presentation, and population served:

Adults 18 and Over

Screening

Required screening instruments for adults include:

- Depression: PHQ-9
- Anxiety: Generalized Anxiety Disorder-7 (GAD-7)
- Suicide Risk: Columbia Suicide Severity Rating Scale (C-SSRS)

[10] https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

- Alcohol Use Disorder / SUD / Opioid Use Disorder: Single Question Screening for AUD & Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)
- SDOH: Accountable Health Communities Health-Related Social Needs (AHC-HRSN)

Physical health and chronic disease screenings should also be conducted, as further described under Primary Care Screening and Monitoring, including:

- Comprehensive primary care questionnaire
- Vital signs (Body Mass Index (BMI), blood pressure, heart rate)
- HIV and viral hepatitis screening tests as indicated
- Tobacco use
- Labs or additional screenings as clinically indicated
- Optional screening for chronic pain when relevant

Assessment

- Adults with SMI: LOCUS
- Adults requiring SUD treatment: American Society of Addiction Medicine (ASAM) Level of Care assessment and treatment planning modules, including a comprehensive evaluation
- Adults requiring Intensive Outpatient Services for SUD: DLA-20

Diagnosis

- Clinical diagnoses must be based on comprehensive assessments, standardized tools, and clinical interviews
- CCBHCs must consider and document whether individuals have co-occurring mental health and substance use disorders
- CCBHCs should incorporate understanding of the individual's medical, psychosocial, and cultural considerations when making a diagnosis

Children and Youth 17 and Under

Screening

Required screening instruments for youth include:

- Depression: PHQ-Adolescent
- Anxiety: GAD-7
- Suicide Risk: C-SSRS
- Alcohol/Drug Use: The CRAFFT Screening Tool
- SDOH: AHC-HRSN

Physical health screenings should mirror adult protocols in an age-appropriate format, including vital signs, primary care questionnaires, and labs as clinically indicated. This includes the following:

- Age-appropriate primary care questionnaire
- Vital signs: BMI, blood pressure, heart rate
- HIV and viral hepatitis screening tests (as indicated)
- Tobacco use
- Labs or additional screenings as clinically indicated

Assessment

- For children under 6, the ECSII assessment modules
- For children and youth ages 6-17, CALOCUS-CASII assessment modules
- Youth requiring only SUD treatment: American Society of Addiction Medicine (ASAM) Level of Care assessment and treatment planning modules
- For all children and youth regardless of age and diagnosis, an age-appropriate comprehensive evaluation must be included for treatment planning

Diagnosis

- Diagnoses must be based on standardized assessments and clinical interviews
- For children and youth, diagnoses must be developmentally appropriate and reflective of psychosocial context
- CCBHCs should incorporate understanding of the individual and family's medical, psychosocial, and cultural considerations when making a diagnosis

Person-Centered and Family-Centered Treatment Planning

Montana CCBHCs are required to provide person-centered and family-centered treatment planning for all members receiving behavioral health services. Treatment plans must be individualized, recovery-oriented, and developed collaboratively with the individual and, when appropriate, their family or caregivers. CCBHC treatment planning services should adhere to Policy #120.[11]

The treatment plan must reflect findings from the individual's comprehensive evaluation. In alignment with Montana state requirements, the individualized plan must be completed within 21 days of admission to the CCBHC.

[11] https://dphhs.mt.gov/assets/BHDD/MedicaidManual/120IndividualizedTreatmentPlansforBehavioralHealthTreatment.pdf

Plans must be reviewed and reassessed at least every 90 days or sooner if there are changes in the member's condition, strengths, areas of concern, or treatment goals. Reviews must document progress and result in either plan amendments or confirmation of continued appropriateness.

The plan must be signed and dated by the individual receiving services (or guardian for minors). Adults direct their own plan; for minors, family/caregivers are actively involved. Plans must also be reviewed and signed by at least one appropriately licensed behavioral health professional, including one of the following:

- a physician licensed under Title 37, chapter 3
- an advanced practice registered nurse, as provided for in 37-8-202, with a clinical specialty in psychiatric mental health nursing
- a psychologist licensed under Title 37, chapter 17
- a social worker licensed under 37-39-308
- a professional counselor licensed under 37-39-309
- an addiction counselor licensed under 37-39-310
- a marriage and family therapist licensed under 37-39-311
- a physician's assistant licensed under Title 37, chapter 20

Plans emphasize strengths, resiliency, and wellness for each individual served. Treatment planning must incorporate the member's and family's values, beliefs, and cultural background. Each treatment plan must:

- Clearly define problems, functional impairments, goals, objectives, and interventions
- Include type, duration, and frequency of services, and discharge/step-down criteria for when a service is no longer required
- For Children/Youth, the treatment plan should also include family strengths, goals, cultural considerations, and evidence of family involvement

Outpatient Mental Health and Substance Use Services

Montana CCBHCs provide outpatient behavioral health services, including both mental health and SUD treatment, directly or through a DCO. Services are evidence-based, recovery-oriented, and tailored across the lifespan to meet the unique needs of adults, children, adolescents, and families.

Mental Health outpatient services include individual, family, and group psychotherapy in which diagnosis, assessment/reassessment, psychotherapeutic interventions, and related services are provided as outlined in the American Medical Association's Common

Procedural Terminology manual. Additional information can be found in Policy Number 425 (services for adults)[12] and the Children's Mental Health Bureau Medicaid Services Provider Manual (services for children)[13].

Substance Use outpatient services (ASAM 1.0) include recovery or motivational enhancement therapies/strategies. Services include individual, family, and group therapy in which diagnosis, assessment, psychotherapy, and related services are provided. Services are designed to help members achieve changes in alcohol and/or drug use and addictive behaviors and often address issues that have the potential to undermine the patient's ability to cope with life tasks without the addictive use of alcohol, other drugs, or both. Additional information can be found in Policy Number 520.[14]

For all outpatient services, services may be provided by a master's-level licensed mental health professional and/or licensed addiction counselor operating within their scope of practice. Licensure candidates may provide services under supervision in CCBHC settings.

In addition, for all outpatient services, groups are limited to a maximum of 16 participants. No prior authorization or continued stay review is required, though documentation of medical necessity is mandatory. Services must be based on a comprehensive assessment and incorporated into the individual's treatment plan.

Intensive Outpatient Services

In addition, CCBHCs must offer Intensive Outpatient Program services for individuals with SUD (ASAM Level 2.1). This is a structured program for clients who have a moderate or severe SUD diagnosis, as well as a willingness to engage in and a need for core service components. Services must follow ASAM Level 2.1 service planning standards, including therapies, support systems, assessment/treatment plan review, staff qualifications, and documentation. Additional information can be found in Policy # 525.[15]

While CCBHCs will bill for these services under the daily PPS-1 rate structure, minimum weekly hours (nine hours of services for adults and six hours of services for youth) must be met. Any exceptions require documentation and reassessment related to the appropriate level of care for the individual.

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[12] https://dphhs.mt.gov/assets/BHDD/SubstanceAbuse/Proposed_425MHOPTherapy_eft.10.1.pdf

[13] https://dphhs.mt.gov/assets/BHDD/CMB/providermanuals/FinalCMHBMedicaidServicesProviderManual050926.pdf

[14] https://dphhs.mt.gov/assets/BHDD/MedicaidManual/520SUDASAM1_0.pdf

[15] https://dphhs.mt.gov/assets/BHDD/SubstanceAbuse/525_SUD_ASAM2.1_eff.3.8.25.pdf

Prior authorization is not required. Continued stay review is required after 120 days and every 30 days thereafter.

Evidence-Based Practices

Montana CCBHCs are required to use EBPs for mental health and SUD treatment, including the following:

Montana CCBHC Required Evidence-based programs	**Description**
Motivational Interviewing (MI)	An effective, evidence-based technique for helping clients resolve ambivalence about behaviors that prevent change. The core goals of MI are to express empathy and elicit clients' reasons for and commitment to changing substance use and other unhealthy behaviors.[16]
Cognitive Behavioral Therapy (CBT)	A form of psychological treatment that has been demonstrated to be effective for a range of problems including depression, anxiety disorders, alcohol and drug use problems, marital problems, eating disorders, and severe mental illness.[17]
Dialectical Behavior Therapy (DBT)	A type of psychotherapy used to treat people with certain mental health conditions that involve problems in regulating emotions. [18]
Seeking Safety	Treatment that helps people with trauma, posttraumatic stress disorder, and substance misuse. [19]
Program for Assertive Community Treatment (PACT), or its adapted model of Montana Community Treatment	A specialized outpatient service that helps adults experiencing serious and long-lasting mental health challenges.[20,21] Additional information about this EBP can be found below this table here: PACT/Montana Community Treatment.
Medications for Addiction Treatment, including Medications for Opioid Use Disorders, Alcohol Use	Montana CCBHCs must ensure access to FDA-approved medications for addiction treatment for individuals with opioid, alcohol, and tobacco use disorders, including the capacity to prescribe and manage medications such as

[16] https://library.samhsa.gov/sites/default/files/PEP20-02-02-014.pdf
[17] https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral
[18] https://www.yalemedicine.org/conditions/dialectical-behavior-therapy-dbt
[19] https://www.samhsa.gov/resource/dbhis/seeking-safety
[20] https://dphhs.mt.gov/assets/BHDD/SubstanceAbuse/460_PACT_eff.3.8.25.pdf
[21] https://dphhs.mt.gov/assets/BHDD/SubstanceAbuse/455_MCT_eff.3.8.25.pdf

Disorders, and Tobacco Use Disorders	buprenorphine, naltrexone, and other evidence-based pharmacotherapies. Consistent with the CCBHC Certification Criteria, CCBHCs that do not directly provide methadone must make a good faith effort to establish referral and care coordination relationships with an Opioid Treatment Program to ensure timely access to this service. Medication treatment should be delivered as part of a comprehensive, person-centered approach that incorporates counseling, recovery supports, care coordination, and ongoing monitoring to support long-term recovery and wellness. Additional information about this EBP can be found below this table here: Medications for Addiction Treatment in a CCBHC.
Parent management training	An evidence-based approach that helps parents manage challenging behaviors and create lasting, positive change. PMT has been shown to be effective in decreasing oppositional, aggressive, and antisocial behavior among participating children.[22]
Suicide safer care plan	Curriculum related to skills for suicide risk assessment, evidence-based interventions, referral and transition, and changing the culture of addressing suicide risk across clinical practice.[23]

This list is not intended to be all-inclusive. CCBHCs are encouraged to, based on their community needs assessment, determine whether other evidence-based treatments may be appropriate, such as Coordinated Specialty Care (CSC) for First Episode Psychosis; long-acting injectable medications for mental health and SUD; and Trauma-Focused CBT (TF-CBT).

Regardless of intervention, CCBHCs must provide developmentally appropriate services, considering age, life stage, cognitive abilities, and family involvement, particularly for children, adolescents, transition-age youth, and older adults. Measurement-based care (MBC) is encouraged to monitor client outcomes and adjust treatment as necessary.

Medications for Addiction Treatment in a CCBHC

Medications for Addiction Treatment (MAT) are among the most effective evidence-based interventions available for treatment of substance use disorders and are a required

[22] https://parentmanagementtraininginstitute.com/research
[23] https://clinicians.org/programs/suicide-safer-care/

component of CCBHC service delivery. Montana CCBHCs must ensure timely access to FDA-approved medications for individuals living with opioid use disorder (OUD), alcohol use disorder (AUD), and tobacco use disorder (TUD), delivered as part of a comprehensive, person-centered treatment approach that includes screening, assessment, counseling, recovery supports, care coordination, and ongoing monitoring. CCBHCs must employ or formally partner with qualified medical providers as a DCO, who can prescribe and manage these medications (not including methadone) and must integrate pharmacotherapy into broader treatment and recovery plans.

Medications for Opioid Use Disorder

CCBHCs must make medications such as buprenorphine and naltrexone available to individuals with OUD who may benefit from treatment. Extensive research has demonstrated that medications for OUD reduce opioid use, decrease overdose risk, improve treatment retention, and support long-term recovery. Consistent with Montana Medicaid guidance, medication treatment services for OUD should be billed using either of the following when the service meets the requirements of that code and stated billing guidance:

- H0016 Medication-Assisted Therapy (MAT) Intake
- H0016 HG Medication-Assisted Therapy (MAT) Established

For more information about requirements related to MOUD services, please see Policy #550.[24]

If a CCBHC does not directly provide methadone for OUD, it must make a good-faith effort to establish and maintain referral and care coordination relationships with Opioid Treatment Programs (OTPs) to ensure access to methadone when clinically indicated. When no OTP operates within the CCBHC's catchment area, the CCBHC should still seek to establish a care coordination agreement with the nearest OTP, including documenting at least one outreach attempt. In this instance, if an OTP is established within the CCBHC's catchment area during the Demonstration period, the CCBHC must proactively engage with the provider to develop a formal care coordination agreement and establish referral protocols to support integrated, comprehensive care for the individuals we serve. While geographic barriers may limit access, these partnerships help ensure that individuals are informed about methadone as a treatment option and can be connected to services when clinically appropriate and aligned with their preferences.

[24] https://dphhs.mt.gov/assets/BHDD/MedicaidManual/550MAT.pdf

Medications for Alcohol Use Disorder

Additionally, CCBHCs should ensure access to FDA-approved medications to support individuals with AUD, such as naltrexone, acamprosate, and disulfiram, when clinically indicated. These medications can reduce cravings, decrease alcohol consumption, and help individuals maintain recovery when combined with counseling and other recovery supports. Medication management services for AUD should generally be billed using the applicable Evaluation and Management codes associated with the medical visit (99202-99205 [new patient] or 99211-99215 [established patient]).

