Chapter 503
Licensed Behavioral Health Center (LBHC) Services

Appendix 503I
Certified Community Behavioral Health Clinics

TABLE OF CONTENTS

BACKGROUND

On April 1, 2014, the Protecting Access to Medicare Act (PAMA) was signed into law. Section 223 of PAMA established the Certified Community Behavioral Health Clinic (CCBHC) model. The CCBHC model was launched in 2017 with the Section 223 CCBHC Demonstration in 66 clinics across eight states. The CCBHC certification criteria developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) coupled with the Medicaid prospective payment system (PPS) guidance established by the Centers for Medicare and Medicaid Services (CMS) have created a comprehensive framework to improve the availability and quality of mental health and substance use care across the nation. The criteria's uniform standards provide for comprehensive, coordinated, trauma-informed, and recovery-oriented care for mental health and substance use conditions.

The CCBHCs are designed to ensure access to coordinated comprehensive behavioral healthcare. The CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age. This includes developmentally appropriate care for children and youth.

In March 2021, the West Virginia legislature enacted WV *§9-5-30*, directing the Bureau for Medical Services (BMS), in partnership with the Bureau for Behavioral Health, to establish a state certification process and payment system for CCBHCs. The process must be consistent with the demonstration program established by Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA) (P.L. 113-93, 42 U.S.C. 1396a note), to the fullest extent practicable. *§9-5-30(c)* requires that all nonprofit comprehensive community mental health centers (CMHCs), comprehensive intellectual disability facilities, licensed behavioral health centers (LBHCs), and all providers set forth in the Medicaid CCBHC State Plan Amendment (SPA) as established by *§27-2A-1* of this code be eligible to apply for certification as a CCBHC.

This Appendix describes requirements for CCBHC administration, operations, and service delivery based on current federal and state-specific criteria, as well as requirements for reimbursement of CCBHC services provided by certified CCBHC behavioral health providers in West Virginia.

The CCBHCs must bill the correct provider type for the population to whom they are rendering the services. Any service procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise, in writing, by BMS. West Virginia has the authority to cover all services listed in the current CCBHC certification criteria under § 9-5-30 of the Human Services Article and the Medicaid State Plan. Under this authority, the CCBHC model provides an unprecedented opportunity for behavioral health providers to receive payment through PPS for delivering effective, evidence-based care.

CCBHCs must coordinate care for all members. Coordination of care includes activities and services delivered within the CCBHC, services delivered by designated collaborating organization (DCO) partners, services delivered by other healthcare providers, and any services and supports identified to address health-related social needs. CCBHCs must help ensure that quality care is delivered, and that safety is at the forefront of the members' treatment.

CCBHCs must deliver all required services and coordinate care in compliance with all state and federal laws that govern confidentiality of physical and behavioral health information, including the Health Insurance Portability and Accountability Act (HIPAA) 42 U.S. Code § 290dd-2, 42 CFR Part 2, and as further described in the Appendix.

PROGRAM DESCRIPTION

The CCBHC program is aligned with West Virginia's shared vision and values.

Shared Vision: We envision a proud West Virginia comprised of healthy, resilient communities, where all individuals are supported, purposeful and hopeful throughout their lifespan.

Core Values:

- Cross-sector collaboration and building upon current planning efforts
- Community engagement
- Evidence-based practices, policies, and programs
- Sustainability
- Data-driven and stakeholder-driven decision-making
- Cultural competency
- Strengths, assets, and protective factors

West Virginia CCBHCs will address three main goals:

1. CCBHCs will provide integrated healthcare services that are evidence-based, trauma-informed, recovery-oriented, and person- and family-centered across a continuum of care and throughout the lifespan of the individual.
2. CCBHCs will increase access to services by offering a comprehensive range of mental health, substance use disorder (SUD), and primary care screening services through systems integration and monitoring.
3. CCBHCs will maintain and expand upon established collaborative relationships with other service providers and healthcare systems to promote effective coordination of care.

In West Virginia, a CCBHC is required to be an LBHC and meet the additional responsibilities required under the national CCBHC model, including the provision of a set of required services to all individuals regardless of residency or ability to pay. CCBHCs are responsible and accountable for providing all CCBHC required services across the lifespan within dedicated geographic regions, representing that region's behavioral health system of care. "Behavioral health" is a general term that encompasses the promotion of emotional health; the prevention of mental health disorders and substance use disorders; and treatments and services for mental and/or substance use disorders.

CCBHCs must directly deliver the majority (51% or more) of encounters across the required services rather than through DCOs. Crisis services are excluded when assessing the proportion of services delivered directly versus through a DCO.

The CCBHC required services are:

- Crisis mental health services, including 24-hour mobile crisis teams, emergency intervention services, and crisis stabilization
- Screening, assessment, and diagnosis, including risk assessment
- Patient-centered treatment planning, including risk assessment and crisis planning
- Outpatient mental health and substance use services
- Outpatient clinic primary care screening and monitoring of key health indicators and health risks
- CCBHC targeted case management
- Psychiatric Rehabilitation Services
- Peer support, counseling, and family support
- Intensive, community-based behavioral healthcare for members of the armed forces and veterans, particularly those members and veterans located in rural areas. Care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the VHA Uniform Mental Health Service Handbook
- All models of Assertive Community Treatment (ACT) as designated by the BMS, and
- Children's Serious Emotional Disorder Waiver (CESDW) services.

POLICY

503I.1 MEMBER ELIGIBILITY

The CCBHC services are available to all Medicaid members with a known or suspected behavioral health disorder.

503I.2 MEMBER CHOICE

All Medicaid members have the right to freedom of choice when choosing a provider for treatment. A member's freedom to choose a provider for any Medicaid-covered service is not limited by the member receiving some or all of their services at a CCBHC. The individual may receive services from one or more CCBHCs or a combination of other providers.

503I.3 MEDICAL NECESSITY

All CCBHC services covered in this Appendix are subject to a determination of medical necessity defined as services and supplies that are:

- Appropriate and medically necessary for the symptoms, diagnosis, or treatment of an illness;
- Provided for the diagnosis or direct care of an illness;
- Within the standards of good practice;
- Not primarily for the convenience of the member or provider; and
- The most appropriate level of care that can be safely provided.

Consideration of these factors in the person-centered treatment planning must be documented and updated, as described in Section 503I.23, Person- and Family-Centered Treatment Planning as necessitated by the members' needs. Diagnostic and standardized instruments may be administered at

the initial evaluation and as clinically indicated. The results of these measures must be available as part of the clinical record, as part of the documentation of the need for the service, and as justification for the level and type of service provided.

503I.4 PROVIDER ENROLLMENT

All Medicaid providers must meet the provider enrollment requirements in *Chapter 300, Provider Participation Requirements*.

503I.4.1 Provider Enrollment

A CCBHC must meet the following requirements:

- Be a nonprofit organization.
- Be an LBHC in good standing with West Virginia Department of Human Services (DoHS).
- Be enrolled as a Medicaid provider in the state of West Virginia.
- Be an LBHC with a CCBHC certification as determined by the West Virginia DoHS.
- Be compliant with all federal, state, and local regulation, certification, and required auditing processes.
- Participate in the SAMHSA Behavioral Health Treatment Locator.

Providers are expected to recertify after three years and will be subject to a site visit.

The BMS reserves the right to terminate certification due to non-compliance of policy, state licensing revocation, or reports of abuse, fraud or other issues that are indicative of improper practice. A decertified CCBHC may reapply for certification upon receipt and approval by BMS of remedial plan that addresses prior deficiencies.

503I.4.2 Electronic Health Records

The CCBHC must have a certified Electronic Health Record (EHR) system. The EHR system must have the capacity to time/date stamp the services needed for auditing. If the CCBHC EHR system cannot currently report the required data, it is the expectation that the applicable CCBHC will make EHR refinements as needed.

The CCBHC must produce a plan to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan shall include information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care, integrating clinically relevant treatment records (evaluation planning, treatment, and care coordination) generated by the DCO for people receiving CCBHC services and incorporating them into the CCBHC health record, and ensure all clinically relevant treatment records maintained by the CCBHC are available to DCOs within the confines of federal and/or state laws governing sharing of health records.

503I.5 PRIVACY AND CONFIDENTIALITY

The CCBHCs must have procedures in place that ensure compliance with HIPAA and 42 CFR (Code of Federal Regulations) Part 2, including requirements specific to minors, pertaining to release of SUD treatment records, and all other state and federal privacy requirements.

The CCBHC policies have explicit provisions for ensuring that all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider, including but not limited to the requirements of HIPAA, 42 CFR Part 2, patient privacy requirements specific to care for minors, and other state and federal laws.

The CCBHC contracts with DCOs must specify the data the CCBHC needs to fulfill the reporting obligations, how and with what frequency that data will be securely transmitted from the DCO to the CCBHC, and that appropriate data-sharing agreements and consent from the person receiving services are in place pursuant to HIPAA, 42 CFR Part 2, and other federal and state privacy requirements.

503I.6 CCBHC COMMUNITY NEEDS ASSESSMENT

Prior to the CCBHC certification and within three years of applying for certification, the CCBHCs must complete a CCBHC Community Needs Assessment, and develop a governance structure and staffing plan that is reflective of the needs and culture of the community they intend to serve.

The CCBHC Community Needs Assessment must address and document the following elements:

- A description of the physical boundaries and size of the service area, including identification of sites where services are delivered by the CCBHC, including through DCOs.
- Information about the prevalence of mental health and substance use conditions and related needs in the service area, such as rates of suicide and overdose.
- Economic factors and social determinants of health affecting the population's access to health services, such as percentage of the population with incomes below the poverty level, access to transportation, nutrition, and stable housing.
- Cultures and languages of the populations residing in the service area.
- The identification of the underserved population(s) within the service area.
- A description of how the staffing plan does and/or will address the findings.
- Plans to update the Community Needs Assessment every three years.
- Input regarding:
    a. Cultural, linguistic, physical health, and behavioral health treatment needs;
    b. Evidence-based practices (EBPs) and behavioral health crisis services;
    c. Access and availability of CCBHC services including days, times, and locations, and telehealth options; and
    d. Potential barriers to care such as geographic barriers, transportation challenges, economic hardship, lack of culturally responsive services, and workforce shortages.
- Input from the following entities if they are in the CCBHC service area:
    e. People with lived experience of mental and substance use conditions and individuals who have received/are receiving services from the clinic conducting the needs assessment;
    f. Health centers, including Federally Qualified Health Centers (FQHCs) in the service area;

g. Local health departments (LHDs) (Note: LHDs also develop community needs assessments that may be helpful);
h. Inpatient psychiatric facilities, inpatient acute care hospitals, and hospital outpatient clinics;
i. One or more Department of Veterans Affairs facilities;
j. Representatives from local K-12 school systems; and
k. Crisis response partners such as hospital emergency departments, emergency responders, crisis stabilization settings, crisis call centers and warmlines.

- The Community Needs Assessment must be completed prior to application for certification of a CCBHC and submitted as part of the application process.
- CCBHCs shall update their Community Needs Assessment prior to applying for re-certification.

503I.7 CCBHC GOVERNANCE

The CCBHCs must have a governance structure that is informed by representatives of the individuals served by the CCBHC. The CCBHC will facilitate and incorporate meaningful participation from individuals with lived experience of mental health disorder and/or SUD, including youth and families. This participation is designed to help ensure that the perspectives of people receiving services, their families, and people with lived experience of mental health and substance use conditions are heard by leadership and incorporated into decision-making processes.

“Meaningful participation” is defined as supporting a substantial number of people with lived experience and family members of people receiving services or individuals with lived experience, so that they can be involved in developing initiatives; identifying community needs, goals, and objectives; providing input on service development and Continuous Quality Improvement (CQI) processes; and budget development and fiscal decision-making. CCBHCs must reflect such participation by one of two options:

Option 1: At least 51% of the CCBHC governing board is comprised of individuals with lived experience of mental health and/or SUD and families.

Option 2: Other means are established to demonstrate meaningful participation in board governance involving people with lived experience, such as creating an advisory committee that reports directly to the board. The CCBHC provides staff support to the individuals involved in any alternate approach that is equivalent to the support given to the governing board.

Under Option 2, individuals with lived experience of mental and/or substance use disorders and family members of people receiving services must have representation in governance that assures input into:

- Identifying community needs and goals and objectives of the CCBHC
- Service development, quality improvement, and the activities of the CCBHC
- Fiscal and budgetary decisions
- Governance (human resource planning, leadership recruitment and selection, etc.)

Under Option 2, the governing board must establish protocols for incorporating input from individuals with lived experience and family members. Board meeting summaries must be shared with those participating in the alternative arrangement and recommendations from the alternative arrangement shall be entered

into the formal board record; participants in processes established under Option 2 must be invited to board meetings; participants must have the opportunity to address the board, share recommendations directly with the board, and have their comments and recommendations recorded in the board minutes directly and regularly.

The CCBHC shall provide staff support for posting an annual summary of the recommendations from the alternate arrangement under Option 2 on the CCBHC website.

503I.8 CCBHC STAFFING REQUIREMENTS

503I.8.1 Management/Executive Team

The CCBHCs must have a management/executive team structure embedded in an organizational chart. The Chief Executive Officer (CEO) of the CCBHC, or equivalent, must maintain a fully staffed management team as appropriate for the size and needs of the clinic, as determined by the current Community Needs Assessment and staffing plan. The management team will include, at a minimum, a CEO or equivalent and a medical director who meets the requirements of "SR 4" in Section 503I.40, CCBHC Criteria of this Appendix. The medical director does not need to be a full-time employee of the CCBHC.

503I.8.2 General Staffing Requirements

The CCBHCs must create and maintain a staffing plan that reflects the findings of the needs assessment. The staffing plan must demonstrate that staff (both clinical and nonclinical) is appropriate in size and composition to meet the clinical, recovery, social determinants of health (SDOH), and care coordination needs of the population, while respecting and supporting the diverse community needs and preferences of the CCBHC service area.

The CCBHCs staff with specific training in serving the population identified in the CCBHC Community Needs Assessment. CCBHCs must document efforts to alleviate any workforce shortages identified in their needs assessment, including recruitment and retention strategies.

The CCBHC must maintain liability/malpractice insurance, adequate for the staffing and scope of services provided. Staff certifications and credentials must be embedded in an organizational chart and listed in the CCBHC application.

503I.8.3 Staffing Plan

1. Medical Director: the CCBHCs must have a medical director with at least two years of mental health and/or SUD experience and expertise. This can be a contracted position. The CCBHC must ensure that the medical director is available to provide services at least 15 hours per week (which may be provided via telehealth). The following practitioners are considered appropriate to serve as a medical director:
    a. Psychiatrist;
    b. Physician with an addiction fellowship;

   c. Physician working toward board certification in psychiatry or addiction. CCBHCs must demonstrate this designee is actively working toward board certification within a two-year period;
   d. Psychiatric nurse practitioner

   If a CCBHC is unable, after reasonable efforts, to employ or contract with any of the above professionals, a medically trained behavioral healthcare provider with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, who can prescribe and manage medications independently, pursuant to state law, may serve as the medical director. 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. “Reasonable efforts” are defined as thorough and documented efforts that do not place an undue financial hardship on the employer.
2. The CCBHC staffing plans must have at least one board-certified psychiatrist or one board-eligible psychiatrist, either employed or available through contract with a DCO, who is able to prescribe all forms of Food and Drug Administration (FDA)-approved medications. When allowed under the provider's license, as appropriate and within their scope of practice, physician extenders trained in behavioral health may be used to satisfy this requirement. The prescriber must be enrolled with West Virginia Medicaid.
3. All sites must have access to a physician or physician extenders. Access is allowable via telehealth.
4. The CCBHC staffing plan must include sufficient state certified (West Virginia Association of Addiction and Prevention Professionals) and credentialed substance use disorder specialists to meet the needs of the CCBHC population, At minimum, the CCBHC staffing plan must include at least one staff with one or more of the following credentials:
   a. Alcohol and Drug Counselor (ADC)
   b. Advanced Alcohol and Drug Counselor (AADC)
   c. National Certified Addiction Counselor Level 1 (NCAC 1)
   d. National Certified Addiction Counselor Level 2 (NCAC 2)
   e. National Clinical Supervision Endorsement (NCSE)
   f. Master Addiction Counselor (MAC)
5. The CCBHC must ensure that all master's level staff working with individuals with a primary SUD diagnosis either have or are actively engaged in a certification track for one of the following: ADC; AADC; NCAC 1; NCAC 2; NCSE; or MAC
6. CCBHCs must have identified on-site clinical staff who can provide treatment for trauma, sexual abuse, eating disorders, suicidality, SUD, SED in children, and SMI in adults, and informed by the treatment planning needs of the individuals being served.
7. CCBHCs must have on-site clinical staff, minimum of master’s level or above in an appropriate clinical discipline (e.g., counseling, social work, psychology, psychiatry).
8. If on-site clinical staff are not available, the CCBHC must have clinical staff available by telehealth, and/or must coordinate transportation of the individual to a site that has the appropriate clinical staff available.

