MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 27, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES
MANAGER OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2700 – CERRITFIED COMMUNITY BEHAVIORAL HEALTH CENTER SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2700 – Certified Community Behavioral Health Centers (CCBHC) are being proposed to the CCBHC MSM with regard to the LEAD CASE MANAGER is only used if a recipient is included in more than one target group at a given time or is eligible to receive case management services from different programs (i.e. CCBHC, Managed Care Organization (MCO), or governmental agencies). The Lead Case Manager coordinates the recipient's care and services with another case manager. The Lead Case Manager is responsible for coordinating the additional case management services, whether or not, chronologically, the Lead Case Manager was the original or the subsequent case manager. When a recipient is eligible for MCO, it is the responsibility of the Lead Case Manager to ensure that the identified MCO is notified of the recipient's participation in targeted case management. The Lead Case manager will coordinate all care with the MCO to ensure there is an elimination of any potential for duplication of services.

Entities Financially Affected: This proposed change affects all Medicaid-enrolled providers delivering Targeted Case Management Services (TCM). Those provider types (PT) include but are not limited to CCBHCs (PT 17 Specialty 188), Targeted Case Management (PT 54), and Behavioral Health Outpatient Treatment (PT 14).

Financial Impact on Local Government: Unknown at this time.

These changes are effective January 1, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL OL MSM 2700 – Certified Community Behavioral Health Centers	MTL 03/20 MSM 2700 – Certified Community Behavioral Health Centers

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2703.16.K	**Lead Case Manager**	Added clarifying language to the Lead Case Managers in ensuring case management services are not duplicated between TCM and CCBHCs.

Board of Directors. The review is to be the foundation for opportunities to improve performance by the CCBHC and perception by the recipients.

2703.13 PROVIDER QUALIFICATIONS

A. CCBHC services are provided by qualified individuals in an interdisciplinary treatment team approach. The CCBHC treatment team is comprised of individuals who meet the qualifications of direct care providers under the relevant MSM chapter and who collaborate to provide and coordinate medical, psychosocial, emotional, therapeutic and recovery support services to the recipients served. All direct care providers of CCBHC services must be able to provide services under the CCBHC delivery model and meet the qualification as specified in the relevant MSM chapter.

B. CCBHCs must also ensure all DCO providers are qualified and compliant with the requirements of the CCBHC program, this chapter and all relevant MSM Chapters and the Addendum.

2703.14 TARGET POPULATIONS

The CCBHC target populations are the primary populations of focus. These groups include: COD, Seriously Emotionally Disturbed (SED)/Non-SED, Severely Mentally Ill (SMI)/Non-SMI and SUD. SED/Non-SED and SMI/Non-SMI are defined in the MSM Addendum. COD and SUD are defined above.

2703.15 RECIPIENT ELIGIBILITY

A. Admission Criteria: To be eligible for CCBHC services, a recipient must meet criteria for one of the six target groups.

B. Continuing Stay Criteria: The recipient continues to meet admission criteria and needs restoration for the best possible functioning or is at risk of relapse and a higher level of care.

C. Discharge Criteria: The recipient no longer meets admission and continuing stay criteria; no longer wishes to receive services; or their care has been transferred, the discharge summary has been provided and the coordination of care has been completed with the new provider.

2703.16 SERVICES

This CCBHC program allows for the expansion of existing services and the provision of integrated health care services. CCBHCs must provide the following required services under this program: Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention

services and crisis stabilization; screening, assessment and diagnosis, including risk assessment; patient-centered treatment planning or similar processes, 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 risk; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family supports; intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the VHA, including clinical guidelines contained in the "Uniform Mental Health Services Handbook of such Administration." In addition to the required services, CCBHCs are allowed to provide additional services identified on the Allowable Services grid located with the CCBHC billing guide.

CCBHC treatment and services are based on the individually assessed biopsychosocial needs of the recipient and prescribed on a person- and family-centered integrated treatment plan. Services must be provided under the philosophy of recovery and be informed by best practices for working with individuals from diverse cultural and linguistic backgrounds. The treatment plan guides the prescribed treatment and services and must reflect collaboration with and endorsement by the recipient and their family, when appropriate. The treatment plan identifies the recipient's needs, strengths, abilities and preferences and includes the recipient's goal(s) that is expressed in a manner that captures their own words or ideas and, for children, those of their family/caregiver. In addition, the treatment plan must indicate the recipient's advance wishes related to treatment and crisis management or reflects their decision not to discuss those preferences.