Medications for Tobacco Use Disorder

Finally, CCBHCs should make available evidence-based nicotine replacement therapy medications as part of a comprehensive tobacco cessation strategy. Because tobacco use remains a leading cause of preventable disease and death among individuals with behavioral health conditions, CCBHCs should routinely screen for tobacco use, offer cessation interventions, and incorporate TUD treatment into whole-person care planning. Medication management services for TUD should also be billed using the appropriate codes, in accordance with Montana Medicaid billing requirements and payer guidance, including:

- 99406 or 99407 Tobacco Cessation Intervention
- 99202-99205 (new patient) or 99211-99215 (established patient)

PACT/Montana Community Treatment

As outlined in the above table, CCBHCs in Montana must ensure access to intensive community-based treatment services for individuals with the most significant behavioral health needs by operating (either directly or via DCO agreement) either Montana Community Treatment or Program for Assertive Community Treatment (PACT) services in accordance with the requirements established by DPHHS. Montana Community Treatment and PACT are evidence-based, multidisciplinary team models designed to support individuals who have not benefitted from traditional outpatient services and who are at risk of hospitalization, institutionalization, homelessness, or other adverse outcomes. These models emphasize community-based service delivery, person-centered care, rehabilitation, recovery, and ongoing support through a dedicated treatment team.

To maintain fidelity to the Montana Community Treatment or PACT model, CCBHCs should establish a dedicated team of staff responsible for delivering these services. Team members should be consistently assigned to the Montana Community Treatment or PACT program and participate in team-based care planning, service delivery, and care coordination activities. While staff may devote a portion of their time to other clinical or

operational responsibilities, the CCBHC must ensure adequate staffing continuity and team stability to support the intensive, multidisciplinary approach required under the Montana Community Treatment and PACT policies. Dedicated staffing promotes relationship-based care, supports effective team communication, and helps ensure that members receive consistent services from clinicians familiar with their goals, needs, and treatment history.

Consistent with Montana Medicaid requirements, Montana Community Treatment and PACT services must be delivered through organized multidisciplinary teams that provide comprehensive, community-based treatment, rehabilitation, care coordination, crisis response, and support services. CCBHCs are expected to implement these services in accordance with all applicable provider qualifications, staffing standards, service delivery requirements, and medical necessity criteria outlined in DPHHS Medicaid Policy #455 (Montana Community Treatment) [25] or Policy #460 (PACT)[26], as applicable.

Following at least one year of Montana Community Treatment or PACT operations, CCBHCs will collaborate with DPHHS to participate in fidelity monitoring and quality improvement activities, as applicable to the service model being delivered. Fidelity review activities may include assessment of staffing, service delivery patterns, team functioning, documentation, and adherence to core model components. CCBHCs are expected to use fidelity monitoring results to strengthen program implementation, support continuous quality improvement, and ensure that Montana Community Treatment and PACT services remain aligned with Montana's expectations and evidence-based practice standards

EBP Fidelity Monitoring Requirements

Montana CCBHCs are required to implement and maintain fidelity to designated EBPs to ensure services are delivered consistently, effectively, and in accordance with the research base supporting each model. Fidelity monitoring is essential to demonstrating that EBPs are delivered with integrity and achieve intended clinical outcomes. Fidelity monitoring processes should be proportional to the complexity and intensity of each EBP and integrated into the CCBHC's overall quality improvement and clinical oversight infrastructure.

CCBHCs must establish written fidelity monitoring processes that include, at a minimum:

- clear identification and documentation of the EBPs delivered by the CCBHC
- requirements for staff training and demonstrated competency prior to independent practice

[25] https://dphhs.mt.gov/assets/BHDD/SubstanceAbuse/455_MCT_eff.3.8.25.pdf
[26] https://dphhs.mt.gov/assets/BHDD/SubstanceAbuse/460_PACT_eff.3.8.25.pdf

- ongoing methods for assessing adherence to core model components

Fidelity monitoring activities may include structured supervision, chart or documentation reviews, direct observation (live or recorded, as appropriate), use of validated fidelity or adherence tools when available, and participation in learning collaboratives or consultation specific to the EBP. For team-based models such as PACT/Montana Community Treatment, DPHHS will support fidelity monitoring, which will assess team composition, service intensity, caseload structure, and service delivery patterns consistent with the model after at least one year of PACT/Montana Community Treatment operations.

Within their Staffing Plan, CCBHCs must designate qualified clinical team members who are responsible for EBP oversight and fidelity monitoring, including reviewing fidelity findings, addressing areas of misalignment with the EBP requirements, and ensuring corrective actions when fidelity concerns are identified. Findings from fidelity reviews must be documented and used to inform staff coaching, refresher trainings, technical assistance, and performance improvement activities.

CCBHCs must be able to demonstrate to BHDD, upon request, how fidelity monitoring activities support consistent service delivery across CCBHC sites, populations, and providers, and how fidelity findings are used to improve client outcomes, support workforce development, and maintain alignment with CCBHC certification requirements.

Primary Care Screening and Monitoring

CCBHCs are responsible for ensuring comprehensive primary care screening and ongoing monitoring of key health indicators for individuals receiving behavioral health services, either directly or through DCO. Prevention and early detection of chronic conditions are central to these services, supporting integrated, whole-person care and improved health outcomes.

The CCBHC Medical Director must establish protocols consistent with U.S. Preventive Services Task Force Grade A and B recommendations for populations at risk, including HIV, viral hepatitis, and other clinically indicated conditions.

The required Primary Care Screening components are outlined in the following table:

Screening Components

Health Indicator	Screening Tool/Method	Frequency*	Suggested Staff Responsible	Recommended Ages
Blood Pressure	Manual or automated Blood Pressure cuff	At intake, then annually	RN, LPN, or Medical Assistant (MA)	Adults 18+ annually and pregnant women
Body Mass Index (Height & Weight)	Scale and stadiometer	At intake, then annually	RN, LPN, or MA	All ages; annually for adults
Tobacco Use	Standardized questionnaire, such as the Fagerstrom	At intake, then annually	Behavioral Health Clinician	All ages; annually for adolescents and adults
Diabetes	HbA1c - Lab test or point-of-care device	Annually for at-risk individuals	Primary Care Provider (PCP) or RN	Adults 35-70 who are overweight or obese
Cholesterol	Lipid profile	Every 5 years or as clinically indicated	PCP or RN	Men age 35+; men and women 20+ with cardiac risk factors
HIV	Point of Care rapid HIV screening test	At intake (if never been tested or if risk is identified), then as needed	PCP or RN	Ages 15-65; at least once and as needed based on risk
Viral Hepatitis	Point of Care rapid HCV screening test	At intake (if never been tested or risk is identified),	PCP or RN	Adults age 18 - 79

		then as needed		

**If the person receiving services' primary care provider conducts the necessary screening and monitoring, the CCBHC is not required to do so as long as it has a record of the screening and monitoring and the results of any tests that address the health conditions included in the CCBHC's screening and monitoring protocols developed in response to this table.*

In addition to the above conditions, we encourage CCBHCs to incorporate screenings for other commonly occurring or emerging conditions impacting their population served and community, such as syphilis, which is increasing in prevalence in Montana.[27]

A sample Screening Questionnaire related to these conditions is included as an Appendix.

CCBHCs must track and coordinate with members' primary care providers (PCPs) to ensure screenings are performed and results are documented, whether services are provided by the CCBHC, DCO, or external PCP. Any abnormal results related to primary care screenings should trigger a referral to a PCP or specialist for further management

CCBHCs should confirm each client's connection with a PCP during intake. Once confirmed/connected, the CCBHC should seek to obtain consent to access records from the PCP and incorporate these results into the client's care plan. The CCBHC should also seek to establish formal care coordination agreements where feasible for shared clients.

Ongoing monitoring should include periodic laboratory testing, tracking chronic health conditions, coordinating care with PCPs and specialty providers, and promoting healthy behaviors. CCBHCs that are conducting laboratory tests directly onsite must attain a Clinical Laboratory Improvement Amendments (CLIA) certification.[28]

Targeted Case Management Services and Activities to Meet Individuals' Concrete Needs

CCBHCs are responsible for providing targeted case management (TCM) services directly to assist individuals in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports. TCM provides an intensive level of support beyond the basic care coordination provided to all individuals served by the CCBHC.

[27] https://dphhs.mt.gov/publichealth/hivstd/stdprevention/Syphilis
[28] https://dphhs.mt.gov/oig/Certification/clia/

Within the CCBHC initiative, TCM should include supports for individuals deemed at high risk of suicide or overdose, especially during transitions such as discharge from residential treatment, hospital emergency departments, or psychiatric hospitalization. Services should also be accessible during other critical periods, such as episodes of homelessness or transitions from jails or prisons. TCM is intended for individuals with complex or serious mental health or substance use conditions and for those with short-term needs during acute episodes or care transitions.

In Montana, CCBHCs must have the capacity to identify and address individuals' concrete and transitions of care related needs. Specifically, that includes the following four activities:

1. **Concrete Needs Assessment**, during which the CCBHC conducts a functional assessment capturing concrete needs (e.g., food insecurity, housing instability, safety concerns, functional limitations and support needs, and transition-of-care needs, such as connecting individuals to services that support safety, stability, and/or risk reduction related to suicide or overdose).
2. **Targeted Case Management Service Planning**, during which the identified need(s) is documented, and TCM-related goals, interventions, and service activities are incorporated into the individual's comprehensive CCBHC treatment plan and coordinated with all other services and supports identified to meet the individual's needs.
3. **Referral**, during which the CCBHC provides direct linkage to external services outside of the CCBHC, including warm hand-offs.
4. **Monitoring**, during which the CCBHC coordinates and verifies delivery of services, ensuring continuity and effectiveness.

Depending on the CCBHC's workflows, these activities can be completed by the same staff member or a team of staff members. The cost of what is required to do these activities (e.g., staffing) should be included in the CCBHC's Cost Report. Activities 1 and 2 (Concrete Needs Assessment and Service Planning) are billed as triggering event services under the PPS rate, while activities 3 and 4 (Referral and Monitoring) are included in the carried costs of the PPS rate and do not, in and of themselves, trigger the PPS rate. For more information about billing, see the Triggering Event and Carried Cost sections of CCBHC Billing, below.

Eligible Populations for TCM services at a Montana CCBHC include:

- Adults with Mental Illness
- Youth with Serious Emotional Disturbance (SED)
- Individuals with SUD

- Individuals at high risk of suicide or overdose
- Individuals experiencing transitions from residential treatment, hospital emergency departments, or psychiatric hospitalization
- Individuals experiencing homelessness
- Individuals transitioning from jails or prisons

For populations eligible for Targeted Case Management (TCM) services under existing Administrative Rules or DPHHS policies, CCBHCs must comply with all applicable service requirements specified in those authorities. For example, TCM services provided to children and youth with SED must adhere to the requirements outlined in ARM 37.87.823.[29]

All CCBHC TCM services should be provided by an individual meeting the qualification requirements described above in CCBHC Staffing, who is working under the supervision of a licensed behavioral health professional.

In addition:

- Verification that the individual is not receiving TCM services from another provider/program (e.g., a Waiver program) is required during the service planning component. Verification of non-duplication may be based on the individual's self-report/self-attestation and must be documented in the EHR
- TCM is provided only to clients who are not actively receiving or have not received TCM from another provider in the past three months, unless the client requests a transition. If the client requests to transition to receiving TCM services from the CCBHC, this should be documented in the CCBHC's EHR prior to beginning TCM service delivery
- Ongoing engagement in the referrals and coordination service components is included in PPS carried costs but is not separately billable (in and of themselves, these service components do not trigger a PPS payment)

Psychosocial Rehabilitation Services

Psychosocial Rehabilitation (PSR) is a required CCBHC service and is designed to support individuals with SMI, SED, SUD, and COD in developing, restoring, and sustaining the skills and supports necessary for independent functioning, community integration, and recovery. When this service is provided to an individual with SMI, CCBHCs should follow the

[29] https://rules.mt.gov/browse/collections/aec52c46-128e-4279-9068-8af5d5432d74/policies/46c92c0f-4b82-4f81-bda1-cdafdc250954

requirements outlined in Policy #420 related to Community Based Psychiatric Rehabilitation Support Services.[30]

In alignment with the CCBHC Certification Criteria, PSR services focus on building functional, social, vocational, and daily living skills that are individualized, strengths-based, culturally responsive, and informed by each person's goals and preferences. PSR must be provided as part of a comprehensive, person- and family-centered treatment plan and coordinated with other CCBHC services, including outpatient mental health and SUD services, care coordination, and crisis services, as appropriate.

CCBHCs may provide PSR services through individual or group-based modalities and in a variety of settings, including clinic-based, community-based, or other natural environments, consistent with client needs and Montana-specific requirements. Please note that individual PSR services are billable as a triggering event (H2019). While the costs of providing PSR via group-modalities can be included in the Cost Report as part of the CCBHC's carried cost, they do not by themselves trigger a PPS payment.

Psychosocial Rehabilitation services must be delivered by qualified staff operating within their scope of practice and supported by appropriate supervision. Documentation of PSR services must clearly reflect the rehabilitative intent, alignment with treatment goals, and coordination with the broader CCBHC service array.

Peer Supports, Peer Coaching, and Family/Caregiver Supports

CCBHCs provide peer supports, peer coaching, and family/caregiver support services directly. These services are delivered to individuals 18 and over by Certified Behavioral Health Peer Support Specialists (CBHPSS) with lived experience, either with behavioral health challenges or as caregivers, and are intended to promote recovery, resilience, and community integration for individuals receiving behavioral health services. CBHPSS must be certified by the Montana Board of Behavioral Health (BBH).

Peer support includes coaching to restore skills, facilitating access to community resources, crisis/relapse support, and strengthening social support networks and self-advocacy skills. This can include, but is not limited to:

- Peer wellness and recovery support services
- Peer education and leadership development
- Peer navigators for transitions between programs and levels of care
- Peer-led/supported crisis planning

[30] https://dphhs.mt.gov/assets/BHDD/MedicalServicesProviderManual/420CBPRSeffective5-2023.pdf

- Mutual support and self-help groups *(this is a carried cost, not associated with a triggering event when provided by itself, as further outlined below)*

Peer support services provided by a CCBHC should follow Policy Number 415.[31]

In addition, Certified Family Peer Support Specialists can provide supports to families and caregivers of children with significant behavioral health needs at a CCBHC, which can include the following:

- Education on community resources
- Navigation assistance for behavioral health and other supportive services
- Behavioral health and crisis support
- Parent and caregiver training and education

All peer support services are delivered one-to-one to promote coping skills, recovery, self-advocacy, and goal achievement. Group peer support and transportation provided by peers is allowable; however, these services alone are not services that would trigger the PPS rate.

