The New York State Council for Community Behavioral Healthcare (The Council) is grateful for the opportunity to submit comments on Subpart 600-1 CCBHC to the State of New York Offices of Mental Health and Addiction Services and Supports. Since the passage of the Excellence in Mental Health Act of 2014, The Council has been a strong and vocal supporter of New York's CCBHC initiative. We are grateful that the state is submitting a State Plan Amendment to CMS so that CCBHCs can become a permanent piece of New York's behavioral health delivery system. As the representative of 170 organizations providing behavioral health care to over 1 million New Yorkers, The Council's north star is, was, and always will be access to quality behavioral healthcare for any New Yorker who needs it. We offer these comments on the proposed regulations with confidence that together we can leverage the CCBHC initiative to ensure more New Yorkers can access high quality, integrated, comprehensive, and coordinated behavioral healthcare.

Section	Text	Comment
600-1.4(3)	Approved medication means any medication approved by state or federal authorities for the treatment of medical and psychiatric conditions, including those conditions caused by the use of such substances.	Please clarify whether, if a CCBHC's practitioner participates in NYS' Medical Cannabis Program, medical marijuana is included as an approved medication under this definition.
600-1.4(6)(i-iii)	Behavioral Health Disorder means a mental health or addiction condition consistent or corresponding with the current edition of the Diagnostic and Statistical Manual (DSM) with the exception of:	Please clarify if this section is intended to indicate that CCBHCs cannot serve individuals with the diagnoses outlined in sub-parts i-iii. If so: • Individuals with Autism Spectrum Disorder (which would be included as a neurodevelopmental disorder in the DSM) should be able be served by a CCBHC

	(i) neurodevelopmental disorders in the absence of other mental health conditions defined in the DSM or ICD except Attention-Deficit/Hyperactivity Disorder and Tic Disorders; (ii) major neurocognitive disorder, traumatic brain injury, or mental disorders due to another medical condition; or (iii) V-Codes. Other conditions that may be a focus of clinical attention (commonly described with Z codes), except for Parent-Child Relational Problem, relational problems related to the addiction disorder of a significant other, problem related to unspecified…	• Similar to CFTSS, we would like the Departments to consider that individuals impacted by V-Code conditions should be able to be served by a CCBHC, given the scope of services being offered.
600-1.4(a)(17)	Designated Collaborating Organization (DCO) means an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC to deliver one or more required services or elements of required services. This formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal, legal arrangements describing	The state has been very clear during its group Technical Assistance calls that a DCO agreement related to 24/7 mobile crisis services does not explicitly need payment to be exchanged (a non-financial DCO agreement is allowable), provided the crisis services DCO is already funded to deliver 24/7 mobile crisis services in the catchment area (e.g., through County funding). This is important, because CCBHCs should be encouraged to leverage existing infrastructure (provided it meets the CCBHC criteria/requirements), rather than duplicate existing capacity. Given this, we suggest adding the following to this definition: “describing the parties’ mutual expectations including that services provided shall conform to all relevant CCBHC criteria and establishing

	the parties' mutual expectations including that services provided shall conform to all relevant CCBHC criteria and establishing accountability for services to be provided and funding to be sought and utilized, including data sharing and consent to share Protected Health Information (PHI).	accountability for services to be provided and funding to be sought and utilized (if applicable), including data sharing and consent to share Protected Health Information (PHI)."
600-1.4(a)(23)	Intensive Outpatient Services (IOS)/Intensive Outpatient Program (IOP) is an outpatient treatment service provided by a team of clinical staff for individuals who require an intensive time-limited, multi-faceted, array of services, structure, and support to achieve and sustain treatment and recovery goals and Section 600-1.8 CCBHC Services (d) CCBHCs shall offer Intensive Outpatient Services (IOS)/Intensive Outpatient Program (IOP) as an additional outpatient mental health and substance use service	Please clarify whether (in alignment with the SAMHSA CCBHC criteria) this level of care refers to IOS services for SUD (equivalent to ASAM level 2.1), or if the state intends to require CCBHC Demonstration programs to develop programming for OMH IOP services as well (which would require an additional license approval process and potentially result in delays for providers who do not have this level of care today in getting licensed under Part 600).
600-1.4(a)(28)	Outpatient mental health and substance use services means treatment services provided by a team of clinical staff for individuals who require	We suggest removing the word "intensive" from this definition so there is no confusion between this and IOP. Perhaps (to align with the MHOTRS definition): "Outpatient mental health and substance use services means treatment services provided by a team of clinical staff for individuals who

