RULES OF

Department of Mental Health

Division 30—Certification Standards

Chapter 6—Certified Community Behavioral Health Clinic

TITLE 9 — DEPARTMENT OF MENTAL HEALTH
Division 30 — Certification Standards
Chapter 6 — Certified Community Behavioral Health Clinic

9 CSR 30-6.010 Certified Community Behavioral Health Clinic

PURPOSE: This rule establishes the requirements for Certified Community Behavioral Health Clinic (CCBHC) to provide a comprehensive range of mental health and substance use disorder services to people with serious mental illness, serious emotional disturbances, long-term chronic addiction, mild or moderate mental illness and substance use disorders, and complex health conditions. CCBHC provides services regardless of an individual's ability to pay, including those who are underserved, have low incomes, are insured, uninsured, Medicaid-eligible, and active duty U.S. Armed Forces or veterans.

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Definitions. The following definitions apply to terms used in this rule:

(A) Certified Community Behavioral Health Clinic (CCBHC) — an entity certified by the department to provide CCBHC services within their designated service area(s). The entity must be a nonprofit organization and an administrative agent or affiliate provider in Missouri;

(B) Community Needs Assessment — an assessment of the behavioral health needs of all individuals living in the service area(s) served by the CCBHC, including unserved and underserved communities. The CCBHC's staffing plans, accessibility plans, and scope of services shall be based on results of the community needs assessment;

(C) Department — the Department of Mental Health; and

(D) Designated Collaborating Organization (DCO) — an entity that is not under the direct supervision of a Certified Community Behavioral Health Clinic (CCBHC) but is engaged in a contractual arrangement with a CCBHC to provide CCBHC services under the same requirements as the CCBHC.

(2) Regulations. All CCBHCs shall comply with 9 CSR 10-5 General Program Procedures, 9 CSR 10-7 Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 30-3 Substance Use Disorder Treatment Programs, and 9 CSR 30-4 Mental Health Programs, as applicable.

(3) Designated Service Areas and Community Needs Assessment. Organizations must be certified by the department to provide CCBHC services in one (1) or more service areas as established by the department under 9 CSR 30-4.005. The required CCBHC services, as specified in this rule, must be provided in each designated service area.

(A) Each CCBHC shall develop and maintain services and supports designed to meet the needs of the populations of focus. Populations of focus shall include —

1. Adults with serious mental illness as defined in 9 CSR 30-4.005(6);
2. Children and youth with serious emotional disturbances as defined in 9 CSR 30-4.005(7);
3. Children, adolescents, and adults with moderate to severe substance use disorders;
4. Children with behavioral health disorders who are in state custody;
5. Individuals involved with law enforcement, the courts, and hospital emergency rooms who have been identified as in need of community behavioral health services; and
6. Current or former members of the U.S. Armed Forces.

(B) Each CCBHC shall regularly assess the unique sociodemographic factors of their service area(s) by conducting a community needs assessment and implementing strategies to improve access, quality of care, and reduce health disparities experienced by relevant cultural and linguistic minorities. The needs assessment shall be documented and include, but is not limited to —

1. Description of service area(s) and sites where CCBHC services are offered;
2. Prevalence of mental health and substance use disorders and related needs in the service area(s);
3. Economic factors and social determinants of health affecting access to care in the service area(s);
4. Cultures and languages of populations in the service area(s);
5. Identification of underserved populations;
6. Description of how the CCBHC's staffing plan will address findings of the needs assessment;
7. Input from people with lived experience of behavioral health disorders and key community partners on community needs, CCBHC services, access to care, and barriers to care;
8. Identification of potential partnerships with entities in the service area, including but not limited to —
   A. Schools;
   B. Child welfare agencies;
   C. Youth and adult justice agencies and facilities (including drug, mental health, veterans, and other specialty courts);
   D. Regional treatment centers for youth;
   E. State licensed and nationally accredited child placement agencies for therapeutic foster care services;
   F. Social and human service organizations;
   G. Federally Qualified Health Centers (FQHC) and, as applicable, Rural Health Clinics (RHCs); and
   H. 988 Suicide & Crisis Lifeline call center.