503I.9 CCBHC ADMINISTRATION: STAFF TRAINING

1. The CCBHCs must have policies and procedures in place that describe the initial and ongoing staff training process, how additional employee trainings are identified and how staff training and

competencies are demonstrated and tracked. Training records must be maintained within staff personnel records.

2. CCBHC training plans must require training at new staff orientation and annually thereafter. New staff training must cover, at minimum, the following topics specific to both children and adults:
    a. Risk assessment;
    b. Suicide prevention and suicide response;
    c. Abuse and neglect reporting;
    d. Roles of families and peer staff;
    e. Cultural competence, including protected classes of individuals, as well as other communities identified in the agency's Community Needs Assessment, where applicable;
    f. Provision of care that is person-centered and family-centered, recovery-oriented, evidence-based, and trauma-informed;
    g. Integration of primary care and behavioral healthcare; and
    h. Developing and managing a continuity of operations plan (COOP).
3. Individuals providing training to the CCBHC staff must have the qualifications to do so as evidenced by their education, training, and experience.
4. The CCBHCs must follow all other applicable staff training requirements under this Appendix.

503I.10 CULTURAL AND LINGUISTIC COMPETENCE

The CCBHCs provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse consumers.

Service delivery and staff training shall be informed by and align with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) or similar nationally recognized standard for supporting culturally and linguistically appropriate services. To the extent active-duty military or veterans are being served, services and training must also include information related to military culture. CCBHCs must accommodate or arrange for interpretation and translation services (e.g., bilingual providers, interpreters, and language telephone line) that is appropriate and timely for the size and needs of the client population with Limited English Proficiency (LEP), or vision or hearing-impairment, as identified in the CCBHC's needs assessment.

503I.11 AMERICANS WITH DISABILITIES ACT

The CCBHCs must make all accommodations as required by Title 1 of the Americans with Disabilities Act (ADA) for accessibility tools and approaches for serving individuals with disabilities, including, but not limited to, hearing and sight impairments and cognitive limitations.

503I.12 CRIMINAL BACKGROUND CHECKS

Please see *Chapter 700, West Virginia Clearance for Access: Registry and Employment Screening (WV CARES)* for fingerprint-based background check requirements.

503I.13 CLINICAL SUPERVISION

The CCBHCs must have written policies and procedures that describe the methods used for assessing the skills and competencies of their clinical staff through documented clinical supervision.

503I.14 SERVICE CERTIFICATION REQUIREMENTS

A physician, physician assistant (PA), advanced practice registered nurse (APRN), licensed psychologist, supervised psychologist, licensed professional counselor, and/or licensed independent clinical social worker must certify the need for the CCBHC behavioral health rehabilitation services by signing the "Authorization for Services" form (see Appendix 503 A) within three calendar days of the member's admission to the program for services and prior to the start of treatment.

If an Initial Person-Centered Treatment Plan is created on the day of intake, then a 72-hour authorization form is not required. Upon initiation of the Initial Person-Centered Treatment Plan, the "Authorization for Services" form is no longer in effect since it is no longer necessary. This form, which is filled out by the provider initiating/admitting staff, authorizes the provision of all CCBHC services until the development and initiation of the initial treatment Plan. The initial treatment plan must include all the information that is required on the 72-hour authorization form.

If any CCBHC services are rendered outside the documentation requirements of the forms which authorize services, the services provided are not billable.

503I.15 METHODS OF VERIFYING MEDICAID REQUIREMENTS

Medicaid enrollment requirements, as well as provision of services, are subject to review by the BMS and/or its contracted agents. The BMS-contracted agents may promulgate and update utilization management guidelines that the BMS has reviewed and approved. These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in *Chapter 100, General Information* and *Chapter 800, Program Integrity*, provider manuals; and are subject to review by State and federal auditors.

503I.16 PROVIDER REVIEW

The contracted agent performs on-site, and desk documentation provider reviews and face-to-face member/legal representative and staff interviews to validate documentation and address CMS quality assurance standards. Targeted, on-site CCBHC services provider reviews and/or desk reviews may be conducted by the Office of Health Facility Licensure and Certification (OHFLAC) and/or the Contracted Agent upon receipt of including, but not limited to, Incident Management Reports, complaint data, and Plans of Corrections (POC).

Upon completion of each provider review, the contracted agent conducts a face-to-face exit summation with staff as chosen by the provider to attend. Following the exit summation, the contracted agent will make available to the provider a draft exit report and a POC to be completed by the CCBHC services provider. If potential disallowances are identified, the CCBHC services provider will have 30 calendar days from receipt of the draft exit report to send comments back to the contracted agent. After the 30-day

comment period has ended, the BMS will review the draft exit report, and any comments submitted by the CCBHC services provider and issue a final report to the CCBHC services provider's executive director. The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of CCBHC services.

A cover letter to the CCBHC services provider's executive director will outline the following options to effectuate repayment:

- Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or
- Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or
- A recovery schedule of up to a 12-month period through monthly payments or monthly liens against future payments.

If the provider disagrees with the final report, the provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in *Chapter 100, General Information*, policy manual. The CCBHC services provider must still complete the written repayment arrangement within 30 days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed and set forth in detail the items in contention. The letter must be addressed to the following:

Commissioner
Bureau for Medical Services
Attn: Legal Department/Document Desk Review
350 Capitol Street, Room 251
Charleston, WV 25301

If no potential disallowances are identified during the contracted agent review, then the CCBHC services provider will receive a final letter and a final report from the BMS.

For information relating to additional audits that may be conducted for services contained in this Chapter please see *Chapter 800, Program Integrity*, policy manual which identifies other State/federal auditing bodies and related procedures.

POC: In addition to the draft exit report sent to the CCBHC services provider, the contracted agent will also send a draft POC electronically. CCBHC services providers are required to complete the POC and electronically submit it to the contracted agent for approval within 30 calendar days of receipt of the draft POC from the contracted agent. The BMS may place a pay hold on claims if an approved POC is not received by the contracted agent within the specified time frame. The POC must include the following:

- How the deficient practice for the services cited in the report will be corrected;
- What system will be put into place to prevent recurrence of the deficient practice;
- How the provider will monitor to assure future compliance and who will be responsible for the monitoring;
- The date the POC will be completed; and
- Any provider-specific training requests related to the deficiencies.

503I.17 TRAINING AND TECHNICAL ASSISTANCE

The contracted agent develops and conducts training for providers and other interested parties approved by BMS as necessary to improve systemic and provider-specific quality of care and regulatory compliance. Training is available through both face-to-face and web-based methods.

503I.18 TRAINING AND TECHNICAL ASSISTANCE

The provider must ensure implementation of the BMS policies and procedures pertaining to person-centered treatment planning, documentation, and case record review.

- Uniform guidelines for case record organization must be used by staff, so similar information will be found in the same place from case record to case record and can be quickly and easily accessed. If it is not readily accessible, this could be cause for disallowment.
- Copies of completed release of information forms and consent forms must be filed in the case record.
- Copied or boilerplate language in documentation will not be reviewed and will cause disallowment.
- Records must contain complete member identifying information. The member's individual plan of service must contain service goals and objectives which are derived from a comprehensive member assessment and must stipulate the planned service activities and how they will assist in goal attainment. Discharge reports must be filed upon case closure.
- Records must be legible. Illegible documentation will result in disallowment.
- Prior to the retrospective review, all records requested must be presented to the reviewers completing the retrospective review.
- If requested, the providers must provide electronic access and/or copies of Medicaid members' records within one business day of the request.
- Providers must facilitate the records access that is requested as well as equipment that may need to be utilized to complete the Comprehensive Retrospective Review process.
- A point of contact must be provided by the provider throughout the Comprehensive Retrospective Review process.
- In addition to the documentation requirements described in this Chapter, CCBHC services providers must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Information* and *Chapter 300, Provider Participation Requirements,* provider manuals.
- Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the member.
- Reimbursement is not available for electronic mail message (email), or facsimile transmission (fax) between a provider and a member. Services provided via telehealth must align with requirements in *Chapter 519.17, Telehealth Services.*
- Medicaid will reimburse according to the established PPS for CCBHC covered services and current fee schedule for required services not covered under PPS.
- CCBHCs must have adequate COOP/disaster response plans in place, including, but not limited to, chemical exposure, disease exposure, and natural disasters.

503I.19 TELEHEALTH SERVICES

West Virginia Medicaid encourages providers that have the capability to render services via telehealth to allow easier access to services for its members. The CCBHCs must have the capacity to provide the full range of Medicaid eligible telehealth services for children and adults at all CCBHC and DCO sites that align with the policy in *Chapter 519.17, Telehealth Services* and corresponding appendices. Services in this manual are identified as either "Available" or "Not Available" for telehealth and providers must document when services are rendered under this modality.

503I.20 AVAILABILITY AND ACCESS TO SERVICES

The CCBHCs are required to have policies and procedures in place to facilitate accessibility and access to services in their service area. This section describes access standards specific to current military personnel and veterans, general requirements of access and availability, timely access to services and assessment, access to Crisis Management services, and the provision of services regardless of ability to pay and residence.

Current Military Personnel

All individuals inquiring about services are asked whether they have ever served in the U.S. Military. People affirming current military service will be offered assistance in the following manner:

1. Active-Duty Service Members (ADSM) must use their servicing military treatment facility (MTF). The CCBHC will obtain consent from the individual and contact their MTF primary care managers (PCMs) for a referral outside the MTF when needed.
2. ADSMs and activated Reserve Component (Guard/Reserve) members who reside more than 50 miles (or one hour's drive time) from a military hospital or military clinic enrolled in TRICARE PRIME Remote and use the network PCM or select any other authorized TRICARE provider as the PCM. The PCM refers the member to specialists for care he or she cannot provide and works with the regional managed care support contractor for referrals/authorizations. The CCBHC must accept such referrals.
3. Members of the Selected Reserves, not on active-duty orders, are eligible for all veteran/military insurance programs and can schedule an appointment with any authorized provider, network, or non-network.

Veterans

If an individual affirms they are a veteran, the CCBHC must offer them assistance with enrolling with the VHA for their health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with clinical guidelines contained in the VHA Uniform Mental Health Services Handbook.

503I.20.1 General Requirements of Access and Availability

Clinic Hours

The CCBHC outpatient clinic hours must include evening and weekend hours to meet the needs of the population served and to increase access at times and locations to be determined. A minimum of 8 hours

of service from midnight Friday through midnight Sunday must be provided. These hours will be designated by each agency and must be approved by BMS. CCBHCs will provide outreach and communication to help ensure the community is aware of increased hours of operation/available services.

Core staffing for weekend hours must include a minimum of a masters-level, non-licensed practitioner with access to a licensed physician or physician extender. Providers must have the ability to conduct intake and assessment services, provide supervision, and address other clinical issues that may arise. These services may be made available at a provider's primary practice site or at other locations as long as there is access to transportation and/or telehealth service delivery as appropriate.

Transportation

CCBHCs must have a contract with the state Non-Emergency Medical Transportation (NEMT) broker to provide NEMT services.

Telehealth

CCBHCs must have capacity to provide the full range of CCBHC services eligible for telehealth for children and adults at all CCBHC and through DCO sites as outlined in *Chapter 519.17, Telehealth Services* policy manual.

Referrals from Courts or Division of Corrections and Rehabilitation

To the extent that any state, county, or municipal court has developed service standards, the CCBHC providers must be familiar with, and align the delivery of covered services to conform with applicable voluntary and/or court-ordered services.

When a referral or request comes from the West Virginia DoHS, court system, or from the Division of Corrections and Rehabilitation for an evaluation or assessment, the service must be provided within three business days of the request regardless of payor source.

Services to Individuals Outside of Catchment/Service Area

The CCBHCs must have policies and procedures that help ensure services are not denied to individuals who live outside the CCBHC service area. This includes the provision of crisis services and other needed services, and coordination and follow-up with providers in the individual's home service area. CCBHC policies and procedures shall also help ensure that services will be available to people receiving services living in the CCBHC service area but who reside at some distance from the CCBHC. The CCBHCs must have policies and procedures in place to ensure that individuals are not denied services due to place of residence, homelessness, and/or lack of a permanent address.

503I.20.2 Timely Access to Services and Initial and Comprehensive Evaluation

The CCBHCs must see a child or adult with routine needs within 10 business days of the requested date for service. For individuals presenting an urgent need, an appointment must be provided within one business day.

To identify routine and urgent needs, the CCBHC shall conduct a preliminary triage and risk assessment, as described in this policy. The preliminary triage and risk assessment shall be followed by: (1) an initial evaluation and (2) a comprehensive evaluation, with the components of each as specified in this Chapter Appendix. Comprehensive evaluations shall be completed within 60 days.

Access Standards

The CCBHC shall conduct a standardized and validated preliminary triage and risk assessment when a person makes initial contact with the clinic to request services.

1. If the CCBHC determines that the person has routine needs, the CCBHC shall provide an appointment within 10 business days of receiving the request for services.
    a. The CCBHC shall conduct an initial evaluation for a person with routine needs within 10 business days of receiving the request for services. Per OHFLAC requirements, this initial evaluation shall be conducted no later than 48 hours after admission to the CCBHC.
2. If the CCBHC determines that the person has urgent needs, clinical services shall be provided, including an initial evaluation within one business day of the time the request is made.
    a. An urgent need is one that if not addressed immediately could result in the person becoming a danger to self or others, lead to emergency room or hospital admission, involvement of law enforcement, or cause a health risk.
    b. For those presenting with emergency or urgent needs, if the initial evaluation is conducted telephonically, once the emergency is resolved, the person receiving services should be seen in-person at the next subsequent encounter and the initial evaluation reviewed.

Section 503I.22, Screening, Assessment, and Diagnosis of this Appendix describes additional requirements for performing initial and comprehensive evaluations.

503I.20.3 Timely Access to Crisis Management Services

The CCBHCs must have in place policies and procedures that describe how the CCBHC helps to ensure immediate, clinically directed action, including crisis planning and necessary subsequent outpatient follow-up if and when the risk assessment, screening, or evaluation identifies an emergency or crisis need.

CCBHCs are required to work with the person receiving services at intake and after a psychiatric emergency or crisis to create, maintain, update, and implement the crisis safety plan embedded in the treatment plan.

503I.21 CARE COORDINATION

Care coordination is an activity and an essential feature of the CCBHC model. It is not a distinct service, but a way of delivering care that ensures care is systematically integrated, that necessary communication with other providers and community resources happens routinely, that barriers to care are actively identified and mitigated, that all members of the treatment team have access to timely information needed to provide treatment, and that data, electronic health records, and electronic health information are used

effectively. Care Coordination activities are routine, embedded, and systematic, and serve the entire CCBHC population. It is an expectation of the CCBHC model that any and all individuals receiving services from the CCBHC can benefit from care coordination, regardless of diagnosis or functional acuity.