	an intensive time-limited, multi-faceted, array of services, structure, and support to achieve and sustain treatment and recovery goals	require a multi-faceted, array of services, structure, and support to achieve and sustain treatment and recovery and enhance the Individual's continuing functioning in the community. The intensity of services and number/duration of visits may vary."
600-1.4(a)(31)	Person or Family Centered Treatment Planning means an ongoing process directed by the individual in collaboration with the individual's family or other collaterals, to treat an individual's mental health condition, or addiction including substance use disorder, gambling disorder, or problem gambling in a manner consistent with the individual's preferences, phase of life and development. Treatment planning addresses treatment and rehabilitative goals, needs, preferences, capacities and desired outcomes for the provision of CCBHC services as well as monitoring of treatment of physical health conditions. Services are informed and determined by the preliminary triage screening, assessment, and diagnosis process and reflected in the treatment plan.	We suggest at minimum the following additions, in order to reinforce and concretize in regulation the requirement that CCBHCs provide integrated, whole-person care: "Person or Family Centered Treatment Planning means an ongoing process directed by the individual in collaboration with the individual's family or other collaterals, to treat an individual's mental health condition and/or addiction including substance use disorder, gambling disorder, or problem gambling in a manner consistent with the individual's preferences, phase of life and development." Additionally, this definition does appear to preclude CCBHCs from engaging in treatment planning and developing Treatment Plans for individuals who may not be ready to engage in treatment, but who are willing to engage in supportive services to meet their immediate concrete needs (e.g., Targeted Case Management). If the Departments want NY CCBHCs to be truly person-centered/client-driven, we suggest modifying this definition as follows: "Person or Family Centered Treatment Planning means an ongoing process directed by the individual in collaboration with the individual's family or other collaterals, to treat an individual's mental health condition, and/or addiction including substance use disorder, gambling disorder, or problem gambling in a manner consistent with the individual's preferences, phase of life and

		development, and/or concrete health related social needs impacting the individual's behavioral health and wellbeing."
600-1.4(a)(42)	Treatment Plan means a dynamic document that is current, reflects the unique strengths and needs of the individual and family, establishes the individual and family's goals and identifies the services and interventions needed to assist in accomplishing these goals. It also includes a means for determining when goals have been met, and the criteria for appropriate discharge or transition to other needed services.	As the Departments are aware, there is a lot of confusion about Treatment Plans within the context of a CCBHC. We appreciate the efforts the authors of these regulations have taken to alleviate some of that confusion. However, we believe that adding "the criteria for appropriate discharge or transition to other needed services" to the definition of the Treatment Plan will lead to further confusion, especially in the context of a CCBHC's outpatient service setting. We suggest removing that from the "Treatment Plan" definition, as follows, and (similar to the MHOTRS Guidance) requiring CCBHCs to have a policy on "Criteria for discharge from the CCBHC." "It also includes a means for determining when goals have been met~~, and the criteria for appropriate discharge or transition to other needed services~~."
600-1.4(b)(1)	Professional Staff means an individual who is qualified by license, credentials, training and experience to provide supervision and direct service related to the treatment of physical health, mental health disorders, or addiction, including substance use disorders, gambling disorders, or problem gambling, or co-occurring disorders in a CCBHC and may include but not be limited to the following:	We appreciate the addition of these professional staff, as we think they will be very valuable members of the CCBHC Multi-disciplinary Team. However, we suggest that the Departments consider adding Medicaid Procedure Codes associated with the services that can be provided by these professional staff types to the CCBHC CPT Code Crosswalk (e.g., Medical Nutrition Therapy). Otherwise, the viability of hiring these staff to provide services at the CCBHC will be limited.

600-1.4(b)(3)	Peer support workers are individuals who are qualified by having personal experience and holding a standard or provisional certification, or credentialed, or provisionally credentialed as provided below: (i) A New York Certified Peer Specialist (NYCPS): An individual who is over 18 years old who has been granted the status of a Certified Peer Specialist by the New York Peer certification board and certifying authority recognized by the commissioner of OMH. (ii) A Certified Recovery Peer Advocate (CRPA): An individual who holds a certification issued by an entity approved and recognized by the commissioner of OASAS. (iii) A Credentialed Family Peer Advocate (FPA): An individual who is credentialed as a family peer support worker in New York State from a certifying authority recognized by the Offices. (iv) A Credentialed Youth Peer Advocate (YPA): An individual who is credentialed as a youth peer support worker in New York State from a certifying authority	In the spirit of integrated MH and SU care, we encourage the Departments to consider an integrated Peer certification process. Having separate OMH and OASAS certification pathways (and associated separate scopes of practice) often leads to barriers for individuals with lived experience to become certified as a Peer, and CCBHCs (and their associated peer workforce) often experience confusion about the different scopes of practice among their certified Peers (e.g., OASAS CRPAs cannot lead peer support group sessions, while OMH NYCPS can).

	recognized by the Offices.	
600-1.4(b)(6)	Targeted Case Management (TCM) Case Managers means individuals who are at least 18 years of age and have a high school diploma or equivalent. They may be unlicensed staff with appropriate training as determined by the Offices.	Please identify what "appropriate training as determined by the Offices" is. Currently, the NYS CCBHC Provider Manual states "Case Managers must be trained and demonstrate a basic knowledge and understanding of working with populations targeted by this service." If the Departments are going to put in place additional training requirements for TCM Case Managers, that needs to be made explicit, and there should be a period of time whereby CCBHCs with existing TCM Case Managers can have their staff be trained while continuing to deliver TCM services at the CCBHC.
600-1.5(a)(3)(ii)	Applications shall demonstrate that the provider is: (ii) in compliance with all applicable requirements of OMH and OASAS, including but not limited to Parts 599 and 822 of this Title, unless as otherwise specified in this Subpart and applicable Federal, State and local requirements	Our understanding is that once these regulations are published, CCBHCs will be licensed and held to the standards of these Part 600.1 joint regulations, rather than Parts 599 and 822. This is a positive development and will help to alleviate the current challenge of adhering to Part 822 and MHOTRS regulations (which sometimes conflict) as part of their integrated CCBHC programs. We want to confirm this understanding is correct, and if so, suggest the following addition: "*Once licensed under this Subpart, CCBHCs will continue to adhere to Part 600.1 of this Title for their operations*." We suggest this explicit addition because there are a number of places where the Part 600.1, Part 599, and Part 822 regulations conflict (e.g., Treatment Plan Reviews), so continuing to require adherence to MHOTRS and 822 requirements, along with these new regulations, will invite more confusion than there already is about which regulations to adhere to as a CCBHC.
600-1.5 (a)(3)(v)(c)	a statement indicating that the CCBHC has been	If this is going to be a requirement of the application, please confirm that the LGUs