(C) Informed by the community needs assessment, the CCBHC shall conduct outreach, engagement, and retention activities to support inclusion and access to services for unserved and underserved individuals and populations.

(D) A staffing plan shall be developed based on results of the needs assessment, including staff identified in section (7) of this rule.

(E) The community needs assessment and staffing plan shall be updated as needed, no less frequently than every three (3) years.

(4) Availability and Accessibility of Services. Services shall not be denied or limited based on an individual's ability to pay, place of residence, homelessness, or lack of permanent address.

(A) CCBHCs shall provide, at a minimum, crisis response, evaluation, and stabilization, as needed, for individuals who present for services but do not reside within the CCBHC's designated service area(s). Policies and procedures shall specify the CCBHC's process for managing the ongoing treatment needs of such individuals, such as linkage to a CCBHC in the

service area where the individual currently lives.

(B) Informed by the community needs assessment, CCBHCs shall provide outpatient services at times and locations that ensure accessibility and meet the needs of individuals in the service area, including some evening hours and, when appropriate and practicable, weekend hours.

(C) CCBHCs shall ensure —

1. No individual in the populations of focus is denied services including, but not limited to, crisis management because of an inability to pay for such services; and

2. Any fees or payments required by the CCBHC for such services shall be reduced as provided by the sliding fee schedule described in section (14) of this rule in order to enable the CCBHC to fulfill the assurance described in paragraph (4)(C)1. of this rule.

(D) CCBHCs shall ensure individuals determined to need specialized behavioral health services beyond the scope of its program are referred to a qualified provider(s) for necessary services.

(E) CCBHCs shall utilize telehealth/telemedicine, video conferencing, remote monitoring, asynchronous interventions, and other technologies, to the extent possible, in alignment with the preferences of the individual receiving services to support access to all required services.

(5) Certification and National Accreditation. CCBHCs shall maintain national accreditation and/or department certification as specified below.

(A) Certification/deemed certification from the department in accordance with 9 CSR 30-3 and 9 CSR 30-4 to provide —

1. American Society of Addiction Medicine (ASAM) Level 1 Outpatient and Level 2.1 Intensive Outpatient Services for adolescents and adults, and Level 1-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring for adults. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, 3rd edition (2013), incorporated by reference and made a part of this rule, is developed by and available from the American Society of Addiction Medicine, Inc., 11400 Rockville Pile, Suite 200, Rockville, MD 20852, (301) 656-3920. This rule does not incorporate any subsequent amendments or additions to this publication; and

2. Community Psychiatric Rehabilitation (CPR) for children, youth, and adults.

(B) Appropriate accreditation from CARF International (CARF), The Joint Commission (TJC), Council on Accreditation (COA), or other accrediting body approved by the department for the following services. National accreditation as a CCBHC or recognition as a CCBHC in states other than Missouri does not constitute an award of certification status as a CCBHC by the department:

1. Certified Community Behavioral Health Clinics;

2. Healthcare home for children, youth, and adults;

3. Outpatient mental health and substance use disorder treatment services for children, youth, and adults;

4. Crisis and information call center for the provision of a twenty-four- (24-) hour crisis line for children, youth, and adults with mental health and/or substance use disorders;

5. Crisis intervention services for the provision of a twenty-four- (24-) hour mobile crisis team for children, youth, and adults with mental health and substance use disorders.

A. If the CCBHC contracts with a DCO to provide crisis and information call center and/or crisis intervention services, the DCO must be accredited as specified above.

(C) Provisional certification from the department to provide outpatient mental health treatment and substance use disorder treatment for children, youth, and adults is acceptable until accreditation is obtained as specified.

(D) Temporary waiver. Upon effective date of this rule, the department will grant a one- (1-) year waiver from the requirements specified in paragraph (5)(B)1.

(E) Waivers shall be temporary and time limited.