Care coordination differs from CCBHC Targeted Case Management (TCM). Any individual receiving services at the CCBHC may benefit from care coordination activities. However, people receiving services from the CCBHC who have significant functional impairment and require intensive, individualized supports should be assessed for and referred to CCBHC TCM services as needed. See Section 503I.26, CCBHC Targeted Case Management Services.

CCBHC care coordination can be both population-based and person-specific. Population-based care coordination approaches such as routine review of Admission, Discharge, and Transfer data or closed-loop referral protocols can help coordinate the care of all individuals receiving services from the CCBHC. Person-specific care coordination, such as occasional or time-limited coordination support to an individual who does not meet the criteria for more intensive CCBHC TCM services, would also fall under care coordination.

CCBHC Care Coordination Requirements

CCBHCs are required to coordinate the care of all individuals receiving CCBHC services. Care coordination is an organized set of activities, systems, and tools incorporated into CCBHC management and service delivery and embedded in the treatment delivered to all enrolled CCBHC members. Care coordination is designed to support treatment goals, improve quality of care, and improve the health outcomes of the CCBHC population. Care coordination is provided, when appropriate, in collaboration with the family/caregiver of the person receiving services.

The CCBHCs may not bill for care coordination, but the cost of supporting these activities, systems, and tools for all individuals receiving CCBHC services is included in the CCBHC PPS. CCBHCs must have care coordination policies and procedures that describe:

1. Coordination of services when people receiving CCBHC services present to local emergency departments; including CCBHC procedures upon notification of utilization of Emergency Department services.
2. Involvement of law enforcement.
3. Methods/strategies to reduce delays in initiating services during and after an individual has experienced a behavioral health crisis.
4. Description of how the CCBHC tracks and transitions individuals from settings such as inpatient acute care hospitals and inpatient psychiatric facilities, emergency departments, hospital outpatient clinics, urgent care centers, crisis stabilization units, SUD and mental health residential treatment (all levels) and medical withdrawal management settings, to help insure discharge to accessible and safe community settings, timely transfer of medical records and prescriptions, active linkage and follow-up to services and supports, and, where appropriate, a plan for suicide prevention and safety and for ongoing provision of peer support services.
5. Description of how the CCBHC ensures and documents attempts to contact all individuals receiving CCBHC services who are discharged from the settings specified above within one business day of discharge.

6. To support care coordination activities, all CCBHCs must have a certified EHR, as described under Section 503I.4.2, Electronic Health Records of this Appendix.
7. Description of how the CCBHC identifies and documents medications prescribed by other providers, including protocol for routine consultation and documentation of medications from the West Virginia Controlled Substance Automated Prescription Program (CSAPP), and how, with appropriate consent to release of information, the CCBHC provides such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care.

Care Coordination Activities

Care coordination activities include but are not limited to:

- Convening multi-disciplinary team meetings that review and address behavioral, physical, and health-related social needs, including chronic care needs, for individual members.
- Ensuring members have complete, accurate, and up to date consent forms that comply with state law, HIPAA, and 42 CFR part 2.
- Performing routine referral, linkage, coordination and monitoring of member care across the spectrum of behavioral and physical services and supports as identified in the member's person-centered treatment plan (including services that are not provided directly by the CCBHC), such as physical health (primary, acute, and chronic) and behavioral healthcare, social services, housing, educational and employment supports, and other services to address health-related social needs and facilitate wellness and recovery.
- Follow-up and timely support to ensure seamless transitions to and from levels of care, including inpatient, emergency department, crisis stabilization, ambulatory and medical withdrawal management, post-withdrawal step-down services, and residential programs (unless there is a formal transfer of care to a non-CCBHC entity).
- Supporting freedom of choice for members to choose appropriate providers within the CCBHC unless safety issues are identified or it would be clinically contraindicated.
- Developing a crisis plan with the member, including sharing information about the use of the National Suicide and Crisis Lifeline, local hotlines, warmlines, mobile crisis, and stabilization services should a crisis arise when providers are not in their office. Crisis plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving services. The psychiatric advance directive, if developed, is entered in the member's EHR so that the information is available to providers in emergency care settings where those EHRs are accessible.

Additional care coordination systems and tools may include, but are not limited to:

- Electronic health system tools that provide clinical decision supports;
- Connection to West Virginia Health Information Exchange (WVHIN) to share and review clinical data;
- Systematic use of admission, discharge, and transfer (ADT) data;
- Population health management strategies that use panel-wide clinical and demographic data to identify, track and anticipate member needs, address disparities, and improve CCBHC population health;
- Adoption of care pathways and administrative workflows that support best practices.

Staffing for Care Coordination

Care coordination is a key feature of the CCBHC model. All staff of the CCBHC are required to ensure that individuals experience care that is coordinated across all CCBHC services and functions.

- All Staff:
  - All staff at the CCBHC engage in care coordination activities as described in this section within the scope of their administrative or clinical roles.
  - The CCBHC shall have protocols that describe the respective roles and expectations for administrative and clinical staff for care coordination across the agency.
- Care Coordination Staff:
  - CCBHCs must also have designated care coordinators who perform care coordination activities as part of the clinical team.
  - Designated care coordinators must work within the scope of their practice and meet the qualifications and supervision requirements for Case Managers I and/or II per Section 503I.26 of the Appendix.

Formal Partnerships

The CCBHCs must have an understanding of and formal partnerships with local and state facilities, organizations, resources, and services necessary to support member care as identified in the CCBHC Community Needs Assessment. This includes Veteran's services. These partnerships should strengthen the level of coordination with other agencies and organizations in order to:

- Facilitate timely notification of ADT status to and from settings and levels of care, including inpatient, emergency department, crisis stabilization, ambulatory and medical withdrawal management, post-withdrawal step-down services, residential programs, foster care, and corrections settings;
- Enable routine sharing of clinical and nonclinical information across organizations, as appropriate and within privacy and confidentiality restrictions;
- Strengthen the ability of the CCBHC to provide timely and reliable linkages, referrals, and warm hand-offs to other agencies and providers as needed; and
- Enhance access to resources for health-related social needs, including food, transportation, employment, housing, housing supports, and income assistance.

The CCBHCs must have policies and procedures that describe the CCBHC strategy for formalizing and documenting partnerships with key agencies and organizations that serve the CCBHC identified service area, and for conducting ongoing outreach to maintain and/or expand these partnerships. Key agencies and organizations include but are not limited to:

- Primary care practices, such as FQHCs, free clinics, and Rural Health Clinics (RHCs);
- Specialty care providers for common chronic conditions, Ryan White, and other resources for people with Human Immunodeficiency Virus (HIV), Hospice and Palliative care providers;
- State crisis hotlines such as 988 and HELP4WV, warmlines, help lines and Quick Response Teams (QRTs);
- Inpatient and residential treatment facilities (including child residential), including for substance use, mental health, and veterans;
- Specialty providers of medication for opioid use disorder and alcohol dependence;

- Homeless shelters, housing agencies, and related service providers;
- Local Veterans Administration Hospitals, veteran's centers; the West Virginia Department of Veterans Assistance;
- Indian Health Services and partners;
- Employment services and vocational rehabilitation;
- Local Education Agencies (LEAs);
- Regional Prevention Lead Organizations (PLOs) and Expanded School Mental Health (ESMH) grantees for prevention and clinical services;
- Child welfare agencies, juvenile justice services, youth regional treatment centers, and licensed/accredited child placing agencies for therapeutic foster care services;
- Certified domestic violence centers;
- The Bureau of Senior Services; adult protective services through the Bureau for Social Services; and Aging and Disability Resource Centers (ADRC of West Virginia);
- Law enforcement, local corrections facilities, treatment courts, community corrections;
- Faith-based entities;
- Other social and human services as identified in the CCBHC Community Needs Assessment.

Formal partnerships with residential treatment facilities must include language requiring SUD residential treatment centers to track and report on warm hand-offs to CCBHC providers and any required or applicable measures.

503I.22 SCREENING, ASSESSMENT, AND DIAGNOSIS

The CCBHCs are required to provide screening, assessment, and diagnosis services and must:

- Use standardized, validated and developmentally appropriate screening and assessment tools. Screening and Assessment tools are culturally and linguistically appropriate and accommodate all literacy levels and disabilities as needed.
- When clinically indicated, use brief motivational interviewing techniques to facilitate engagement.

Service Requirements

The CCBHCs must provide the services included in the CCBHC Service Code Matrix in Appendix 503I.2 for Screening, Assessment, and Diagnosis; and meet the current criteria and policy requirements found in the following where applicable:

- Section 503I.20, Availability and Access to Services of this Appendix.
- Section 14 Assessment Services of Chapter 503 Licensed Behavioral Health Centers (LBHC) policy manual,
- Section 12 Testing Services of Chapter 521 Behavioral Health Outpatient Services policy manual

Initial Assessment

The initial assessment, which shall include information gathered during preliminary screening and risk assessment, shall be conducted within 10 business days of initial contact and no later than 48 hours after admission to the CCBHC. The initial assessment shall include, at minimum:

1. Demographic data;

2. Preliminary diagnoses;
3. Medically Necessary Purpose Statement (i.e., indicates a known or suspected behavioral health condition requiring an assessment to determine diagnosis(es) and treatment recommendations;)
4. Reason for seeking care, as stated by the client or other individuals who are significantly involved;
5. Identification of the client's immediate clinical care needs related to the diagnosis for mental health and substance use disorders;
6. Initial evaluation may include brief intervention, and if warranted a full assessment and referral to the appropriate level of care if screening identifies unsafe substance use including problematic alcohol or other substance use.
7. List of current prescriptions and over-the-counter medications, as well as other substances the client may be taking;
8. Assessment of need for medical care (with referral and follow-up as required);
9. Assessment of whether the client is a risk to self or to others, including suicide risk factors;
10. Assessment of whether the client has other concerns for their safety, including screening for intimate partner violence using standardized tools such as Humiliation, Afraid, Rape, and Kick (HARK) questionnaire, Hurt, Insult, Threaten, Scream (HITS); Extended–Hurt, Insult, Threaten, Scream (E-HITS); Partner Violence Screen (PVS); and Woman Abuse Screening Tool (WAST) and clinical observation.
    a. If the screening identifies a more immediate risk to the safety of the person receiving services, the clinician shall document appropriate action as described in Section 503I.20.2, Timely Access to Services and Initial and Comprehensive Evaluation.
11. Determination of whether the person presently is or ever has been a member of the U.S. Armed Services.

Comprehensive Assessment

A comprehensive assessment is required for all people receiving CCBHC services. Clinicians should use their clinical judgment with respect to the depth of questioning within the assessment so that the assessment actively engages the person receiving services around their presenting concern(s). The assessment should gather the amount of information that is necessary and commensurate with the complexity of the individual's or family's specific needs and prioritize the preferences of people receiving services with respect to the depth of evaluation and their treatment goals. The comprehensive evaluation shall include:

1. Demographic data (name, age, date of birth, etc.);
2. Medically Necessary Purpose Statement (i.e., indicates a known or suspected behavioral health condition requiring an assessment to determine diagnosis(es) and treatment recommendations;)
3. Presenting problem(s) (must establish medical necessity for evaluation) including a description of frequency, duration, and intensity of presenting symptomatology that warrants admission;
4. Impact of presenting symptoms on current level of functioning which may include as appropriate a description of activities of daily living, social skills, role functioning, concentration, persistence, and pace; for children, current behavioral and academic functioning;
5. Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments.
6. History of any prior suicide/homicide attempts, high risk behaviors, self-injurious behaviors, etc.;
7. Relevant medical history and major health conditions that impact current. psychological status.

8. Medication list including prescriptions, over-the-counter medications, herbal remedies, dietary supplements, and other treatments or medications of the person receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies, including medication allergies.
9. Social history which may include family history as relevant, description of significant childhood events, arrests, educational background, current family structure, vocational history, financial status, marital history, domestic violence (familial and/or personal), substance abuse (familial and/or personal), military history if any.
10. An overview of relevant social supports; SDOH; and health-related social needs such as housing, transportation, and nutrition; vocational and educational status and needs; family/caregiver/social obligations and supports; legal issues; and insurance status.
11. Assessment of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person.
12. A description of cultural and environmental factors that may affect the treatment plan of the person receiving services, including the need for linguistic services or supports for people with LEP.
13. The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services.
14. Assessment of the need for other services required to be provided by the CCBHC required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services).
15. Assessment of any relevant social service needs of the person receiving services, with necessary referrals made to social services. For children and youth receiving services, assessment of systems involvement such as child welfare and juvenile justice and referral to child welfare agencies as appropriate.
16. An assessment of need for a physical exam or further evaluation by appropriate healthcare professionals, including the primary care provider (with appropriate referral and follow-up) of the person receiving services.
17. The preferences of the person receiving services regarding the use technologies such as telehealth/telemedicine, video conferencing, remote patient monitoring, and asynchronous interventions.
18. Pregnancy and/or parenting status.
19. Mental status examination: The Mental Status Exam must include the following elements:
    a. Appearance
    b. Behavior
    c. Attitude
    d. Level of Consciousness
    e. Orientation
    f. Speech
    g. Mood and Affect
    h. Thought Process/Form and Thought Content
    i. Suicidality and Homicidality
    j. Insight and Judgment
    k. Recommended treatment (initial);

20. Validated screening tool for substance use disorder
21. Diagnostic Impression, (must be approved/signed by licensed clinical professional with diagnostic privileges in scope of practice)
22. Efficacy of and compliance with past treatment. (If past treatment is reported);
23. Past treatment history and medication compliance (If past treatment is reported);
24. Place of assessment, date of assessment, start and stop times, signature, and credentials of evaluator.

503I.23 PERSON- AND FAMILY-CENTERED TREATMENT PLANNING

All members assigned to the CCBHC must have a person- and/or family-centered treatment plan that is developed in collaboration with the CCBHC treatment team, based on information obtained through the risk assessment, screening, and comprehensive assessment, and driven by the individual's and/or family's goals and preferences. The plan must address the person's prevention, behavioral, physical, and health-related social needs.

Person- and Family-Centered Treatment Planning

1. For individuals receiving CCBHC Targeted Case Management, development of the person-centered treatment plan shall align with current criteria and policy requirements found in *Chapter 503 Licensed Behavioral Health Centers,* Section 16 Service Planning Requirements. For these individuals, the initial treatment plan shall be developed within 7 days of intake. The comprehensive treatment plan must be completed within 30 days and updated no less frequently than every 90 days.
2. For individuals receiving services through the CSEDW, development of the treatment plan shall adhere to current Plan of Care criteria, policy, and billing requirements found in *Chapter 502 Children with Serious Emotional Disorder Waiver (CSEDW)*.
3. For all other individuals receiving services at the CCBHC, the treatment plan shall be developed pursuant to this section. The initial treatment plan must be developed within seven days of intake, and the comprehensive treatment plan must be completed within 30 days from the date of the initial plan. The treatment plan shall be reviewed at least every 90 days unless an alternative time frame is specified in the plan, with a rationale explaining the alternate time frame, but shall not exceed 180 days. Notwithstanding any alternative timeframe referenced in the treatment plan, the treatment plan shall be reviewed at any critical treatment juncture.
    a. "Critical treatment juncture" includes occurrences such as:
        i. Significant change in physical or behavioral health diagnoses, anti-psychotic medication, response to treatment, functional status, treatment engagement. And/or treatment goals;
        ii. Utilization of crisis services or emergency department services;
        iii. Transition from inpatient, residential, or other facility-based treatment;
        iv. Corrections or law enforcement involvement related to behavioral health needs;
        v. Homelessness or risk of homelessness;
        vi. Other significant stressors or major life event that may cause exacerbation of physical or behavioral health conditions or symptoms.