CCBHC services are projected to reduce the number of behavioral health emergency room (ER) visits in communities, increase positive outcomes of treatment and reduce the negative impacts of social determinants of health on recovery. Nevada Medicaid reimburses for the following services provided under a CCBHC delivery model in accordance with this chapter, MSM Chapter 100, MSM Addendum and all relevant MSM Chapters. The services describe below include criteria specific to the CCBHC delivery model. Additional requirements are specified in the relevant MSM Chapter and Addendum.

A. CRISIS BEHAVIORAL HEALTH SERVICES:

CCBHCs must provide through an existing state-sanctioned, certified or licensed system or network, rapid crisis response to address immediate needs, triage, stabilization and/or appropriate transfer to a higher level of care. Crisis behavioral health services include but are not limited to:

1. 24-hour mobile crisis to include evaluations, interventions and stabilization;

2. Telephonic crisis services. The CCBHC must ensure, once the emergency has been resolved, the recipient is seen in-person at the next encounter and the initial evaluation is reviewed;

3. Comprehensive suicide assessments and interventions using the Collaborative Management and Assessment of Suicidality to identify and address the immediate safety needs of the recipient;

4. Identifying and managing recipients who may be at-risk of or are currently experiencing withdrawal and determining the level of care needed to safely manage the severity of the withdrawal. When clinically indicated, recipients must be assessed for signs and symptoms of withdrawal using the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA/CIWA-Ar) and the Clinical Opiate Withdrawal Scale (COWS);

5. Ambulatory withdrawal management for recipients who can be managed in the community and coordinated referral for recipients who require higher levels of withdrawal management;

6. Targeted Case Management (TCM), links to community resources to address social determinates of health, such as access to safe housing, food and basic health care. When the TCM provider is working with children and their families, community resources must also be leveraged to provide wrap-around supports to increase family resiliency and reduce the risk of further crisis;

7. Brief, solution-focused interventions to assist recipients and/or their families in finding strength-based ways to address their needs and ameliorate further crisis. These interventions include Solution-Focused, Brief Psychotherapy (SFBT) and the use of Wellness Recovery Action Plans (WRAP) for the development of a crisis plan to support recipients in advocating for their own preferences for care; and/or

8. Care coordination and discharge planning for recipients needing referrals to higher levels of care.

B. SCREENING, ASSESSMENT AND DIAGNOSTIC SERVICES

CCBHCs must appropriately screen, assess and diagnose recipients with behavioral health disorders for their optimal success and to provide the foundation for treatment and services. CCBHCs must also utilize standardized, validated evidenced-based screening and assessment tools with developmentally, culturally and linguistically appropriate measures, and, where appropriate, motivational interviewing techniques.

1. SCREENING

CCBHCs must:

a. Ensure all new recipients receive a preliminary screening and risk

assessment to determine acuity of needs;

b. Upon completion of a screen, provide further diagnostic assessment/ evaluation services when clinically indicated; and

c. Ensure immediate, appropriate action, including any necessary subsequent outpatient follow-up if the screening or other evaluation identifies an emergency or crisis need.

2. ASSESSMENT AND DIAGNOSIS

All CCBHC services must be based on a comprehensive person- and family-centered diagnostic and treatment planning evaluation. This biopsychosocial assessment must be completed with the recipient and in consultation with the primary care provider, if any, within 60 calendar days of the first request for services.

Standardized and evidence-based biopsychosocial assessments help guide the clinician, in collaboration with the recipient and/or their families, to make informed decisions on their treatment and recovery support options. Assessments include aspects of motivational interviewing and treatment matching options and consider a recipient's or family's preferences and stages of treatment engagement. To ensure continuity of care, avoid duplication of services and to reduce frustration on the part of the recipient and/or their family due to repetitious disclosure, the CCBHC must make every effort to obtain and update the most recent comprehensive assessment available.

3. The initial evaluation must include:

a. Preliminary diagnoses and severity rating;

b. Source of referral;

c. Reason for seeking care, as stated by the recipient or other individuals who are significantly involved;

d. Identification of the recipient's immediate clinical needs related to the behavioral health diagnosis(es);

e. List of current prescriptions and over-the-counter medications, as well as other substances the recipient may be taking;

f. Assessment of whether the recipient is a risk to self or others, including

suicide risk factors;

g. Assessment of whether the recipient has other concerns for their safety;

h. Assessment of the need for medical care (with referral and follow-up as required);

i. Determination of whether the recipient presently is or ever has been a member of the U.S. Military;

j. Assessment and documentation of COD, SED/Non-SED, SMI/Non-SMI or SUD status; and in addition;

k. For children, a comprehensive assessment must include:

1. The Children's Uniform Mental Health Assessment (CUMHA) and the Child and Adolescent Service Intensity Instrument (CASII); and

2. Other age appropriate screening and prevention interventions including, where appropriate, assessment of learning disabilities.

l. For adults, the comprehensive assessments must include:

1. Level of Care Utilization System (LOCUS); or

2. American Society of Addiction Medicine-Patient Placement Criteria (ASAM); and

3. World Health Organization Disability Assessment Scale Version 2 (WHODAS 2.0).

C. CHRONIC DISEASE MANAGEMENT: Recipients with chronic health conditions must receive specific documented approaches intended to manage and monitor their disease(s). This includes coordinating care to reduce the impact on their overall physical health care and behavioral health recovery. Chronic disease management includes recipient and/or family education, support and assistance for self-management.

