HFS
Illinois Department of
Healthcare and Family Services

Illinois Medicaid Certified Community Behavioral Health Clinic (CCBHC) Initiative

Frequently Asked Questions

September 22, 2023[1]

Application Requirements and Selection Process

1) Is this CCBHC demonstration application only open to CCBHC grantees or can regular Behavioral Health Clinics (BHCs) apply as well?

A: The 2022 Bipartisan Safer Communities Act (BSCA) expands the CCBHC federal Medicaid Demonstration to an additional 10 states every two years beginning July 1, 2024. HFS is currently in the process of completing all planning activities required for the Demonstration and will submit an application to the Centers for Medicare and Medicaid Services (CMS) in March 2024. Each selected state's demonstration period will be four years.

All eligible providers are welcome to apply to become an Illinois Certified CCBHC under the CCBHC Medicaid Demonstration. Interested providers should carefully review the eligibility and program criteria contained in the Illinois CCBHC Application materials before moving forward with the application process. Providers who have received SAMHSA CCBHC grants are not automatically eligible to participate in the Demonstration.

The application process is the first step in becoming an Illinois-certified CCBHC. Providers must be approved in the application process to move to the second step, which is the actual certification review. Organizations that successfully demonstrate compliance with program requirements and readiness to implement CCBHC services will be designated as Illinois certified CCBHCs and selected for the Illinois Demonstration application.

Organizations not selected for certification or who do not pass the certification review will not be eligible for the Demonstration or the CCBHC PPS payment. However, those providers will be eligible to participate in a state-led Learning Collaborative that will support providers in enhancing their scope of practice to, eventually, meet requirements. HFS will consider certifying additional providers that demonstrate readiness in future years of the four-year Demonstration.

[1] Responses provided as of September 19, 2023 are based on information available based on the current demonstration guidance, and may be modified dependent upon the release of any new Demonstration guidance.

2) When do providers need meet all the CCBHC model of care criteria?

A: Providers must be able to provide all required services from the nine (9) required service categories prior to the start of the Demonstration in July 2024, unless otherwise specified. Please see the Readiness Assessment Tool *Illinois Certified Community Behavioral Health Clinic Service Requirements document* for the timelines associated with the Illinois specific requirements.

3) Is there going to be a limit to the number of CCBHCs selected?

A: As part of its Demonstration application, the State is committed to the development of a robust, evidence-based CCBHC program which ensures both access to care coupled with the provision of high quality service. The state will make the determination on the number of CCBHCs to include in the CCBHC Demonstration based on the number of providers who demonstrate they are qualified and ready to meet certification requirements starting in July 2024.

4) Can two CCBHCs serve the same area?

A: Yes.

5) Are there grant funds associated with the Illinois CCBHC application?

A: No, there is no grant funding associated with the Illinois CCBHC application.

6) Please confirm whether each individual site location will require an application?

A: Yes – each site an organization is seeking to certify as a CCBHC must have a separate CCBHC application, CCBHC Provider Readiness Tool (CPRT), and required plans must be submitted. Each individually certified CCBHC site location must directly deliver the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through Designated Collaborating Organization (DCO) agreements.

7) How are the following timelines in the CPRT and Illinois CCBHC Service Requirements defined?

A: Immediately is defined as no later than July 1, 2024. Within 12 months is defined as no later than July 1, 2025. Within 24 months is defined as no later than July 1, 2026.

8) Could you provide instructions on what HFS is looking for regarding the Evidence-Based Practice/Evidence-Informed Services (EBP/EIS) Plan for

CCBHC Services, the Pathways Services implementation plan, and the ABS implementation plan? In other words, what is the required content for the Plans?

A: The Illinois CCBHC Service Requirements document (p. 5) indicates the EBP/EIS Plan must include targeted populations, projected costs, and EBP/EIS fidelity requirements. Entities seeking to qualify as a CCBHC should review their community needs assessment, target populations, and service options when determining which other (non-mandated) EBP/EIS the site intends to introduce and detail within their EBP/EIS Plan an overview of the estimated volume of customers to be served, fidelity costs, and staffing assumptions that would be integrated into the site's PPS and ultimately impact the buildup of the site PPS.

It is recommended that a Pathways and ABS service plans highlight the steps the entity intends to take to make the CCBHC site a Pathways to Success and/or ABS provider, consistent with Department policy, within 12 months of being certified as a CCBHC.