Treatment Planning Service Requirements

The CCBHC directly provides Person- and Family-Centered Treatment Planning that meets the current criteria of Section 2402(a) of the Affordable Care Act and incorporates processes and elements outlined in Guidance for Implementing Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs, and is:

- Understandable by the person and/or representative;
- Strengths-based; and
- Documents goals in the person's and/or representative's own words.

The treatment plan is developed by the CCBHC treatment team in collaboration with and endorsed by the member, the adult client's family to the extent the person receiving services directs, or by the family/ caregivers of youth and children.

The treatment plan documents the need for all services and supports delivered to the member by the CCBHC and DCO. The plan may include services, supports, and resources that are not delivered directly by the CCBHC or DCO but will be coordinated by the CCBHC to assist the member in achieving treatment goals. Implementation of the plan is coordinated across CCBHC staff, programs, DCOs, and other internal or external resources necessary to carry out the plan.

The treatment plan will incorporate findings from the initial triage and risk assessment, screening, and evaluation. It shall describe services, supports, and resources necessary to assist the individual in meeting his or her physical and behavioral health goals.

The treatment team should use clinical judgment when developing the treatment plan so that the plan is focused on and actively engages the person receiving services around their presenting concern(s). The treatment plan shall include the components listed below, although the depth and scope of the treatment plan may vary depending on the needs of the individual. For instance, a brief and more narrowly focused treatment plan may be appropriate for individuals with less acute or less complex needs, including individuals who do not meet the criteria for receipt of CCBHC Targeted Case Management.

Treatment Plan Components:

1. Statement or statements of the person- centered, positive, and outcome-oriented goal(s) of services in general terms;
2. Specific objectives that the individual and service provider(s) hope to achieve or complete related to behavioral and physical health, prevention, and health-related social needs, as appropriate. Objectives should be SMART: specific, measurable, realistic, and capable of being achieved in the time available in the projected duration of the program or service.
    a. The measurable objectives should describe steps toward achievement of specified outcomes, with realistic dates of achievement specified for each objective.
3. Modalities, services, interventions and resources and frequency needed to achieve plan goals, which may include:
    a. Identification of and follow-up with necessary medical providers;
    b. Identification of and follow-up with support needs for chronic conditions;
    c. Identification of and follow-up with service and support providers for non-CCBHC services;

   d. Identification of and follow-up with consultation needed beyond CCBHC to address specific and/or complex issues;
   e. Identification of and follow-up with resources for health-related social needs to support treatment goals including transportation, housing, nutrition, vocational and educational needs;
   f. Family, community, and other informal supports.
4. A crisis safety plan and documentation that the member has been provided with information on how to access crisis services, including the 988 Suicide and Crisis Certified Community Behavioral Health Lifeline (by call, chat, or text) and other area hotlines and warmlines, and overdose prevention, if risk is indicated.
5. A psychiatric advance directive, or documentation that the member does not currently want to develop an advanced directive.
6. A date for review of the plan, timed in consideration of the expected duration of the program/service; and
7. A signature page that includes credentials, the date, and start/stop times of attendance of all participants in the development of the plan.

Review of Treatment Plan

When an intervention proves to be ineffective, the treatment plan must reflect consideration by treating provider and/or members of treatment team of changes in the intervention strategy.

A treatment plan review must address whether objectives are to be continued, modified, or discontinued; a summary of treatment provided during the period under review, which addresses barriers to progress and identify whether those barriers are agency or member based.

A physician, PA, APRN, licensed psychologist, supervised psychologist, licensed professional counselor, and/or licensed independent clinical social worker must be present in-person or by telehealth and participate in all treatment planning sessions for members who meet any of the following criteria:

- Receive psychotropic medications prescribed by the agency;
- Have a diagnosis of major psychosis or major affective disorder;
- Have an Intellectual/Developmental Disability (I/DD) diagnosis;
- Have major medical problems in addition to major psychosis and medications; or
- The presence of the physician, PA, or APRN has been specifically requested by the case manager or the member.

Documentation

Documentation must contain the physician, PA, APRN, licensed psychologist, supervised psychologist, licensed professional counselor, and/or licensed independent clinical social worker dated signature and credential on the completed service plan or service plan update and the time spent providing the service by listing the start and stop times of his/her participation.

If the member, their guardian, or the member's requested representative does not attend the service planning meeting, the reason for the member's absence must be documented in the clinical record. If unable to attend, the service plan must be reviewed and signed within seven business days by the

member or their guardian. If the clinical record does not include a valid signature page with required signatures, the service plan will be invalid, and subsequently, no services provided under its auspices will be billable.

Service Requirements: CCBHCs must provide the services included in the CCBHC Service Code Matrix in Appendix 503I.2 for Person-Centered and Family-Centered Treatment Planning; and meet the current criteria and policy requirements found in the *Chapter 503 Licensed Behavioral Health Centers,* Section 16 Service Planning and Requirements.

Service Unit: 15 minutes
Telehealth: Available with GT Modifier
Service Limits: 16 units per 90-day period.
Prior Authorization: Refer to CCBHC Service Code Matrix in Appendix 503I.2
Limitations: Plan of Care development per Chapter 502 CSEDW is reimbursed through that Chapter and may not be billed through the CCBHC PPS per diem rate.

503I.24 OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE SERVICES

The CCBHCs are required to provide outpatient mental health and SUD services and must:

- Have policies and procedures in place to facilitate integration and coordination between SUD and mental health treatment for people with co-occurring conditions.
- Have policies and procedures in place to facilitate integration and coordination between behavioral health treatment and other healthcare, including primary care and care for chronic conditions.
- Have policies and procedures in place that describe intake for new people receiving services that include administration of an evidence-based preliminary screening and risk assessment to determine and act upon the acuity of individuals and their needs in accordance with state and CCBHC standards.
- Operate at least one Intensive Outpatient Program (IOP) for adults and one IOP for children/adolescents with co-occurring mental health and SUD in their service areas.
- CCBHCs must have agreements with SUD treatment providers that have access to FDA-approved Medication Assisted Treatment (MAT) if this service is not available from the CCBHC.
- Support referral, when needed, to outside providers for specialized SUD services, including Opioid Treatment Programs (OTP), SUD residential, SUD withdrawal management, IOP, and peer support services beyond the expertise of the CCBHC through DCOs.

Service Requirements

The CCBHCs must provide all services included in the CCBHC Service Code Matrix in Appendix 503I.2 for Outpatient Mental Health and Substance Use Services; and meet the current criteria and policy requirements found in *Chapter 503 Licensed Behavioral Health Centers,* Sections 17 Therapy and Supportive Services and 23 Behavior Management Services.

503I.25 PRIMARY CARE SCREENING AND MONITORING

The CCBHCs are required to provide outpatient clinic primary care screening and monitoring of key health indicators and health risks.

The CCBHC must have a medical director that oversees the agency's creation of screening protocols based on A and B scores of the United States Preventive Services Task Force Recommendations for the following conditions:

- HIV and viral hepatitis,
- Screening required for clinic-collected quality measures and reporting, per state and federal criteria.

Other clinically indicated key health indicators and or screening protocols, for children, adults, and older adults receiving services, based on the environmental factors, SDOH, and common chronic and physical health conditions experienced by the population of people receiving CCBHC services as informed by the Community Needs Assessment.

Screening protocols shall ensure screening for people receiving CCBHC services who are at risk for common physical health conditions experienced by the CCBHC population across the lifespan and must include:

- Identifying and documenting member's existing for chronic conditions
- Identifying and documenting member's physical health conditions and symptoms
- Establishing systems for collection and analysis of laboratory samples
- Conducting identified screening, as needed
- Identifying and documenting existing primary care provider care or specialty care relationships; if any
- Coordinating regularly with members' primary care and specialty providers to ensure that screenings occur with appropriate frequency for both identified CCBHC priority conditions and for any existing physical health conditions identified by the member

The CCBHCs must be able to collect biologic samples directly, through a DCO, or through protocols with an independent clinical lab organization. Laboratory analyses can be done directly or through another arrangement with an organization separate from the CCBHC.

Service Requirements

Primary care services provided by CCBHCs include outpatient clinic primary care screening and monitoring of key health indicators and health risks. The CCBHC must provide the services included in the CCBHC Service Code Matrix in Appendix 503I.2 for Primary Care Services and meet all pertinent criteria and policy requirements for these services found in *Chapter 519.8 Evaluation and Management Services Section 519.8.1.1 Preventive Care Services and 519.8.1.2 Early Periodic Screening, Diagnosis and Treatment* policy manual.

Service Limits

- If the person receiving CCBHC services has a primary care provider, the CCBHC will coordinate with the member's primary care provider to coordinate care, share pertinent healthcare information, and ensure that no duplication of services occurs.
- The CCBHC billing for physical health services for adults is limited to Evaluation and Management (E&M) CPT codes 99201 – 99205 and 99211 – 99215 and to the billing procedures found in West Virginia's Medicaid-mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program under *Chapter 519.8 Evaluation and Management Services, Section 519.8.1.2 EPSDT* policy manual for children up to 21 years of age.

503I.26 CCBHC TARGETED CASE MANAGEMENT SERVICES (TCM)

The CCBHCs are required to provide CCBHC TCM for children and adults with significant needs who meet CCBHC TCM Criteria. The CCBHCs must follow requirements under this Appendix and may not bill for services under *Chapter 523, Targeted Case Management* policy manual.

The CCBHC TCM is an intensive service designed to meet the needs of children and adults with complex and/or chronic conditions who have substantial functional impairments that inhibit their ability to access or engage in services without support.

The CCBHC TCM is distinct from care coordination. Care coordination is a systematic and organized approach to care delivery, and involves activities, systems, and tools that improve care across the organization and for the entire population receiving services. It is not a billable service. Additional requirements for care coordination are covered under Section 503I.21, Care Coordination of this Appendix.

CCBHC TCM Service Requirements - Eligibility

To receive CCBHC TCM services, individuals must have a serious emotional disorder (SED), a SMI and/or an SUD as well as substantial functional impairment, as follows:

1. Diagnosis(es) within the past 12 months of an SED, an SMI and/or a SUD per the most current Diagnostic and Statistical Manual of Mental Disorders for chronic mental health disorder or substance abuse and:
    a. Demonstrated substantial functional limitations in two or more major life areas as determined by a State-approved nationally validated, standardized assessment instrument(s) appropriate to the age of the individual being assessed. Major life areas are considered based on the age of the child, youth, or adult and may include substantial functional impairment in areas such as ability to work or maintain employment; attend school, study, or learn; make or maintain social, interpersonal, or family relationships; capacity for routine self-care, self-regulation, and control; ability to live independently; and/or
    b. Individual is homeless or at risk of homelessness; has had two or more inpatient admissions or use of emergency department services in the last 12 months due to behavioral health disorder, or two or more law enforcement or corrections involvement due to behavioral health disorder in the past 12 months; and/or
    c. Is transitioning from an inpatient, residential, or corrections settings and at increased risk of poor health or behavioral health outcomes without additional support.

2. Individuals must be reassessed at least annually for functional limitation status to determine continuing medical need.

Service Description

The CCBHC TCM services assist individuals with gaining access to needed behavioral, medical, social, educational services, including health-related social needs, as described in the individual's person- or family-centered treatment plan. Services in the treatment plan may be services delivered by the CCBHC, a DCO, or an external agency.

Linkage and Referral: Linkage, referral, and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:

1. Activities that help link the individual and/or family with needed preventive, behavioral, medical, social, educational, and other health-related services; or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the treatment plan.
2. Facilitating the individual's and/or family's access to the care, services and resources through linkage, coordination, referral, and consultation.
3. Evaluating, coordinating, and arranging immediate services or treatment needed in situations that appear to be emergent in nature or which require immediate attention or resolution to avoid, eliminate or reduce a crisis for a specific individual.
4. Acquainting the individual, his or her parent(s) or legal guardian with resources in the community and providing information.
5. Accessing West Virginia's referral lines, including Help4WV and the Children's Crisis and Referral Line.
6. Documented communication with the member and/or the member's family, legal representative, caregivers, service providers, and other relevant people to help member problem-solve, identify, and address barriers, and assist the individual in choosing and accessing services.

Linkages and referral may be accomplished through in-person and telephone contacts with the individual, their parent(s) or legal guardian, and with service providers and other individuals relevant to the care plan on behalf of the individual. In-person meetings will occur as necessary, but at least every 90 days.

Monitoring and follow-up activities: The CCBHC targeted case manager shall conduct regular monitoring and follow-up activities with the individual, their legal representative, or with other related service providers, including the following:

1. Activities and contacts (either in-person or telephonic) that are necessary to ensure the treatment plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least every 90 days, to determine whether the following conditions are met:
    a. Services are being furnished in accordance with the individual's treatment plan.
    b. Services in the treatment plan are adequate.
    c. Changes in the needs or status of the individual are reflected in the treatment plan, including any necessary adjustments to goals or services.

   d. The individual continues to make progress on the treatment plan goals and objectives and services continue to be appropriate and effective.
   e. The targeted case manager ensures appropriate quality, quantity, and effectiveness of services in accordance with the treatment plan.
   f. The targeted case manager may only utilize and bill for this monitoring component when one of the above components have been utilized and determined to be a valid TCM activity. The amount of time spent to "monitor/follow-up," a TCM service shall not exceed the amount of time spent rendering the valid activity.
   g. This review may result in revision or continuation of the plan, or termination of TCM services if they are no longer appropriate.
2. Documented communication with the member and the member's family, legal representative, caregivers, service providers, and other relevant people identified as necessary to ensure the implementation, update, and/or monitoring of the goals of the individual's treatment plan.

Staffing Requirements

Providers must assure that all staff that provide CCBHC TCM services shall have appropriate training and supervision and meet one of the following qualifications:

Case Manager I

1. Associate degree in a human services field; **or**
2. High school diploma and two years' experience working in a behavioral health setting or as a certified peer support provider **and**
3. Documentation in employee file of completion of a State-approved TCM training that consists of core TCM concepts, such as:
   a. Plan implementation and coordination
   b. Monitoring and reassessment
   c. Engagement and facilitation skills
   d. Regulation: Privacy, confidentiality, client rights, documentation
4. Works under the supervision of and receives regularly scheduled supervision from a case manager II with at least two years of full-time experience as a case manager in a behavioral health setting.
5. "Regularly scheduled supervision" means the following: a minimum of two hours of individual supervision and one hour of group supervision per month. This supervision must be documented.

Case Manager II

1. A psychologist with a masters' or doctoral degree from an accredited program
2. A licensed social worker
3. A licensed registered nurse
4. A master's or bachelor's degree granted by an accredited college or university in one of the following human services fields:
   a. Psychology;
   b. Criminal Justice;
   c. Board of Regents with health specialization;
   d. Recreational Therapy;

e. Political Science;
f. Nursing;
g. Sociology;
h. Social Work;
i. Counseling;
j. Teacher Education;
k. Behavioral Health;
l. Liberal Arts or other Degrees approved by the West Virginia Board of Social Work.

Documentation

Providers maintain case records that document the following for all individuals receiving CCBHC TCM:

- The name of the individual and parents or guardians, as appropriate;
- The dates of the CCBHC TCM services;
- The nature, content, units of CCBHC TCM services received and whether goals specified in the treatment plan have been achieved;
- Whether the individual has declined services in the treatment plan;
- The need for, and occurrences of, coordination with other case managers;
- A timeline for obtaining needed services; and
- A timeline for reevaluation of the plan.

The CCBHC must provide the services included in the CCBHC Service Code Matrix in *Appendix 503I.2, CCBHC Service Codes* for CCBHC TCM services and meet all pertinent criteria and policy requirements for services in the Appendix.

Service Unit: 15 minutes
Telehealth: Yes, excluding the 90-day face-to-face contact
Prior Authorization: Refer to CCBHC Service Code Matrix in *Appendix 503I.2, CCBHC Service Codes*

If, between regular service planning sessions, the member requires access to a service not previously mentioned on the case management section of their service plan, both the member (or their legal guardian) and their CCBHC targeted case manager must agree and attach an addendum signed and dated by the targeted case manager and the member (or their legal guardian) addressing the needed service to the plan. For continued eligibility one valid TCM activity must be rendered for the member at least every 30 days.

