Comments for Chapter 522

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1	9/04/2015 Bottom of page 3	Other Chapters, such as Chapter 503 that I am familiar with, have indicated specific processes for provider reviews. Does the absence of this section in this manual indicate that reviews are of differing processes or by different entities than Chapter 503? Is there a way to be more specific in this manual so that providers know with more detail what to expect with reviews? If the reviews are the same as other manuals, perhaps a simple reference to those manuals would work.	**No Change Made**		FQHC's and RHC's services are subject to review by the Bureau for Medical Service's Office of Program Integrity. . For more information please refer to *Chapter 800, Program Integrity*.
2	9/04/2015 522.9 page 10	1. This section does not indicate that behavioral health treatment can be provided in the school system. Counseling is listed but that is not specified as to behavioral health or health related counseling. Can this be further clarified to include behavioral health treatment? Perhaps a list of services like at the bottom of page 4 or the bottom of page 5 and top of page 6 would be more helpful? 2. In this same section, it states that the services are outside of those in chapter 538. Does this mean that services should not be provided if they would be a	**1. Change** **2. No Change**	1. The word "counseling" has been changed to "behavioral health".	2. Yes. Duplication of services should not take place concerning counseling or psychological services.

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		duplicate to those already performed by the school?			
3	9/04/2015 522.8 page 10	This section prohibits FQHCs from being a distant site which seems important and reasonable if providing services outside of the FQHC area. However, this seems very limiting in certain circumstances where telehealth could be provided to patients in their own homes or in a local public facility equipped for telehealth. An example may be in providing psychotherapy to patients in their homes who suffer from agoraphobia and who would otherwise decline an office visit. Another example may be when there is inclement weather and travel is not possible. I don't know anyone who currently practices this, but it is not an unreasonable future step. FQHCs are focused on increasing patient access to care and this would seem to be an important tool.	**No Change Made**		The prohibition on FQHC being a distant site concerning telehealth is Federal rule and WV BMS is unable to change that.
4	9/10/2015	FQHC is supportive of the proposed changes to the BMS FHC/RHC provider manual. WV is currently facing multiples challenges regarding access to behavior health services, especially for children and individuals seeking substance abuse	**No Change Made**		The proposed policy addresses all that is stated in this comment. *Please note: Your comment refers to a

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		counseling. Community health centers across the state are preparing to address this crisis by increasing access to behavior health services. In order to increase access to behavioral health services, it is critical that health centers have the ability to utilize the expertise of multiple provider types including master's prepared psychologists. Licensed certified social workers (LCSW) licensed graduate social workers (LGSW) and licensed professional counselors (LPC). This additional staff will have to be hired in order to expand access to behavioral health services, pending the revisions to the provider manual.			master's prepared psychologist. FQHCs and RHCs may not bill for a supervised psychologist or unlicensed psychologist. The master's prepared psychologist must be licensed as well.
5	9/10/2015	FQHC is also supportive of the changes to allow community health centers to utilize dental hygienists within the school-based health setting. Without this change, current mobile dental service to eight Boone County elementary schools would have to end. By following the legislative rule (Section 5-13-6. General Supervision of Dental Hygienists), dental hygienists, with public practice permit, will be able to provide preventive services to children	**No Change Made**		The proposed policy addresses all that is stated in this comment.

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		under general supervision. Given WV shortage of dentists, especially in rural, isolated, underserved areas, this reimbursement policy change is critically important to the health of our children.			
6	9/11/2015	Monongahela Valley Association of Health Centers, Inc. is providing this letter of support for the proposed changes to the BMS FQHC/RHC provider manual. West Virginia is currently facing multiple challenges regarding access to behavioral health services, especially for children and individuals seeking substance abuse counseling. Community health centers across the state, including Monongahela Valley Association of Health Centers, Inc., are preparing to address this crisis by increasing access to behavioral health services. In order to increase access to behavioral health services, it is critical that health centers have the ability to utilize the expertise of multiple provider types including master's prepared psychologists, licensed certified social workers (LCSW), licensed graduate social workers (LGSW) and licensed professional counselors (LPC). Monongahela Valley Association of	**No Change Made**		The proposed policy addresses all that is stated in this comment. *Please note: Your comment refers to a master's prepared psychologist. FQHCs and RHCs may not bill for a supervised psychologist or unlicensed psychologist. The master's prepared psychologist must be licensed as well.