1. The initial waiver period of one (1) year may be renewed or extended by the department annually thereafter.

2. The total waiver period shall not exceed three (3) years unless otherwise determined by the department.

(6) Required Services. CCBHCs shall provide a comprehensive array of services to create and enhance access, stabilize people in crisis, and provide the necessary treatment for individuals with the most serious, complex mental illnesses and substance use disorders.

(A) The following core CCBHC services must be directly provided by the CCBHC or by contract with an approved DCO in each designated service area:

1. Crisis mental health services, including —

A. Twenty-four- (24-) hour crisis receiving and stabilization services that include, at a minimum, walk-in mental health and substance use disorder services for voluntary individuals;

B. Twenty-four- (24-) hour mobile crisis response teams; and

C. Twenty-four- (24-) hour emergency crisis intervention services.

(B) The following services must be directly provided by the CCBHC:

1. Screening, assessment, and diagnosis, including risk assessment;

2. Individualized treatment, including risk assessment and crisis prevention planning (supports for children and adolescents must comprehensively address family/caregiver, school, medical, mental health, substance use, psychosocial, and environmental issues);

3. Outpatient mental health services;

4. Substance use disorder treatment services including —

A. Individual and group counseling;

B. Group rehabilitative support;

C. Community support;

D. Peer support;

E. Family therapy;

F. Medication services to support medication assisted treatment; and

G. American Society of Addiction Medicine (ASAM) Level 1 Outpatient and Level 2.1 Intensive Outpatient, Level 1-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring as referenced in paragraph (5)(A)1. of this rule. Services shall include treatment of tobacco use disorders;

5. Outpatient clinic primary care screening and monitoring of key health indicators and health risks;

6. Community support;

7. Psychiatric rehabilitation services;

8. Peer support, counseling, and family support services, including peer and family support services for individuals receiving CPR and/or Comprehensive Substance Treatment and Rehabilitation (CSTAR) services, consistent with the array of services and supports specified in the job descriptions of Certified Family Support Providers and Certified Peer Specialists;

9. Outpatient mental health services for active members of the U.S. Armed Forces and veterans;

10. Outreach services to reduce unnecessary utilization

of emergency rooms by the populations of focus, including community support specialists to respond to and engage individuals who present at collaborating emergency rooms. Individuals shall be assisted in accessing necessary resources to meet basic needs, on an emergency basis, as well as accessing CCBHC services on an emergency, urgent, and/or routine basis, as needed; and

11. Outpatient primary care screening and monitoring of key health indicators and health risk –

A. The medical director shall develop organizational protocols that conform to A and B grade screening recommendations of the United States Preventive Services Task Force, including but not limited to human immunodeficiency virus (HIV) and viral hepatitis;

B. The medical director shall develop organizational protocols to ensure screening for individuals receiving services who are at risk for common physical health conditions experienced by CCBHC populations across the lifespan. Protocols shall include –

(I) Identifying people receiving services with chronic diseases;

(II) Ensuring that people receiving services are asked about physical health symptoms; and

(III) Establishing systems for collection and analysis of laboratory samples.

(C) In addition to the core services, CCBHCs shall directly provide, contract with a DCO, or have a documented relationship with an organization that is certified/deemed certified by the department to provide the following services:

1. General adult, adolescent, and women and children's CSTAR services;

2. Recovery support services, if services are available in the CCBHC's designated service area(s); and

3. Outreach, engagement, and retention activities to support inclusion and access to services by underserved individuals and populations, as informed by the community needs assessment.

(7) Required Staff and Training. Informed by the community needs assessment, CCBHCs shall maintain adequate staffing to meet the needs of individuals receiving services, as reflected in treatment plans, and as required to meet the requirements of this regulation. Staff may be full- or part-time employees of the CCBHC or contracted by the CCBHC to provide services.