The case manager must have at least one face-to-face contact for a valid TCM activity with the member every 90 days. Any TCM service may be conducted via telehealth except for the 90-day face-to-face encounter with the targeted case manager.

503I.27 PSYCHIATRIC REHABILITATION SERVICES

CCBHCs are required to provide psychiatric rehabilitation services and must provide services included in the CCBHC Service Code Grid in *Appendix 503I.2, CCBHC Service Codes* for Psychiatric Rehabilitation Services; and meet the current criteria and policy requirements found in *Chapter 503 Licensed Behavioral*

Health Centers (LBHC), Section 20 Comprehensive Programs and Services and Section 21.2 Community Psychiatric Supportive Treatment.

503I.28 PEER SUPPORTS AND FAMILY CAREGIVER SUPPORTS

Procedure Code: H0038
Modifier Code: HE – Mental Health
Modifier Code: HA – Family Peers
Service Units: 15 minutes
Prior Authorization: Refer to CCBHC Service Code Matrix in Appendix 503I.2
Telehealth: Available
Limitations: Group peer support services are not a covered service. CCBHCs may not be reimbursed for peer support services except for services described in this Appendix.

The CCBHCs are required to provide individual, and family/caregiver supports for people with or effected by SED, SMI, or SUD. CCBHCs must provide the services included in the CCBHC Service Code Grid in *Appendix 503I.2, CCBHC Service Codes* for Peer Supports and Family Caregiver Supports.

Service Requirements

For Peer Recovery Support Services for SUD, the CCBHCs must meet the current criteria and policy requirements found in *Chapter 504 Substance Use Disorder Services, Section 15 Peer Recovery Support Services* policy manual.

For Peer Parent Supports, CCBHCs must meet the current criteria and policy requirements found in *Chapter 502 Children with Serious Emotional Disorder Waiver, Section 502.25.3* policy manual.

Peer Support Services for Mental Health Disorder: A Peer Support for Mental health disorders is an individual who shares the direct experience of recovery from a mental health disorder. Peer recovery support services are strengths-based, non-clinical services that assist individuals in their recovery and support goals as identified in the individual's person-centered treatment plan. Peers use their lived experience, in addition to skills learned in formal training, to provide a range of nonclinical supports that may include: assisting individuals in developing their goals, assisting an individual in identifying services and activities that promote recovery and lead to increased meaning and purpose, sharing their own recovery stories that are relevant and helpful in overcoming the obstacles faced by other people with mental health disorders, promoting personal responsibility for recovery, serving as an advocate, and modeling skills in recovery and self-management. Services are delivered in a trauma-informed, culturally responsive, person-centered, recovery-oriented manner.

Family Peer Support Services (FPSS): A FPSS is an individual who shares the direct experience of a parent, family member, or caregiver who has navigated child or adult serving systems on behalf of their family member with social, emotional, developmental, health and/or behavioral healthcare needs. FPSS services are strengths-based, nonclinical services that assist individuals and families in their recovery and support goals as identified in the individual's person- or family-centered treatment plan. The FPSS uses their lived experience, in addition to skills learned in formal training, to provide a range of nonclinical supports that may include assisting families/caregivers in developing goals, sharing their own stories that

are relevant and helpful in overcoming the obstacles, serving as an advocate, and assisting families/caregivers in understanding systems and services. The FPSS provides a structured, strength-based relationship between a family peer support provider and the parent/family member/caregiver for the benefit of the individual with social, emotional, developmental, health and/or behavioral healthcare needs. Services are delivered in a trauma-informed, culturally responsive, person-centered, recovery-oriented manner.

Role Description: The primary role of Peer Support Services and Family Caregiver Support Services is to assist the CCBHC member in overcoming barriers and helping them bridge the gaps between their needs and available resources in their community to make progress in their recovery and/or the recovery of their loved one. The PRSS-MI and the FPSS providers are individuals who have the respective qualifications, education, and established experience to provide these services.

Services
Services shall be delivered in accordance with the person- or family-centered treatment plan. All services provided must be documented. Services include:

1. Advocacy and self-advocacy support for individuals/families
2. Sharing resources
3. Skill-building
4. Crisis support
5. Building community and relationships
6. Leading recovery groups or family groups that provide information, education, and training
7. Mentoring and helping to identify and set goals

Staffing Requirements
To deliver services, the PRSS-MI and the FPSS must have received certification and be in good standing by a certifying body as identified by BMS and/or receive training to provide these services, as approved by BMS. Supervision shall be described in the CCBHC Staffing Plan.

Peers shall not perform services outside of the boundaries and scope of their expertise, shall be aware of the limits of their training and capabilities, and shall collaborate with other professionals and recovery support specialists to best meet the needs of the member and/or family served.

In addition to certification or training as approved by BMS, Other requirements include:

1. Current CPR/First Aid card.
2. Fingerprint-Based Background Check. Please see *Section 4 Fingerprint-Based Background Checks, Chapter 504 Substance Use Disorder Services* for more information.
3. The individual must be employed by either a CCBHC or LBHC.
4. Documentation of all requirements, including certification, must be maintained in the PRSS personnel files by the CCBHC.

Documentation
Documentation report must be maintained in the member's record and contain the following:

1. Member name and family/caregiver name, if applicable;
2. Date, location, and start/stop time of service/meeting;
3. Signature and credentials of the staff providing the service;

4. Activity note (describing each activity per service description above) and relationship to specific objectives in the service plan.

CCBHC must provide the services included in the CCBHC Service Code Matrix in Appendix 503I.2 for Peer Services.

503I.29 COMMUNITY CARE FOR UNIFORMED SERVICE MEMBERS AND VETERANS

CCBHCs are required to ensure services to U.S. Military and Veterans. Services must be provided directly by the CCBHC. CCBHCs services provided to service members, veterans, and their families must be recovery-oriented and consistent with VHA recovery and with mental health and substance use disorders guidelines promulgated by the VHA, including clinical guidelines contained in the Uniform MH/SUD Handbook of such administration.

CCBHCs must have formal partnerships with the West Virginia Department of Veterans Assistance and local Veterans Administration Hospitals and vet centers as required under *Section 503I.21, Care Coordination* of the Chapter Appendix.

Service Requirements
CCBHCs must ask all recipients inquiring about or requesting services whether they have ever served in the U.S. Military. For those individuals who report that they have served in the military, the CCBHC must offer assistance enrolling in the VHA programs and ensure veterans and AD military receive the required CCBHC services. Every veteran identified for behavioral health services must be assigned to a Principal Behavioral Health Provider. This provider maintains regular contact with the individual and coordinates behavioral healthcare across providers of different specialties to ensure the following requirements are fulfilled:

1. Regular contact is maintained with the veteran as clinically indicated if ongoing care is required.
2. A psychiatrist or such other independent prescriber satisfies the current requirements of the VHA Uniform Mental Health Services Handbook reviews and reconciles each veteran's psychiatric medications on a regular basis.
3. Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision-maker's consent when the veteran does not have adequate decision-making capacity).
4. Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained.
5. The treatment plan is revised, when necessary.
6. The principal therapist or Principal Behavioral Health Provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision-making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral healthcare treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2).

7. The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the Principal Behavioral Health Provider has reason to believe the veteran lacks the capacity to decide about the mental health treatment plan, the provider must ensure the veteran's decision-making capacity is formally assessed and documented. When it is determined that a veteran lacks capacity, the provider must identify the authorized surrogate and document the surrogate's verbal consent to the treatment plan.

Staff Requirements
CCBHCs' staff who are not service members or veterans and who work with military or veteran people receiving services must be trained in cultural competence, including specific information related to active military and veteran culture.

CCBHCs should include a veteran liaison embedded in their organizational chart to help ensure engagement in the veteran communities, organizations, and increase access for veterans in their service area.

Documentation
When veterans are seeing more than one behavioral health provider and when they are involved in more than one program, the identity of the Principal Behavioral Health Provider must be made clear to the veteran and identified in the health record. The Principal Behavioral Health Provider is identified on a tracking database for those veterans who need case management.

503I.30 BEHAVIORAL HEALTH CRISIS SERVICES

CCBHCs are required to:

1. Work with the person receiving services at intake and after a psychiatric emergency or crisis to create, maintain, update, and implement the crisis safety plan embedded in the treatment plan.
2. Provide same-day access to crisis services for children and adults with emergent behavioral health needs and maintain an average of one hour for such access following completion of the initial call to the toll-free hotline. These crisis services must be available and accessible 24 hours a day/365 days a year.
3. Establish access to a Crisis Stabilization Unit (CSU) for individuals with mental health and/or co-occurring SUD.
4. Track and report to BMS quarterly on same-day access to crisis services for children and adults, with an average of one hour for such access following completion of the initial call to the toll-free hotline. Reporting will be submitted in a standardized format to be provided by BMS.
5. Ensure that policies and procedures include a description of methods used for providing a continuum of crisis prevention, response, and post intervention services:
    a. Methods must include a description of the continuum of care and how to access the services, including but not limited to, the 988 Suicide and Crisis Lifeline (by call, chat, or text) and other area hotlines and warmlines, and overdose prevention services. This information must be available to the public and compliant with the requirements as described under Section 503I.10, Cultural and Linguistic Competence of this Chapter Appendix.

6. Have policies and procedures that help ensure that crisis services are not denied to those who live outside the CCBHC service area.

Service Requirements
CCBHCs must provide the services included in the CCBHC Service Code Matrix in Appendix 503I.2 for Crisis Services; and meet the current criteria and policy requirements found in Appendix 503H Community-Based Mobile Crisis Intervention Services policy manual.

503I.31 LABORATORY SERVICES

To fulfill the requirements under Section 503X.25, Primary Care Screening and Monitoring, the CCBHC must have the ability to collect biologic samples directly, through a Memorandum of Understanding (MOU), or other formal partnership, or through protocols with an independent clinical lab organization. Laboratory analyses can be done directly or through another arrangement with an organization separate from the CCBHC.

CCBHCs must have the capacity to provide the following either directly, through an MOU, or other formal partnership, or through referral to an independent clinical lab organization:

1. Lipid Panel
2. Triglycerides
3. Total Cholesterol
4. Hemoglobin A1C
5. Glucose blood test
6. HIV
7. Urinalysis
8. Presumptive Drug Testing

Service Requirements
CCBHCs must meet the current criteria and policy requirements found *Section 1.1 Laboratory Services*, *Section, 1.2 Pathology Services*, and *Section 1.3 Specimen Collection*, *Chapter 529 Laboratory and Pathology Services* policy manual.

503I.32 ASSERTIVE COMMUNITY TREATMENT (ACT)

CCBHCs are required to have at least one ACT team, as described under *Section 22 Assertive Community Treatment, Chapter 503 Licensed Behavioral Health Center (LBHC)* policy manual, to help ensure that individuals who appear to meet the current criteria have access to services in the community instead of having to rely on institutional facilities.

Limitations
CCBHCs are required to seek reimbursement using State Plan ACT policies and codes and cannot be reimbursed using the CCBHC per diem rate.

503I.33 CSED 1915C WAIVER SERVICES

CCBHCs are required to be an active CSED Waiver provider and be in compliance with all CSED Waiver

requirements as described under *Chapter 502 Children with Serious Emotional Disorder Waiver (CSEDW)* policy manual.

Limitations
CCBHCs are required to seek reimbursement using 1915c CSED Waiver policies and codes and cannot be reimbursed using the CCBHC per diem rate except for peer parent support for established CCBHC members.

503I.34 SERVICE LIMITATIONS

Service limitations governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 100, General Information* of the Provider Manual.

503I.35 SERVICE EXCLUSIONS

In addition to the exclusions listed in Chapter 100, General Information and Section 503.26, Service Exclusions, reimbursement from BMS is not allowed for the following services:

1. CCBHC must provide all nine required CCBHC services to all individuals who meet medical necessity for these services, regardless of ability to pay, but may not seek Medicaid reimbursement for services provided to non-Medicaid members. ACT, CSU, and CSED services are exempt from this requirement.
2. Encounters for non-Medicaid clients will be calculated in the PPS rate setting process. In addition to the nine required services, services to non-Medicaid clients will be delivered in alignment with the CCBHC model, including care coordination and integrated care.

503I.36 DESIGNATED COLLABORATING ORGANIZATION (DCO)

A DCO is a distinct legal entity, not under the direct supervision of the CCBHC, that delivers one or more CCBHC required services on behalf of the CCBHC per a contract, MOU, Memorandum of Agreement (MOA) or similar written agreement. The relationship between CCBHC and DCO creates the platform for seamlessly integrated services delivered across providers under the umbrella of a CCBHC.

Certain CCBHC required services may be provided by a DCO. These include Developmental Testing; Neurobehavioral Status Exam; Psychological Testing Evaluation Services; Neuropsychological Testing Evaluation Services; and Psychological or Neuropsychological Test Administration and Scoring.

CCBHCs must refer to the CCBHC Service Code Matrix in Appendix 503I.2 for the specific services and appropriate codes that may be provided by a DCO.

DCO Documentation
The CCBHC and DCO relationship is evidenced by a contract, MOA, MOU, or other formal, legal arrangement describing the parties' mutual expectations and establishing accountability and standards for services to be provided.

Services received through a DCO should be part of a coordinated package with other CCBHC services and not simply referring the individual to a different service provider. All DCO documentation must be

reviewed and updated annually as needed. DCO documentation must clearly define the roles and responsibilities of both the CCBHC and DCO. DCO agreements shall include provisions that require the DCO to deliver CCBHC services in a manner that meets the standards set in the most current West Virginia CCBHC certification criteria.

DCO Documentation Requirements

1. DCO documentation must be attached to the CCBHC application and must include the DCO NPIs.
2. DCOs must be an enrolled Medicaid provider.
3. DCOs may only deliver and receive reimbursement through a CCBHC if proper DCO – CCBHC documentation is in place prior to service delivery.
4. CCBHCs must inform BMS of any new DCO relationships within 30 days and provide BMS with completed documentation.

DCO Service Requirements

1. From the perspective of the person receiving services and their family members, services received through a DCO should be part of a coordinated package with other CCBHC services and not simply accessing services through another provider organization.
2. DCOs and CCBHCs must take active steps to reduce administrative burden on people receiving services and their family members when accessing DCOs services through measures such as coordinating intake process, coordinated treatment planning, information sharing, and direct communication between the CCBHC and DCO to help prevent the person receiving services or their family from having to relay information between the CCBHC and DCO.
3. CCBHCs and their DCOs must work toward inclusion of additional integrated care elements (e.g., including DCO providers on CCBHC treatment teams, collocating services).
4. CCBHC services provided by DCOs must meet the same quality standards as those required of the CCBHC. If the DCO no longer meets the quality standards, the CCBHC must terminate the contract and contract with a new DCO or the CCBHC must provide the service directly.

Reimbursement

Payment for DCO services is included within the CCBHC PPS, and DCO encounters are treated as CCBHC encounters for purposes of the PPS. The NPI of the rendering DCO provider is included on the claim when the CCBHC bills for any DCO-delivered service.

To the extent that services are needed by an individual or their family that cannot be provided by either the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for care coordination including services to which it refers. Payment for those referred services is not through the PPS but may be made through existing reimbursement mechanisms within Medicaid or other funding sources.