	included in an approved "local services plan" developed pursuant to article 41 of the MHL for each local government located within the CCBHC's service area	have been informed of this requirement, so that there is no unnecessary delay in the applications for existing CCBHCs. Currently, many of our member organizations that are CCBHCs are not included in their region's 2025 Local Services Plan (or the agencies are included but related to separate programs that they operate [e.g., CFTSS]). If this is going to be a requirement (which goes above and beyond what was previously required – for CCBHCs to consult with their LGU) – we ask that the Departments inform the LGUs that if they want the CCBHC in their community to continue operating, they will need to specifically include it in their local services plan. In addition, if this is required, the Departments should consider the timing of when this will be possible based on whether the next Local Service Planning process aligns with the finalization of these regulations and the ensuing application process.
600-1.5 (a)(3)(v)(d)	confirmation of required services being delivered at every site identified by the CCBHC.	For clarity, we suggest referencing down to sub-section (g) in this line (as the required services are based on the type of site). Perhaps: "confirmation of required services being delivered at every site identified by the CCBHC, based on the specific type of site as defined in 600-1.5(g)."
600-1.5 (a)(3)(v)(h)	a description of how Individuals are represented in governance of the CCBHC	We believe this is intended to read: "a description of how Individuals with Lived Experience are represented in governance of the CCBHC."
600-1.5(g)(1) and (2)	CCBHC sites.	We appreciate the clarity of what needs to be delivered at each type of CCBHC site (main vs. satellite) within these regulations. However, we were curious about the rationale to include Targeted Case Management as a required service that is located at a CCBHC satellite and not a

		CCBHC main site. For many CCBHCs, Targeted Case Management is a service that happens in the community (outside of the clinic's four walls), so at the very least, we suggest recognition of that fact, perhaps by saying: "however, satellite sites must minimally provide the following services on-site: Screening, Assessment, and Diagnosis; Outpatient Mental Health and Substance Use Disorder Services, and Person-Centered and Family-Centered Treatment Planning. <u>In addition, Targeted Case Management must be available to individuals served by the CCBHC satellite site, either at the site location or in the community based on their preferences</u>." We also suggest beginning this same section (g) with an explicit reference that all services must be provided by the CCBHC across all of its site locations: • "The following outlines site-specific requirements for CCBHCs. However, across all of its site locations within the catchment area, the CCBHC must be able to provide all nine CCBHC services: ○ Crisis Services ○ Screening, Diagnosis and Risk Assessment ○ Person- and Family-Centered Treatment Planning ○ Outpatient Mental Health and Substance Use Services ○ Peer Family Support and Counselor Services ○ Targeted Care Management ○ Outpatient Primary Care Screening and Monitoring ○ Psychiatric Rehabilitation Services ○ Community-Based Mental Health Care for Veterans" Finally, we were curious about the explicit exclusion of Crisis, Peer, Psychiatric

		Rehabilitation, Veterans Services from the required lists of what needs to be delivered at each CCBHC site type, given the importance of these services to the whole-person CCBHC model. We suggest: • A requirement that all CCBHC sites be able to provide onsite crisis receiving/stabilization services (when needed) during their operating hours • A reference that at least one CCBHC site should be able to offer in-person Peer, Psychiatric Rehabilitation and Veterans services in person (perhaps via the above suggested addition)
600-1.5 (g)(2)	CCBHC satellite sites, which are determined by the Offices to be CCBHC satellite sites of a CCBHC main site, shall meet the following requirements:	We are assuming that when a CCBHC is providing regular and routine CCBHC services at an offsite location, this will need to become a CCBHC Satellite Site? If this is the case, requiring CCBHCs to deliver Screening, Assessment, and Diagnosis; Outpatient Mental Health and Substance Use Disorder Services; Person-Centered and Family-Centered Treatment Planning; and Targeted Case Management at every CCBHC Satellite site has the potential unintended consequence of placing barriers on the provision of in-community services in community locations. A number of CCBHCs here in NYS provide regular and routine services in settings like schools, shelters, etc., but the ability to provide the full scope of the four aforementioned services is limited (due to workforce, space considerations, etc.). We ask the Departments to consider an "Access Site" option, whereby consumers could have access to a more limited set of regular and routine onsite CCBHC services at a non-clinic community location (with