(A) Required staff shall include –

1. Medical Director who is a licensed psychiatrist.

A. If after reasonable efforts a CCBHC is unable 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, psychiatric consultation shall 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;

2. Licensed mental health professionals with expertise and specialized training in the treatment of trauma-related disorders;

3. Community Behavioral Health Liaison (a cooperative agreement with a CCBHC that employs a Community Behavioral Health Liaison is acceptable);

4. Clinical staff to complete comprehensive assessments, annual assessments, and treatment plans;

5. Licensed mental health professionals who have completed training on evidence-based, best, and promising practices as required by the department;

6. Qualified practitioner(s) to treat opioid use disorders with Food and Drug Administration (FDA) approved medications. Methadone must be provided by a certified opioid treatment program;

7. Community Support Specialists who have completed department-approved wellness training;

8. Individuals who have completed department-approved smoking cessation training;

9. Certified Family Support Providers who are credentialed by the Missouri Credentialing Board; and

10. Certified Peer Specialists who are credentialed by the Missouri Credentialing Board.

(B) CCBHCs shall have a training plan for all staff (directly employed and contracted) who have direct contact with individuals served and/or their family members/natural supports.

1. As part of employee orientation, and at reasonable intervals thereafter, training shall be provided on –

A. Evidence-based practices;

B. Cultural competency;

C. Person-centered, family-centered, and recovery-oriented planning and services;

D. Trauma-informed care;

E. CCBHC policies and procedures for continuity of operations/disasters;

F. CCBHC policies and procedures for integration and coordination with primary care providers;

G. Services for individuals with co-occurring mental health and substance use disorders.

2. As part of employee orientation and annually thereafter, training shall be provided on –

A. Risk assessment;

B. Suicide and overdose prevention and response; and

C. Role of family support providers and certified peer specialists in service delivery.

3. Training may be provided online.

4. Training shall be aligned with the *National Standards for Culturally and Linguistically Appropriate Services (CLAS)*, 2013, incorporated by reference and made a part of this rule, developed by and available from the U.S. Department of Health and Human Services, Office of Minority Health, Tower Oaks Bldg., 1101 Wootton Parkway, Suite 100, Rockville, MD 20852, (800) 444-6472. This rule does not incorporate any subsequent amendments or additions to this publication.

5. CCBHCs shall have written policies and procedures describing its method(s) of assessing staff competency and maintaining written documentation of in-service training. Documentation shall include training provided to each employee having direct contact with individuals served for the duration of their employment with the CCBHC.

(8) Screening, Assessment, Treatment Planning, and Crisis Planning. Unless a specific tool is required by the department, CCBHC staff shall use standardized and validated screening and assessment tools, including functional assessments and screening tools that are age appropriate, accommodate all literacy levels and disabilities (such as hearing disability and/or cognitive limitations), and brief motivational interviewing techniques, when appropriate.

(A) At first contact, whether in person, by telephone, or using other remote communication, individuals seeking CCBHC

services shall receive a preliminary screening to determine acuity of need. Emergency, urgent, or routine service needs shall be identified and addressed as follows:

1. Individuals who present with emergency needs shall receive services immediately, including arrangements for any necessary outpatient follow-up services;

2. Individuals who present with an urgent need shall receive clinical services and an eligibility determination within one (1) business day of the time the request was made; and

3. Individuals who present with routine needs shall receive clinical services and an eligibility determination within ten (10) days of first contact.

(B) Following the preliminary screening, qualified staff shall conduct a comprehensive assessment or eligibility determination. Completion of the eligibility determination is not required; however, it may be completed before the comprehensive assessment to expedite the admission process as specified in 9 CSR 30-3.151(2)(D)-(E) and 9 CSR 30-4.035(2). A risk assessment shall be included as part of the eligibility determination or comprehensive assessment, whichever occurs first, and shall include –

1. Depression screening for all adolescents age thirteen (13) to eighteen (18) years of age;

2. Depression screening for all adults age nineteen (19) and older;

3. Suicide risk assessment for all adolescents and adults diagnosed with major depression;

4. Brief health screen, as specified by the department;

5. Alcohol use disorder screening; and

6. Substance use disorder screening, including opioid use disorder.

(C) The comprehensive assessment must be completed within the first three (3) outpatient visits or within treatment program timelines as specified in 9 CSR 30-3.151(3) and 9 CSR 30-4.035(4).