503I.37 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention requirements governing the provision of all WV Medicaid services will apply pursuant to *Chapter 100, General Information* and *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual. Providers of CCBHC services must comply, at a minimum, with the following documentation requirements:

1. Providers must maintain a specific record for all services received for each WV Medicaid eligible member including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current treatment plan signed by the provider, signature and credentials of staff providing the service, designation of what service was provided, documentation of services provided, the dates the services were provided, and the actual time spent providing the service by listing the start and stop times as required by service.
2. Signature and credentials of staff providing the service, designation of what service was provided, documentation of services provided, the dates the services were provided, and the actual time spent providing the service by listing the start and stop times as required by service.
3. All required documentation must be maintained for at least five years in the provider's file subject to review by authorized BMS personnel. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.
4. Failure to maintain all required documentation may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to BMS upon request.
5. CCBHCs must ensure that consent documentation is regularly offered, explained, and updated. If the CCBHC is unable, after reasonable attempts, to obtain consent for any care coordination activity, such attempts must be documented and revisited periodically.
6. CCBHCs must comply with all specific documentation requirements applicable to the CCBHC criteria or service, as described elsewhere in this Appendix.

503I.38 BILLING PROCEDURES

Claims from providers must be submitted on the BMS designated form or electronically transmitted to the BMS fiscal agent and must comply with requirements set forth in *Section 503.30, Billing Procedures*. Providers should assign revenue codes for the UB-04 claim form.

CCBHCs will utilize the T10140 code in conjunction with one of the CCBHC service category codes.

CCBHC encounters must be submitted with the T1040 code in addition to all service category codes for the individual seen for the date of service being submitted. If a claim is submitted with the T1040 code and no other code the claim will be denied, and no payment will be rendered. It is expected that the CCBHC will follow-up on denied claims for reprocessing when the denial is a result of an error.

503I.39 REIMBURSEMENT METHODOLOGY

Prospective Payment System (PPS)
All CCBHCs shall be reimbursed on a daily PPS rate for services delivered by a CCBHC. The calculation of PPS will conform to Section 223 of the Protecting Access to Medicare Act (PAMA).

PPS is a cost-based, per clinic daily rate that applies uniformly to all CCBHC services rendered by a certified clinic. The PPS rate is based on each facility's average cost of providing services to all clients, regardless of payer. The PPS is paid when a CCBHC delivers at least one CCBHC triggering service, and when a valid procedure code for the service is reported for the day.

The BMS bases CCBHC reimbursement on the CMS approved Medicaid SPA. CMS only permits reimbursement based upon reasonable costs for services defined in the West Virginia Title XIX State Plan. Reasonable costs do not include unallowable costs, which are expenses incurred by a clinic that are not directly related to the provision of covered services, according to applicable laws, rules, and standards. Allowable costs must be reasonable and necessary and may include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of the CCBHC services.

The payment rate for CCBHC services is based on the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. Allowable costs include the salaries and benefits of Medicaid providers, the cost of services provided per the DoHS, and other costs such as insurance or supplies needed to provide CCBHC services. Indirect costs include site and administrative costs associated with providing CCBHC services. For the purposes of calculating rates, visits include all visits for CCBHC services including both Medicaid and non-Medicaid visits. Allowable costs are identified using requirements in 45 CFR §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement. CCBHCs must provide data on costs and visits to the BMS or its successor annually using the CMS CCBHC cost report or currently authorized template. Annual CCBHC cost reports based on audited financials shall be submitted to BMS annually. Upon receipt from the CCBHC, the cost reports are reviewed by a Certified Public Accounting (CPA) firm. Upon acceptance of the CCBHC cost reports from the accounting firm, BMS sets the rates for the following rate year. The rate year follows the calendar year.

Initial Payment Rates: The BMS will establish a provider-specific bundled daily payment rate using audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period. The initial rates include expected costs and visits that are subject to review by a CPA and the state. The bundled daily rate is calculated by dividing the total annual allowable expected costs of CCBHC services by the total annual number of expected CCBHC Medicaid and non-Medicaid visits.

Rebasing and Inflation Adjustments: CCBHC payment rates are rebased after the first two rate periods and every three years following the last rebasing thereafter. Rates are rebased by dividing the total annual allowable CCBHC costs from the CCBHC's most recent 12 month audited cost report by the total annual number of CCBHC Medicaid and non-Medicaid visits during that 12-month time period. The resulting rate is trended from the midpoint of the cost report period to the midpoint of the rate year using the Medicare Economic Index (MEI). Initial payment rates are rebased once the CCBHC submits the first audited cost report including a full year of actual cost and visit data for CCBHC services under the State Plan. Rates are rebased using actual data on costs and visits. Rebased rates take effect the following January, and the State does not reconcile previous payments to cost. Payment rates are updated between rebasing years by trending each provider-specific rate by the MEI for primary care services. Rates are trended from the midpoint of the previous calendar year to the midpoint of the following year using the MEI.

Quality Bonus Payment (QBP): CCBHCs may be eligible for a QBP based on reaching specific numeric thresholds on State-identified performance metrics. Any QBP would be in addition to payments under the

bundled payment rate and paid to CCBHCs that achieve specific performance thresholds as identified by the state. CCBHCs would need to achieve thresholds on all identified quality measures in order to be eligible for a QBP. To participate in a QBP program, CCBHCs will need to demonstrate the ability to submit electronic data to BMS in a form, with sufficient detail, and for a defined period of time to determine QBP eligibility. QBPs will be calculated for each CCBHC pursuant to published BMS rule.

Fee for Service (FFS) Reimbursement
With the exception of non-reimbursable services listed under *Section 503I.35, Service Exclusions* of this Appendix, required CCBHC services not reimbursed under the PPS are paid at the appropriate fee schedule amount, including services described under *Chapter 502, Children with Serious Emotional Disorder Waiver (CSEDW)* and *Section 22, Assertive Community Treatment (ACT), Chapter 503 Licensed Behavioral Health Center (LBHC)* policy manuals.

Refer to *Chapter 300, Provider Participation Requirements* and *Chapter 600, Reimbursement Methodologies*, policy manuals for additional information related to reimbursement.

503I.40 CCBHC CRITERIA

The following section describes the standards that CCBHCs must meet to become certified to deliver CCBHC services in the state of West Virginia. Criteria are organized as follows:

- General Service Provisions/Scope of Services (SS)
- Staffing Requirements (SR)
- Availability and Accessibility of Services (AA)
- Care Coordination (CC)
- Quality and Other Reporting (QR)
- Organizational Authority, Governance, and Accreditation (OAG)

Specific criteria within these sections are each assigned a number. These numbers are referenced within this appendix and in the WV CCBHC Certification Application.

CCBHCs must deliver all required services directly or, where permitted, through Designated Collaborating Organizations (DCOs). Whether services are delivered by the CCBHC or by a DCO, the CCBHC is clinically responsible for all care provided. The scope of services provided by the CCBHC will be determined during the WV CCBHC certification process and reflect the needs of their community. The CCBHC has responsibility and accountability for the clinical care of all individuals receiving CCBHC services through their organization. It is expected that CCBHCs will be designed so most services are provided by the CCBHC rather than by DCOs as this will enhance the ability of the CCBHC to coordinate services.

General Service Provisions/Scope of Services (SS 1 – SS 7)

- **SS 1** The following services are explicitly included among CCBHC services that are provided directly for the provision of crisis behavioral health services:
  1. 24-hour mobile crisis teams
  2. Emergency crisis intervention services
  3. Crisis stabilization services

4. Suicide crisis response
5. Services for substance use crisis and intoxication, including ambulatory and medical detoxification services of the person receiving services immediate clinical care needs related to the diagnoses for mental and substance use disorders
6. A list of current prescriptions and over-the-counter medications, as well as other substances the person receiving services may be taking
7. An assessment of whether the person receiving services is a risk to self or to others, including suicide/homicide risk factors
8. An assessment of whether the person receiving services has other concerns for their safety
9. Assessment of need for medical care (with referral and follow-up as required)
10. A determination of whether the person presently is or ever has been a member of the U.S. Armed Services
11. Other assessment as the state may require as part of the initial evaluation

- **SS 2** All DCO documents must be reviewed annually and updated as needed. The DCO documentation must clearly define roles and responsibilities of both the CCBHC and DCOs/Health and Non-Health partnering agencies.
- **SS 3** CCBHCs must have a formal policy and procedure to help ensure people receiving services and families have access to benefits, including Medicaid, and help enroll them in programs or supports that may benefit them.
- **SS 4** Referrals can be made to outside providers for specialized SUD services, including Opioid Treatment Program (OTP), SUD residential services, SUD withdrawal management SUD detox, treatment, IOP, and peer support services beyond the expertise of the CCBHC through formal relationship.
- **SS 5** CCBHCs must have a formal policy and procedure to help ensure people receiving services are fully informed of, and have access to, CCBHC grievance procedures and independent advocacy services, including for CCBHC services provided by a DCO. Grievance procedures must be provided in an intake package for people receiving services and posted in CCBHC waiting area and website.
- **SS 6** CCBHCs services provided by a DCO must meet the same quality standards as those required of the CCBHC. If the DCO no longer meets the quality standards, the CCBHC must terminate the contract and contract with a new DCO or the CCBHC must provide the service directly.
- **SS 7** CCBHCs must have at least one IOP program for adults and one program for children/adolescents with co-occurring mental health and SUD to serve in their service area.

Crisis Behavioral Health Services (SS 8 – SS 11)

- **SS 8** CCBHCs will provide same-day access to crisis services for children and adults with emergent behavioral health needs and maintain an average of one hour for such access following completion of the initial call to the toll-free hotline. These crisis services are available and accessible 24 hours a day/365 days a year.
- **SS 9** CCBHCs must establish access to a CSU for adults (and children when available) with emergent behavioral health needs, including providing or facilitating transportation as necessary.
- **SS 10** CCBHCs must track and report to BMS quarterly on same-day access to crisis services for children and adults, with an average of one hour for such access following completion of the initial

call to the toll-free hotline. Reporting will be submitted in a standardized format to be provided by BMS.

- **SS 11** CCBHCs must include a description of methods used for providing a continuum of crisis prevention, response, and post intervention services in their policies and procedures. This includes the continuum of care and how to access the services, including but not limited to the 988 Suicide and Crisis Lifeline (by call, chat, or text) and other area hotlines and warmlines, and overdose prevention services. The CCBHC must make this information available to the public and in compliance with SR 20 and SR 21.

Screening, Assessment, and Diagnosis (SS 12 – SS 14)

- **SS 12** CCBHCs must use standardized, validated, evidence-based, culturally, and age-appropriate screening and assessment tools, and, where appropriate, motivational interviewing techniques.
- **SS 13** CCBHCs must routinely screen for intimate partner violence by using standardized tools such as HARK questionnaire, HITS; Extended–Hurt, Insult, Threaten, Scream (E-HITS); PVS; and WAST and clinical observation.
- **SS 14** If screening identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the person receiving services is provided a full assessment and treatment, if appropriate within the level of care of the CCBHC or referral to the more appropriate level of care. If the screening identifies more immediate threats to the safety of the person receiving services, the CCBHC will take appropriate action as described in AA8, AA9, and AA10.

Person-Centered and Family-Centered Treatment Planning (SS 15 – SS 17)

- **SS 15** CCBHCs are advised to seek clinical consultation for complex cases, with the results of such consultation included in the person/family-centered treatment plan.
- **SS 16** The person's health record shall document any advance directives related to treatment and crisis planning. If the person receiving services does not wish to share their preferences, that decision must be documented.
- **SS 17** The person-centered and family-centered treatment plan must be reviewed and updated as needed by the treatment team, in coordination with DCOs, and any community providers. Treatment plan development must be developed with and endorsed by the person receiving services; their family (to the extent the person receiving services so wishes); and family/caregivers of youth and children or legal guardians and coordinated with staff or programs necessary to carry out the plan. The CCBHC must develop an individualized treatment plan based on information obtained through the comprehensive evaluation and reflect the person receiving services' goals and preferences. The plan must address the person's prevention, medical, and behavioral health needs. The treatment plan must be updated when changes occur with the status of the person receiving services, based on responses to treatment or when there are changes in treatment goals.

Outpatient Mental Health and Substance Use Services (SS 18– SS 20)

- **SS 18** The CCBHC must help ensure there is integration or coordination between the care of substance use disorders and other mental health conditions for those individuals who experience

both, and for integration or coordination between care for behavioral health conditions and other components of their health care.

- **SS 19** CCBHCs must provide services for children and adults across their lifespan.
- **SS 20** Policies and procedures for new people seeking services shall include administration of an evidence-based preliminary screening and risk assessment to determine and act upon the acuity of individuals and their needs in accordance with state standards. CCBHCs must identify EBPs utilized upon application.

Outpatient Clinic Primary Care Screening and Monitoring (SS 21 – SS 23)

- **SS 21** The CCBHC is responsible for ensuring that screening and monitoring of primary health indicators and risks, including prevention measures, are conducted. The CCBHC medical director must oversee the agency's creation of screening protocols based on A and B scores of the United States Preventive Services Task Force Recommendations for conditions including required screenings such as HIV and viral hepatitis, and other screenings such as clinically indicated key health indicators, primary care screening, domestic and intimate partner violence screening, Appendix B: Behavioral Health Clinic Quality Measures, and other clinically indicated primary care key health indicators of children, adults, and older adults receiving services, based on environmental factors, SDOH, and common physical health conditions experienced by the population of CCBHC people receiving services.
- **SS 22** CCBHCs are responsible for outpatient clinic primary care screening, monitoring of key health indicators and health risks, and helping to assure that care is coordinated and integrated.
- **SS 23** The CCBHC medical director will develop organizational protocols to ensure that people receiving services who are at risk for common physical health conditions are screened and monitored across the lifespan. Organizational protocols must include:
    - Identifying people receiving services with chronic diseases;
    - Ensuring that people receiving services are asked about physical health symptoms; and
    - Establishing systems for collection and analysis of laboratory samples.

To fulfill the requirements under SS21, SS22, and SS23, the CCBHC must have the ability to collect biologic samples directly, through a DCO, or through protocols with an independent clinical laboratory. Laboratory analyses can be done directly or through another arrangement with an organization separate from the CCBHC. The CCBHC must also coordinate with the primary care provider to ensure that screenings occur for the identified conditions. If the individual's primary care provider conducts the necessary screening and monitoring, the CCBHC is not required to do so as long as it has a record of the screening and monitoring and the results of any tests that address the health conditions included in the CCBHCs screening and monitoring protocols developed under SS23.

Assertive Community Treatment (ACT) (SS24)

- **SS 24** CCBHCs must have at least one ACT team to help ensure that individuals who meet the criteria have access to ACT services in the community instead of having to rely on institutional facilities.

CCBHC Targeted Case Management Services (SS 25)

- **SS 25** CCBHCs must provide CCBHC Targeted Case Management (CCBHC TCM) services for children and adults with mental health, SUD, and/or co-occurring SUD.

Peer Supports, Peer Counseling, and Family/Caregiver Supports (SS 26)

- **SS 26** CCBHCs provide MH, SUD, and/or family/caregiver support services.

Intensive, Community-Based Mental Healthcare for Members of the Armed Forces and Veterans (SS 27– SS 30)

- **SS 27** CCBHCs services provided to service members, veterans, and their families are recovery-oriented and consistent with VHA recovery and with mental health and substance use disorders guidelines promulgated by the VHA, including clinical guidelines contained in the Uniform MH/SUD Handbook of such Administration.
- **SS 28** CCBHCs' staff who are not service members or veterans and who work with military or veterans receiving services must be trained in cultural competence, including specific information related to active military and veteran culture.
- **SS 29** CCBHCs must include a veteran liaison embedded in their organizational chart to help ensure engagement in the veteran communities, organizations, and increase access for veterans in their service area.
- **SS 30** Every veteran seen for behavioral health services must be assigned a Principal Behavioral Health Provider. When veterans are seeing more than one behavioral health provider and when they are involved in more than one program, the identity of the Principal Behavioral Health Provider is made clear to the veteran and identified in the health record. The Principal Behavioral Health Provider is identified on a tracking database for those veterans who need case management. The Principal Behavioral Health Provider ensures the following requirements are fulfilled:
    1. Regular contact is maintained with the veteran as clinically indicated if ongoing care is required.
    2. A psychiatrist or other independent prescriber who satisfies the current requirements of the VHA Uniform Mental Health Services Handbook reviews and reconciles each veteran's psychiatric medications on a regular basis.
    3. Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision-maker's consent when the veteran does not have adequate decision-making capacity).
    4. Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained.
    5. The treatment plan is revised, pursuant to CCBHC Criteria SS 15 – SS 17The principal therapist or Principal Behavioral Health Provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision-making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral healthcare treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2).
    6. The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the Principal Behavioral Health Provider

has reason to believe the veteran lacks the capacity to decide about the mental health treatment plan, the provider must ensure the veteran's decision-making capacity is formally assessed and documented. If it is determined that a veteran lacks capacity, the provider must identify the authorized surrogate and document the surrogate's verbal consent to the treatment plan.