		connection back to the CCBHC Main site when additional supports are needed). Alternatively, CCBHC services could be provided off site with maximum flexibility (in a similar way to CFTSS). This is critical for CCBHCs' ability to offer true person-centered care that is (by definition) convenient and accessible for the client and family being served. Under the current process, CCBHCs are asked to apply for approval of a new site location when services at the community site become 'regular and routine,' so (assuming that continues) the definitions of this section seem to limit (for example) CCBHCs' ability to co-locate a single Clinician within a partner school site to promote access to CCBHC services.
600-1.5(h)(3)	CCBHC required services must be reasonably accessible to communities identified in the Community Needs Assessment. Reasonable accessibility is defined as the lesser of either 30 miles or 30 minutes to access all nine required services. Any variations beyond this parameter of a reasonably accessible location of services must be approved by the Offices.	While we do understand NY is retaining its existing definition of "reasonably accessible" for a CCBHC in these regulations (and we appreciate the variation approval process offered), we encourage the Departments to consider an alternative definition for rural areas, given the geographic realities and workforce shortages that exist in these areas. Many other states have different definitions of reasonably accessible for rural vs. urban (e.g., Michigan and Alabama both use 30 miles/30 minutes for urban areas and 60 miles/60 minutes for rural areas for their CCBHCs). In addition, we suggest that the Departments provide additional guidance related to how off-site/in-community and/or telehealth options can be used to meet the reasonably accessible definition, especially in very geographically large/sparsely populated rural areas of the state.

600-1.7(b)(2)	The CCBHC may have an Advisory Board that represents individuals with lived experience or with behavioral substance use disorders and mental health disorders, including youth and families.	For clarity on this requirement (assuming the Departments' intention is that youth and families are included in the definition of individuals with lived experience who can be included on the Advisory Board; not that each CCBHC must include youth and families on their Advisory Board), we suggest the following revision: "The CCBHC may have an Advisory Board that represents individuals with lived experience or with behavioral substance use disorders and mental health disorders. <u>This includes, but is not limited to, individuals who are current or former clients of the CCBHC (across the lifespan), as well as family members of individuals with behavioral health needs</u>."
600-1.7(d)(7)	to develop, approve, and periodically review and revise as appropriate all programmatic and administrative policies and procedures. Such policies and procedures shall include, but are not limited to, the following	We recognize that the CCBHC criteria requires the governing body to have input into service development. However, the list of required CCBHC policies feels out of place in this section. A number of policies listed (e.g., reporting SUD treatment data to CDS) don't necessarily need nor will they benefit from Board review/approval. Additionally, while some do, many CCBHCs don't have processes to have their governing body approve **<u>all</u>** programmatic and administrative policies and **<u>procedures</u>**. We suggest allowing for the following: <u>"The governing body may delegate the responsibility for procedure development/revision to a designated professional(s) who is qualified by training and experience related to the subject matter. However, in this case, the CCBHC must be able to demonstrate its processes for assuring meaningful engagement of individuals with lived experience in the development and refinement of CCBHC policies and procedures."</u>

600-1.7(j)(2)	The fee schedule(s) must be submitted and approved by OMH and OASAS	This requirement, which has not been the practice heretofore, would place an additional administrative burden on the organization's administrative staff. Given the fact that the sliding fee schedule is already publicly posted, we believe this requirement is duplicative and unnecessary.
600-1.7(k)	CCBHCs and DCOs shall obtain from each Individual, prior to treatment, a release permitting the CCBHC to disclose Individual's clinical records to DCOs, other providers and Payers and permitting CCBHC and Payers to re-disclose patient information to Related Organizations to the extent necessary for referral and treatment, payment for services, and support with health related social needs and quality assurance. CCBHC shall immediately notify other parties if the Individual revokes or modifies any consent to disclosure of health information. Such release does not preclude authorized disclosure permitted by state or federal law.	We suggest the following update: "CCBHCs and DCOs shall <u>seek to</u> obtain from each Individual, prior to treatment, a release permitting the CCBHC to disclose Individual's clinical records to DCOs, other providers and Payers and permitting CCBHC and Payers to re-disclose patient information to Related Organizations to the extent necessary for referral and treatment, payment for services, and support with health related social needs and quality assurance. CCBHC shall immediately notify other parties if the Individual revokes or modifies any consent to disclosure of health information. <u>If an Individual refuses to provide such consent, this should not impact their ability to receive services provided by the CCBHC.</u> Such release does not preclude authorized disclosure permitted by state or federal law." Additionally, for some services, the DCO agreement itself (e.g., for crisis intervention) addresses confidentiality and reduces the need for an additional release of information, in order to promote rapid access to services and reduce administrative burden.
600-1.7(m)	The CCBHC must have an Electronic Health Record (EHR) that has the capacity to collect, report, and track encounter, outcome, and quality data. CCBHCs	Currently, the only State-Collected quality measure that CCBHCs collect/report on to the state manually is the Assessment of Care surveys. For all other state-led measures, OMH/OASAS extracts these data from Medicaid claims databases. If this is going to change, it is critical that the