(D) Results of the comprehensive assessment shall be utilized to develop an initial treatment plan within sixty (60) days of the individual's first contact with the CCBHC, unless a shorter time frame is required by a specific treatment program. The treatment plan shall be developed collaboratively with the individual served and/or parents/guardian, family members, and other natural supports, as appropriate.

(E) At a minimum, treatment plans shall be reviewed and updated every six (6) months, or more frequently if clinically indicated or as outlined according to service fidelity/criteria. Changes shall be made in accordance with personal preference by the individual receiving services, when appropriate. To align documentation between multiple programs, treatment plan reviews shall be coordinated with the individual's entire treatment team to cover goals addressed in all programs. A functional assessment may be utilized as the treatment plan review/update.

1. The occurrence of a crisis or significant clinical event may require a further review and modification of the treatment plan.

2. The updated treatment plan shall reflect the individual's current strengths, needs, abilities, and preferences in the goals and objectives that have been established or continued based on the review. Updates must be documented in the individual record by one (1) of the following:

A. A progress note which specifies updates made to the treatment plan; or

B. A treatment plan review; or

C. An updated functional assessment score with a brief narrative.

(F) The initial treatment plan and treatment plan updates must include the dated signature(s), title(s), and credential(s) of staff completing the plan. The individual served shall also sign the plan unless there is a current signed consent to treatment included in the individual record.

(G) Individuals who are receiving services from a CCBHC and are seeking routine outpatient clinical services must be provided with an appointment within ten (10) business days of the request for an appointment.

1. If an individual receiving services from a CCBHC presents with an emergency/crisis need, appropriate action shall be taken immediately based on the needs of the individual, including immediate crisis response if necessary.

2. If an individual receiving services presents with an urgent, non-emergency need, clinical services are generally provided within one (1) business day of the time the request is made, or at a later time if that is the preference of the individual.

(H) If a potential risk for suicide, violence, or other at-risk behavior (such as increased isolation, increased substance use, heightened depression or anxiety) is identified during the assessment process and any time during the individual's time in services, a crisis prevention plan shall be developed with the individual as soon as possible.

1. At a minimum, the crisis prevention plan shall include factors that may precipitate a crisis, a hierarchical list of self-care and self-help strategies identified by the individual to regain a sense of control to return to their level of functioning before the crisis or emergency, and a hierarchical list of staff interventions that may be used when a critical situation occurs.

(I) Individuals receiving services from a CCBHC shall be educated about crisis planning, psychiatric advanced directives, and access to crisis services, including the 988 Suicide & Crisis Lifeline (by call, chat, or text), other area hotlines and warm lines, as appropriate, and if risk indicates, overdose prevention, including access to naloxone for opioid overdose.

1. The individual's health record shall include documentation of any advance directives related to treatment and crisis planning. If the individual receiving services does not wish to share their preferences, that decision shall be documented.

(J) Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers. To the extent that state law allows, the state Prescription Drug Monitoring Program (PDMP) must be consulted during the comprehensive assessment. Upon appropriate consent to release of information, the CCBHC is also required to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care. Current state regulations found in 9 CSR 30-3 significantly restrict the provider type eligible to access the PDMP.

(9) Consent to Treatment. Each individual served or a parent/guardian must provide informed, written consent to treatment.

(A) A copy of the consent form, which must include the date of consent and signature of the individual served or a parent/guardian, shall be retained in the individual record.

(B) Consent to treat shall be updated annually, including the date of consent and signature of the individual served or a parent/guardian, and be maintained in the individual record.

(10) Services for Members of the U.S. Armed Forces and Veterans. CCBHCs must determine whether all individuals seeking service are current or former members of the U.S. Armed Forces.

(A) CCBHCs shall refer Active Duty and activated Reserve

Component service members to their Military Treatment Facility or TRICARE PRIME Remote Primary Care Manager for referral to services.

(B) Selective Reserve service members not on active duty, who are enrolled in TRICARE Reserve Select, shall be referred to a TRICARE Reserve Select provider.