D. INTENSIVE FAMILY INTERVENTION SERVICES: Family-centered and family-driven services that are based on the strengths of the recipient's family and include family support services. The focus of these services is to preserve and empower families by finding solutions that best meet their needs through home-based interventions, education and skills building. These services include assisting families to get their basic needs met (e.g., food, housing, transportation and/or childcare).

E. INTENSIVE COMMUNITY-BASED BEHAVIORAL HEALTH CARE FOR MEMBERS OF THE U.S. MILITARY AND VETERANS: Care that is consistent with the minimum clinical mental health guidelines promulgated by the VHA and the VHA's Uniform Mental Health Services Handbook. These integrated and coordinated care services are provided by the CCBHC to:

1. U.S. Military members located 50 miles are more (or one hour's drive time) from a Military Treatment Facility; and

2. Veterans living 40 miles or more (driving distance) from a VA medical facility, or as otherwise required by federal law.

F. PRIMARY CARE SCREENING AND MONITORING SERVICES: Basic preventive health services for recipients to improve overall health outcomes. These services are considered to have high value in the prevention and intervention of preventable health and chronic health conditions and include family planning, vaccinations and well-visits. Primary care services include outpatient primary care screening and monitoring. This service monitors key health indicators and health risks and identifies the need for the coordination of care. CCBHCs must provide, collect, report, monitor and document the following services on the integrated treatment plan:

1. Adult body mass index (BMI) screening and follow-up;

2. Adult major depressive disorder suicide risk assessment;

3. Child and adolescent major depressive disorder suicide risk assessment;

4. Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications;

5. Screening for clinical depression and follow-up plan;

6. Tobacco use, screening and cessation intervention;

7. Unhealthy alcohol use, screening and brief counseling; and

8. Weight assessment and counseling for nutrition and physical activity for children and adolescents.

G. OCCUPATIONAL THERAPY: Services provided by an Occupational Therapist licensed in the State that are designed to restore self-care, work and leisure skills to eligible recipients with functional impairments in order to increase their ability to perform tasks of

daily living. Services must meet medical necessity and comply with the requirements of MSM Chapter 1700 – Therapy.

H. PEER SUPPORT SERVICES: Services to improve recipient engagement by providing them support from individuals with lived experience to bring meaningful insights into the journey of recovery.

I. PSYCHIATRIC REHABILITATION: Recovery supports that are rehabilitative in nature and are behavioral health services/interventions designed to engage recipients in regaining skills and abilities necessary to live independent and self-directed lives.

J. SMOKING CESSATION: Evidence-based strategies to assist the recipient in quitting smoking to include referral to the Nevada Tobacco Quit Line and health education classes aimed at providing support information and needed encouragement.

K. TARGETED CASE MANAGEMENT (TCM): Services that assist CCBHC recipients in gaining access to needed medical, social, educational and other support services including housing and transportation needs; however, they do not include the direct delivery of medical, clinical or other services. Components of TCM services include case management assessment, care planning, referral/linkage and monitoring/follow-up.

All TCM services provided must comply with MSM Chapter 2500, Case Management. Target groups for the CCBHC include those listed under MSM Chapter 2500, Non-Seriously Mentally Ill (Non-SMI) Adults, Serious Mental Illness Adult, Non-Severely Emotionally Disturbed (Non-SED Children and Adolescents), Severe Emotional Disturbance (SED) Children and Adolescents

1. LEAD CASE MANAGER is only used if a recipient is included in more than one target group at a given time or is eligible to receive case management services from different programs (i.e. CCBH, MCO, or governmental agencies). The Lead Case Manager coordinates the recipient's care and services with another case manager. The Lead Case Manager is responsible for coordinating the additional case management services, whether or not, chronologically, the Lead Case Manager was the original or the subsequent case manager. When a recipient is eligible for MCO, it is the responsibility of the Lead Case Manager to ensure that the identified MCO is notified of the recipient's participation in targeted case management. The Lead Case Manager will coordinate all care with the MCO to ensure there is an elimination of any potential for duplication of services.

2703.17 DOCUMENTATION REQUIREMENTS