9) **What documents must be submitted to meet the application's community needs assessment requirement?**

A: HFS expects that providers who need to complete a community needs assessment that meets the criteria detailed in section 1.a.1.1 of the Readiness Assessment Tool will do so by February 15, 2024. The provider's plan for completing the community needs assessment must be included as an attachment to the application.

If the provider has already completed a CCBHC needs assessment that meets the criteria detailed in section 1.a.1.1 of the Readiness Assessment Tool, then it must be included as an attachment to the application.

10) **On the Provider Readiness Tool there are four (4) Readiness options, including "Implemented" or "Ready to Implement." Can HFS clarify how an agency that does not have a current CCBHC should respond? For example, my agency does have some components in place even though we are not a CCBHC. So, would we indicate "Implemented" or "Ready to Implement"?**

A: The Readiness Assessment Tool allows the provider to self-assess their current ability to meet each of the CCBHC criteria. The provider needs to complete the tool based on their ability to implement the criteria at the time the tool is completed. The term "Implemented" means that the site currently provides the service being identified under the Illinois Medical Assistance Program. The term "Ready to Implement" means that the site has the resources, staff, licensures, and approvals

to deliver the service being identified but the site has not begun delivery of the service.

11) To qualify for preferred applicant status, do you have to commit to providing both Pathways Services as well as ABS Services?

A: No. Entities applying to participate in the CCBHC Demonstration that are determined to be qualified will be placed in a pool of qualified candidates. Qualified sites will then be granted tiers of preferential applicant status, depending upon three factors: 1) the site's existing SAMHSA CCBHC grant; 2) a site's willingness to become a Pathways to Success provider; and 3) a site's willingness to become an ABS provider. The most preferred applications will be qualified sites that have an existing SAMSHA CCBHC grant and commit to providing both Pathways and ABS services.

12) Is a CCSO allowed to apply as a preferred Pathways Provider?

A: CCSOs applying to be a CCBHC whose proposed CCBHC site is located within, or contiguous to, one of the counties in the CCSOs covered DSA, will be granted the Pathways services preferred applicant status. The applicant should indicate they are a CCSO within their application; a Pathways services implementation plan is not required for active CCSOs. Please note, CCSOs may not provide additional Pathways services and should not submit implementation plans for those services.

13) Can a provider use a DCO agreement for Pathways to Success or Adaptive Behavior Support (ABS) services to obtain the preferred applicant status?

A: No, CCBHC sites that commit to providing Pathways or ABS services will be expected to deliver these services directly from the CCBHC site.

Service Areas

14) Are CCBHCs required to provide services across the entire Designated Service Area (DSA) in which it is located?

A: No, there is no expectation that a certified CCBHC provide services across the entire geography of the DSA in which the CCBHC is located.

15) Could you explain the "site based" nature of the CCBHC certification? For example, if we get a site certified, but believe we could be more effective reaching a subpopulation by establishing a service location in that neighborhood or county, could that site be considered part of the CCBHC operations?

A: CCBHCs are a new provider type intended to provide a comprehensive, integrated array of services at a single location. Unlike Community Mental Health Centers and Behavioral Health Clinics, CCBHCs are allowed to utilize Designated Collaborating Organizations (DCOs) for up to 49% of encountered services, but the majority of service delivery (51% or more) must be delivered from the certified CCBHC site location. Satellite sites are not recognized under the CCBHC Demonstration model. HFS' certification of CCBHCs will be site specific, meaning the CCBHC requirements are expected to be met from a single, physical plant site (fully recognizing DCO flexibilities).

As a final note, it is feasible that an organization with multiple provider sites (CCBHC, BHC, CMHC, etc.) may establish a DCO agreement between the CCBHC location and another provider site operated by the same organization, assuming all DCO requirements are in place to support the relationship and service delivery.

16) Will agencies, particularly thinking about rural agencies, have flexibility to determine what geographic area each service/team covers, regardless of where that employee or team is housed?

A: Yes. The intent is for organizations to identify the geographic area in which they will provide CCBHC services, either directly or through DCO agreements. The state is not defining the geographic area that a CCBHC must cover.

<u>Designated Collaborating Organizations (DCOs)</u>

17) Can HFS provide clarification on which of the Illinois required elements can be provided by a DCO (or referral)? Are there are elements the agency itself must provide?

A: HFS has established no limitations or requirements specific to CCBHC establishment of DCO agreements for the delivery of the nine core service categories or the Illinois specific service requirements under those nine categories. It is a federal expectation that CCBHCs provide, at a minimum, 51% of all encountered services directly from the CCBHC site.