Staffing Requirements (SR)
Staffing requirements describe general staffing requirements, Community Needs Assessment, and staffing plans; licensure and credentialing of providers; and training related to cultural and linguistic competence, and trauma-informed care.

General Staffing Requirements (SR 1 – SR 8)
Prior to WV CCBHC certification, clinics must complete a Community Needs Assessment and a staffing plan that is reflective of the needs and culture of the community they intend to serve. The staffing plan must be regularly updated, but no less than once every three years.

- **SR 1** CCBHCs must complete a Community Needs Assessment that addresses cultural, linguistic, treatment and staffing needs; the existing resources of the area to be served by the CCBHC; potential service barriers, such as lack of transportation, housing, food, and other potential service barriers. The needs assessment must identify populations particularly affected by health disparities and/or health-related social needs and any applicable workforce shortages. The needs assessment must document how people receiving services, family members, and relevant communities were consulted in a meaningful way, such as people's experiences receiving services, barriers, service gaps, and opportunities for improved access. The Community Needs Assessment must be completed prior to application and submitted as part of the application process. CCBHCs shall also update their Community Needs Assessment prior to applying for re-certification.
- **SR 2** CCBHCs must create and maintain a staffing plan that reflects the findings of the needs assessment. The plan must demonstrate that the staff (both clinical and nonclinical) is appropriate in size and has the composition to meet the clinical, recovery, SDOH, and care coordination needs of the population, while respecting and supporting the diverse community needs and preferences of the CCBHC service area.
- **SR 3** CCBHCs must deliver treatment by staff with specific training in serving the segment of the population identified/outlined in the needs assessment.
- **SR 4** CCBHCs must have a medical director employed directly or by contract. The medical director is required to provide services at least 15 hours per week. The following practitioners may serve as a medical director: psychiatrist; physician with an addiction fellowship; physician working toward board certification in psychiatry or addiction providing the CCBHC documents that the individual is actively working toward and anticipates board certification within a two-year period from the individual's start date; psychiatric nurse practitioner.
- **SR 5** CCBHCs must have a management/executive team structure embedded in an organizational chart. The CEO of the CCBHC, or equivalent, maintains a fully staffed management team as appropriate for the size and needs of the clinic, as determined by the current Community Needs Assessment and staffing plan. The management team will include, at a minimum, a CEO or equivalent Project Director and a medical director who meets the requirements of SR4. The medical director need not be a full-time employee of the CCBHC.

- **SR 6** CCBHCs must have a full-time on-site Clinical Director, minimum of master's level or above in an appropriate clinical discipline (e.g., counseling, social work, psychology, psychiatry). The Clinical Director must be employed directly by the CCBHC.
- **SR 7** CCBHCs must demonstrate efforts to alleviate the workforce shortages they identified in their needs assessment where they exist, including retainment and recruitment strategies.
- **SR 8** The CCBHC maintains liability/malpractice insurance adequate for the staffing and scope of services provided.

Licensure and Credentialing of Providers (SR 9 – SR 16)

- **SR 9** CCBHCs must be compliant with all federal, state, and local regulations, certification, and required auditing processes.
- **SR 10** CCBHCs must have at least one board-certified psychiatrist or one board-eligible psychiatrist who will prescribe all forms of FDA-approved medications. When allowable under the purview of the provider's license, as appropriate and within their scope of practice, physician extenders may be used to satisfy this requirement.
- **SR 11** CCBHC staffing plans must include a physician or a physician extender trained in behavioral health, either employed or available through contract with a DCO, who can prescribe and manage medications independently under state law, including buprenorphine products, naltrexone, and other medications used to treat opioid and/or alcohol use disorders.
- **SR 12** CCBHC staffing plans require a minimum of one staff with at least one of the following credentials:
    - Alcohol and Drug Counselor (ADC)
    - Advanced Alcohol and Drug Counselor (AADC)
    - National Certified Addiction Counselor Level 1 (NCAC 1)
    - National Certified Addiction Counselor Level 2 (NCAC 2)
    - National Clinical Supervision Endorsement (NCSE)
    - Master Addiction Counselor (MAC)

  CCBHCs staffing plans also require a minimum of one state certified (WV Association of Addiction and Prevention Professionals) substance use disorders specialist, as well as individuals actively working toward certification.
- **SR 13** CCBHCs must provide nicotine education and cessation by trained staff.
- **SR 14** CCBHCs must identify and have on-site staff that can clinically treat trauma, sexual abuse, eating disorders, suicidality, SUD, and SED in children and adults with SMI as informed by the treatment planning needs of the individuals being served. Staff certifications must be embedded in an organizational chart. The certifications must be listed in the application.
- **SR 15** CCBHC staffing plans must incorporate disciplines that can address the needs identified by the agency needs assessment.
- **SR 16** CCBHC staffing plans require credentialed substance abuse specialists. The CCBHC must ensure that all master's level staff working with the Individuals with primary SUD diagnosis either have or are actively engaged in a certification track for one of the following: ADC, AADC, NCAC 1, NCAC 2, NCSE, or MAC.

Cultural Competence and Other Training (SS 17 – SS 19)

- **SR 17** CCBHCs must have policies and procedures in place that describe the initial and ongoing staff training process, tracking and how additional as needed employee trainings are identified

and demonstrate staff competencies. Training records must be maintained within staff personnel records.

- **SR 18** CCBHCs have written policies and procedures that describe the methods used for assessing the skills and competencies of their clinical staff through documented clinical supervision.
- **SR 19** CCBHC training plans must require training, at new staff orientation and annually thereafter, which covers the following topics specific to both children and adults: risk assessment; suicide prevention and suicide response; abuse and neglect reporting, roles of families and peer staff; cultural competence, including protected classes of individuals, as well as other communities identified in the agency's Community Needs Assessment, where applicable; provision of care that is person-centered and family-centered, recovery-oriented, evidence-based, and trauma-informed; integration of primary care and behavioral healthcare; and developing and managing a COOP.

Linguistic Competence (SR 20 – SR 22)

- **SR 20** CCBHCs must accommodate or arrange for interpretation and translation services (e.g., bilingual providers, interpreters, and language telephone line) that is appropriate and timely for the size and needs of the client population with LEP, vision, and hearing-impaired CCBHC identified in the agency's needs assessment.
- **SR 21** CCBHCs must make all accommodations as required by Title 1 of the ADA for accessibility tools and approaches for serving individuals with disabilities (including, but not limited to, hearing and sight impairments and cognitive limitations).
- **SR 22** CCBHCs must have procedures in place that comply with HIPAA and 42 CFR (Code of Federal Regulations) Part 2 requirements specific to minors, release of SUD treatment records, and other federal privacy requirements.

Availability and Accessibility of Services (AA)

CCBHCs are required to help ensure accessibility and access to services in their community. This section describes general requirements of access and availability, timely access to services and assessment, access to Crisis Management Services, and the provision of services regardless of ability to pay or residence.

General Requirements of Access and Availability (AA 1 – AA 7)

- **AA 1** CCBHC outpatient clinic hours include evening and weekend hours to meet the needs of the population served and to increase access at to be determined times and locations. A minimum of 8 hours of service from midnight Friday through midnight Sunday must be provided. These hours will be designated by each agency and must be approved by BMS. CCBHCs will provide outreach and communication to help ensure the community is aware of increased hours of operation/available services.
- **AA 2** CCBHCs must provide transportation services for people receiving services to receive services and have a contract with the state broker for non-emergency transportation services.
- **AA 3** CCBHCs must have capacity to provide the full range of Medicaid eligible telehealth services for children and adults at all CCBHC and DCO sites as outlined in Chapter 519.17.
- **AA 4** All sites must have access to a physician and or physician extenders. Access is allowable via telehealth.

- **AA 5** CCBHC services must be aligned with state and county/municipal court standards for the provision of court-ordered services.
- **AA 6** CCBHCs must have adequate COOP/disaster response plans in place, including, but not limited to, chemical exposure, disease exposure, and natural disasters.
- **AA 7** When a referral or request comes from the WV DoHS, court system, or the Division of Corrections and Rehabilitation for an evaluation or assessment, the requested service must be provided within three business days of the request regardless of payor source.

Timely Access to Services and Initial and Comprehensive Evaluation (AA 8 – AA 11)

- **AA 8** CCBHC must provide an appointment for children and adults with routine needs within 10 business days of the requested date for service. For individuals presenting an urgent need, an appointment must be provided within one business day from the day of the request.
- **AA 9** The preliminary triage and risk assessment will be followed by: (1) an initial evaluation and (2) a comprehensive evaluation, with the components of each as specified in program policy. Urgent need should prompt an initial evaluation within one business day. Comprehensive evaluations should be completed within 60 days. Routine services should be accessed within 10 business days.
- **AA 10** CCBHCs must complete a Routine Assessment and Evaluation within 10 business days of referral or request. Routine Assessment and Evaluation are defined by Chapter 503.
- **AA 11** CCBHCs must have in place policies and procedures to help ensure immediate, clinically directed action, including crisis planning and necessary subsequent follow-up if and when the screening or other evaluation identifies an emergency or crisis need.

24/7 Access to Crisis Management Services (AA 12)

- **AA 12** CCBHCs are required to work with the person receiving services at intake and after a psychiatric emergency or crisis to create maintain/update and implement the crisis safety plan embedded in the treatment plan.

No Refusal of Services due to Inability to Pay (AA 13)

- **AA 13** CCBHCs must have policies and procedures in place that address and help ensure provision of services regardless of ability to pay, including waiver or reduction of fees for those unable to pay any or all of the full amount due, and an equitable use of a sliding fee discount schedule. CCBHCs must provide information to the person receiving services related to the sliding fee discount schedule, such as providing information in intake packets, posting on the CCBHC website, posting information in waiting rooms, and providing all information in a format that helps to ensure meaningful access for the person receiving services and/or family to the information, regardless of the person receiving service's residence.

Provision of Services Regardless of Residence (AA 14)

- **AA 14** CCBHCs' policies and procedures help ensure services must not be denied to those who live outside the CCBHC service area. This includes provision of crisis services, provision of other identified medically necessary CCBHC services and coordination and follow-up with providers in the individual's home service area. CCBHC policies and procedures will also help ensure that services will be available for the people receiving services living in the CCBHC service area but who reside at some distance from the CCBHC.

Care Coordination (CC)
Care coordination is an activity which all CCBHCs are required to provide. This section describes the general requirements of care coordination, health information systems, agreements to support care coordination, treatment team, planning, and care coordination activities.

General Requirements of Care Coordination (CC 1-CC 5)

- **CC 1** CCBHCs must provide treatment planning and care coordination that are person- and family-centered.
- **CC 2** CCBHCs must have policies and procedures for documented care coordination across the spectrum of healthcare services, including physical and behavioral health and other social services.
- **CC 3** CCBHCs consent documentation is regularly offered, explained, and updated.
- **CC 4** CCBHCs satisfy the requirements of privacy and confidentiality while encouraging communication between providers and family of the person receiving services.
- **CC 5** The people receiving services have the freedom to choose appropriate providers within the CCBHC unless safety issues are identified or it would be clinically contraindicated.

Care Coordination and Other Health Information Systems (CC 6 – CC 7)

- **CC 6** CCBHCs must have a certified EHR system. The EHR system must have the capacity to time/date stamp the services needed for auditing; if the EHR system cannot currently report required data, it is the expected that the applicable CCBHC will make any needed EHR refinements.
- **CC 7** CCBHCs have contracts with DCOs that specify the data the CCBHC needs to fulfill their reporting obligations, how and with what frequency that data will be securely transmitted from the DCO to the CCBHC, and that appropriate data-sharing agreements and consent from the person receiving services are in place pursuant to HIPAA, 42 CFR Part 2, and other federal and state privacy requirements.

Formal Partnerships (CC 8 – CC 27)

- **CC 8** The CCBHC must coordinate care in keeping with the preferences of the person receiving services and their care needs. To the extent possible, care coordination should be provided, as appropriate, in collaboration with the family/caregiver of the person receiving services and other supports identified by the person. To identify the preferences of the person in the event of psychiatric or substance use crisis, the CCBHC develops a crisis plan with each person receiving services. At minimum, people receiving services should be counseled about the use of the National Suicide and Crisis Lifeline, local hotlines, warmlines, mobile crisis, and stabilization services should a crisis arise when providers are not in their office. Crisis plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving services. Psychiatric Advance Directives, if developed, are entered in the EHR of the person receiving services so that the information is available to providers in emergency care settings where those electronic health records are accessible.
- **CC 9** CCBHCs must have formal partnerships in place with primary care agencies, such as Federally Qualified Health Centers (FQHCs), free clinics and, where relevant, RHCs, unless healthcare services are provided directly by the CCBHC. No formal partnership is required if the CCBHC renders primary care services.

- **CC 10** CCBHCs and DCOs must have formal partnerships with all levels of inpatient psychiatric treatment facilities, SUD residential services, pregnant and parenting women (PPW) SUD residential services, subacute and partial hospitalization programs, unless these services are provided directly by the CCBHC.
- **CC 11** CCBHCs must track data on people who are admitted to and discharged from inpatient psychiatric treatment, with ambulatory and medical detoxification, post-detoxification step-down services, and residential programs (unless there is a formal transfer of care to a non-CCBHC entity). CCBHCs must track data on people receiving services who are admitted to and discharged from inpatient treatment facilities.
- **CC 12** CCBHCs must have formal partnerships with the applicable state crisis (such as 988 and HELP4WV) and help lines to connect callers with CCBHC services to help ensure coordination of crisis services, care, and follow-up.
- **CC 13** CCBHCs must have formal partnerships with SUD treatment providers that have access to FDA-approved MAT if this service is not available from the CCBHC.
- **CC 14** CCBHCs must have formal partnerships with the following organizations in their service areas:
    - Local Education Agencies (LEAs);
    - Regional Prevention Lead Organizations (PLOs);
    - Expanded School Mental Health (ESMH) grantees for prevention and clinical services;
    - Child welfare agencies;
    - Juvenile services and criminal justice agencies;
    - Inpatient Facilities, including substance use, mental health, veterans, and other treatment courts;
    - Youth regional treatment centers;
    - State licensed and nationally accredited child placing agencies for therapeutic foster care services;
    - Certified domestic violence centers;
    - The West Virginia Department of Veterans Assistance;
    - The Bureau of Senior Services;
    - Other social and human services agencies;
    - Other potentially relevant groups to collaborate with include the following:
    - Specialty providers of medications for treatment of opioid and alcohol dependence;
    - Suicide/crisis hotlines and warm lines;
    - Homeless shelters and service providers;
    - Housing agencies;
    - Employment services systems;
    - Services for older adults, such as ADRC of WV;
    - End of life/hospital providers;
    - Palliative care providers;
    - Faith-based entities;
    - Local Veterans Administration Hospitals and vet centers;
    - Other social and human services (e.g., domestic violence centers, grief counseling programs, Affordable Care Act navigators, food access and transportation programs).

  These formal partnerships must cover all SDOH. Service areas and clinic sites will be identified by the provider at the time of application.