	must collect and report the Clinic-Collected and State-Collected quality measures identified as required by the Offices.	Departments alert the CCBHCs early and provide sufficient lead time to implement these changes.
600-1.7(o)(2)(i)	CCBHCs shall secure partnerships to provide services for individuals across the lifespan. Such partnership agreements must minimally include: (i) the 988 Suicide and Crisis Lifeline call center for the service area(s) in which the CCBHC serves, as determined by their CNA	Many of the current CCBHCs, especially in NYC, have reported that their local 988 call center operator will not enter into a written agreement with any provider. If it will be a requirement of CCBHCs to have a written partnership agreement, we suggest that the Departments communicate this requirement to and require this of the 988 call center operators as well, so that they can be prepared to change their policies where needed.
600-1.8(c)(2)(i)	It shall contain the current goals and services of the individual, including goals identified by all practitioners working with the enrolled individual.	For clarity, we suggest the following addition: "It shall contain the current goals and services of the individual, including goals identified by all CCBHC practitioners working with the enrolled individual."
600-1.8(c)(2)(ii)	It shall contain a means of determining when goals have been met, and criteria for appropriate disenrollment and transition to other needed services where applicable which shall include but is not limited to identifying:	Similar to the above comment on Section 600-1.4(a)(43), we suggest removing (or adding additional clarity on what is meant by) "criteria for appropriate disenrollment and transition to other needed services where applicable" in the context of the Treatment Plan. The list that follows that reference (a – e) does not seem to relate to criteria for disenrollment/transition.
600-1.8(c)(2)(ii)(b)	steps on how to achieve the identified goals:	We believe (b) "steps on how to achieve the identified goals," is a reference to objectives under each Treatment Plan goal. If this is the case, we suggest being explicit about naming that, as not doing so is likely to lead to confusion about what the Departments are requiring.
600-1.8(c)(2)(ii)(e)	the level of care determination using Level	We suggest only including "the level of care determination using Level of Care

	of Care Determination Protocol (LOCADTR) where substance use or gambling disorders are identified.	Determination Protocol (LOCADTR) where substance use or gambling disorders are identified" in the list of things that must be in the Treatment Plan if the individual accepts SU services (either from the CCBHC or otherwise). There have been a few instances where CCBHCs have been advised that they should engage the individual in the LOCADTR even if the individual declines SU services. A more person-centered process would be to allow the CCBHC to provide services that meet the individual's immediate needs and goals, while they work to engage them in other needed services (including engaging them in the LOCADTR when they are ready to address their SU needs).
600-1.8(c)(2)(iv)	Treatment Plan Reviews shall occur at a minimum of every twelve months.	While we welcome this change in frequency (currently, the NYS CCBHC Provider Manual requires "Treatment Plans must be reviewed and updated no less frequently than every 6 months."), we do want to note that many CCBHCs just recently transitioned from annual Treatment Plan reviews/updates to every six months. These types of evolving timeframe requirements can be difficult for behavioral health providers, as each new timeframe update requires a change in policy/procedure, staff training, and (often) EHR/infrastructure adjustments.
600-1.8(c)(2)(vii)	When changes to the Treatment Plan are prompted by reasons other than those identified in this paragraph, such updates may be documented in the service progress notes.	In these regulations, there is no reference to "Treatment Plan Updates." Can we interpret this guidance to mean that CCBHCs must do Treatment Plan reviews at least every 12 months (unless otherwise indicated by the client's changing needs), and that changes that would have otherwise been considered a formal Treatment Plan update under MHOTRS guidance (e.g., new services are added, service intensity is increased) should be made through the Treatment Plan review process (inclusive of assessment of

		progress, adjustment of goals, client input, and signature of the clinician)? Additionally, there is no reference (as there is in MHOTRS guidance) to the practitioner(s)/prescriber who must sign the Treatment Plan. If the Departments and NY Medicaid intend for there to be signature requirements for the Treatment Plan, we suggest adding it to this section for clarity. This is an important clarification because if CCBHCs are only required to do Treatment Plan Reviews (not Treatment Plan Updates), that would indicate to us that the primary clinician could sign the Treatment Plan Review and that it does not have to have a psychiatrist/NPP signature as was previously required for a Treatment Plan Update in MHOTRS. This would be a welcome change in the required processes, due to the administrative burden and workforce challenges.
600-1.8(d)(3)	For individuals with a substance use and/or problem gambling disorder diagnosis, the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR)is a required web-based tool to assist providers in determining the most appropriate level of care	We suggest a revision to this section similar to the one we proposed for 600-1.8(c)(2)(ii)(e), that engagement of individuals in the LOCADTR is not based solely on identified SU need/diagnosis, but also the individual's readiness to address their SU needs.
600-1.8(d)(7)	CCBHCs shall offer Intensive Outpatient Services (IOS)/Intensive Outpatient Program (IOP) as an additional outpatient mental health and substance use service	We would like to clarify that with this statement the Departments are intending to align with the SAMHSA CCBHC Criteria related to CCBHCs offering SUD services that align with ASAM 2.1 (intensive outpatient (SUD) program), and are not requiring CCBHCs to seek OMH prior approval to offer MHOTRS-based Intensive Outpatient Program (MH) services. If MHOTRS-based Intensive Outpatient Program (MH) services are now going to be