Additionally, CCBHC sites electing to provide Pathways to Success (Pathways) services and/or Adaptive Behavior Support (ABS) services from their CCBHC site, must deliver those services directly from the CCBHC location. Pathways and ABS services are NOT eligible to be delivered via a DCO partnership.

18) DCO agreements with inpatient facilities, FQHCs, etc. are only required if they are providing some service that is within the 9 core services that the applicant cannot provide, correct? Similarly, we are expected to have care coordination

agreements with other frequently referred providers, like FQHCs, inpatient hospitals, inpatient SUD, detox facilities, etc., correct?

A: Correct.

CCBHCs are only required to establish DCO agreements if another healthcare provider organization is delivering one or more of the mandated services detailed within the 9 core CCBHC service categories. It is feasible that a comprehensive CCBHC could deliver all required CCBHC services directly, without any DCO agreements.

Additionally, all CCBHCs are expected to have care coordination agreements established with healthcare providers that deliver services outside of the CCBHC service array. Below are the SAMHSA CCBHC criteria regarding CCBHC Care Coordination agreements.

SAMHSA's CCBHC criteria requires:

Standard 3.c.1 - CCBHC has a partnership establishing care coordination expectations with Federally Qualified Health Centers (FQHCs) (and, as applicable, Rural Health Clinics (RHCs)) to provide health care services, to the extent the services are not provided directly through the CCBHC.

Standard 3.c.2 - CCBHC has partnerships that establish care coordination expectations with programs that can provide inpatient psychiatric treatment, OTP services, medical withdrawal management facilities and ambulatory medical withdrawal management providers for substance use disorders, and residential substance use disorder treatment programs (if any exist within the CCBHC service area).

CCBHC Model of Care

19) Would HFS consider making some criteria allowable vs required and based on the community needs assessment?

A: Working with input from multiple State of Illinois Agencies, HFS established the Illinois-specific Service Requirements for entities seeking to be selected as partners in the Department's FY2024 CCBHC Implementation Demonstration application. Following feedback from various provider organizations, HFS has sought to introduce the following flexibilities to the CCBHC service requirements:

1. Methadone. Category 9 – Psychiatric Rehabilitation Services of the Illinois' CCBHC Scope of Services indicates that, "All FDA-approved forms of medication to be used in the delivery of Medication Assisted Recovery (MAR)." This

requirement would be inclusive of Methadone. Understanding the regulatory requirements specific to Opioid Treatment Programs (OTP) and the delivery of methadone, the Department has moved methadone from a required service under this category to an allowable service. This change in designation will allow a CCBHC to include the delivery of methadone in the cost build up that establishes the sites PPS rate, but CCBHCs will not be required to provide methadone to qualify as a CCBHC site.

2. Assertive Community Treatment (ACT) in rural areas. Category 9 – Psychiatric Rehabilitation Services of the Illinois' CCBHC Scope of Services indicates that, "Within 12 months, the provider must enhance psychiatric rehabilitation services to include…Assertive Community Treatment (ACT)." In response to provider concerns about the ability to establish and maintain ACT teams in certain areas of the state, HFS is introducing the flexibility that CCBHCs in rural areas may elect to provide Community Support Team in lieu of ACT. CCBHCs located in urban areas of Illinois are required to introduce ACT within 12 months of certification.

The determination of Rural versus Urban classification for the purposes of this policy shall be made in accordance with the Illinois Counties by Rural/Urban Classification model found on the Illinois Department of Public Health website: https://dph.illinois.gov/content/dam/soi/en/web/idph/files/rur-urb-2021.pdf.

These new flexibilities are being introduced in addition to the CCBHC model allowing up to 49% of services be provided by another healthcare provider under a DCO agreement and the introduction of an Evidence Based Practice / Evidence Informed Services Plan.

20) Could HFS clarify the requirement to provide access to Medication Assisted Recovery (MAR) within 24 hours of a SUD crisis event?

A: The requirement means that the customer is connected to a provider capable of providing MAR services, as clinically appropriate, to the customer within 24 hours after a SUD crisis event.

21) Can providers utilize MAR Now to meet the requirement to provide access to MAR within 24 hours of a SUD crisis event? MAR NOW connects callers to immediate treatment for opioid use disorder, including telephonic prescription and home induction on buprenorphine or same-day clinic appointments for methadone, buprenorphine, or naltrexone. MAR NOW can also connect patients to withdrawal management and residential treatment.