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		Health Centers, Inc. plans to hire a master's prepared psychologist and LGSW this fall to expand access to behavioral health services, pending the revisions to the provider manual. Monongahela Valley Association of Health Centers, Inc. is also fully supportive of the changes to allow community health centers to utilize dental hygienists within the school-based health setting. By following the legislative rule (Section 5-13-6 General Supervision of Dental Hygienists), dental hygienist, with a public practice permit, will be able to provide preventive services to children under general supervision. Given West Virginia shortage of dentists, especially in rural, isolated, underserved areas, this reimbursement policy is critically important to the health of our children.			
7	9/14/2015	Roane County Family Health Care is providing this letter of support for the proposed changes to the BMS FQHC/RHC provider manual. West Virginia is currently facing multiple challenges regarding access to behavioral health services, especially for children and individuals seeking	**No Change Made**		The proposed policy addresses all that is stated in this comment. *Please note: Your comment refers to a master's prepared psychologist. FQHCs and

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		substance abuse counseling. Community health centers across the state, including Roane County Family Health Care, are preparing to address this crisis by increasing access to behavioral health services. In order to increase access to behavioral health services, it is critical that health centers have the ability to utilize the expertise of multiple provider types including master's prepared psychologists, licensed certified social workers (LCSW), licensed graduate social workers (LGSW) and licensed professional counselors (LPC). Roane County Family Health Care plans to hire a master's prepared psychologist and LGSW this fall to expand access to behavioral health services, pending the revisions to the provider manual. Roane County Family Health Care is also fully supportive of the changes to allow community health centers to utilize dental hygienists within the school-based health setting. By following the legislative rule (Section 5-13-6 General Supervision of Dental Hygienists), dental hygienist, with a public practice permit, will be able to provide preventive services to children			RHCs may not bill for a supervised psychologist or unlicensed psychologist. The master's prepared psychologist must be licensed as well.

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		under general supervision. Given West Virginia shortage of dentists, especially in rural, isolated, underserved areas, this reimbursement policy is critically important to the health of our children.			
8	9/24/2015	On behalf of the Board of Directors of the West Virginia Psychological Association (WVPA), I would like to thank you for the opportunity to comment on the WV Medicaid FQHC/RHC Chapter 522 proposed changes. We understand that West Virginia is a largely rural state and that our citizens are disproportionately underserved as it applies to health and mental health needs. We are also cognizant of the vital role that primary care plays in both the prevention of future illness and the maintenance of current wellness for West Virginians. Thus, we at WVPA welcome innovative ideas to promote statewide health. For this reason, we applaud the spirit of this change to provide increased access to mental health services in our state's FQHCs. WVPA recognizes that a growing number of patients presenting in the primary care setting have primary mental health diagnoses. For a larger group of	**No Change Made**		BMS works to have adequate provider capacity to ensure readily available access to services by qualified and credentialed providers and will continue to work with our community partners to ensure both goals are met. BMS is also required by CMS to ensure that services are rendered by appropriately credentialed providers and as such follow the WV State Codes that outlines and mandates boards of examiners and certifying boards for each of the approved providers for FQHC. The Bureau will continue to follow the federal requirements of

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		patients, mental health symptoms pose substantial barriers to optimal treatment of a primary medical diagnosis. In all these cases, it is essential that primary care physicians are able to confidently hand their patient off to a trained provider who understands the intersection between the mental and medical presentation and can ease that transition of care so that continuity is maintained. While we are eager for our citizens to receive valuable mental health services in a primary care setting, we do have concerns about the training and scope of practice issues that would coincide with this change. Members of WVPA have been providing integrated primary care services for years in clinics throughout the state such as Cabin Creek Health Systems, Family Care, Valley Health Systems, and the CAMC Family Medicine Center of Charleston. Our psychologists have received training in graduate school, internship and postdoctoral experiences that have prepared them for their role as a team member in a health clinic. The day to day activities in a primary care clinic are vastly different than those in a mental			CMS as well as WV state law in respect to these certifying and licensing bodies.

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		health clinic. Those providing services in FQHC's need expertise in providing brief therapy sessions (30 minutes or less), more succinct reports/notes, an open door policy for therapy/interventions, "curbside" consultations with medical team, warm hand-offs from medical providers, and a greater emphasis on understanding and treating patients whose behavioral problems are a significant barrier to treatment of their medical problems. In short, there are specific competencies involved when mental health providers deliver services in a primary care setting which necessitate a shift in how they are educated and trained. We not only need to be educated on the common mental health issues (e.g. depression, anxiety) but also the common medical issues that we routinely encounter (e.g. diabetes, coronary artery disease). The American Psychological Association (McDaniel, et al. 2012*) recently listed competencies in primary care psychology for all providers to inform the education, practice and research of integrated primary care. The key point was that the national governing			