Peer and family/caregiver services are coordinated with other CCBHC services to ensure comprehensive, person-centered care.

Face-to-face service delivery is the preferred modality for peer support services; however, telehealth may be used if clinically indicated or if face-to-face services are inaccessible, with documentation of rationale and local support attempts.

Intensive Community-Based Mental Health Care for Members of the Armed Forces and Veterans

CCBHCs provide intensive, community-based behavioral health care for members of the U.S. Armed Forces and veterans, particularly those who reside 50 miles or more (or one hour's drive time) from a Military Treatment Facility (MTF) or 40 miles or more from a Veterans Affairs (VA) medical facility. Care for veterans follows the minimum clinical mental health guidelines established by the Veterans Health Administration (VHA), including the Uniform Mental Health Services Handbook.

All individuals inquiring about/receiving services from a CCBHC are asked if they have ever served in the U.S. military as part of the initial evaluation.

[31] https://prod-dphhs.mt.gov/assets/BHDD/MedicaidManual/415CertifiedPeerSupport-MentalHealth.pdf

Active Duty Service Members (ADSMs) are referred to their servicing MTF. The CCBHC communicates with the individual's MTF Primary Care Manager (PCM) regarding referrals outside the MTF.

ADSMs and activated Reserve Component members who live more than 50 miles from a military hospital or clinic enroll in TRICARE PRIME Remote and receive care via the network PCM or other authorized TRICARE providers.

Selected Reserves not on Active Duty orders are eligible for TRICARE Reserve Select and may schedule appointments with any TRICARE-authorized provider.

Veterans are offered assistance to enroll in VHA services. Veterans who prefer to receive services from the CCBHC are provided care consistent with VHA clinical guidelines and the Uniform Mental Health Services Handbook. This includes:

- Integrating substance use disorder and mental health treatment and support services, as well as coordination with broader healthcare needs for veterans.
- Coordinating care with other providers and facilities, including VA facilities.
- Assigning every veteran a Principal Behavioral Health Provider (PBHP), who:
    - Maintains regular contact with the veteran as clinically indicated.
    - Ensures psychiatric medications are reviewed and reconciled by a psychiatrist or authorized prescriber per VHA guidelines.
    - Develops and coordinates the treatment plan with input from the veteran and, when appropriate, family or authorized surrogates.
    - Monitors and documents implementation of the treatment plan, tracking progress, outcomes, and goals.
    - Revises the treatment plan as needed.
    - Communicates with the veteran and authorized family or surrogate regarding the treatment plan, future care planning, and any concerns.
    - Ensures informed consent is obtained in accordance with VHA Handbook 1004.1, and assesses decision-making capacity when needed.
- Applying VHA recovery principles, including: Hope, Person-driven care, Multiple pathways, Holistic care, Peer support, Relational support, Cultural sensitivity, Trauma-informed approaches, Strengths/responsibility focus, and Respect.

All CCBHC staff receive training in military and veteran culture at orientation and annually thereafter. In particular, staff who are not veterans receive specialized training to understand the unique experiences and contributions of service members and veterans.[32]

[32] While the specific training is at the discretion of each CCBHC, there are resources available free of cost that may be worth considering, such as those available from Face the Fight®, which was founded by USAA,

CCBHC Community Outreach

In addition to the above service components, House Bill 574 requires CCBHCs to directly provide community outreach. Outreach is a core strategy for improving access to care, promoting early engagement in services, and reducing avoidable use of emergency and high-cost systems. Each CCBHC's outreach activities should be informed by the CCBHC's Community Needs Assessment and designed to address barriers to care for underserved, high-need populations within the clinic's designated catchment area.

In accordance with House Bill 574, each CCBHC must provide structured outreach and education by:

- Establishing and maintaining partnerships with hospitals and critical access hospitals to encourage individuals who present to emergency departments with behavioral health needs to engage in ongoing treatment through the CCBHC, with the goal of reducing repeated emergency department utilization.
- Working collaboratively with local law enforcement agencies by offering or participating in training related to effective responses to individuals experiencing behavioral health crises and by responding directly when individuals come into contact with law enforcement due to behavioral health needs
- Designating staff to conduct outreach to individuals who are high utilizers[33] of acute Medicaid services but are not actively engaged in behavioral health treatment, with a focus on outreach, engagement, and connection to appropriate CCBHC services and supports

These outreach activities must be integrated into the CCBHC's interdisciplinary and care coordination workflows and documented, at the provider's discretion, in the EHR or other organizational records in a manner sufficient to demonstrate to CCBHC certification reviewers that the outreach activities occurred and to support any resulting care coordination or follow-up activities.

Reach Resilience, Endeavors Foundation, and the Humana Foundation to dramatically reduce veteran suicide by 2032.

[33] It is up to the discretion of each CCBHC to use their Community Needs Assessment to define "high utilizers" in their local community and to develop associated protocols. We encourage consideration of individuals who are frequently visiting the emergency department and those being admitted to inpatient services for mental health and/or substance use needs who are not yet connected to care (e.g., two or more visits over a specified time period).

Client Discharge from the CCBHC

Discharge occurs when a recipient is no longer engaged in services at a CCBHC or transitions to another level of care more appropriate for their needs. CCBHCs are responsible for the following as it relates to clients who are discharging from the CCBHC:

- Documenting the reason for discharge
- Supporting warm connections and referrals to other providers, facilities, or levels of care when needed (e.g., residential treatment, hospital care)
- Ensuring continuity of care during transitions, including transfer of treatment records and communication with the receiving provider
- Informing clients who are disenrolling of their rights, available options, and how to re-engage with CCBHC services in the future if needed

Progress Notes

CCBHCs are required to complete progress notes for each client service contact in accordance with ARM 37.85.414.[34]

Each session or service contact must have a written record that is individualized to the client. Progress notes should reflect the specific interactions, interventions, and responses of the member during the session.

For all ongoing CCBHC services, progress notes must be legible and contain the following elements:

- Member's name and date of birth
- Date of service, time in/time out, and duration of session
- Type of session or service provided and a summary of the session
- Member participation during the session
- Documentation of measurable progress toward treatment plan goals and objectives
- Name and signature of the staff member providing the session or service, including the date of completion

These required elements do not all apply to mobile crisis engagements (e.g., relation to treatment plan goals/objectives), as those services are designed to address immediate, short-term needs.

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[34] https://dphhs.mt.gov/assets/BHDD/MedicaidManual/130ProgressNotes.pdf

All progress notes should provide a detailed record of each service contact and support continuity of care, clinical decision-making, and compliance with state and federal auditing requirements. Notes serve as documentation of interventions and outcomes to evaluate member progress toward individualized treatment plan goals.

Care Coordination Agreements

Montana CCBHCs are required to establish and maintain agency-to-agency partnerships that support care coordination across the full continuum of services. These agreements are essential to ensuring seamless transitions between behavioral health, physical health, and social supports, and to reducing fragmentation in care delivery. At a minimum, agreements must:

- Define the roles and responsibilities of each party in supporting coordinated care and reducing risks of duplication
- Include procedures for sharing information and facilitating transitions between settings, consistent with privacy and consent laws, including ensuring timely communication of admissions, discharges, and follow-up needs, particularly for individuals at risk for suicide or overdose
- Be reviewed and updated periodically to ensure continuity despite staff turnover

Montana CCBHCs must maintain agreements or joint protocols with the following entities who are delivering services in their catchment area:

- Primary Care partners: Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to ensure access to PCPs and other primary care services that are not directly provided by the CCBHC or DCO.
- Inpatient and Substance Use Disorder Programs: Psychiatric hospitals, withdrawal management services, residential treatment programs, and tribally operated behavioral health services.
- Hospitals and Emergency Departments: Local acute-care hospitals, urgent care centers, and emergency departments to ensure smooth transitions following admissions and discharges.
- Veterans Services: Nearby Department of Veterans Affairs (VA) medical centers, outpatient clinics, and drop-in facilities.
- Schools and Child-Serving Systems: Local education agencies, child welfare organizations, and licensed therapeutic foster care providers.

- Justice Systems: Juvenile and criminal justice agencies and facilities, including specialty courts and detention centers.
- Community Supports: Regional service providers, including but not limited to Indian Health Service (IHS) treatment centers, housing and employment agencies, peer-run programs, and other social service organizations.
- Crisis Systems: The 988 Suicide & Crisis Lifeline call center serving the CCBHC's catchment area.

Each of the above CCBHC's Care Coordination partnerships should ideally be supported by signed agreements, as outlined above. Where this is not possible, unsigned but jointly developed protocols are acceptable. In this case, CCBHCs should also document their outreach attempts to establish/strengthen the partnership in lieu of a formal agreement.

CCBHCs are expected to actively deepen their care coordination partnerships over time, strengthening accountability and improving coordination across the system of care.

Requesting Approval for an Exemption to a CCBHC Requirement

DPHHS recognizes that, despite a provider's best efforts, circumstances may arise that prevent full compliance with one or more CCBHC requirements. Because Montana's geographic, workforce, environmental, and operational conditions can present unique challenges to service delivery, DPHHS allows CCBHCs to request exemptions from specific CCBHC requirements on a case-by-case basis. Exemption requests should be submitted as soon as the need is identified, but no later than 45 days before the anticipated need for the exemption. All requests must be submitted using the BHDD-approved exemption request template and should clearly describe the specific requirement for which an exemption is being requested, the barriers preventing compliance, and the justification for the exemption. Providers must also identify current mitigation efforts, proposed alternative approaches to service delivery, and the steps that will be taken to ensure continued access to all required CCBHC services while the exemption is in effect.

The exemption request process is intended to balance fidelity to CCBHC requirements with the practical realities of delivering behavioral health services in communities across Montana. As part of the request, CCBHCs are expected to demonstrate how they will minimize the impact of the exemption on service access, quality, care coordination, and participant safety. This includes describing any alternative implementation strategies, such as telehealth services, partnerships, staffing arrangements, operational modifications, or technology solutions that will be used to achieve the intent of the requirement to the greatest extent possible. Providers must also outline an improvement plan toward

compliance that includes specific objectives, responsible parties, anticipated timelines, and ongoing efforts to build capacity and reduce reliance on the exemption over time.

DPHHS will review exemption requests based on several factors, including whether the provider has clearly identified the requirement for which the exemption is requested, provided a reasonable and well-supported explanation of the barriers preventing compliance, and demonstrated that appropriate mitigation efforts have been undertaken. Reviewers will also evaluate whether the proposed alternative implementation plan sufficiently maintains access to services and reduces risks associated with noncompliance, whether the provider has established a realistic path toward full compliance, and whether granting the exemption is unlikely to result in significant adverse impacts to service quality, regulatory compliance, or fidelity to the CCBHC model.

Exemptions are not intended to serve as permanent alternatives to required standards. CCBHCs that continue to require an exemption must submit a renewal request at least annually using the BHDD-approved template. Renewal requests must document progress made since the original exemption approval, including actions taken to build capacity, infrastructure improvements, staffing or operational enhancements, partnership development, and other efforts to move toward compliance. Providers must also explain any ongoing barriers that continue to prevent full compliance and identify a projected timeframe for meeting the requirement without an exemption. If full compliance is not anticipated during the requested exemption period, the provider should explain why and describe the additional steps that will be taken to continue advancing toward compliance.

Freedom of Choice and Non-Duplication of Services

All CCBHC services must be provided following an appropriate screening and assessment process that establishes medical necessity and informs service planning. Individuals served by a CCBHC retain full freedom of choice in selecting providers that best meet their clinical needs, preferences, and circumstances. This includes the right to receive services from a CCBHC, a DCO, a non-CCBHC provider, or a combination of providers, provided those providers are qualified and able to meet the individual's needs. CCBHCs must ensure that individuals are informed of their right to choice and that no individual is required to receive services exclusively from a single provider when alternative appropriate options are available.

While individuals may receive services from multiple providers, duplication of services is prohibited. CCBHCs are responsible for coordinating care in a manner that prevents overlapping or redundant services and ensures efficient, clinically appropriate use of resources and services. The CCBHC's care coordination activities, including Targeted Case

Management (TCM) where applicable, must be used to identify services being delivered by other providers, clarify roles and responsibilities, and support continuity of care across systems. When individuals receive services from both a CCBHC and other providers, the CCBHC must coordinate with those providers, with appropriate client consent, to avoid service duplication, support integrated service delivery, and ensure that services are complementary and aligned with the individual's treatment goals.

CCBHCs must document care coordination activities, including client decisions related to freedom of choice and activities to ensure nonduplication of services in the client's clinical record, as appropriate. This includes documentation of external services the individual is receiving, efforts to coordinate care, and steps taken to resolve or prevent service duplication.