A: Yes, CCBHCs could utilize MAR NOW (where available) to assist in meeting the requirement to help customers access MAR within 24 hours after a SUD crisis event. CCBHCs should ensure they are helping coordinate ongoing follow-up services for customers in collaboration with MAR Now care managers.

Applicants are also reminded that the SAMHSA CCBHC criteria 1.b.2 requires the CCBHC staff include *"a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other FDA approved medications used to treat opioid, alcohol, and tobacco use disorders."*

HFS would expect CCBHCs to develop protocols for connecting customers to MAR services utilizing their required prescriber, with additional protocols to supplement this access as needed through other arrangements (e.g., DCOs, MAR NOW protocols).

22) Are the supplements in the IM+CANS acceptable to meet the screening requirements for substance use disorder, mental health disorder, physical health screening, and developmental screening?

A: The Health Risk Assessment addendum to the IM+CANS could be utilized as a physical health screening but isn't required to be utilized by CCBHCs. The IM+CANS itself would not be appropriate to utilize as a stand-alone screening tool for mental health, SUD, or developmental disabilities.

HFS would be open to discussions with providers about creating a subset of the IM+CANS that might be appropriate to utilize as a screening tool in the future. Alternatively, providers could utilize other nationally recognized and validated screening tools to meet this requirement (e.g., CRAFFT, DAST, AUDIT, ASQ, Devereux, Vineland, PHQ, GHQ, GAD-7).

23) Would HFS consider making Developmental Screening (including for autism) allowable rather than required and based on community needs assessment?

A: HFS is not considering removing the requirement for developmental screening to be included as part of the CCBHC array. Screening customers, particularly children, for developmental delays or disorders is a standard component of any preventive health screening program. This does not mean that every customer the CCBHC serves must receive a developmental screen; rather, the Medical Director and other clinical leaders within the CCBHC should be establishing policies and protocols for when customers will be screened for various disorders based upon standards of care and clinical best practice.

24) Would everyone require a psychological or neuropsychological assessment? What would be the trigger for the assessment requirement? There is not enough neuropsychological service capacity statewide for implementation within 12 months.

A: CCBHCs are not required to have 100% dedicated FTE psychologists on staff; however, all CCBHCs are required to establish sufficient capacity to perform psychological assessments and/or neuropsychological assessments for customers in their self-defined service area.

The CCBHC Medical Director, in collaboration with other clinical leaders within the CCBHC, will be required to establish the policies and protocols for when customers should receive a psychological assessment consistent with standards of care and clinical best practice.

25) We currently have an arrangement for psychiatry as part of a co-location agreement with our local FQHC. (i.e., they have a presence at our planned CCBHC site and provide psychiatric and primary care services utilizing our nursing staff). Is this type of arrangement for access to psychiatry acceptable within the bounds of the CCBHC requirement or will we need to dismantle this arrangement and directly hire/contract for psychiatric access?

A: Based on the SAMHSA CCBHC criteria, the CCBHC site must demonstrate reasonable effort to employ or contract a psychiatrist to serve as the Medical Director at the CCBHC. However, if after reasonable efforts, the organization is unable to hire or contract for a psychiatrist, additional options are permitted. See the criteria guidance below.

Criteria 1.a.3 states: The Chief Executive Officer (CEO) of the CCBHC, or equivalent, maintains a fully staffed management team as appropriate for the size and needs of the clinic, as determined by the current community needs assessment and staffing plan. The management team will include, at a minimum, a CEO or equivalent/Project Director and a psychiatrist as Medical Director. The Medical Director need not be a full-time employee of the CCBHC. If a CCBHC is unable, after reasonable efforts, to employ or contract with a psychiatrist as Medical Director, a medically trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law, may serve as the Medical Director. In addition, if a CCBHC is unable to hire a psychiatrist and hires another prescriber instead, psychiatric consultation will be obtained regarding behavioral health clinical service delivery, quality of the medical component of care, and integration and coordination of behavioral health and primary care.

The CCBHC may also establish arrangements for access to additional psychiatric resources beyond the Medical Director, as needed, and could utilize a DCO agreement to provide this access.

26) Could HFS clarify the requirements around lab services? What direction can HFS provide on the requirements for screening and testing for hepatitis and HIV and targeted toxicology services? Does this mean that providers should be able to perform urine analysis and blood draws but send the lab out for results?