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		body of psychologists wants to make sure those who provide services to our citizens have the adequate training to collaborate effectively with team members and treat patients in primary care. Perhaps the most important question is how do we train other mental health providers for their role if this change takes place? This question impacts the mental health provider, the clinic and most importantly the people seeking the services in the clinic. We at WVPA are committed to helping in this cause and engaging in a dialogue to help prepare and train mental health providers in our state for the changes that this shift would necessitate. There are numerous courses of varying length that are taught nationally to help prepare mental health providers of various backgrounds for work in primary care settings. We would be happy to discuss them and to help. Our biggest concern is that without training, mental health providers will not be able to adequately deal with the demands of a busy primary care practice and thus the state's healthcare disparities would not			

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		improve in the long term. On a final note, we would like to address an issue that was brought up in a prior comment by Sam Hickman of the National Association of Social Workers (NASW). Mr. Hickman astutely pointed out how it is inappropriate to require prior authorization for behavioral health services in the context of a brief assessment in a primary care clinic. This is one situation where we would agree that the fiscal practice does not follow the evidence base. The requirement of pre-authorization in this situation is tethered to the traditional model of mental health where the consumer sits down for an hour or two and a complete mental health intake is performed. This is not the practice nor is there an evidence base for this practice in any primary care clinic to our knowledge. If we are to take this plunge as a state and expand mental health services in the FQHCs, then we must change this rule about prior authorization so that mental health practitioners can adequately do their job. This venture will be unsuccessful if			

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		mental health providers are required to spend over an hour with each new patient that they meet in a primary care setting. Simply put, the volume of patients will overwhelm them and they will not be available to help medical providers out during times of urgent need. On behalf of the WVPA Board of Directors, thank you once again for the opportunity to provide these comments. WVPA is committed to providing assistance in the continued growth of integrated primary care services and we are most highly motivated to do our part to make sure it is a positive experience for patients and the primary care centers where they seek their care. Please feel free to contact me if you require additional information.			
9	9/24/2015	I am writing due to concerns about the proposed changes to the level of education and clinical preparation required to provide behavioral health services at Federally Qualified Health Centers. It is my strong belief that the level of education and clinical experience hitherto required has been to the benefit of the public by ensuring that individuals	**No Change Made**		BMS works to have adequate provider capacity to ensure readily available access to services by qualified and credentialed providers and will continue to work with our community partners to ensure both goals are met.

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		receive adequate services. The proposal to allow LGSW's to provide these services without the necessary preparation would be a potential harm to the public and against the public interest. As a graduate of doctoral training in clinical psychology who underwent rigorous training and a year-long full-time internship, I have an appreciation for how much I did not know before those experiences. I have also had occasion to work with individuals who have not had this training to see the difference in their understanding of the nuances of clinical presentations and their lack of skills implementing treatment interventions. Requiring supervision from an LICSW is not enough. Supervision does not substitute for education and training. A person cannot ask a supervisor for information and help with what they do not know that they don't know. I have repeatedly seen under-qualified clinicians misdiagnose serious behavioral health problems and implement wholly inappropriate treatment plans. West Virginians deserve high quality healthcare. Even those who are			BMS is also required by CMS to ensure that services are rendered by appropriately credentialed providers and as such follow the WV State Codes that outlines and mandates boards of examiners and certifying boards for each of the approved providers for FQHC. The Bureau will continue to follow the federal requirements of CMS as well as WV state law in respect to these certifying and licensing bodies.

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		experiencing financial hardship. The problem caused by having too few qualified clinicians is that WV has extremely high rates of mental illness (SAMSHA, 2014) and medical conditions associated with behavior health (DHHR, 2013). Please keep in mind that suicide is one of the top 4 leading causes of death for individuals ages 10 - 44 (CDC, 2013). Health conditions affected by behavior and mental health (such as heart disease, diabetes and cancer) are the leading causes of death currently (CDC, 2015). There are real health outcomes at stake. This problem is not solved by having people who are not adequately trained talk to people with real problems. In fact, that strategy is more likely to cause harm by delaying those individuals from seeking adequate care (because they will believe they have already received it), deterring them from seeking behavioral health services in the future (if it didn't work or was harmful, why try again?) or harming them with inappropriate interventions or unethical practice. Thank you for your time. I appreciate			

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		your concern for West Virginia citizens. I hope that you are moved not to lower the standard of credentials required for behavioral health practice at FQHCs in West Virginia. We deserve better.			
10	9/29/2015	E. A. Hawse Health Center is pleased to provide his letter of support for the proposed changes to the BMS FQHC/RHC provider manual. Of all the statewide challenges facing West Virginia from a health care perspective, access to behavioral health services for low income children and adults deserves priority. It is imperative that patients are treated as a whole. For example: medical needs and behavioral health needs are uniquely joined when dealing with many chronic diseases and the depression and anxiety the patient experiences as a result of the diagnosis. Abuse, in its many forms, is far more common than many wish to believe, especially within the low income families. Add to these the OCD, ADHD AND PTSD diagnoses; ignoring any of the above does not demonstrate clinical competence. Community health centers across the	**No Change Made**		The proposed policy addresses all that is stated in this comment. *Please note: Your comment refers to a master's prepared psychologist. FQHCs and RHCs may not bill for a supervised psychologist or unlicensed psychologist. The master's prepared psychologist must be licensed as well.