(C) If an individual is a veteran not currently enrolled in the Veterans Health Administration (VHA), CCBHC staff must offer to assist them in enrolling in the VHA.

(11) Withdrawal Management. CCBHCs must have partnerships that ensure care coordination to the appropriate level of withdrawal management services, if such services exist within the CCBHC service area as follows:

(A) Each CCBHC shall directly provide ASAM Level 1-Withdrawal Management (WM) services as referenced in paragraph (5)(A)1. of this rule;

(B) Each CCBHC shall have an agreement with a partnering entity, if the CCBHC does not directly provide the following services or if such an entity exists within the CCBHC's service area to provide –

1. ASAM Level 2-WM with and without Extended On-Site Monitoring;

2. ASAM Level 3.2 Clinically Managed Residential Withdrawal Management; and

3. ASAM Level 3.7 Medically Monitored Inpatient Withdrawal Management.

(12) Care Coordination. CCBHCs shall actively pursue and promote collaborative working relationships with the broad array of community organizations and providers that deliver services and supports for individuals receiving services from the CCBHC.

(A) CCBHC policies and procedures shall describe its care coordination roles and responsibilities with other community providers (with other community providers within the CCBHC service area), including but not limited to –

1. Primary care providers;
2. Emergency rooms;
3. Hospitals;
4. Inpatient psychiatric facilities;
5. Opioid treatment programs;
6. Residential substance use disorder treatment programs; and
7. Residential programs serving children and youth.

(B) These partnerships should be supported by formal, signed agreements detailing the role(s) of each party, but if not possible, the CCBHC shall document attempts to develop formal agreements and describe its unsigned joint protocols for care coordination.

(C) Consistent with requirements of privacy, confidentiality, and individual preference and need, CCBHC staff shall assist individuals and family members/natural supports of children and youth who are referred to external providers or resources in obtaining an appointment and track participation in services to ensure coordination and receipt of support. Policies and procedures shall ensure reasonable attempts are made and documented to –

1. Track admissions and discharges of individuals not eligible for Medicaid benefits to and from a variety of settings, and to provide transitions to safe community settings; and

2. Follow up with individuals served within twenty-four (24) hours following hospital discharge.

(D) Nothing about a CCBHC's agreements for care coordination shall limit an individual's freedom of choice of provider(s) with the CCBHC or its DCOs.

(E) CCBHCs shall utilize Missouri Behavioral Health Connect (MOConnect), the designated platform to identify, unify, and track behavioral health treatment resources.

(F) For all individuals in the populations of focus, CCBHC staff shall inquire whether they have a PCP, assist individuals who do not have a PCP to acquire one, and establish policies and procedures that promote and describe the coordination of care with each individual's PCP.

(G) For all individuals in the populations of focus, CCBHC staff shall document in the individual record the name of each individual's PCP, indicate they are assisting them in acquiring a PCP, or the individual refuses to provide the name of their PCP or accept assistance in acquiring a PCP.

(13) Evidence-Based Practices. CCBHCs shall incorporate evidence-based and emerging best practices into its service array.

(A) CCBHCs shall have adopted, or be participating in, a department-approved initiative to promote supported employment, trauma-informed care, and suicide prevention.

(B) CCBHCs shall have adopted with fidelity a model for providing integrated treatment for co-occurring disorders approved by the department.

(C) CCBHCs shall demonstrate a continued commitment to adopting or continuing evidence-based and emerging best practices to fidelity, such as –

1. Assertive Community Treatment (ACT);
2. Measurement-Based Care;
3. Supported housing;
4. Parent-Child Interaction Therapy;
5. Dialectical Behavior Therapy;
6. Multi-systemic Therapy;
7. First Episode Psychosis; and
8. Eye Movement Desensitization and Reprocessing (EMDR).

(14) Fee Schedule. CCBHCs shall publish a sliding fee discount schedule that includes all services the CCBHC offers. The fee schedule shall conform to applicable state or federal statutory and administrative requirements for existing clinics. Absent applicable state or federal requirements, the schedule is based on locally prevailing rates or charges and include reasonable costs of operation.