		a required part of the CCBHC scope in NY, we suggest the Departments provide a ramp-up period for the existing CCBHC Demonstration providers to attain their MH IOP certification and ramp up their staffing/processes to meet this expanded requirement. Alternatively, if the Departments' intention is to remain aligned with the federal CCBHC criteria (e.g., requiring SU/OASAS IOS (equivalent to ASAM Level 2.1) and making MH/OMH IOP an optional level of care), we suggest making that explicit in these regulations.
600-1.8(e)(1)	The CCBHC shall make crisis services available through DCO agreements **required** with existing state sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services or provide them directly as identified in these criteria and to supplement any gaps in crisis coverage.	The use of the word "required" here is confusing. Are CCBHCs required to enter into agreements with state-sanctioned crisis service providers in their catchment area? If so, we ask the Departments to consider the feedback/context in response to 600-1.8(e)(3), and also consider making this more clear, along the following lines: "*The CCBHC is required to attempt to enter into a DCO agreement with existing state sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services where these exist and if possible. If the capacity does not exist in the local service area or partnership is not possible, a CCBHC should provide crisis service directly as identified in these criteria and to supplement any gaps in crisis coverage.*"
600-1.8(e)(3)	The CCBHC shall provide community-based behavioral health crisis intervention services using existing state-sanctioned mobile crisis teams, and then supplementing with DCO agreements with other providers or utilizing their own staff for mobile crisis	We appreciate this idea in theory. However, in practice, we have heard from multiple CCBHCs that agencies operating existing mobile crisis teams have been unwilling or unable to partner with CCBHCs due to capacity concerns. If it is going to be a requirement for CCBHCs to use existing state-sanctioned mobile crisis teams, and then supplement with other capacity, this requirement must also be made explicit to the state sanctioned MCT providers.

	services or on an on call basis to ensure twenty-four hours per day, seven days per week to adults, children, youth, and families anywhere within the service area including at home, work, or anywhere else where the crisis is experienced.	Additionally (similar to the Care Coordination agreement requirements), you could add the following statement to this requirement – "If the existing state-sanctioned mobile crisis team is unable or unwilling to enter into a partnership to respond on behalf of the CCBHC (within its current capacity), the CCBHCs will document all efforts to engage with the state-sanctioned mobile crisis team." Also, it is important to be explicit about what agreement and/or data-sharing protocols need to be in place between the CCBHC and existing state-sanctioned mobile crisis team(s). e.g.: • Does there need to be a written agreement documenting the fact that the CCBHC is using the existing mobile crisis team's capacity? • If the CCBHC is using an existing state-sanctioned mobile crisis team to provide community-based behavioral health crisis intervention services, does this need to be captured as part of the ISERV sub-measure 3 data (time to (in person) crisis services)? Further, if a CCBHC has established its own 24/7 Mobile Crisis Team to meet the CCBHC Criteria, would they be considered a 'state-sanctioned' mobile crisis team? If not, we suggest being clear about how the CCBHC can apply for the state sanction, so that this important existing capacity can be sustained under the SPA. Finally, if the state-sanctioned mobile crisis team cannot meet the required CCBHC response timeframes outlined in (i), should the CCBHC not plan to use the existing mobile crisis team to respond?

		How does this need to be documented/communicated to the Departments?
600-1.8(g)(4)	Where an individual is enrolled in a Health Home the CCBHC must make the appropriate care linkage and conduct care coordination activities solely with the Health Home. Individuals cannot receive TCM through the CCBHC and receive Health Home Care Management services at the same time.	We understand the rationale behind this requirement and also that it is a continuation of what is currently required of CCBHCs. However, we have heard from a number of CCBHCs that it is sometimes difficult to ascertain whether an individual is enrolled in health home care management services (those who are not health home providers themselves with access to MAPP can check ePACES, but this information is oftentimes outdated). Is it possible to have a single location where any CCBHC can identify whether an individual is currently engaged with a Health Home (e.g., through access to the enrollment data in MAPP)?
600.1.8(f)	Outpatient Primary Care Screening and Monitoring	With the intention of expanding whole person services within NY CCBHCs, we encourage the Departments to expand the primary care services that CCBHCs can offer, going beyond simply screening and monitoring services. Other states have done this with great success (e.g., Oregon requires CCBHCs to offer primary care services onsite at least 20 hours per week, which has greatly supported access to integrated care). We encourage the Department to add this option to deliver primary care services (including allowable CCBHC services) as part of New York's regulations.
600-1.9(b)(2)	If the patient entering the CCBHC is being treated with MAT outside of the CCBHC, then the provider must collaborate with the existing provider or practitioner to maintain MAT through the course of treatment.	Related to this, we have heard from CCBHCs, especially in rural areas of the state, that the co-enrollment restrictions between a CCBHC and another outpatient SUD provider can restrict access to care (i.e., there are areas upstate where the County LGU operates outpatient SUD sites but not other important services (e.g., mental health, peer, TCM, PSR), so the individual either has to leave their long-

		standing treatment provider or forgo broader CCBHC services). While this statement is likely intended to relate to MAT services being provided by a PCP or OTP, we want to highlight that this could also relate to other SU/822 providers (and currently, co-enrollment between a CCBHC and 822 provider is not allowed). Therefore, we request that the Departments review and update the Co-enrollment restrictions as is feasible, in order to support access to care in alignment with this part of the regulations (and overall).
600-1.10(b)(4)(ii)	students must be part of a staffing plan that is approved by OMH and OASAS.	Additional clarification is needed regarding this proposed change. As you are aware, students can be fluid as the numbers depend on the ability of the student to complete an internship as well as providers are not always aware until the last minute the number of students they may have in any given semester. It is difficult to add to a staff plan as the number can often change. We suggest the following language as an amendment: • "*where the CCBHC plans to utilize students within their CCBHC, the supervisory structure and scope of their practice should be communicated to the Departments for approval during the licensing process*."
600-1.10(d)	The Offices may approve other qualified staff, as appropriate including but not limited to Targeted Case Management (TCM) Case Managers, Psychiatric Rehabilitation Services (PRS) Staff, and staff trained in Intensive Community-Based Behavioral Health Care	We are not sure what "may approve" means in this context; CCBHCs are required to deliver these services, so we suggest a revision to this statement that explicitly states that CCBHCs must include other qualified staff to deliver these services in their staffing plan (and staff should meet the qualifications included in Section 600-1.4(b)).