Special Populations and Service Duplication Considerations

CCBHCs may serve individuals receiving care in certain facility-based or structured outpatient settings when rehabilitation, recovery, and community integration remain the primary treatment goals and outpatient care is clinically appropriate. Programs listed below, such as Waiver services, Assisted Living Facility services, and Partial Hospitalization Programs, are carved out of the CCBHC PPS, meaning those services continue to be billed separately. However, individuals participating in these programs may still receive non-duplicative CCBHC services. The table below outlines these special circumstances and any applicable service restrictions. In all cases, CCBHC services must be carefully coordinated to supplement, rather than duplicate, services provided through the individual's primary treatment setting or program. This includes ensuring (and documenting) that the CCBHC is intentionally doing the following:

- Delivering services that enhance, complement, or coordinate care, rather than replicating services already included in another program or bundled rate
- Avoiding billing for services that are covered under another provider's scope of services or reimbursement bundle
- Coordinating closely with the individual's other provider(s) to ensure clear delineation of roles and responsibilities

Special Populations	**Service Duplication Restrictions for CCBHCs**
Individuals Enrolled in any of Montana's Medicaid Waiver Programs (e.g., 1915, HCBS, HEART)	CCBHCs may provide services that are outside the scope of the Waiver, but they must not duplicate any services covered by the Waiver, including: • T1016 Targeted Case Management

	• H2019 Community-based Psychiatric Rehabilitation and Support Services
Individuals residing in an Assisted Living Facility not covered under a Medicaid Waiver	CCBHCs may provide all services to individuals residing in these residential settings, provided they are not already receiving a duplicative service from another provider.
Individuals Participating in Partial Hospitalization Programs (PHP): Adult or Youth	CCBHCs may provide services that are outside the scope of the PHP, but must not duplicate any services included in the PHP bundled rate. CCBHCs may not provide: • H2012 Day Treatment • H2019 Community-based Psychiatric Rehabilitation and Support Services • 90832 – 90837 Outpatient Psychotherapy • 90846 – 90849 Family-based Psychotherapy focused on MH (Family Psychotherapy to address SUD needs can be provided by a CCBHC, when an individual has a co-occurring SUD diagnosis) • 90853 Group Psychotherapy focused on MH (Group Psychotherapy to address SUD needs can be provided by a CCBHC, when an individual has a co-occurring SUD diagnosis) • H0037 Montana Community Treatment • H0040 PACT • H0046 Intensive Individual DBT Psychotherapy Services • S9480 Intensive Outpatient Psychiatric Therapy
Individuals Participating in ASAM Level 2.5 SUD Programs	CCBHCs may provide services that are outside the scope of the Level 2.5 program, but must not duplicate any services included in the Level 2.5 bundled rate. CCBHCs may not provide: • G0396 – G0397 Alcohol and SUD Intervention • 90846 – 90849 Family-based Psychotherapy focused on SUD (Family Psychotherapy to address MH needs can be provided by a CCBHC, when an individual has a co-occurring MH diagnosis) • 90853 Group Psychotherapy focused on SUD (Group Psychotherapy to address MH needs can be provided by a CCBHC, when an individual has a co-occurring MH diagnosis) • H0015 SUD Intensive Outpatient (ASAM 2.1)
Individuals Served by Comprehensive School and	CCBHCs may provide services that are outside the scope of the CSCT, but must not duplicate any services

Community Treatment (CSCT) Programs	included in the CSCT bundled rate. CCBHCs may not provide: • H2012 Day Treatment • H2019 Community-based Psychiatric Rehabilitation and Support Services • 90832 – 90837 Outpatient Psychotherapy • 90846 – 90849 Family-based Psychotherapy focused on MH (Family Psychotherapy to address SUD needs can be provided by a CCBHC, when an individual has a co-occurring SUD diagnosis) • 90853 Group Psychotherapy focused on MH (Group Psychotherapy to address SUD needs can be provided by a CCBHC, when an individual has a co-occurring SUD diagnosis) • S9480 Intensive Outpatient Psychiatric Therapy
Individuals Served by Therapeutic Foster Care	CCBHCs may provide services that are outside the scope of the Therapeutic Foster Care Program. CCBHCs may not provide: • 90846 – 90849 Family-based Psychotherapy • H2020 Home Support Services • S9480 Intensive Outpatient Psychiatric Therapy
Adult Foster Care	CCBHCs may provide services that are outside the scope of the Adult Foster Care Program; however, they must not deliver services that would duplicate what is offered at the Adult Foster Home, including: • H2019 Community-based Psychiatric Rehabilitation and Support Services • H0037 Montana Community Treatment • H0040 PACT • T1016 Targeted Case Management

Populations that May Not be Served by a CCBHC

In general, when an individual is receiving a higher level of care or services delivered within a facility-based setting that assumes full responsibility for treatment, the CCBHC must not bill for or deliver duplicative services under the CCBHC model during that time period.

With this guiding principle in mind, the following populations are not eligible to receive CCBHC services while actively admitted to or residing in the specified settings:

Populations Not Allowed to be Served by a CCBHC	**Considerations and Requirements**

Individuals admitted to an inpatient medical or psychiatric facility	CCBHC services must not be provided during inpatient admission. However, CCBHCs should coordinate with facility staff (when appropriate to the needs and preferences of the individual) to participate in discharge planning; support care transitions back to the community; and ensure continuity of care following discharge.
Individuals enrolled in a 72+ hour crisis stabilization program	CCBHC services must be suspended for the duration of the stabilization stay. However (when appropriate to the needs and preferences of the individual), CCBHC staff should coordinate with the stabilization center staff to support transition back to the community and service engagement once stabilized
Individuals receiving services in an ASAM Residential SUD Treatment Facility (Levels 3.1, 3.2, 3.3, 3.5, 3.7)	CCBHC services must not be provided during the individual's residential stay. Outside of the CCBHC model (e.g., under the provider's CMHC Provider ID), providers may deliver needed services not included in the residential bundle (e.g., mental health treatment) on a fee-for-service (FFS) basis, as appropriate and allowable
Individuals enrolled in psychiatric residential treatment programs	CCBHC services must not be provided during the individual's residential stay. Outside of the CCBHC model (e.g., under the provider's CMHC Provider ID), providers may deliver needed services not included in the residential bundle (e.g., substance use treatment) on a FFS basis, as appropriate and allowable
Individuals residing in therapeutic group home settings for youth	CCBHC services must not be provided during the individual's group home stay. Outside of the CCBHC model (e.g., under the provider's CMHC Provider ID), providers may deliver needed services not included in the residential bundle (e.g., substance use treatment) on a FFS basis, as appropriate and allowable
Individuals residing in an adult behavioral health group home	CCBHC services must not be provided during the individual's group home stay. Outside of the CCBHC model (e.g., under the provider's CMHC Provider ID), providers may deliver needed services not included in the residential bundle (e.g., substance use treatment) on a FFS basis, as appropriate and allowable
Individuals residing in a nursing home or skilled nursing facility	CCBHC services must not be provided while an individual is residing in a nursing home/facility. However, when/if an individual is in the process of transitioning back to the community, CCBHCs should coordinate with facility staff regarding discharge planning (when

	applicable), and prepare for re-engagement in CCBHC services upon return to the community

Although CCBHC services are not billable during the periods described above, CCBHCs are expected to maintain a strong care coordination and transition role as these individuals are transitioning back to the community (when CCBHC services are aligned with the person's needs and preferences), including:

- Collaborating with facility-based providers to support transitions
- Supporting discharge and after care planning
- Ensuring timely follow-up and re-engagement post discharge

CCBHC Billing

Prospective Payment System Structure

Montana CCBHCs participating in the CCBHC Demonstration are reimbursed using the CCBHC PPS-1 daily rate. Under PPS-1, each CCBHC is paid a fixed, clinic-specific daily rate for Medicaid beneficiaries when at least one qualifying CCBHC service is provided on a given day. This bundled daily rate reflects the expected cost of delivering the full scope of required CCBHC services and supports the flexibility needed to provide comprehensive, coordinated, and person-centered care. Under PPS-1, only one PPS payment may be made per CCBHC, per Medicaid beneficiary, per day, regardless of how many CCBHC services are provided on that day.

CCBHCs are expected to deliver all required services in compliance with certification standards regardless of service frequency or intensity on a given day and may not bill separately for services included within the PPS-1 bundle. The PPS-1 structure is designed to support integrated, recovery-oriented care by allowing CCBHCs to deploy services flexibly across settings, modalities, and disciplines without being constrained by individual fee-for-service billing codes. CCBHCs must maintain appropriate documentation to support medical necessity, service delivery, and compliance with CCBHC requirements, while also ensuring that PPS-1 payments do not result in duplicate billing or payment for services outside the approved scope of the Demonstration.

Initial CCBHC PPS Rate Setting

Each CCBHC's initial PPS-1 rate is established using the CMS CCBHC Cost Report[35] and supporting documentation. To develop this rate, CCBHCs must report all allowable direct and indirect costs associated with CCBHC operations. Allowable costs include direct service delivery as well as essential non-billable "carried costs" required under the CCBHC model, such as care coordination, outreach, workforce development, quality improvement, and infrastructure necessary to ensure access and continuity of care. Clinics must also report historical qualifying visit data and anticipated changes in costs and service utilization expected during the prospective rate period. DPHHS will review submitted Cost Reports for completeness, accuracy, and compliance with federal requirements before calculating the clinic-specific PPS-1 rate. Consistent with CMS guidance, the final PPS-1 rate will be calculated by dividing total allowable CCBHC costs (including approved indirect costs and anticipated adjustments) by the total number of historical and anticipated qualifying daily visits, then trending the resulting rate to the applicable rate year using the Medicare Economic Index (MEI).

The initial cost reporting process is intended to ensure that each CCBHC's PPS-1 rate appropriately reflects the anticipated cost of providing comprehensive, person-centered behavioral health services in accordance with the CCBHC model. CCBHCs are expected to maintain documentation supporting reported costs, allocation methodologies, visit counts, and anticipated adjustments, and to submit annual Cost Reports as required by federal and state policy to support ongoing rate oversight and rebasing activities.

Annual Cost Reporting

As part of the CCBHC Demonstration, SAMHSA requires all CCBHCs to submit an annual CCBHC Cost Report, with supporting documentation, within six months of the end of each demonstration year. BHDD will then review the submission for accuracy and completeness, provide clarifying information if requested, and forward the report to CMS within nine months after the close of the demonstration year.

In alignment with these requirements, Montana CCBHCs will submit a complete Cost Report with all supporting data to BHDD within six months after the demonstration year ends. BHDD will review the reports for compliance; request clarification as needed; approve the Cost Report submission; and transmit the finalized materials to CMS within the federally required nine-month timeframe.

[35] https://www.medicaid.gov/medicaid/financial-management/certified-community-behavioral-health-clinic-ccbhc-demonstration/ccbhc-cost-reporting

Triggering Events

A CCBHC triggering event occurs when an individual receives at least one qualifying CCBHC service that meets medical necessity requirements and falls within the State approved scope of CCBHC services. Triggering events are used to identify when a PPS-1 payment may be made and are not tied to the number, duration, or intensity of services delivered on a given day. When at least one triggering service is provided to a Medicaid enrollee, the CCBHC may receive one PPS payment for that individual for that service date, regardless of how many additional CCBHC services are furnished on the same day. Triggering events may occur across multiple service categories, such as crisis services, screening and assessment, outpatient mental health and substance use services, targeted case management, primary care screening and monitoring, peer support, and psychosocial rehabilitation services.

BHDD has identified a list of triggering events for Montana CCBHCs, which include the following:

Code	Modifier Required	Definition	CCBHC Services Category
H0002		Psychotherapy for After-hours Crisis; first 60 minutes	Crisis Services
H2011	U1, U2, U3	Crisis Intervention / Mobile Crisis	Crisis Services
S9484		Crisis Receiving Program	Crisis Services
90791		Psychiatric Diagnostic Evaluation	Screening, Assessment, Diagnosis & Risk Assessment
90792		Psychiatric Diagnostic Evaluation with Medication Services	Screening, Assessment, Diagnosis & Risk Assessment
96116		Neurobehavioral Status Exam - Physician/Qualified Healthcare Professional (QHP) (1st Hour)	Screening, Assessment, Diagnosis & Risk Assessment
96156		Health behavior assessment or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)	Screening, Assessment, Diagnosis & Risk Assessment
96110		Developmental Screening with Scoring and Documentation - per standardized instrument	Screening, Assessment, Diagnosis & Risk Assessment
96112		Developmental Test Administration with Interpretation and Report - first hour	Screening, Assessment, Diagnosis & Risk Assessment
96127		Brief Emotional/Behavioral Assessment	Screening, Assessment, Diagnosis & Risk Assessment
96130		Psychological Testing Evaluation - Physician or QHP	Screening, Assessment, Diagnosis & Risk Assessment
96132		Neuropsychological Testing Evaluation - Physician/QHP (1st Hour)	Screening, Assessment, Diagnosis & Risk Assessment

96136		Psychological or Neuropsychological Testing – Administration and Scoring - Physician/QHP (1st 30 minutes)	Screening, Assessment, Diagnosis & Risk Assessment
96138		Psychological or Neuropsychological Testing – Administration and Scoring - Technician (1st 30 minutes)	Screening, Assessment, Diagnosis & Risk Assessment
90832		Psychotherapy with the patient/patient and family – 30 Minutes	Outpatient Mental Health & Substance Use Services
90834		Psychotherapy with the patient/patient and family – 45 Minutes	Outpatient Mental Health & Substance Use Services
90837		Psychotherapy with the patient/patient and family – 60 Minutes	Outpatient Mental Health & Substance Use Services
90839		Psychotherapy – Crisis – 60 Minutes	Outpatient Mental Health & Substance Use Services
90846		Family Psychotherapy Without Patient	Outpatient Mental Health & Substance Use Services
90847		Family Psychotherapy With Patient	Outpatient Mental Health & Substance Use Services
90849		Multiple Family Group Psychotherapy	Outpatient Mental Health & Substance Use Services
90853		Group Psychotherapy	Outpatient Mental Health & Substance Use Services
99202		Office/Outpatient Visit - New	Outpatient Mental Health & Substance Use Services
99203		Office/Outpatient Visit - New	Outpatient Mental Health & Substance Use Services
99204		Office/Outpatient Visit - New	Outpatient Mental Health & Substance Use Services
99205		Office/Outpatient Visit - New	Outpatient Mental Health & Substance Use Services
99211		Office/Outpatient Visit - Established	Outpatient Mental Health & Substance Use Services
99212		Office/Outpatient Visit - Established	Outpatient Mental Health & Substance Use Services
99213		Office/Outpatient Visit - Established	Outpatient Mental Health & Substance Use Services
99214		Office/Outpatient Visit - Established	Outpatient Mental Health & Substance Use Services
99215		Office/Outpatient Visit - Established	Outpatient Mental Health & Substance Use Services
H0015		SUD Intensive Outpatient (ASAM 2.1)*	Outpatient Mental Health & Substance Use Services
H0016		Medication-Assisted Therapy (MAT) Intake*	Outpatient Mental Health & Substance Use Services
H0016	HG	Medication-Assisted Therapy (MAT) Established	Outpatient Mental Health & Substance Use Services
H2020		Home Support Services*	Outpatient Mental Health & Substance Use Services
G0396		Alcohol/substance use intervention 15-30mn	Outpatient Mental Health & Substance Use Services
G0397		Alcohol/substance use intervention Greater than 30 min	Outpatient Mental Health & Substance Use Services