(A) Written policies and procedures shall be maintained by the CCBHC describing eligibility for services and implementation of the sliding fee discount schedule which must ensure –

1. Equitable use of the sliding fee schedule for all individuals seeking services;
2. The provision of services regardless of ability to pay; and
3. Waiver or reduction of fees for those unable to pay.

(B) The CCBHC shall screen each individual seeking services to determine eligibility for a sliding fee discount.

(C) If a CCBHC service is provided through a DCO, the DCO shall provide such services in accordance with the CCBHC fee schedule and corresponding policies and procedures.

1. The CCBHC shall provide the DCO with a copy of its policies and procedures related to the sliding fee discount program.

2. Prior to the provision of a CCBHC service, the CCBHC shall inform the DCO if an individual has been determined eligible for a fee discount. The DCO is not required to conduct its own discount eligibility screening.

(D) CCBHCs (and their DCOs, as applicable) shall provide individuals and their family members/natural supports with

information regarding the sliding fee discount program.

1. The fee discount schedule shall be communicated in languages and formats appropriate for individuals seeking services who have limited English proficiency, literacy barriers, or disabilities.

2. The fee discount schedule shall be posted on the CCBHC/DCO website, posted in the CCBHC waiting/reception area, and accessible to people receiving services and family members/natural supports.

(15) Quality and Reporting. CCBHCs shall maintain a health information technology (HIT) system that includes but is not limited to electronic health records of all individuals served. Electronic health record systems must comply with state and federal regulations.

(A) The CCBHC uses technology that has been certified to current criteria on the Certified Health IT Product List (CHPL) for the following required core set of certified HIT capabilities:

1. Capability to capture structured information in individual records, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status;

2. At a minimum, support care coordination by sending and receiving summary of care records;

3. Provide people receiving services with timely electronic access to view, download, or transmit their health information or to access their health information via an application programming interface (API) using a personal health app of their choice;

4. Provide evidence-based clinical decision support; and

5. Electronically transmit prescriptions to the pharmacy.

(B) The following information shall be collected and be available for reporting to the department or other entities, upon request:

1. The number and percentage of new and established individuals served who were determined to need emergency, urgent, and routine care;

2. The number and percentage of new and established individuals with urgent needs who began receiving needed clinical services within one (1) business day;

3. The number and percentage of new and established individuals with routine needs who began receiving needed clinical services within ten (10) business days; and

4. The mean number of days from first contact to completion of the comprehensive assessment/eligibility determination and initial treatment plan for individuals served.

(C) The CCBHC shall develop, implement, and maintain an effective, CCBHC-wide continuous quality improvement (CQI) plan for the services provided.

1. The medical director shall be involved in the aspects of the CQI plan that apply to the quality of the medical components of care, including coordination and integration with primary care.

2. A critical review process shall be developed to review CQI outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services.

3. The plan shall focus on indicators related to –

A. Improved behavioral and physical health outcomes for individuals served and actions to demonstrate improvement in CCBHC performance, when warranted; and

B. Improved patterns of care delivery such as reductions in emergency department use, rehospitalizations, and repeated crisis episodes for individuals served.

4. The CQI plan shall include provisions to ensure known significant events are reviewed including, at a minimum –

A. Deaths by suicide or suicide attempts of people receiving services;

B. Fatal and non-fatal overdoses;

C. All-cause mortality for individuals receiving CCBHC services;

D. Thirty (30) day hospital readmissions for psychiatric or substance use reasons; and

E. Events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.

5. The CQI plan shall include a specific focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and address how the CCBHC will use disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health disparities.

(D) The CCBHC shall have a continuity of operations/disaster plan that ensures staff, individuals receiving services, and healthcare and community partners are notified when a disaster/emergency occurs or services are disrupted.

1. The CCBHC shall, to the extent feasible, identify alternative locations and methods to sustain service delivery and access to behavioral health medications during emergencies and disasters.