	for Members of the Armed Forces and Veterans.	
600-1.10(e)	The Offices may approve the transition of CCBHCs to heightened licensure requirements set by the New York State Education Department or other licensing or credentialing authority to the extent permitted by law.	Please be explicit about what the "heightened licensure requirements" being referenced here mean. We would like more clarification as to what this means in practice.
600-1.10(g)(1)(ii)(a)	The Medical Director shall be a psychiatrist, internist (internal medicine), or family medicine physician with experience in the assessment, diagnosis and treatment of mental health disorders and addiction disorders, substance intoxication and withdrawal; pharmacological management of intoxication, withdrawal, and SUDs; ambulatory withdrawal management; outpatient addiction treatment; toxicology testing; and pharmacodynamics of commonly used substances.	Due to significant workforce shortages, we encourage the Departments to allow CCBHCs to hire a Medical Director who is a Psychiatric Nurse Practitioner (in addition to the qualifications listed), in alignment with the federal CCBHC criteria (*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*.)
600-1.10(g)(3)	At least one (1) part-time nurse practitioner, physician's assistant, registered nurse, or a licensed practical nurse supervised by a registered nurse, employed or contracted by the CCBHC.	We ask that the Departments consider adding reference to other primary care staff who can support these team members and provide primary care services at a CCBHC, including a Medical Assistant.

600-1.10(g)(5)	CCBHCs are required to provide Peer Support Services across the lifespan based on the needs of their service area. This may include a combination of Peer staff with the following credentials: *(a)* New York Certified Peer Specialist (NYCPS), *(b)* OASAS Certified Recovery Peer Advocate (CRPA), *(c)* Credentialed Family Peer Advocate (FPA-C), and *(d)* Credentialed Youth Peer Advocate (YPA-C)"	Currently, CCBHCs are required to have at minimum a NYCPS, CRPA, and FPA-C on staff. If this is going to be a continued requirement, we suggest being explicit about what combination of peer credentials are required vs. optional. However, if the Departments' intention with this new language is to provide CCBHCs with the flexibility to determine what peer staff (and associated certifications) are most appropriate within their catchment area, we support this modification as part of these regulations.
600-1.12(a)(7)	There should be sufficient separation and supervision of various treatment groups and waiting areas, including adults and children or youth, to ensure the safety of the population receiving CCBHC services.	We fully support and recognize the importance of assuring each CCBHC site supports safety and developmentally appropriate services/spaces. However, many CCBHCs do not have the facility space to create separate waiting areas for adults and children/youth. We request the Departments amend this statement to be clear about the requirement, e.g., "<u>The site's waiting areas and common/shared spaces should be structured to assure safety for all individuals served, with sufficient supervision to ensure the safety of all individuals served regardless of age.</u> Additionally, there should be sufficient separation and supervision of various treatment groups <u>and modalities</u>, including adults and children or youth, to ensure the

		safety of the population receiving CCBHC services." We suggest an addition of the following to this section as well (adapted from MHOTRS guidance but also relevant for CCBHCs): "The program should also have a designated space for individuals presenting in acute crisis. The designated space should be safe, accessible, and therapeutically appropriate, and it should be separate from the primary waiting area."
600-1.13(c)(1)	In order to provide telehealth services, the distant site telehealth practitioner must: (1) possess a current, valid license, permit, limited permit, or credential to practice in New York State, or is designated or approved by OMH and OASAS to provide services and be in good standing with the appropriate licensing/credentialing authority	This does not include Targeted Case Managers (TCM), who do not carry the listed credentials. Not allowing TCMs to utilize telehealth services would create a significant barrier to supporting many clients who may require immediate TCM support. We suggest a revision that is inclusive of all staff types that a CCBHC is able to have, aligned with the Staffing section above.
600-1.13(d)(5)	The Offices shall provide approval to utilize telehealth services in writing. The CCBHC must retain a copy of the approval document and shall make it available for inspection upon request of the Offices.	If an existing CCBHC already has approval to utilize telehealth services in writing from the Offices, is that sufficient to meet the requirements outlined under this section? Or must CCBHCs resubmit their policies (etc.) in alignment with this section in order to be approved? We strongly recommend reducing administrative burden and supporting continued access to care by stating that if a CCBHC already has received this approval to provide services via telehealth, that is sufficient to meet these requirements.
600-1.14	Medical Assistance Billing Standards	We ask that the Departments incorporate the APA flexibilities for CPT time ranges as permitted during the COVID-19 pandemic,