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		state, including E. A. Hawes, are, and have bee, providing behavioral health services for many years. However, we have been limited by current BMS laws and regulation regarding the acceptability of certain provider types and the general lack of qualified candidates available to us in the local employment market. Addressing behavioral health needs by increasing access to behavioral health services is a very worthy cause and E. A. Hawse supports this effort. As proposed, it is critical that health centers have the ability to utilize the expertise of multiple provider types and be reimbursed. The currently approved BMS non physician FQHC provider types include PhD Psychologists and Licensed Independent Clinical Social Workers. The limited provider base was the direct results of CMS rules related to FQHCs. Regrettably, under previous administrations, CMS rules were used by BMS to limit FQHCs to the detriment of many West Virginias. With nearly 20% of the state's population eligible for Medicaid, something has to be done. Including master's prepared			

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		psychologists, licensed certified social workers (LCSW), licensed graduate social workers (LGSW), and licensed professional counselors (LPC) as approved FQHC providers will address access issues. E. A. Hawes will expand access to behavioral health services immediately, pending the revisions to the provider manual. We will do so and not compromise the quality of the behavioral health services by providing appropriate clinical oversight supervision by our tenured therapists. By following the legislative rule (Section 5-13-6 General Supervision of Dental Hygienists), dental hygienist, with a public practice permit, will be able to provide preventive services to children under general supervision. Given West Virginia shortage of dentists, especially in rural, isolated, underserved areas, this reimbursement policy is critically important to the health of our children.			
11	9/29/2015	The West Virginia Primary Care Association (WVPCA) is in receipt of public comment letters submitted by the West Virginia Psychological Association and the West Virginia Chapter of the	**No Change Made**		BMS works to have adequate provider capacity to ensure readily available access to services by

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		National Association of Social Workers. We are providing the following feedback to assure the Bureau for Medical Services (BMS) that the community health centers recognize the need for training of new behavioral health providers and that all health centers maintain a new orientation training program for all employees. Training and technical assistance is a core function of the WVPCA and we have provided numerous educational programs over the past several years related to behavioral health integration. The WVPCA utilized the expertise of the Cherokee Health System and Alexander Blount, a national expert in behavioral health integration. The WVPCA is working with the health centers that recently received HRSA funding to expand behavioral health to share best practices and develop their approach to behavioral health services. The WVPCA is currently developing a behavioral health educational program to be offered in January 2016. Dr. Scott Fields, WV Psychological Association and Sam Hickman, WV Chapter of the National Association of Social Workers are working with WVPCA staff to develop the content for the program. Dr. Fields and Mr. Hickman are also assisting the WVPCA in identifying in-depth trainings available to health centers specific to the fully integrated care model. Additionally, the WVPCA hosts numerous			qualified and credentialed providers and will continue to work with our community partners to ensure both goals are met. BMS is also required by CMS to ensure that services are rendered by appropriately credentialed providers and as such follow the WV State Codes that outlines and mandates boards of examiners and certifying boards for each of the approved providers for FQHC. The Bureau will continue to follow the federal requirements of CMS as well as WV state law in respect to these certifying and licensing bodies.

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		list serves for health center staff to query other health centers on a variety of topics, including behavioral health. While we agree that it is important for behavioral health providers to receive appropriate training regarding integrated care, we also believe that the approach to training is the decision of the individual organization and that it is not the role of BMS to determine training requirements for health center staff.			
12	9/30/2015	As part of the Valley Health Behavioral Health Team. I was asked to take the opportunity to comment on the WV Medicaid FQHC/RHC Chapter 522 proposed changes and to response that reflects current concerns and discussion within our department. It is Valley Health mission to provide quality healthcare to underserved patients in or area. Since opening our first health care centers, Valley Health has become aware of an acute need for primary care in rural WV and has sought to expand breadth and depth of services in order to meet patient needs. Given the number of patients presenting in primary care with mental health concerns as well as the	**No Change Made**		WV Medicaid works to have adequate provider capacity to ensure readily available access to services by qualified and credentialed providers and will continue to work with our community partners to ensure both goals are met.