T1016		Targeted Case Management, inclusive of a TCM needs assessment and service planning	Targeted Case Management
99401		Preventive Counseling Individual – Typically 15 Minutes	Outpatient Primary Care Screening and Monitoring
99402		Preventive Counseling Individual – Typically 30 Minutes	Outpatient Primary Care Screening and Monitoring
99403		Preventive Counseling Individual – Typically 45 Minutes	Outpatient Primary Care Screening and Monitoring
99404		Preventive Counseling Individual – Typically 1 Hour	Outpatient Primary Care Screening and Monitoring
99408		Alcohol and/or Substance Abuse Screening, 15-30 minutes.	Outpatient Primary Care Screening and Monitoring
99409		Alcohol and/or Substance Abuse Screening, greater than 30 minutes	Outpatient Primary Care Screening and Monitoring
H0038		Peer Support (Certified) Individual	Peer, Family Support & Counselor Services
96158		Health behavior intervention, individual, face-to-face; initial 30 minutes	Psychiatric Rehabilitation Service
96167		Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes"	Psychiatric Rehabilitation Service
96170		Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	Psychiatric Rehabilitation Service
90867		Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	Psychiatric Rehabilitation Service
90868		Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management	Psychiatric Rehabilitation Service
90869		Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	Psychiatric Rehabilitation Service
99406		Smoking and Tobacco Cessation Counseling 3-10 MIN	Psychiatric Rehabilitation Service
99407		Smoking and Tobacco Cessation Counseling < 10 MIN	Psychiatric Rehabilitation Service
H0037		Montana Community Treatment*****	Psychiatric Rehabilitation Service
H0040		Program of Assertive Community Treatment (PACT)*****	Psychiatric Rehabilitation Service
H0040	HT	Community Maintenance Program	Psychiatric Rehabilitation Service
H0046	HB	Intensive Individual DBT Psychotherapy Services	Psychiatric Rehabilitation Service
H2012	HB, HA	Day treatment – Adult Half day/Youth day Treatment*	Psychiatric Rehabilitation Service
H2014		Dialectical Behavior Therapy – Skill Development – Individual	Psychiatric Rehabilitation Service
H2014	HQ	Dialectical Behavior Therapy – Skill Development – Group	Psychiatric Rehabilitation Service

H2015	HB	Illness Management and Recovery – Individual	Psychiatric Rehabilitation Service
H2017	HQ	Illness Management and Recovery – Group	Psychiatric Rehabilitation Service
H2019	U1, HA, HB, HQ, No Modifier	Community-based psychiatric rehabilitation & support – individual	Psychiatric Rehabilitation Service
S9480		Intensive Outpatient Psychiatric Therapy*	Psychiatric Rehabilitation Service

For all codes, CCBHCs must follow the Montana Medicaid billing guidance and ARMs, as well as CPT/HCPCS code requirements.

*The following service codes have unique considerations for CCBHCs, as follows:

- H0015: SUD Intensive Outpatient (ASAM 2.1)
    - CCBHCs billing H0015 for SUD Intensive Outpatient services must continue to comply with all applicable DPHHS requirements, including level-of-care criteria, service delivery standards, staffing requirements, and documentation expectations outlined in the *Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health*, including SUD IOP Services Policy #525.[36]
    - For each day that SUD Intensive Outpatient services are provided, the CCBHC must bill the bundled service code H0015 and report all applicable service codes representing the services delivered on that visit day (e.g., individual counseling, group counseling, peer support). The reported service codes must be supported by the clinical record and reflect the specific services furnished as part of the individual's SUD IOP treatment on that date of service.
    - Providers must maintain documentation supporting medical necessity and ASAM 2.1 level-of-care placement and ensure services are delivered in accordance with DPHHS-established IOP standards.
    - DPHHS reserves the right to conduct targeted reviews, audits, or spot checks of H0015 claims and supporting clinical documentation to verify compliance with Medicaid requirements, ASAM criteria, and applicable DPHHS policies.
    - Failure to maintain appropriate documentation or demonstrate adherence to required level-of-care criteria may result in corrective action, recoupment, or other actions consistent with Medicaid program requirements.
- H0037: Montana Community Treatment/H0040: Program of Assertive Community Treatment (PACT)

[36] https://dphhs.mt.gov/assets/BHDD/MedicalServicesProviderManual/525SUDASAM2.1effective5-2023.pdf

- CCBHCs may bill H0037 (Montana Community Treatment) or H0040 (PACT) on a daily basis when Montana Community Treatment services are provided in accordance with applicable CCBHC and Medicaid requirements.
- For each day that Montana Community Treatment and PACT services are provided, the CCBHC must bill the applicable bundled service code H0037/H0040 and report all applicable service codes representing the services delivered on that visit day (e.g., individual counseling, medication management, peer support). The reported service codes must be supported by the clinical record and reflect the specific services furnished as part of the individual's Montana Community Treatment/PACT services on that date of service.
- Providers billing H0037 must continue to comply with all DPHHS requirements governing Montana Community Treatment/PACT services, including service definitions, staffing standards, fidelity expectations, documentation requirements, and medical necessity criteria outlined in the Medicaid Services Provider Manual, including Policies #455[37] and #460[38].
- DPHHS reserves the right to conduct targeted reviews, audits, or spot checks of H0037 claims and supporting clinical documentation to verify compliance with Medicaid requirements and Montana Community Treatment/PACT service standards.
- Failure to maintain appropriate documentation or demonstrate adherence to required level-of-care criteria may result in corrective action, recoupment, or other actions consistent with Medicaid program requirements.

- S9480: Intensive Outpatient Psychiatric Therapy
  - CCBHCs may bill S9480 (Intensive Outpatient Psychiatric Therapy) on a daily basis when services are provided in accordance with applicable CCBHC and Medicaid requirements. S9480 is identified as a CCBHC triggering code and may be billed once per day when medically necessary services are delivered.
  - For each day that Intensive Outpatient Psychiatric Therapy services are provided, the CCBHC must bill the bundled service code S9480 and report all applicable service codes representing the services delivered on that visit day (e.g., individual counseling, group, peer support). The reported service codes must be supported by the clinical record and reflect the specific services furnished as part of the individual's Intensive Outpatient Psychiatric Therapy services on that date of service.

[37] https://dphhs.mt.gov/assets/BHDD/SubstanceAbuse/455_MCT_eff.3.8.25.pdf
[38] https://dphhs.mt.gov/assets/BHDD/SubstanceAbuse/460_PACT_eff.3.8.25.pdf

- Providers billing S9480 must continue to comply with all applicable Montana Guidelines, including those outlined in the Children's Mental Health Bureau Medicaid Services Provider Manual related to admission criteria, medical necessity requirements, treatment planning expectations, staffing requirements, documentation standards, and continued stay criteria established by DPHHS.
- CCBHCs must maintain documentation demonstrating that the individual meets the applicable clinical criteria for intensive outpatient psychiatric services and that services are delivered consistent with DPHHS requirements and the individual's person-centered treatment plan.
- DPHHS reserves the right to conduct targeted reviews, audits, or spot checks of S9480 claims and supporting clinical documentation to verify compliance with Medicaid requirements, clinical management guidelines, medical necessity standards, and program service expectations.
- Failure to maintain appropriate documentation or demonstrate adherence to required level-of-care criteria may result in corrective action, recoupment, or other actions consistent with Medicaid program requirements.

- H2012: Day Treatment
  - CCBHCs may bill H2012 (Day Treatment) once per day when Day Treatment services are provided in accordance with applicable CCBHC and Medicaid requirements.
  - Providers billing H2012 must continue to comply with all applicable DPHHS licensure, service delivery, assessment, treatment planning, staffing, documentation, and quality assurance requirements for Day Treatment services established in ARM 37.106,[39] including requirements governing licensed Mental Health Centers and Adult Day Treatment programs.
  - CCBHCs must maintain documentation demonstrating medical necessity, completion of required assessments, development and implementation of individualized treatment plans, and delivery of services consistent with applicable DPHHS regulations and the individual's person-centered treatment plan.
  - DPHHS reserves the right to conduct targeted reviews, audits, or spot checks of H2012 claims and supporting clinical documentation to verify compliance

[39] https://rules.mt.gov/browse/collections/aec52c46-128e-4279-9068-8af5d5432d74/sections/9034d8f6-b5c4-499d-ac3c-62cb0c398022

with Medicaid requirements, ARM 37.106[40] standards, service delivery expectations, and program integrity requirements.
    - Failure to maintain appropriate documentation or demonstrate adherence to required level-of-care criteria may result in corrective action, recoupment, or other actions consistent with Medicaid program requirements.
- H0016: Medication-Assisted Therapy (MAT) Intake and Established (HG)
    - Under the CCBHC Demonstration, billing for H0016 (both intake and established) is moving to the daily PPS billing structure. For Medicaid enrollees, CCBHCs will submit a claim on each visit day when a Medication Assisted Treatment for an individual with OUD is provided (in alignment with the applicable CCBHC and Montana Medicaid requirements). Outside of billing for these services daily, MAT Intake and Established services must be delivered consistent with the requirements established in DPHHS Medicaid Services Provider Manual Policy#550 Medication Assisted Treatment (MAT).
    - Reimbursement for MAT Intake is limited to the first one to three visit days during which MAT is initiated and stabilized. Once induction is complete and the individual has transitioned to ongoing maintenance treatment, subsequent services must be billed using H0016 - HG Medication-Assisted Therapy (MAT) Established on each day a service is provided.
    - Providers billing H0016 and H0016 HG must continue to comply with all DPHHS MAT requirements, including applicable medical necessity criteria, provider qualifications, intake assessment requirements, behavioral health assessment requirements, required screenings, medication induction activities, treatment planning expectations, and federal requirements governing the provision of MAT services.
    - CCBHCs must maintain documentation demonstrating that the individual meets MAT eligibility criteria and that all required intake components and services were completed in accordance with DPHHS MAT policy and the individual's person-centered treatment plan.
    - DPHHS reserves the right to conduct targeted reviews, audits, or spot checks of H0016 and H0016 HG claims and supporting clinical documentation to verify compliance with Medicaid requirements, MAT program standards, medical necessity criteria, and applicable state and federal requirements.

[40] https://rules.mt.gov/browse/collections/aec52c46-128e-4279-9068-8af5d5432d74/sections/9034d8f6-b5c4-499d-ac3c-62cb0c398022

- Failure to maintain appropriate documentation or demonstrate adherence to required level-of-care criteria may result in corrective action, recoupment, or other actions consistent with Medicaid program requirements.

In addition to the above, please keep in mind that when billing H2020 - Home Support Services, providers must continue to adhere to all requirements outlined in the Children's Mental Health Bureau Medicaid Services Provider Manual[41] and ARM 37.87 standards,[42] including those related to weekly timeframe requirements.

CCBHCs are responsible for ensuring that triggering events are supported by appropriate documentation demonstrating medical necessity, service delivery, and alignment with the individual's person-centered treatment plan. The presence of a triggering event does not alter CCBHC obligations related to access, continuity of care, or service coordination, nor does it authorize duplicate billing for services already encompassed within the PPS-1 payment. CCBHCs must also ensure that triggering events are accurately captured through approved service codes and that internal workflows support compliance with State MMIS rules, program integrity requirements, and CCBHC certification standards. These processes are intended to support consistent PPS implementation while reinforcing the CCBHC model's emphasis on comprehensive, coordinated, and recovery-oriented care rather than volume-based service delivery.

Carried Costs

The daily CCBHC PPS-1 rate is designed to reflect not only the costs of direct clinical services that trigger payment, but also the broader set of "carried costs" required to operate a fully compliant CCBHC. Carried costs include essential clinical, administrative, and infrastructure activities that support access, coordination, quality, and continuity of care but may not generate a separate triggering event on a given service date.

Many of these carried costs are embedded within the PPS rate and are not billed separately by service or activity. However, there are a few activities that DPHHS is asking CCBHCs to include on the claims when they are provided as carried costs, in order to track the delivery of these services. These codes should not be billed by themselves without a triggering event, but should be included on the claim if they are provided on the same day as a triggering event service:

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41 https://dphhs.mt.gov/assets/BHDD/CMB/providermanuals/FinalCMHBMedicaidServicesProviderManual050926.pdf

42 https://rules.mt.gov/browse/collections/aec52c46-128e-4279-9068-8af5d5432d74/sections/5b0910d3-ee78-4603-8b19-98d056b457e4

Code	Modifiers Required	Definition	Required Services Category
96121		Neurobehavioral status exams, specifically the additional hour(s) performed by a physician or qualified healthcare professional	Screening, Assessment, Diagnosis & Risk Assessment
96131		Psychological testing evaluation services provided by a physician or qualified healthcare professional, additional hour	Screening, Assessment, Diagnosis & Risk Assessment
96133		Neuropsychological testing evaluation services performed by a physician or other qualified healthcare professional, additional hour	Screening, Assessment, Diagnosis & Risk Assessment
96137		Administration of psychological or neuropsychological tests by a physician or qualified health professional (QHP) for each additional 30 minutes	Screening, Assessment, Diagnosis & Risk Assessment
96139		Administration of tests by trained staff under the supervision of a qualified healthcare professional (QHP)	Screening, Assessment, Diagnosis & Risk Assessment
T1023		Assessment Brief, Pre-Admission - 15 min	Screening, Assessment, Diagnosis & Risk Assessment
80305		Presumptive, direct-observation, optical-observation drug screen	Outpatient Primary Care Screening and Monitoring
80306		Presumptive instrument-assisted drug testing	Outpatient Primary Care Screening and Monitoring
80307		Drug test presumptive chemistry analyzer screenings	Outpatient Primary Care Screening and Monitoring
81000		Non-automated urinalysis with microscopy	Outpatient Primary Care Screening and Monitoring
81001		Automated urinalysis with microscopy	Outpatient Primary Care Screening and Monitoring
81002		Non-automated urinalysis without microscopy	Outpatient Primary Care Screening and Monitoring
81003		Automated urinalysis without microscopy	Outpatient Primary Care Screening and Monitoring
81005		Urinalysis	Outpatient Primary Care Screening and Monitoring
99484		Behavioral Health Integration (BHI) care management services	Outpatient Primary Care Screening and Monitoring

G0445		High Intensity Behavioral Counseling to Prevent STDs 30 Minutes	Outpatient Primary Care Screening and Monitoring
G0480		Definitive Drug Test Covering 1-7 Classes	Outpatient Primary Care Screening and Monitoring
G0481		Definitive Drug Test Covering 8-14 Classes	Outpatient Primary Care Screening and Monitoring
G0482		Definitive Drug Test Covering 15-21 Classes	Outpatient Primary Care Screening and Monitoring
G0483		Definitive Drug Test Covering 22+ Classes	Outpatient Primary Care Screening and Monitoring
H0048		Alcohol and/or drug testing; Collection and handling only, specimens other than blood	Outpatient Primary Care Screening and Monitoring
90833		30-minute individual psychotherapy performed alongside an Evaluation and Management (E/M) service	Outpatient Mental Health & Substance Use Services
90836		45-minute individual psychotherapy performed alongside an Evaluation and Management (E/M) service	Outpatient Mental Health & Substance Use Services
90838		60-minute individual psychotherapy performed alongside an Evaluation and Management (E/M) service	Outpatient Mental Health & Substance Use Services
Q3014		Telehealth Facility Fee	Outpatient Mental Health & Substance Use Services

Allowable Modifiers

As a reminder, this guidance does not change existing modifier requirements for Medicaid billing. When billing Medicaid for a CCBHC visit day, CCBHCs should continue to include all required modifiers associated with the codes billed for services provided on that visit day. In addition to the modifiers identified in the tables above, CCBHCs may use modifier GT to indicate that services were delivered via telehealth.