		as well as the CFTSS CPT codes, especially those related to engaging collaterals (e.g., engaging with teachers and parents to support the CCBHC's work with children).
600-1.14(d)	To receive reimbursement for services, a provider must demonstrate that they have provided at least one of the following services:	To avoid confusion in this section, we recommend referencing/linking directly to the Departments' CCBHC Allowable CPT Code List, rather than the nine CCBHC services, as there are services within the nine (e.g., care for veterans, treatment planning) that don't have a qualifying CPT code that would allow a CCBHC to bill for a daily visit.
600-1.14(g)	In the case that the same individual is seen by multiple providers on the same day, the provider who holds the treatment plan for that individual will be the only provider eligible to receive payment for that day, for that individual.	This statement is confusing, because presumably any provider who is delivering a service to an individual (within the scope of the CCBHC services) will have a treatment plan. This could be true (for example), in the case of an individual receiving treatment and support services from the CCBHC, and MAT (buprenorphine) services from their PCP (which the regulations state is allowable). Both these providers would have a treatment plan, and although buprenorphine is traditionally considered part of the CCBHC's scope, Section 600-1.9 above is clear that this is allowable, so presumably, both providers would be able to bill and get paid for this service. We suggest you provide more specifics about what types of providers you are referring to. Do you mean if two CCBHCs serve the same individual on the same day? Or if the person is discharged from a hospital setting and then goes to the CCBHC on the same day? How will "holding the treatment plan" be determined, when each provider has their own treatment plan based on the services they are providing?
600.1.15	Medical Assistance Certified Community Behavioral Health Center	We suggest adding a statement about how CCBHC's Consolidated Financial Reports (CFRs) will align with their CCBHC Cost

	program reimbursement system	Report submissions (submission timeline, site-specific reporting, etc.). Additionally, we ask that the Departments add information about the CCBHC Uncompensated Care Pool and how this fits into the overall CCBHC reimbursement structure.
600.1.15(b)(2)	The State will recalculate the rate once sufficient cost data is available within a timeframe to be determined by the State and within the first three years for which there is a completed annual cost report. Once the rebased rate is calculated using a year of actual costs, the State will have the discretion to reconcile previous payments made with the initial payment rate to cost if actual costs are determined to be significantly less than total payments	This should be updated to include the option for reconciliation if actual costs are significantly different (less or more) than payments made to date, i.e.,: "Once the rebased rate is calculated using a year of actual costs, the State will have the discretion to reconcile previous payments made with the initial payment rate to cost if actual costs are determined to be significantly less <u>or significantly more</u> than total payments." Additionally, we suggest that the state establish a specific threshold at which this would occur (e.g., if the difference between previous payments and actual costs are greater than 20%) to mitigate the concerns this statement raises with assuring consistent and reliable revenue for NY CCBHCs.
600.1.15(b)(3)	If the State determines there are sufficient providers to establish a representative regional average CCBHC rate, the State may elect to reimburse newly certified CCBHC providers such regional average rate, as an alternative to establishing rates based upon anticipated costs, until such time as the provider is rebased	We strongly advise against this methodology, until such time we can be sure that the existing CCBHC rates within a region are true to actual costs/visits (e.g., as communicated to Cohort 3 during the TA sessions, the 13 CCBHCs in the third cohort will not re-base until their third Demonstration Year (7/01/27-6/30/28) using DY2 costs (7/01/26-6/30/27)). Also, if this becomes a true option, we do request the opportunity to provide public comment on the State's consideration of what "sufficient providers" in a region looks like. The CCBHC model is intended to support agencies to implement the

		CCBHC model in a way that is directly responsive to their catchment area and associated needed capacity (e.g., as documented in an agency-specific Cost Report and justified via the CNA). Regionalization of rates in this way (even if just as part of starting up a new CCBHC) feels contradictory to this intention of a localized model of care.
600-1.17	Application and Approval Process for CCBHC established under federal demonstration	Given the extensive competitive application and certification process that CCBHC Cohorts 2 and 3 recently underwent, we respectfully request that the Departments consider the information they have already collected from these CCBHCs (as recently as a few months ago for Cohort 3) prior to requesting additional information as part of this new application process. Wherever possible, reducing administrative burden during this transition for our provider community is appreciated. In addition, there are a number of regions of the state where there is not sufficient CCBHC capacity to meet the need. When possible, we request the Departments consider allowing providers who are seeking to attain a CCBHC license who are not currently participating as a CCBHC Demonstration provider to apply on an any-capable-provider standard as soon as is practical.
600-1.17(c)	Such designation is provisional and will expire on the 90th calendar day after the date that the notice of adoption of final OMH and OASAS CCBHC regulations is published in the New York State Register. Such designation shall be extended, as necessary, for any CCBHCs	We want to assure that existing CCBHC Demonstration providers in New York will continue to be able to implement CCBHC services and receive the PPS rate as they await the publication of these regulations, and then subsequently a decision (approval or disapproval) about their application. Our concern relates to the anticipated gap between the end of the CCBHC Demonstration program here in NY, and the ultimate decisions by the

	previously established under the federal demonstration that apply, on or before such 90th calendar day, for certification as a CCBHC under this Subpart, until such certification application is approved or disapproved	Departments to approve a CCBHC under these new regulations. Additionally, 90 days for CCBHCs to submit an application for licensure under the new Subpart 600-1 regulations and the state to approve it (presumably including a site visit process to each of our service sites) seems very quick. While we appreciate the option for an extension, we recommend the state change this language to indicate that currently operating CCBHC Demonstration providers will be able to continue operating until such time that OMH and OASAS make a determination about the provider's licensure under this Subpart.