A: Based on the SAMHSA CCBHC criteria, CCBHCs must establish protocols for conducting primary care screening and monitoring of key health indicators, including establishing systems for the collection and analysis of laboratory samples. This means the CCBHC must have the ability, either directly or through a DCO, to perform the laboratory collection (UA, blood draw) and analysis. The laboratory testing and analysis can be done directly or through one or more DCO arrangements with an organization separate from the CCBHC.

SAMHSA CCBHC criteria (section 4.g.2):
In order to fulfill the requirements under 4.g.1 and 4.g.2 the CCBHC should have the ability to collect biologic samples directly, through a DCO, or through protocols with an independent clinical lab organization. Laboratory analyses can be done directly or through another arrangement with an organization separate from the CCBHC. The CCBHC must also coordinate with the primary care provider to ensure that screenings occur for the identified conditions. 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 CCBHCs screening and monitoring protocols developed under 4.g.

In terms of toxicology – the UA toxicology should be targeted based on the treatment (e.g., if a customer is on buprenorphine or methadone, testing for buprenorphine, other opioids, fentanyl, methadone, benzodiazepines, and alcohol would be recommended; these are other respiratory suppressants that can impact the customer's care and are critical to discuss with the customer), community drug supply, and goals of care. Most programs utilize a screening-based approach with confirmatory testing, if clinically indicated. As discussed in this guideline, there are false positives and false negatives in the screening.
https://eguideline.guidelinecentral.com/i/840070-drug-testing-pocket-guide/23

For hepatitis and HIV screening, this should be done at least once in a lifetime and then as indicated based on risk factors – incarceration, intravenous drug use, sexual risk factors, etc. Customers should be screened appropriately and referred internally or externally for treatment. CCBHCs can provide lab services directly or through DCO agreements.

27) Concerning opioid treatment requirements, do we have to be approved to provide methadone or make it available by DCO?

A: HFS has update the Illinois CCBHC service requirements to adjust the language on required psychiatric rehabilitation services. Specifically, the language regarding the provision of opioid treatment has been updated to read as follows (changes noted in red):

"All FDA-approved forms of medication to be used in the delivery of Medication Assisted Recovery (MAR), except for methadone. Methadone, as delivered by an Opioid Treatment Program (OTP) is not a required service but is an allowable service."

MAR utilizing methadone is allowable, but not required of CCBHCs. Applicants that indicate they are already providing methadone-based MAR services or will provide access to it through a DCO by July 2024, will be granted preferred applicant status.

28) Would HFS consider engaging Illinois Veteran's services to help increase coordination and facilitate opportunities for formal agreements? Getting formal agreements with the VA has been extremely challenging.

A: Yes, HFS can initiate discussions with the Department of Veterans' Affairs to facilitate greater collaboration and information sharing.

29) Would HFS consider moving the timeline for implementation of Behavioral Health Urgent Care Centers (UCCs) and Crisis Stabilization Units (CSUs) further out to allow providers more planning time?

HFS is committed to strengthening the state's crisis response infrastructure for customers experiencing a behavioral health crisis. Consistent with the SAMSHA National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit, CCBHCs are envisioned to be *A Place to Go*. By introducing Urgent Care Centers as a core component of CCBHCs and CSUs as a required companion service to CCBHCs from their earliest designs within Illinois, HFS is establishing a clear expectation for its customers and providers that CCBHCs function as part of the state's behavioral health crisis safety net. This design will help communities reduce their reliance upon hospitals, law enforcement, and other social service resources that may not be adequately structured to manage behavioral health crisis. Furthermore, the State's inclusion of these services aligns with the SAMHSA CCBHC criteria, further necessitating the earliest possible implementation of these services.

Criteria 4.C.1: Crisis Behavioral Health Services
Crisis receiving/stabilization: The CCBHC provides crisis receiving/stabilization services that must include at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals. Urgent care/walk-in services that identify the individual's immediate needs, de-escalate the crisis, and connect them to a safe and least-restrictive setting for ongoing care (including care provided by the CCBHC). Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted. The CCBHC should have a goal of expanding the hours of operation as much as possible. Ideally, these services are available to individuals of any level of acuity; however, the facility need not manage the highest acuity individuals in this ambulatory setting. Crisis stabilization services should ideally be available 24 hours per day, 7 days a week, whether individuals present on their own, with a concerned individual, such as a family member, or with a human service worker, and/or law enforcement, in accordance with state and local laws. In addition to these activities, the CCBHC may consider supporting or coordinating with peer-run crisis respite programs. The CCBHC is encouraged to provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care.