For all Medicaid claims, CCBHCs should continue to follow the modifier requirements outlined in the Montana BHDD Medicaid Billing Manuals applicable to the services being provided.

CCBHC Claiming for Services Provided to Medicaid Enrollees

CCBHCs must submit claims in accordance with standard Montana Medicaid billing requirements, except where modified by the CCBHC Demonstration and this Provider Manual. All claims must reflect medically necessary services and must comply with

procedure code definitions, modifier usage, rendering provider requirements, and other Medicaid billing standards.

CCBHCs must submit one claim per service day per individual and may not submit span bills. Each individual date of service must be billed separately; claims with date ranges spanning multiple days on a single claim will be denied. All claims must be submitted under the CCBHC's Medicaid enrollment using Provider Type 80 (CCBHC).

CCBHCs will continue to use the CMS 1500 claim form and must bill using the CCBHC-specific Provider ID as the billing provider. In box 33, CCBHCs should include their:

- Provider NPI
- The appropriate taxonomy with the relevant qualifier (ZZ for paper claims; PRV*VI*PXC for electronic claims)
- The Zip Code + 4 for the relevant site location

For each billable service day, the claim must be structured as follows:

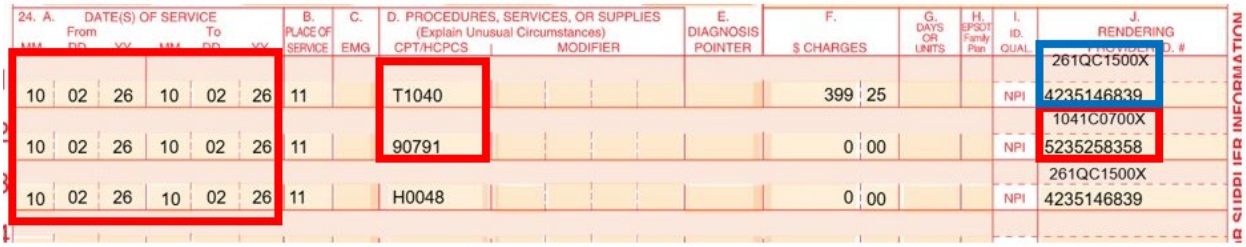
- First claim line: HCPCS code T1040 (Medicaid CCBHC Services, Per Diem)
- Second claim line and below: Valid CPT/HCPCS codes representing the triggering service(s) and any allowable services provided on that same service date

The presence of T1040 on the first claim line signals that the claim is subject to CCBHC PPS processing. All triggering and allowable service codes must be billed in accordance with standard Medicaid rules, including appropriate modifiers and use of the rendering provider's NPI where required. CCBHCs must "shadow claim" all Medicaid reimbursable services delivered on that service date, even though payment is made as a single bundled PPS rate. When any of the below bundled services are provided by a CCBHC, the CCBHC should bill both the service code associated with the bundle (e.g., H0015), as well as the individual services provided on that visit day (e.g., group, individual, peer, etc.), as illustrated below in Figure 3:

- H0015: SUD Intensive Outpatient (ASAM 2.1)
- H0037: Montana Community Treatment
- H0040: Program of Assertive Community Treatment (PACT)
- S9480: Intensive Outpatient Psychiatric Therapy
- H2012: Day Treatment
- H2020: Home Support Services

The following screenshots represent sample CCBHC claims:

Figure 2: Sample CCBHC Claim for Individual Services



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
10	02	26	10	02	26	11		T1040			399 25				261QC1500X
														NPI	4235146839
10	02	26	10	02	26	11		90791			0 00				1041C0700X
														NPI	5235258358
10	02	26	10	02	26	11		H0048			0 00				261QC1500X
														NPI	4235146839

Figure 3: Sample CCBHC Claim for Bundled Services, such as H0015 SUD Intensive Outpatient



	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	10	02	26	10	02	26	11		T1040			399 25				261QC1500X
															NPI	4235146839
2	10	02	26	10	02	26	11		H0015			0 00				1041C0700X
															NPI	5235258358
3	10	02	26	10	02	26	11		H0048			0 00				261QC1500X
															NPI	4235146839
4	10	02	26	10	02	26	11		90838			0 00				1041C0700X
															NPI	5235258358
5	10	02	26	10	02	26	11		90853			0 00				1041C0700X
															NPI	5235258358

Figure 4: Sample Box 33 of a Paper Claim for Services Provided at a Main CCBHC Site

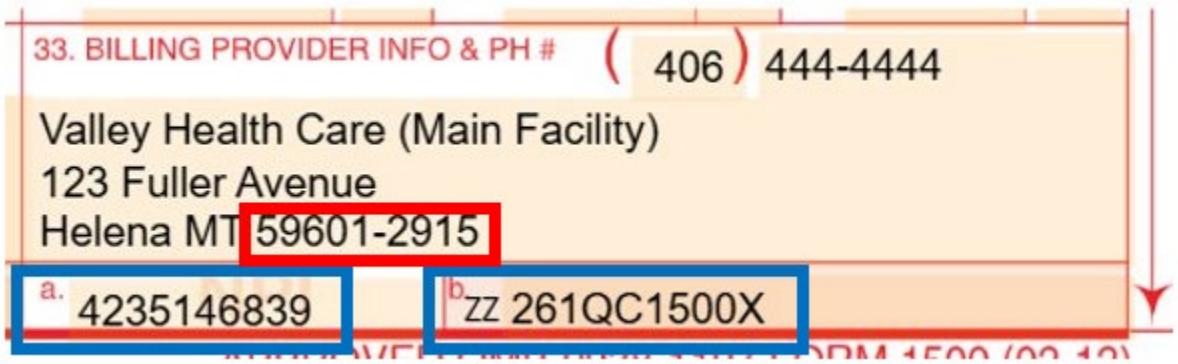


Figure 5: Sample Box 33 of a Paper Claim for Services Provided at a Satellite CCBHC Site

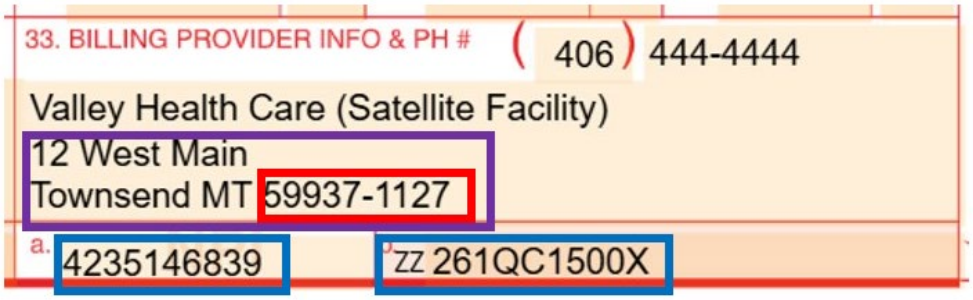


Figure 6: Sample Box 33 of an Electronic Claim for Services Provided at a Main CCBHC Site

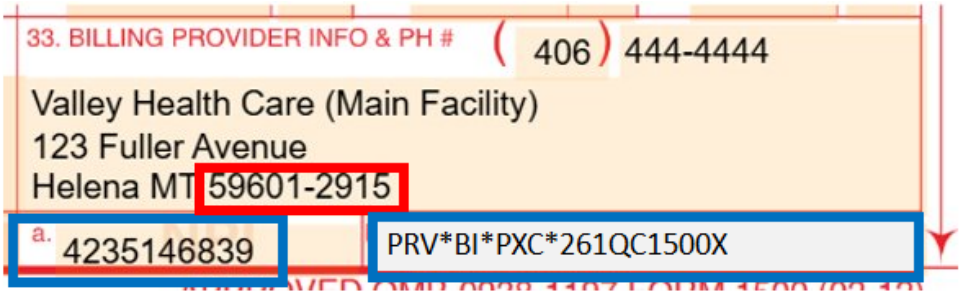
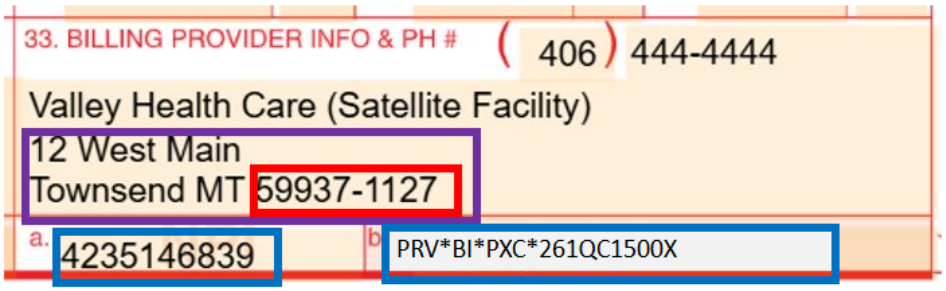


Figure 7: Sample Box 33 of an Electronic Claim for Services Provided at a Satellite CCBHC Site



CCBHCs are prohibited from billing the PPS rate for excluded or carved out services. If a claim includes procedure codes that are not designated as triggering or allowable CCBHC services by the State, the claim will deny. Only T1040 and State approved triggering and allowable service codes may appear on a PPS claim.

Billing for Individuals with Medicaid Plus Another Insurance Coverage Type (e.g., Dually Eligible Individuals)

For individuals who are dually eligible for and enrolled in Medicare and Medicaid, CCBHCs must first submit the claim to Medicare using the appropriate Provider ID as the rendering provider and reflecting covered services billed in accordance with standard Medicare billing rules. When the claim crosses over to Medicaid, the Medicaid claim should include T1040, along with the services provided on that visit day. An Explanation of Benefits (EOB)

from Medicare must be attached when submitting the crossover claim to Medicaid. Montana Medicaid will coordinate benefits and pay up to the CCBHC PPS rate, as appropriate, provided that no excluded services are included in the claim.

For individuals with commercial insurance and Medicaid, CCBHCs should bill the primary commercial insurer first (similar to above) using the appropriate Provider ID as the rendering provider and reflecting covered services billed in accordance with the applicable payer's billing rules. When the claim crosses over to Medicaid, the Medicaid claim should include T1040, along with the services provided on that visit day. When submitting the claim to Medicaid for secondary payment, the commercial insurer's EOB must be attached. As with Medicare crossover claims, PPS reimbursement will not occur if excluded services are included.

Billing for Individuals without Medicaid

The CCBHC PPS payment flows exclusively through Medicaid. CCBHCs are responsible for billing services provided to individuals with non-Medicaid coverage in accordance with the reimbursement methodology and billing requirements established by the applicable payer, including fee-for-service reimbursement where applicable.

Health Information Technology Requirements

CCBHCs in Montana are required to maintain secure and reliable health information technology (health IT) and EHR systems to support high-quality, coordinated care. These systems are central to ensuring accurate data collection, effective care transitions, and meaningful information exchange across providers and settings.

CCBHCs must maintain health IT systems, including EHRs, that support population health management, quality measurement and reporting, and outreach. Systems should utilize nationally recognized standards and adopt certified capabilities such as:

- Demographic data capture
- Care summaries and transitions of care
- Patient access to health records
- Clinical decision support
- Electronic prescribing

With patient consent, clinically relevant records from DCOs and external partners must be incorporated into the CCBHC's records to promote seamless care. In addition, within two years of certification, each CCBHC must implement a plan to enhance electronic care transitions and strengthen data exchange with DCOs and community partners.

Organizational Authority and Governance

CCBHCs in Montana must demonstrate clear organizational authority, inclusive governance, and adherence to national accreditation standards to ensure accountability and quality of care.

Each CCBHC's governance structure must meaningfully include individuals and families with lived experience of mental health and substance use disorders. Clinics may either:

- Ensure at least 51% of board members are individuals with lived experience or family members, **or**
- Establish a formal advisory body composed entirely of such individuals, with defined processes for providing input into planning, quality improvement, and fiscal decisions.

Boards and advisory bodies must reflect the demographics of the community and include members with expertise in areas such as health, finance, law, education, and social services. To prevent conflicts of interest, no more than half of board members may earn more than 10% of their income from the health care industry.

Governing documents and policies must clearly define decision-making authority, leadership oversight, fiscal responsibility, and accountability to the community. CCBHCs must also maintain documentation such as board rosters, meeting minutes, advisory reports, and accreditation certificates. For CCBHCs embedded in larger systems, advisory mechanisms must still provide meaningful consumer and family voice.

Quality and Other Reporting

In accordance with SAMHSA and Montana CCBHC requirements, CCBHCs must have the capacity to collect and monitor encounter, outcome, and quality measure data to support federal and state reporting requirements and continuous quality improvement (CQI) activities. At a minimum, CCBHCs must maintain data systems capable of reporting information related to:

- Characteristics of individuals receiving services
- Staffing and workforce capacity
- Access to and availability of services
- Service utilization patterns
- Screening, prevention, and treatment activities
- Care coordination activities
- Clinical and operational processes

- Costs of care
- Outcomes for individuals served

Whenever possible, data should be captured electronically through the CCBHC's EHR and maintained using nationally recognized standards to promote consistency, interoperability, and reporting accuracy.