2. The plan shall address HIT systems, security/ransomware protection, backup, and access to these IT systems, including health records, in case of disaster.

(16) DCO Contracts. If the CCBHC enters into a contractual agreement(s) with a DCO, the contract shall include the following provisions:

(A) DCO staff having contact with individuals served, and/or their families, are subject to the same training requirements as staff of the CCBHC;

(B) The CCBHC coordinates care and services provided by the DCO in accordance with the individual's current treatment plan;

(C) The CCBHC is ultimately clinically responsible for all care provided;

(D) The individual's freedom to choose service providers is maintained;

(E) All individuals have access to the CCBHC's grievance procedures; and

(F) Services provided by the DCO shall meet the same quality standards as those provided by the CCBHC.

(17) Governing Body Representation. CCBHCs shall ensure a substantial number of people with lived experience of mental health and substance use disorders, and their family members/natural supports, have meaningful participation in developing initiatives, identifying community needs, goals, and objectives, providing input on service development, continuous quality improvement processes, human resource planning, budget development, and decision making.

(A) Meaningful and substantial participation shall be demonstrated by one (1) of the following options:

1. At least fifty-one percent (51%) of the CCBHC governing body consists of individuals with lived experience of mental health and/or substance use disorders and their family members/natural supports. The CCBHC must describe how it meets this requirement, or provide a transition plan with timeline for meeting it; or

2. Other means shall be established to demonstrate meaningful participation in board governance involving

people with lived experience of behavioral health disorders (such as creating an advisory committee that reports to the board). The CCBHC shall provide staff support to the individuals involved in any alternate approach that is equivalent to the support given to the governing board.

(B) If the CCBHC utilizes the criteria specified in paragraph (17)(A)2. of this rule, the governing board shall establish protocols for incorporating input from individuals with lived experience and their family members/natural supports.

1. Board meeting summaries shall be shared with those participating in the alternate arrangement and recommendations from the alternate arrangement shall be entered into the formal board record.

2. A member or members of the arrangement as established in paragraph (17)(A)2. of this rule must be invited to board meetings, and representatives of the alternate arrangement must have the opportunity to regularly address and share recommendations directly with the board and have their comments and recommendations recorded in the board minutes.

3. The CCBHC shall provide staff support for posting an annual summary of the recommendations from the alternate arrangement as established in paragraph (17)(A)2. of this rule on the CCBHC website.

(C) If paragraph (17)(A)2. of this rule is chosen, the CCBHC must obtain approval from the department. The CCBHC shall make available the results of its efforts in terms of outcomes and resulting changes.

(D) If the CCBHC is a subsidiary or part of a larger corporate organization and cannot meet the requirements identified in paragraphs (17)(A)1. and 2. of this rule, the CCBHC shall specify why it cannot meet these requirements. The CCBHC shall have or develop an advisory structure and describe other methods for individuals with lived experience and family members/natural supports to provide meaningful participation with the governing body.

(E) CCBHCs must be able to document input from individuals served and their parents/guardian, family members, natural supports, and communities served, including the impact on its policies, processes, and services.

(F) To the extent practicable, each CCBHC's governing body and/or advisory board shall be representative of the populations served in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, and sexual orientation in terms of health and behavioral health needs.

(G) Each CCBHC's governing body members or advisory board members shall be selected for their expertise in health services, community affairs, local government, finance and accounting, legal affairs, trade unions, faith communities, commercial and industrial concerns, and/or social service agencies within the communities served.

(H) No more than fifty percent (50%) of the governing body members may derive more than ten percent (10%) of their annual income from the health care industry.

AUTHORITY: sections 630.050 and 630.655, RSMo 2016. Emergency rule filed March 20, 2019, effective July 1, 2019, expired Oct. 30, 2019. Original rule filed March 20, 2019, effective Oct. 30, 2019. Amended: Filed June 13, 2023, effective Jan. 30, 2024. Amended: Filed Oct. 9, 2025, effective April 30, 2026.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008, and 630.055, RSMo 1980.*