As for the willingness to extend the service implementation guidelines – HFS understands that some organizations may struggle to marshal the resources, staff, protocols, and structures required to meet the requirements of the State's FY2024 CCBHC Implementation Demonstration. As such, the Department is committed to providing ongoing support to entities that continue on their journey to becoming a CCBHC in Illinois and plans to introduce a CCBHC learning collaborative to support future CCBHC sites.

30) Is there a concrete example that can be provided of the type of peer-directed 24-hour crisis observation service described in the CCBHC requirements? If no such resources exist within the service area, what options do applicants have for meeting this requirement?

A: Currently, there are no existing examples of Medicaid-funded Urgent Care (UCC), 23 Hour Crisis Observation, or Crisis Stabilization Units (CSU) within Illinois' community-based behavioral services array. However, there are multiple examples of existing Illinois programs, national trends, and best practice guidelines that providers can access when seeking to develop their CCBHC Urgent Care Center and Crisis Stabilization Units.

Starting with SAMHSA's National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit, providers can gain an overview of the service design best practices and integration of clinical triage capacity (Urgent Care) and home-like

observation – “Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.”

Additionally, DHS-DMH grant programs such as, The Living Room and Drop In Centers, have provided communities with resources to begin to develop programs that emphasis no wrong door access and peer-led stabilization environments. Grant programs such as these may be of significant interest to CCBHC sites, as they could assist in meeting certain CCBHC requirements under DCO agreements.

Finally, HFS will be providing additional information and policy guidance as it continues to work with the Chief Behavioral Health Officer and multiple other Illinois State Agencies to introduce Behavioral Health Urgent Care, 23 Hour Crisis Observation, and Crisis Stabilization Units into the traditional Medicaid array. These efforts will yield timely direction and support to developing CCBHC Demonstration sites.

31) Could HFS clarify the intent behind having short-term psychiatric prescribing available within Behavioral Health Urgent Care Centers? That ability would require medical and clinical supports beyond what peers can provide.

A: To clarify, HFS expects that peers serve as the primary staff monitoring and providing support to customers while they are under observation for up to 23-hours, as necessary, in the Urgent Care Center. HFS fully recognizes and expects other clinical staff to be present to deliver care to customers as part of the Urgent Care Center, including providing necessary triage and consultation for customers under observation, as necessary.

The intent of having short-term psychiatric prescribing (via a psychiatric resource, such as a psychiatrist or advanced practice nurse with psychiatric specialty) available as part of the service array is to provide urgent access to needed stabilization services to customers experiencing a behavioral health crisis. This is intended to serve as an important bridge for customers until they can be connected with a long-term prescriber (e.g., through their PCP, psychiatrist, or a referral back to the CCBHC for ongoing services).

HFS is open to ongoing conversation with providers about the supports and technical assistance needed to implement these types of urgent supports.

32) Will the Behavioral Health Urgent Care center and Crisis Stabilization Unit services be included under PPS cost-based reimbursement?

A: HFS intends for providers to report these services in the provider's PPS cost reporting materials that will be used to build out the CCBHC PPS rate. Reimbursement of the CCBHC Behavioral Health Urgent Care Center will be included in the CCBHCs PPS reimbursement rate. The Department continues to seek guidance and clarification on the inclusion of CSU services within the PPS Rate structure.

Additional policy efforts from HFS related to behavioral health UCCs and CSUs will create opportunities for the Department and providers/stakeholders to engage on the development of these services. These engagement opportunities will continue to enhance the Department's policy positions and implementation of these services under the CCBHC Demonstration.

33) Will any capital funding be provided by the department? How will clinics fund these expenditures before their PPS kicks in?

A: No. HFS will not be providing "start up funds" to entities seeking to participate in the States FY24 CCBHC Implementation Demonstration. Entities selected to participate in the State's demonstration will be able to record certain capital costs, utilization straight line depreciation, on their PPS Cost Reporting build up. A maximum of one year's depreciation will should be reported and may be included in the sites anticipated costs for PPS buildup. Additional capital costs may be accounted for in the provider's indirect cost allocation under the federal allowable indirect rate. Providers seeking detailed support and technical assistance on these items may reach out the Department during the PPS Cost Reporting period and CCBHC site specific support will be provided.