CCBHCs are responsible for maintaining EHR functionality necessary to accurately collect, track, and report all required quality measures. Clinics must ensure that their health IT systems have the capacity to align with SAMHSA quality measure specifications and any requirements established under Montana's CCBHC program and HB 574. If a CCBHC partners with a DCO for any CCBHC services, CCBHCs must ensure that the DCO can track and share data, in accordance with quality measure reporting requirements and SAMHSA certification criteria section 5.a.2.

CCBHCs are expected to review and understand the applicable technical specifications[43] for all required quality measures in order to ensure that required data elements are captured in a manner that supports state and federal reporting requirements.

Big Sky Care Connect (BSCC), the Health Information Exchange (HIE) in Montana, has been chosen by BHDD to provide quality measure data to the state for reporting, as BSCC houses EHR data from clinics and Medicaid claims data. CCBHCs are required by BHDD to ensure their EHR systems are integrated with BSCC and share the data components required for quality measure calculation with BSCC. As a result of BSCC providing the state with both claims and EHR data, BHDD will be responsible for calculating and reporting both the state- and clinic-collected quality measures. Therefore, CCBHCs will not be responsible for filling out the data reporting template for their clinic-collected measures at the end of the measurement year.

The below table describes the clinic-collected measures. CCBHCs are responsible for ensuring data components for each of these measures are maintained in their EHR and transmitted to BSCC, who will compile the data from all clinic- and state-collected measures and share them with BHDD to ensure that BHDD may complete the required reporting across all quality measures.

Measure	**Overview**[44]	**Measure Steward**

[43] https://www.samhsa.gov/sites/default/files/ccbhc-quality-measures-technical-specifications-manual.pdf
[44] https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/guidance-and-webinars

Time to Services (I-SERV)	Average time (days) until provision of an initial evaluation for new clients	SAMHSA
	Average time (days) until provision of initial clinical services for new clients	
	Average time (hours) until provision of face-to-face crisis services following a crisis episode contact	
Depression Remission at Six Months (DEP-REM-6)	Percentage of clients (12 years of age or older) with a diagnosis of Major Depression or Dysthymia who reach Remission (PHQ-9 score of less than 5) six months (+/- 60 days) after an Index Event Date (the first instance of an elevated PHQ-9 score of greater than 9)	Minnesota Community Measurement
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	Percentage of clients aged 18 years and older who were screened for unhealthy alcohol use using a Systematic Screening Method at least once within the last 12 months	NCQA
	Percentage of clients aged 18 years and older who received brief counseling if identified as an unhealthy alcohol user	
Screening for Social Drivers of Health (SDOH)	Percentage of clients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety	CMS
Screening for Clinical Depression and Follow-Up Plan (CDF-AD and CDF-CH)	**Adults:** Percentage of clients age 18 and older screened for depression on the date of the encounter (qualifying outpatient visit) or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter	CMS
	Youth: Percentage of clients ages 12 to 17 screened for depression on the date of the encounter (qualifying outpatient visit) or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter	
Major Depressive Disorder: Suicide Risk Assessment (SRA-A and SRA-C)	**Adults:** Percentage of all CCBHC visits for those individuals that turn 18 or older during the measurement period in which a new or recurrent diagnosis of major depressive disorder (MDD) was identified and a suicide risk assessment (SRA) was completed during the visit	Mathematica Policy Research

	Youth: Percentage of all CCBHC visits for those individuals ages 6 through 17 years with a diagnosis of major depressive disorder (MDD) with an assessment for suicide risk completed during the visit	
Changes in Functional Assessment Scores: Age 18 and Older (LOCUS)/ Age 6-17 (CALOCUS-CASII)/ ECSII Age < 6	**Adults:** Average change in score between baseline LOCUS screening and final (near the end of an individual's treatment engagement) LOCUS screening	N/A – Measure developed to Adhere to H.B. 574 Requirement
	Youth ages 6-17: Average change in score between baseline CALOCUS screening and final (near the end of an individual's treatment engagement) CALOCUS screening	
	Children under 6: Average change in score between baseline ECSII assessment and final (near the end of an individual's treatment engagement) ECSII assessment	
Housing Status	% of clients that are currently unhoused vs. housed	N/A – Measure developed to Adhere to H.B. 574 Requirement
	% of clients who have a positive change in housing status (move from unhoused to housed) during the measurement year	
	% of clients who have a negative change in housing status (move from housed to unhoused) during the measurement year	
	% of clients who become unhoused who were referred to or provided support/care coordination for housing services during the Measurement Year	
Employment Status	% of clients that are currently unemployed vs. employed	N/A – Measure developed to Adhere to H.B. 574 Requirement
	% of clients who have a positive change in employment status (move from unemployed to employed) during the measurement year	
	% of clients who have a negative change in employment status (move from employed to unemployed) during the measurement year	
	% of clients who become unemployed during the Measurement Year who are referred to or provided support/care coordination for employment services	
Law-enforcement Involvement	% of clients with current law enforcement engagement who were referred to the CCBHC via law enforcement contact	N/A – Measure developed to Adhere to

	At initial contact, record whether there has been a contact with law enforcement or an arrest.	H.B. 574 Requirement
	% of clients who have a positive change in law enforcement involvement (move from having law enforcement involvement to having no law enforcement involvement) during the measurement year Frequency of Screening: Ask patients if they have had law enforcement contact or been arrested at least monthly; not required at every visit.	
	% of clients who have a negative change in law enforcement involvement (move from having no law enforcement involvement to having law enforcement involvement) during the measurement year	
	% of clients who had law enforcement contact during the Measurement Year who are referred to or provided support/care coordination to address associated needs	

For these measures, data should be drawn directly from the CCBHC's Health IT systems such as their EHR or other administrative data sources.

In addition to aggregate reporting, BHDD and SAMHSA require stratification of quality measures by age, insurance status, ethnicity, and race. The following components must also be available in CCBHC EHRs and shared with BSCC to ensure the state can complete reporting and stratification across measures:

- Age Group (< 18 and 18+)
- Insurance Status (Medicaid and Non-Medicaid)
- Ethnicity (Not Hispanic or Latino/Hispanic or Latino/Unknown)
- Race (White or Caucasian/Black or African American/American Indian or Alaska Native/Asian/Native Hawaiian or Other Pacific Islander/More than one race/Unknown)

In addition to the above, BHDD will require CCBHCs to annually complete and submit the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey, aiming to engage at least 300 adults in the survey, or as many participants as possible if there are fewer than those numbers of individuals in the population served by the CCBHC. BHDD will also require CCBHCs to annually complete and submit the Youth/Family Services Survey for Families (YSS-F) Experience of Care Survey, aiming to

engage at least 300 youth/caregivers in the survey, or as many participants as possible if there are fewer than those numbers of individuals in the population served by the CCBHC. More information about these two required state-level CCBHC measures (Patient/Youth and Family Experience of Care Surveys) can be found in the SAMHSA CCBHC Quality Measure Technical Specifications.[45]

In addition, BHDD will also use data from administrative claims, encounter records, pharmacy data, and other data sources available from BSCC to collect and submit data related to the following State-collected CCBHC measures:

- Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
- Initiation and Engagement of Substance Use Disorder Treatment
- Antidepressant Medication Management
- Follow-Up After Emergency Department Visit for Substance Use (Adults and Children)
- Follow-Up After Hospitalization for Mental Illness (Adults and Children)
- Follow-Up After Emergency Department Visit for Mental Illness (Adults and Children)
- Hemoglobin A1c Control for Patients with Diabetes
- Use of Pharmacotherapy for Opioid Use Disorder
- Plan All-Cause Readmission Rate
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia

These state-level quality measures will be calculated by BHDD for each CCBHC and submitted annually to SAMHSA alongside the clinic-collected measures. In alignment with federal requirements, BHDD will transmit both sets of results to SAMHSA within twelve months after the close of each measurement year.

Montana CCBHCs must ensure:

- Data components for clinic-collected quality measures are tracked in their EHR
- Experience of Care surveys are completed and shared with the state, per state and SAMHSA requirements.
- EHR integration and data sharing capability with Big Sky Care Connect
- Cooperation with state review processes for all clinic- and state-collected measures.

[45] https://www.samhsa.gov/sites/default/files/ccbhc-quality-measures-technical-specifications-manual.pdf

- Full compliance with data specification, electronic reporting, and quality tracking expectations.
- Regular review of quality measure performance as part of the organization's quality improvement program.
- Development and implementation of corrective action or improvement strategies when performance trends indicate opportunities to improve access, quality, outcomes, or care coordination.

Continuous Quality Improvement

In compliance with SAMHSA, CCBHCs maintain a Continuous Quality Improvement (CQI) Plan that supports all clinic activities and ensures ongoing improvement in behavioral health care quality, safety, and outcomes. The CQI plan is data-driven, structured, and designed to systematically monitor performance, evaluate outcomes, and implement improvements.[46]

At minimum, the CQI plan includes processes for

1. Monitoring CCBHC Performance

- Ongoing evaluation of care processes and outcomes using internal, state, and federally recognized quality measures.
- Use of iterative improvement methods, such as Plan-Do-Study-Act (PDSA) cycles, to address identified gaps and ensure sustained improvement.
- Tracking of both process and outcome metrics over time, with benchmarking against established standards to identify trends and areas for enhancement.

2. Review of Significant Events

- Systematic review of critical events, including:
    - Deaths by suicide or suicide attempts
    - Fatal and non-fatal overdoses
    - All-cause mortality among individuals receiving services
    - 30-day psychiatric or SUD readmissions
- Reviews incorporate root cause analysis or other structured methodologies to identify systemic issues, determine corrective actions, and ensure follow-up accountability.

3. Data Utilization and Analysis

[46] https://www.samhsa.gov/sites/default/files/quality-measurement-tool-continuous-quality-improvement.pdf

- Integration of clinic-collected and state-collected quality data to monitor performance and guide improvement initiatives.
- Analysis of outcomes and processes to identify barriers, evaluate intervention effectiveness, and inform adjustments in care delivery.
- Trend analysis to assess progress over time and support data-driven decision-making.

4. Addressing Health Disparities

- Disaggregation of data by key demographic and clinical characteristics (e.g., age, gender, race/ethnicity, disability, diagnosis, socioeconomic status) to identify inequities in care and outcomes.
- Development of targeted interventions to improve equity and reduce disparities across populations served.

5. Integration and Coordination

- CQI activities are integrated across all services, including behavioral health, primary care, and care coordination, to ensure comprehensive quality improvement efforts.
- Documentation of all CQI activities, findings, and implemented changes is maintained for accountability, transparency, and continuous learning.

The CCBHC CQI plan should be a living document, regularly updated to reflect emerging evidence, changes in the population served, and lessons learned from ongoing quality improvement initiatives. All staff are engaged in CQI processes to foster a culture of continuous improvement and excellence in care delivery.

Monitoring and Compliance

Program Review and Auditing

BHDD will perform regular reviews of each CCBHC's billing, cost reporting, volume, and operations data by site and across the CCBHC enterprise. Participating CCBHCs must make all records, audits, claims, documentation, and other materials available to BHDD upon request. Following a CCBHC review, BHDD will generate a report identifying any findings and recommendations that require a response by the CCBHC. Depending upon the findings and recommendations of the report, BHDD may:

- Ask the CCBHC site to provide a Corrective Action Plan (CAP) for achieving compliance within 30 days of receiving the state's report (see CAP components below)

- In extreme cases, impose immediate penalties, fines, and restrictions up to and including submitting a recommendation to OIG for decertification of a site(s) or exclusion from participation in the CCBHC program overall

The CCBHC may also present new information to BHDD that demonstrates it was in compliance with the questioned provisions at the time of the review.

Corrective Actions & CCBHC Decertification

Failure to abide by the terms of the federal CCBHC criteria and state requirements may result in disciplinary action, including placing the CCBHC in a probationary period or decertification of a CCBHC site or as a CCBHC provider overall.

DPHHS will use a progressive corrective action approach to support CCBHC compliance. When a deficiency is identified, actions may include (depending on the severity and nature of the identified deficiency), but are not limited to:

- Provision of technical assistance and informal remediation
- Requirement to develop and submit a CAP
- Placement on probationary status with enhanced monitoring (e.g., more frequent site visits or additional data reporting requirements)
- Provisional certification status
- Additional administrative actions as deemed appropriate by DPHHS
- Decertification as a CCBHC provider

Potential reasons for corrective action and/or decertification may include but are not limited to:

- Failure to provide DPHHS with requested documentation demonstrating CCBHC requirements related to the federal CCBHC Criteria and/or this Provider Manual are met
- Failure to correct identified deficiencies in meeting certification requirements
- Consumer complaints related to non-compliance with CCBHC policies or not meeting CCBHC certification criteria
- Failure to provide proof of and maintain required state licensures and certifications
- Non-compliance with rate setting, including rebasing
- Misrepresentation of data related to CCBHC operations

Following the identification of a deficiency in CCBHC operations, DPHHS may require the CCBHC to submit a CAP within 30 days of notification. At a minimum, the CAP must include:

- A description of each identified deficiency
- A root cause analysis of the reason the deficiency is occurring
- Specific corrective actions to be implemented by the CCBHC
- Identification of responsible staff for the corrective actions
- A timeline for implementation of the corrective actions, including when the CCBHC anticipates the deficiency will be fully resolved
- Measurable outcomes or indicators demonstrating resolution of the deficiency

DPHHS will review the CCBHC's CAP upon submission and request additional information/updates as necessary. During the implementation of an approved CAP, DPHHS will provide support (e.g., technical assistance) and conduct enhanced monitoring to assess progress toward compliance and resolution of the identified issue(s). Monitoring activities may include, but are not limited to:

- Increased frequency of reporting
- Submission of additional/accurate documentation or data
- Targeted desk reviews or audits
- Additional on-site or virtual monitoring visits

In an instance where the corrective action does not result in the intended improvements within a reasonable timeframe and/or decertification of a site and/or full CCBHC is required due to the severity of the identified issue, DPHHS will give a CCBHC written notice of the intent to decertify (which could be for a specific site location or the full CCBHC). CCBHCs may either accept the decertification or respond with a detailed plan of additional correction(s) to address the identified reasons for decertification. If DPHHS approves the plan, the CCBHC will be placed on "provisional certification" status while the correction plan is being implemented.