- **CC 15** Formal partnerships with residential treatment facilities must include language requiring SUD RTCs to track and report on warm hand-offs to CCBHC providers and all other required and applicable measures.
- **CC 16** CCBHCs must seek formal partnerships with the nearest Department of Veterans Affairs Medical Center, vet center, independent clinic, drop-in center, or other facility of the Department of Veterans Affairs offices, as veterans/members of the military and their families are a priority population.
- **CC 17** CCBHCs must have a formal partnership in place with inpatient acute care hospitals and inpatient psychiatric facilities, including emergency departments, hospital outpatient clinics, urgent care centers, crisis stabilization units, and SUD Residential (all levels) inpatient facilities. CCBHCs must have provisions for tracking the admission and discharge of individuals from these facilities (unless there is a formal transfer of care from a CCBHC).
- **CC 18** CCBHCs must provide certified peer recovery support specialist (PRSS) services.
- **CC 19** CCBHCs must have policies and procedures that address: coordination of services when people receiving services present to local EDs; the CCBHCs response upon receiving notification and referral; involvement of law enforcement when people receiving services are experiencing a psychiatric/substance use induced crisis; and to reduce delays in initiating services during and after the person receiving services has experienced a psychiatric or substance use induced crisis.
- **CC 20** CCBHCs must have policies and procedures that address transitioning the person receiving services from EDs and other settings to CCBHC care to help ensure decreased time between assessment and treatment, for transfer of medical records, prescriptions, and active follow-up.
- **CC 21** For the people receiving services at a CCBHC who present to a facility at risk for suicide,
- CCBHCs must have care coordination agreements in place that require coordination of consent and follow-up within one business day of the initial crisis event, continuing until the member is linked to services or is assessed as being no longer at risk.
- **CC 22** CCBHCs must make documented attempts to contact all people who received services and were discharged from the settings specified above within 24 hours of discharge.
- **CC 23** CCBHCs must have policies and procedures for tracking people transitioning from EDs and other referenced treatment facilities to an accessible and safe community setting, including transfer of medical records, prescription drugs, active follow-up services and supports, and, where appropriate, a plan for suicide prevention and safety and for ongoing provision of peer support services.
- **CC 24** CCBHCs must develop formal partnerships with Medicaid enrolled pharmacies to address the medication needs of people receiving services in CCBHCs. Such partnerships should help ensure prompt access to all needed prescriptions (including buprenorphine and naloxone) and have a process in place to remediate any pharmacy issues if they arise.
- **CC 25** CCBHCs must be an active Children with a Serious Emotional Disorder (CSED) Waiver provider.
- **CC 26** RTCs that partner with CCBHCs using a Care Coordination Agreement or formal partnership can receive a QBP for reporting in Year 1 and/or meeting the predetermined performance threshold for Year 2 and beyond. To be eligible to receive a QBP, RTCs must submit data on pre-defined performance measures as determined by BMS. For Year 1 of the CCBHC program, RTCs will be paid a pro-rated QBP for submitting data on all required measures. Data from Year 1 will be used to establish benchmarks for Year 2. RTCs who meet the

benchmark threshold for one or more measures, but not all measures, will earn a portion of the bonus payment. RTCs that meet all the performance thresholds for the measures will earn the full bonus payment.

- **CC 27** 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 laws allow, the state PDMP must be consulted before prescribing medications. The PDMP should also be consulted during the comprehensive evaluation. 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.

Quality and Other Reporting (QR)

This section describes the requirements and guidelines for data collection, reporting, and CQI in CCBHCs. QR covers the reporting of specific measures, data tracking for Medicaid enrollees, linking consumer claims, submission of annual cost reports, and the development of CQI plans to enhance outcomes and quality of care. The CQI plans address areas such as suicide attempts, hospital readmissions, medication side effects, and data collection related to RTC services and people receiving SUD services.

Data Collection, Reporting, and Tracking (QR 1 – QR 4)

- **QR 1** CCBHCs are required to report on the following measures: 1.) percentage of referrals that were accepted for assessment, evaluation, and outpatient services; 2.) percentage of new people receiving services, with initial evaluation provided within 10 business days of first contact and 3.) all five SAMHSA required CCBHC measures. Behavioral Health Clinic Quality Measures). Reporting will be submitted in a standardized format to be provided by BMS.
- **QR 2** CCBHCs must demonstrate their capacity and ability to collect, track and report data and quality measures on, at a minimum, all Medicaid enrollees as required by the state criteria, policy, and PPS guidance. Data includes, but is not limited to, people receiving services, demographic characteristics, staffing, access to services, use of services, screening, treatment, care coordination, costs, and outcomes for people receiving services.
- **QR 3** CCBHC claims encounter data must be linkable to the person receiving services, pharmacy claims or utilization information, inpatient and outpatient claims, and any other claims or encounter data necessary to report cost and other required measures.
- **QR 4** CCBHCs must have policies and procedures for the submission of annual cost reporting.

CQI Plan (QR 5 – QR 8)

- **QR 5** The CCBHC must be enrolled as a Medicaid provider and licensed, certified, or accredited provider of both mental health and SUD services including developmentally appropriate services to children, youth, and their families, unless there is a state or federal administrative, statutory, or regulatory framework that substantially prevents the CCBHC organization provider type from obtaining the necessary licensure, certification, or accreditation to provide these services. The CCBHC will adhere to any applicable state accreditation, certification, and/or licensing requirements. Further, the CCBHC is required to participate in SAMHSA Behavioral Health Treatment Locator.
- **QR 6** CCBHCs must have written CQI plans, with a focus on improving behavioral and physical health outcomes and quality of care, and reducing emergency department use, rehospitalization,

and repeated crisis episodes. CQI plans must be reviewed and approved by the WV DoHS Certification Committee upon application for CCBHC certification. CCBHCs are required to update their CQI plans and annually report to BMS. The CCBHC medical director must 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.

- **QR 7** The CCBHC must have a written CQI Plan that addresses priorities for improved quality of care and safety for people receiving services and requires that all improvement activities be evaluated for effectiveness. Specific events are expected to be addressed as part of the CQI Plan, including: 1) suicide deaths or suicide attempts by the person receiving services; 2) Fatal and non-fatal overdoses; 3) all-cause mortality among people receiving services; 4) 30-day hospital readmissions for psychiatric or substance use reasons for the person receiving services; 5) quality of care issues, including monitoring for metabolic syndrome, movement disorders, and other medical side effects of psychotropic medications.
- **QR 8** CCBHCs must collect, track, and report the following data on individuals receiving CCBHC services who also receive RTC services, and all people receiving services with SUD: 1) percentage of inpatient detox episodes that have seven-day follow-up; 2) percentage of outpatient detox episodes that have seven-day follow-up; 3) percentage of people receiving services, regardless of age, discharged from the RTC to home or any other site of care for whom a transition record was transmitted to the CCBHC to help ensure follow-up care within 24 hours of discharge.

Organizational Authority, Governance, and Accreditation (OAG)
This section describes the organizational authority, governance, and accreditation requirements for CCBHCs, including financial audits, meaningful participation of individuals with lived experience, and the representation of diverse populations in decision-making processes.

General Requirements of Organizational Authority and Finances (OAG 1)

- **OAG 1** CCBHCs have policies and procedures for having an annual financial audit conducted and, where indicated, a corrective action plan submitted addressing all findings, questioned costs, reportable conditions, and material weakness.

Governance (OAG 2)

- **OAG 2** CCBHC governance must be informed by representatives of the individuals served by the CCBHC, considering demographic factors such as geographic area, and health and behavioral health needs. The CCBHC will facilitate and incorporate meaningful participation from individuals with lived experience of mental health and/or SUD and their families, including youth. This participation is designed to help assure that the perspectives of people receiving services, families, and people with lived experience of mental health and substance use conditions are heard by leadership and incorporated into decision-making processes. “Meaningful participation” is defined as supporting a substantial number of people with lived experience and family members of people receiving services or individuals with lived experience so that they can be involved in developing initiatives; identifying community needs, goals, and objectives; providing input on service development and CQI processes; and budget development and fiscal decision-making.

CCBHCs must reflect such participation by one of two options:

Option 1: At least 51% of the CCBHC governing board is comprised of individuals with lived experience of mental health and/or substance use disorders and families.

Option 2: Other means are established to demonstrate meaningful participation in board governance involving people with lived experience, such as creating an advisory committee that reports directly to the board. The CCBHC provides staff support to the individuals involved in any alternate approach that is equivalent to the support given to the governing board.

Under Option 2, individuals with lived experience of mental and/or substance use disorders and family members of people receiving services must have representation in governance that assures input into:

1. Identifying community needs and goals and objectives of the CCBHC
2. Service development, quality improvement, and the activities of the CCBHC
3. Fiscal and budgetary decisions
4. Governance (human resource planning, leadership recruitment and selection, etc.)

Under Option 2, the governing board must establish protocols for incorporating input from individuals with lived experience and family members. Board meeting summaries must be shared with those participating in the alternative arrangement and recommendations from the alternative arrangement shall be entered into the formal board record; participants in process established under option 2 must be invited to board meetings; and participants must have the opportunity to address the board, share recommendations directly with the board, and have their comments and recommendations recorded in the board minutes directly and regularly. The CCBHC shall provide staff support for posting an annual summary of the recommendations from the alternate arrangement under Option 2 on the CCBHC website.

REFERENCES

West Virginia State Plan references CCBHC services at sections Supplement 2 to Attachment 3.1-A and 3.1-B, Pages 5.4 - 5.13 Attachment 4.19-B Pages 11.1 and 11.2

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this Chapter. Definitions in this glossary are specific to this Appendix.

CCBHC directly provides: When the term, “CCBHC directly provides” is used within these criteria, it means employees or contract employees within the management structure and, under the direct supervision of the CCBHC, deliver the service.

Community Needs Assessment: A systematic approach to identifying community needs and determining program capacity to address the needs of the population being served.

Engagement: Engagement includes a set of activities connecting people receiving services with needed services and supporting their retention services. This involves the process of making sure people

receiving services and families are informed about and are able to access needed services. Activities such as outreach and education can serve the objective of engagement. Conditions such as accessibility, provider responsiveness, availability of culturally and linguistically competent care, and the provision of quality care also promote consumer person receiving services engagement.

Family: Involvement of families of both adults and children receiving services is important to treatment planning, treatment, and recovery. Families come in different forms and, to the extent possible, the CCBHC should respect the individual consumer's view of what constitutes their family. Families can be organized in a wide variety of configurations regardless of social or economic status. Families can include biological parents and their partners, adoptive parents and their partners, foster parents and their partners, grandparents and their partners, siblings and their partners, extended family members, care givers, friends, and others as defined by the family. The CCBHC respects the view of what constitutes the family of the individual person receiving services.

Family-centered: The Health Resources and Services Administration defines family-centered care, sometimes referred to as "family-focused care," as "an approach to the planning, delivery, and evaluation of healthcare whose cornerstone is active participation between families and professionals. Family-centered care recognizes families are the ultimate decision-makers for their children, with children gradually taking on more and more of this decision-making themselves as developmentally appropriate. When care is family-centered, services not only meet the physical, emotional, developmental, and social needs of children, but also support the family's relationship with the child's healthcare providers and recognize the family's customs and values". More recently, this concept was broadened to explicitly recognize that family-centered services should be both developmentally appropriate and youth guided. Family-centered care is family-driven and youth-driven.

People with Lived Experience: People with lived experience are individuals who have a mental health disorder and/or SUD or is parent or guardian to a person with one of these disorders, who share experiences or backgrounds and can bring the insights from their experience to inform and enhance systems, research, policies, practices, and programs that aim to address the issue(s). Because CCBHCs are designed to serve people with mental disorders, adults with SMI, children with SED and their families, and individuals with substance use disorders, individuals with lived experiences provide valuable insight to improving the delivery of CCBHC services.

Peer/Family/Caregiver Support: A peer support provider is a person who uses their lived experience of recovery from mental or substance use disorders or as a family member/caregiver of such a person, plus skills learned in formal training, to deliver services to promote recovery and resiliency. Peer providers may have titles that may differ from state to state, e.g., certified peer specialist, peer support specialist, recovery coach, family partner, parent partner specialist. In states where Peer Support Services are covered through the state Medicaid Plans, the title of "certified peer specialist" often is used. SAMHSA recognizes states use different terminology for these providers. Peer support may be provided in behavioral health, health, and community settings, e.g., mobile crisis outreach, psychiatric rehabilitation, outpatient mental health/substance use treatment, emergency rooms, wellness programs, peer-operated programs.

Person or People Receiving Services: Within this document, person or people receiving services refers to people of all ages (i.e., children, adolescents, transition age youth, adults, and older adults) who are

receiving one of the nine required services from the CCBHC (including through any DCO arrangements). Use of the term “patient” is restricted to areas where the statutory or other language is being quoted. In many places in the Certification Criteria, the person receiving services has a role in directing, expressing preferences, planning, and coordinating services. In these situations, when there is a legal guardian for the person receiving services, these roles shall also be filled by the legal guardian.

Person-centered care: Person-centered care aligns with the Department of Health and Human Services Guidance to HHS Agencies for Implementing Principles of Section 2402(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs. That guidance defines “person-centered planning” as a process directed by the person with service needs which identifies recovery goals, objectives and strategies. If the person receiving services wishes, this process may include a representative whom the person has freely chosen, or who is otherwise authorized to make personal or health decisions for the person. Person-centered planning also includes family members, legal guardians, friends, caregivers, and others whom the person wishes to include. Person-centered planning involves the person receiving services to the maximum extent possible. Person-centered planning also involves self-direction, which means the person receiving services has control over selecting and using services and supports, including control over the amount, duration, and scope of services and supports, as well as choice of providers.

Practitioner or Provider: Any individual/practitioner or entity/provider engaged in the delivery of healthcare services and who is legally authorized to do so by the state in which the individual or entity delivers the services (42 CFR § 400.203).

Recovery: Recovery is defined as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” The 10 guiding principles of recovery are: hope; person-driven; many pathways; holistic; peer support; relational; culture; addresses trauma; strengths/responsibility; and respect. Recovery includes Health (“making informed healthy choices that support physical and emotional wellbeing”); Home (safe, stable housing); Purpose (“meaningful daily activities … and the independence, income and resources to participate in society”); and Community (“relationships and social networks that provide support, friendship, love, and hope”).

Recovery-oriented care: Recovery-oriented care is oriented toward promoting and sustaining a person's recovery from a behavioral health condition. Care providers identify and build upon each individual’s assets, strengths, and areas of health and competence to support the person in managing their condition while regaining a meaningful, constructive sense of membership in the broader community.

Required services: “Required services” references the nine services identified in PAMA, which CCBHCs must provide to people receiving services based on their needs (described in Program Requirement 4: Scope of Services), 1. Crisis Services; 2. Screening, Assessment, and Diagnosis; 3. Person-Centered and Family-Centered Treatment Planning; 4. Outpatient Mental Health and Substance Use Services; 5. Primary Care Screening and Monitoring; 6. Targeted Case Management Services; 7. Psychiatric Rehabilitation Services; 8. Peer Supports and Family/Caregiver Supports; and 9. Community Care for Uniformed Service Members and Veterans; as well as the two additional services required to be delivered by CCBHCs in WV: CSED and ACT.

Satellite Facility: A satellite facility of a CCBHC is a facility that was established by the CCBHC, operated under the governance and financial control of that CCBHC, and provides the following services: crisis services; screening, diagnosis, and risk assessment; person and family-centered treatment planning; and outpatient mental health and substance use services as specified in CCBHC certification criteria.

Trauma-informed: A trauma-informed approach to care realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in people receiving services, their families, staff, and others involved in the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
New Chapter	Appendix 503I Certified Community Behavioral Health Clinic	October 1, 2024
Entire Chapter	Updated language throughout – no change to services or requirements References – added Medicaid State Plan citations	February 1, 2025