34) How will the EMS regulations be modified to allow EMS staff to identify what clients would be directed to this new model rather than a local emergency room as currently required?

A: HFS cannot speak to EMS regulations but is open to collaborating with all appropriate parties to ensure that law enforcement, EMS personnel, and other first responders are aware of the state's efforts to expand access to behavioral health crisis supports, and to address any barriers to accessing such supports within local communities.

35) Can Behavioral Health Urgent Care center and Crisis Stabilization Unit services be DCO'd or does the CCBHC have to provide these services directly?

A: The CCBHC may use DCO arrangements to meet the requirements for Behavioral Health Urgent Care Center and Crisis Stabilization Unit services.

36) How many Behavioral Health Urgent Care centers and Crisis Stabilization Units does HFS envision needing (e.g., one per county, one per location, one per DSA)? Is there any concern that this may not be needed by each CCBHC?

A: HFS believes that every CCBHC site will require a behavioral health Urgent Care Center and Crisis Stabilization Unit. The concern expressed in this question regarding the potential oversaturation of crisis services will be monitored by the Department and managed accordingly. It is anticipated that most communities will have one, or fewer, CCBHC sites available to serve the area. However, in some areas of Illinois, it is possible that multiple entities are interested in becoming CCBHCs. In instances where multiple parties seek to obtain CCBHC status in the same relative geographic area, HFS will assess the population and needs of the community and either support the independent efforts of multiple entities to achieve CCBHC status or work with the parties to potentially create DCO agreements to avoid creating too much excess capacity within any one area.

37) How will the department ensure the financial viability for Behavioral Health Urgent Care and Crisis Stabilization Unit services? Will there be new codes for billing?

A: CCBHCs are reimbursed pursuant to a Prospective Payment System (PPS) that utilizes provider costs, or anticipated provider costs, to build out a PPS rate that is paid uniquely to each CCBHC site. Illinois has elected to utilize PPS1, meaning that providers will be paid a daily encounter rate for CCBHC services, like the methodology used to reimburse Federally Qualified Health Centers (FQHCs).

Note: HFS recognizes the federal proposal to introduce PPS3 and plans to review the benefits of this PPS approach, when and if it is made available to states.

HFS intends to provide additional policy guidance regarding the delivery of UCC and CSU services, including the service codes used for reporting as the state progresses its work towards applying for the FY24 CCBHC Implementation Demonstration.

38) How will Behavioral Health Urgent Care centers and Crisis Stabilization Units services be licensed by IDPH?

A: HFS does not anticipate that Behavioral Health Urgent Care Centers nor Crisis Stabilization Units will require IDPH licensure to operate under the Illinois Medicaid program.

39) What is the staffing model required for Behavioral Health Urgent Care centers (UCCs) and Crisis Stabilization Units (CSUs)? Will they require a licensed physician or is a mid-level able to be the prescriber?

A: HFS intends to provide additional policy guidance regarding the delivery of UCC and CSU services, including required staffing, as the state progresses its work towards applying for the FY24 CCBHC Implementation Demonstration. For the aspects of UCC and CSU interventions that require a prescriber, HFS intends to recognize all practitioners for whom psychiatric prescribing is within their scope of practice (i.e., physicians, psychiatric advanced practice nurses, certain licensed clinical psychologists).

40) How will these centers be accredited as they should be serving any client in need including Medicaid, Medicare, and commercially insured patients?

A: HFS recognizes that SAMHSA encourages states to require CCBHCs be accredited by an appropriate independent accrediting body (SAMHSA CCBHC Criteria 6.c.3). However, at this time, HFS is not requiring that CCBHCs be accredited.

41) Would HFS consider allowing providers to select a certain number of the PRS services (3 of 7 for example) based on community needs assessment rather than requiring all 7? In particular, would HFS consider altering the requirement for CCBHCs to provide team Based MRO Services includes (VP-CST, CST or ACT), particularly for providers in rural counties?