DPHHS will support the development, implementation, and monitoring of the corrective action plan. DPHHS may also deny the request for corrections, and formal notice of decertification related to the site(s) or full CCBHC will be provided to the agency.

Grievance Processes

Individuals receiving services from a CCBHC or DCO must be informed of and have access to the CCBHC's grievance and complaint procedures, which must comply with all applicable Medicaid and state requirements. CCBHCs must maintain written policies and procedures for receiving, investigating, resolving, and documenting consumer grievances and complaints. Individuals must be informed of their rights, the process for filing a complaint, applicable timelines, and available avenues for appeal or resolution.

CCBHCs are expected to make reasonable efforts to address and resolve complaints at the local level whenever possible. Individuals should be encouraged to first raise concerns with the CCBHC, DCO, facility administrator, or appropriate program staff so that issues can be reviewed and addressed promptly. CCBHCs should also routinely analyze grievance and complaint data to identify opportunities for improvement and implement corrective actions when systemic issues are identified.

If an individual believes their concern has not been adequately resolved through the CCBHC's grievance process, they may submit a complaint to the DPHHS OIG through the state's Certification and Licensure Complaint process.[47] OIG accepts complaints regarding certified and licensed providers and will review allegations in accordance with its established oversight responsibilities. Complainants may submit complaints anonymously; however, providing contact information may assist DPHHS in conducting a more thorough review. DPHHS does not disclose the name of the complainant to the provider during the complaint review process.

CCBHCs must cooperate with all DPHHS and OIG inquiries, investigations, requests for documentation, corrective action activities, and monitoring reviews related to complaints received through the above Certification and Licensure Complaint process. Complaint trends, substantiated findings, corrective action plans, and patterns of grievances may be considered by DPHHS as part of ongoing CCBHC certification monitoring, quality oversight, compliance reviews, and continuous quality improvement activities.

Administrative Review and Fair Hearings

A provider may request an administrative review if they believe the Department has made a decision that fails to comply with applicable laws, regulations, rules, or policies.

To request an administrative review, the provider must submit their written objections to the Department’s decision, along with substantiating documentation, for consideration during the review. The request must be addressed to the division that issued the decision and delivered (or mailed) to the Department. This information is found in the decision letter when an adverse action has been determined. The Department must receive the administrative review request within 30 days from the date the Department’s contested determination was mailed or emailed. Providers may request extensions in writing within 30 days.

A fair hearing may be requested if the provider is not satisfied with the results of the administrative review. Fair hearing requests must contain concise reasons the provider

[47] https://dphhs.mt.gov/oig/certificationcomplaintform

believes the Department's administrative review determination fails to comply with applicable laws, regulations, rules, or policies. This document must be signed and received by the Office of Administrative Hearings within 30 days from the date the Department mailed the administrative review determination. A copy must be delivered or mailed to the division that issued the determination within three working days of filing the request. Contact information and timelines are found in the administrative review determination letter.

Glossary

A

Access Point
A CCBHC service location that provides a subset of required services, including screening, assessment, diagnosis, and outpatient behavioral health services, and facilitates access to the full scope of CCBHC services through coordination with main or satellite sites or DCOs.

Access Standards
Requirements that ensure individuals can obtain behavioral health services in a timely and equitable manner, including 24/7 crisis services and defined timeframes for urgent and routine care.

C

Care Coordination
Deliberate organization of client care activities and information sharing across providers and systems to ensure safe, effective, and continuous treatment.

Carried Costs
Costs included in the CCBHC PPS rate that support required activities (e.g., care coordination, outreach, quality improvement) but do not independently trigger payment on a given service day.

Catchment Area
The defined geographic service area (one or more counties) for which a CCBHC is responsible for providing the full scope of required services.

CCBHC Certification Criteria
Federal standards established by SAMHSA that define required services, staffing, governance, access, and quality expectations for CCBHCs.

Certified Community Behavioral Health Clinic (CCBHC)
A provider organization that meets federal certification criteria established by SAMHSA and delivers a comprehensive range of mental health and substance use services, regardless of individuals' ability to pay.

Continuous Quality Improvement (CQI)
A structured, data-driven process used by CCBHCs to monitor performance, evaluate outcomes, and implement improvements in care and operations.

Co-Occurring Disorders (COD)
The presence of both a mental health disorder and a substance use disorder in the same individual.

D

Designated Collaborating Organization (DCO)
An external provider or partner organization that delivers specific CCBHC services on behalf of a CCBHC through formal agreement while remaining integrated into the CCBHC care model.

Diagnosis
The clinical identification of a mental health or substance use disorder based on assessment findings, standardized tools, and clinical judgment.

Discharge
The process by which an individual exits ongoing CCBHC services, either through completion of treatment, transfer to another provider, or disengagement from care.

E

Electronic Health Record (EHR)
A digital system used to collect, store, and manage patient health information and support care coordination and reporting.

Evidence-Based Practice (EBP)
A clinical intervention that is supported by scientific research and demonstrated effectiveness for treating specific behavioral health conditions.

F

Fidelity Monitoring
Processes used to ensure that evidence-based practices are delivered consistently and in accordance with established models and standards.

H

Health Information Technology (Health IT)
Electronic systems and infrastructure used to support clinical care, data collection, reporting, and care coordination.

I

Integrated Care
A coordinated approach to delivering behavioral health and physical health services to address the whole person.

Intensive Outpatient Program (IOP)
A structured level of care providing multiple hours of treatment per week (9+ hours/week for adults or 6+ hours/week for adolescents, in alignment with ASAM Level 2.1) for individuals with moderate to severe SUD.

M

Main CCBHC Site
A primary service location that must provide all required CCBHC services through in-person delivery.

Medical Necessity
A determination that a service is appropriate and required for the diagnosis or treatment of a condition based on clinical standards.

Measurement-Based Care (MBC)
The systematic use of standardized tools and data to monitor client progress and guide clinical decision-making.

P

Person-Centered Care
An approach to care that emphasizes individual preferences, goals, and values in all treatment decisions.

Prospective Payment System-1 (PPS-1)
A bundled daily payment methodology under which a CCBHC receives a fixed rate per eligible client per day when a qualifying service is delivered.

Primary Care Screening and Monitoring
Services that identify and track physical health conditions and risk factors for individuals receiving behavioral health care.

R

Reasonable Accessibility
A Montana-specific standard requiring that CCBHC satellite sites and access points be located within defined travel times (e.g., within a 120-minute drive time) from a main site.

Recovery-Oriented Care
A service approach that supports individuals in achieving improved health, wellness, and independence based on their personal goals.

S

Satellite CCBHC Site
A secondary service location that provides a core subset of required services and operates under the governance of the CCBHC.

Screening
A brief process used to identify behavioral health risks and determine the need for further assessment or services.

Serious Emotional Disturbance (SED)
A diagnosable mental health disorder in children or youth that substantially interferes with functioning.

Serious Mental Illness (SMI)
A diagnosable mental health disorder in adults that significantly impairs functioning and daily activities.

Social Determinants of Health (SDOH)
Conditions in which people live, learn, work, and age that affect health outcomes and access to care.

Substance Use Disorder (SUD)
A medical condition characterized by the recurrent use of substances despite harmful consequences.

T

Targeted Case Management (TCM)
Services that assist individuals in accessing medical, social, and community resources through assessment, planning, referral, and monitoring.

Treatment Plan
An individualized, documented plan outlining goals, services, and interventions based on assessment findings and developed collaboratively with the individual.

Triggering Event
A qualifying service that allows a CCBHC to bill and receive a PPS-1 payment for a given service day.

W

Warm Handoff
A direct, coordinated transfer of care between providers designed to ensure continuity of services and engagement of the individual.

Appendix

CCBHC Community Needs Assessment

The Community Needs Assessment is a foundational requirement for CCBHCs. It is a systematic process to identify community conditions, gaps in behavioral health care, and the clinic's capacity to respond effectively. The purpose of the assessment is not only to catalog needs but also to ensure that CCBHC services are designed around the realities of the community. This includes aligning staffing, service delivery models, locations, service hours, cultural and linguistic supports, and evidence-based practices with identified needs. The assessment must be thorough and inclusive, reflecting the treatment and recovery needs of individuals across the lifespan, from children and youth to older adults and families. Importantly, CCBHCs are required to revisit and update the community needs assessment at least once every three years, ensuring services remain responsive and relevant.[48]

Each CCBHC in Montana must complete a community needs assessment and submit it for review to OIG as part of the certification process. The community needs assessment must include at minimum the following information:

- Catchment Area Definition: A description of the physical boundaries and size of the service area, including all clinic sites and those provided through DCOs.
- Prevalence Data: Information on rates of mental health and substance use conditions, including critical indicators such as suicide and overdose rates.
- Social Determinants of Health (SDOH) Needs: Economic and social factors that impact access to care, such as poverty, transportation, nutrition, and housing stability.
- Demographic and Cultural Context: Identification of populations residing in the service area, with attention to languages and cultural backgrounds.
- CCBHC Staffing Plan: How the CCBHC's staffing plan addresses the needs identified through the assessment.
- Community Input: Perspectives on cultural, linguistic, physical health, and behavioral health needs; evidence-based practices; crisis services; access to services (including telehealth options); and barriers such as workforce shortages, transportation, or geographic isolation. Input should come from the following entities if they are in the CCBHC service area:

[48] Substance Abuse and Mental Health Services Administration. (2023). *Certified Community Behavioral Health Clinic (CCBHC) certification criteria (2023 update)*. U.S. Department of Health & Human Services. https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

- People with lived experience of mental and substance use conditions and individuals who have received/are receiving services from the clinic conducting the needs assessment;
- Health centers (including FQHCs in the service area);
- Local health departments (Note: these departments also develop community needs assessments that may be helpful);
- Inpatient psychiatric facilities, inpatient acute care hospitals, and hospital outpatient clinics;
- One or more Department of Veterans Affairs facilities;
- Representatives from local K-12 school systems;
- Crisis response partners such as hospital emergency departments, emergency responders, crisis stabilization settings, crisis call centers and warmlines; and
- Other community partners, especially those who also work with people receiving services from the CCBHC and populations that historically are not engaging with health services

Primary Care Screening Template

This is an example of a template that can be built into your EHR for the primary care screening and monitoring required of a CCBHC. This example template focuses on the required primary care screenings (blood pressure, BMI, diabetes, HIV, and viral hepatitis) that will be done by the nurses or other medical staff.

Children and Young Teens (14 and under)

1. Connected to a PCP and seen within the last year?
    - No: Warm connection to PCP
    - Yes: Obtain consent to obtain relevant records and include PCP as part of multidisciplinary team.
2. 6 or older?
    - Yes: BMI

Adolescents (15-17)

1. Connected to a PCP and seen within the last year?
    - No: Warm connection to PCP
    - Yes: Obtain consent to obtain relevant records and include PCP as part of multidisciplinary team.
2. Body Mass Index
3. Ever been tested for HIV?
    - No: FDA-approved point of care rapid screening test
        - If positive, immediate connection to laboratory HIV test
    - Yes: At increased risk? (sexually active men who have sex with men; persons with a sex partner who is living with HIV; or persons who engage in behaviors that may convey an increased risk of HIV infection, such as injection drug use, transactional sex or commercial sex work, having 1 or more new (i.e., since a prior HIV test) sex partners whose HIV status is unknown); high risk setting (e.g. homeless shelter)
        - Yes: Annual screening via FDA-approved point of care rapid screening test
            - If positive, immediate connection to laboratory HIV test
4. At risk of Hepatitis B or pregnant? (people born in country with prevalence of Hepatitis B of ≥ 2%, persons who have injected drugs in the past or currently; men who have sex with men; persons with HIV; and sex partners, needle-sharing contacts, and household contacts of persons known to be HBsAg positive)
    - Yes: FDA-approved point of care HBsAg screening tests

5. At risk of Hepatitis C? (The most important risk factor for HCV infection is past or current injection drug use.)
    - Yes: Periodic screening using point of care rapid HCV antibody screening test followed by polymerase chain reaction testing for HCV RNA

Adults (18+)

1. Connected to a PCP and seen within the last year?
    - No: Warm connection to PCP
    - Yes: Obtain consent to obtain relevant records and include PCP as part of multidisciplinary team.
2. Blood pressure – Is blood pressure ≥ 130 mm Hg systolic or 80 mm Hg diastolic?
    - Yes: Refer to PCP
3. At risk for diabetes? (Age 35 - 70 with BMI ≥25 or on antipsychotics)
        - Yes: HbA1c level. If result ≥ 5.7%, refer to PCP.
4. Cholesterol screening – women age 20+ if increased risk; men age 35+ routinely and age 20+ if increased risk. Risk factors for cardiovascular disease include diabetes, high blood pressure, currently smoking, BMI ≥ 30, family history of heart disease before age 50.
    - Yes: lipid panel
5. Assessment of physical activity and diet
6. Ever been tested for HIV?
    - No: FDA-approved point of care rapid screening test
        - If positive, immediate connection to laboratory HIV test
    - Yes: At increased risk? (sexually active men who have sex with men; persons with a sex partner who is living with HIV; or persons who engage in behaviors that may convey an increased risk of HIV infection, such as injection drug use, transactional sex or commercial sex work, having 1 or more new (i.e., since a prior HIV test) sex partners whose HIV status is unknown)
        - Yes: Annual screening via FDA-approved point of care rapid screening test
            - If positive, immediate connection to laboratory HIV test
7. At risk of Hepatitis B or pregnant? (people born in country with prevalence of Hepatitis B of ≥ 2%, persons who have injected drugs in the past or currently; men who have sex with men; persons with HIV; and sex partners, needle-sharing contacts, and household contacts of persons known to be HBsAg positive)
    - Yes: FDA-approved HBsAg tests
8. Ever tested for Hepatitis C?
    - No: point of care rapid HCV antibody screening test followed by polymerase chain reaction testing for HCV RNA

- Yes: At increased risk? (pregnant or past or current injection drug use)
    - Yes: Periodic screening using point of care rapid HCV antibody screening test followed by polymerase chain reaction testing for HCV RNA