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		role that these concerns play in patient health and well-being, behavioral health services are seen as an important aspect of Valley Health's care for our citizens. Our department has seen rapid expansion and currently includes three full time psychiatrists and six full time doctoral level psychologists. Even with this staff, Valley Health is confronted with challenges to provide quick and efficient access to behavioral health services for our patients. In response to the prosed changes for the WV Medicaid, Valley Health has considered adding other professionals to our behavioral health team in order to meet the high demand for services identified by our patients and by our primary care providers. In considering such expansion of our team, our department is very concerned that our services need to be of high quality in order for them to be helpful to our patients and primary care providers. Out department and administrators actively discussing how to ensure that all our behavioral health providers have appropriate training and experience to			

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		provide these services both behavioral health clinics and as integrated members in the primary teams. There are specific skills sets that our behavioral health providers need to have including expertise in brief psychotherapy sessions, standard for practice. In our discussions of ensuring quality behavioral health services, we are considering how we can utilize the providers we currently have to ensure adequate training and supervision as well as continuing to cultivate a culture that supports ongoing commitment to evidence-based competent practice. This commitment is clearly essential to Valley Health's commitment to providing quality healthcare. Discussions have included ideas such as having our behavioral health providers participate in specific training such as the Behavioral Health Consultant certification program offered through University of Massachusetts, receive supervision and peer review through vertical teams lead by our more advanced behavioral health providers, and participate in journal clubs or other mechanisms for staying up to date on the			

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		research that informs practice. Ongoing discussion and planning with occur within our department with commitment to evidence-based standard of care being our priority. We are hopeful that with thought and careful planning we can work to adequately meet the demands of our patients with top-notch care with utilizing the strengths and training of each of our department members. Thank you for the opportunity to share our concerns and comments.			
13	10/1/2015	In review of the Dental Service Chapters of the WV Medicaid Providers Manual, the WV Dental Hygienist's Association has great concern with Chapter 522.7 SERVICE LIMITATIONS. The following statement specifically causes great unease for collective Dental and Medical Communities, "dental services in the school setting must be provided initially be the Dentist. Subsequent visits are allowed with the dental hygienist on an alternating basis. "The language of this statement is a limitation to the access of care progress that has been made to provide dental care to the children of West Virginia.	Change	4th Bullet in this section has been amended to include preventive oral health services provided by a dental hygienist with a public health practice permit (West Virginia State Code §30-4-11-5)	

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		In 2010, West Virginia received an "F" on the Pew Charitable Trust national report card. Through school-based dental services, projects, and supportive policies such as WV Code §30-4-11, WV has improved to the "B/C" range. This service limitation would be seen as nationally as a setback and harm the Improvements made over the last five years. In addition, 522.3 ENCOUNTERS (BMS Provider Manual/ Page 5) provides a list of "Eligible Practitioners" that should include a sequential professional list in order of healthcare specialty. Below "Dentist (DDS or DDM)." Should read, "registered Dental Hygienist (RDH," as dentists and registered dental hygienist are the only two, licensed, oral healthcare providers. Any further "eligible practitioner" scope of practice details regarding registered dental hygienist should be offered in an appendix notation, "Registered Dental Hygienists (RDH) provide services in school settings {outside of services identified in Chapter 538 School-Based Health Services through the West Virginia Department of Education (DOE) or Local Education			

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		Agency (LEA)}. Concerns with Service limitations are as follows: 1. Currently, dental hygienists are licensed, eligible practitioners providing oral health care services in a school setting. Limiting preventative dental hygiene therapy/oral health services provided by a registered dental hygienist (RDH) by requiring an initial exam by a dentist is not consistent with or supportive of: a. CMS Center for Medicaid and CHIP Services Oral Health Initiative {see attached} i. CMS Oral Health Initiative Goals ii. CMS Policy Supports Dental Workforce Innovations b. West Virginia State Code §30-4-11			
14	10/1/2015	Updated references throughout policy for LCSW from: Licensed Clinical Social Worker (LCSW) to Licensed Certified Social Worker	**C**	Changed throughout policy for LCSW to:	

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		(LCSW)		Licensed Certified Social Worker	
15	10/1/2015	Section 522.3 Encounters Need to correct bullet: from: 4. Licensed Psychologist and Licensed Clinical Social Worker Services specified in 42 CFR §405.2450 To the following: 4. Clinical Psychologist and Clinical Social Worker Services as specified in 42 CFR §405.2450	**C**	Updated bullet to read: 4. Clinical Psychologist and Clinical Social Worker Services as specified in 42 CFR §405.2450	