A: As referenced in question 19 above, HFS has adjusted the requirements for Psychiatric Rehabilitation services to read as follows (changes noted in red):

CCBHCs are required to offer the following seven (7) EBPs/EISs immediately:

- *Cognitive Behavioral Therapy (CBT);*
- *Wellness Recovery Action Plan (WRAP);*
- *Motivational Interviewing;*
- *One of the Team-based MRO Services detailed in 89 ILAC 140.453(d)(4);*
- *Supportive Employment;*
- *Supportive Housing; and*
- *All FDA-approved forms of medication to be used in the delivery of Medication Assisted Recovery (MAR), except for methadone. Methadone, as delivered by an Opioid Treatment Program (OTP) is not a required service but is an allowable service."*

Within 12 months, all providers must enhance psychiatric rehabilitation services to include the following:

- *Dialectical Behavior Therapy (DBT);*
- *Trauma Informed Cognitive Behavioral Therapy (TF-CBT); and,*
- *Eye Movement Desensitization and Reprocessing (EMDR).*

Additionally, providers located in urban counties, pursuant to the Counties by Rural/Urban Classification model found on the Illinois Department of Public Health

website, must also add Assertive Community Treatment (ACT) services within 12 months. ACT is not a required service addition for providers located in rural counties but is an allowable service.

42) Would HFS consider making supported housing and supported employment allowable rather than required services?

A: HFS is not considering relaxing the requirement for CCBHCs to provide supported housing and supported employment services. The SAMHSA CCBHC criteria requires that these services be provided as a component of psychiatric rehabilitation services.

SAMHSA CCBHC criteria (section 4.i.1 – HFS emphasis added in bold):
The CCBHC is responsible for providing directly, or through a DCO, evidence-based rehabilitation services for both mental health and substance use disorders. Rehabilitative services include services and recovery supports that help individuals develop skills and functioning to facilitate community living; support positive social, emotional, and educational development; facilitate inclusion and integration; and support pursuit of their goals in the community. These skills are important to addressing social determinants of health and navigating the complexity of finding housing or employment, filling out paperwork, securing identification documents, developing social networks, negotiating with property owners or property managers, paying bills, and interacting with neighbors or coworkers. ***Psychiatric rehabilitation services must include supported employment programs designed to provide those receiving services with on-going support to obtain and maintain competitive, integrated employment*** *(e.g., evidence-based supported employment, customized employment programs, or employment supports run in coordination with Vocational Rehabilitation or Career One-Stop services).* ***Psychiatric rehabilitation services must also support people receiving services to:***

- *Participate in supported education and other educational services;*
- *Achieve social inclusion and community connectedness;*
- *Participate in medication education, self-management, and/or individual and family/caregiver psycho-education; and*
- ***Find and maintain safe and stable housing****.*

43) How will HFS and DMH work together to bring WRAP training to Illinois with the frequency needed to meet training needs?

A: As part of implementation planning, the state will engage with providers to better understand any barriers and needs for additional supports, and to strategize potential solutions.

44) Would HFS consider including Pathways services in the PPS rate rather than carving them out?

A: HFS is not considering including Pathways services in the PPS rate at this time.

45) Would HFS consider not requiring the treatment plan be built off the IM+CANS?

A: No. HFS is fully committed to the importance of having a standardized assessment and treatment planning protocol that is customer-focused and creates a common understanding of the needs, strengths, and opportunities of our customers. Given the overall volume of customers, diversity of providers, and multiple payers found within the Illinois Medicaid program, the IM+CANS represents a significant benefit that HFS is seeking to capitalize upon with as many provider types, as possible.

46) What number of EBP/EIS are expected?

A: Please refer to the answer to question 41 for the list of state required EBP/EIS. There is no requirement that providers offer additional EBP/EIS; however, providers may choose to include additional EBP/EIS, as outlined in their EBP/EIS Plan and as approved by HFS.

47) What is the expected timeframe for implementing additional EBP/EIS interventions outlined in the EBP/EIS Service Plan?

A: Providers are not required to introduce EBP/EIS beyond those mandated by the HFS for the Demonstration. However, providers wanting to include proposed EBP/EIS into their cost reporting as anticipated costs for inclusion in their CCBHC site PPS must propose those services in advance of the development of their PPS rate and implement within the following state fiscal year.

48) Will the costs of establishing and maintaining fidelity of EBP/EIS be included in cost report?

A: Yes, providers should include all necessary cost factors for providing EBP/EIS interventions within the provider's EBP/EIS Plan. Following HFS' review and approval of all proposed EBP/EIS services, those costs can then be introduced into the provider's CCBHC cost reporting to be used to build out the sites PPS rate.

49) Will targeted case management services fall under NCQA or other accreditation requirements?

A: No. HFS is not requiring specific accreditation from NCQA, or any other organization, for the delivery of targeted case management services at this time.

Additional questions can be submitted by email at
ILCCBHC@mslc.com
Please continue to monitor the FAQ for more information.