

MEDICAID SERVICES MANUAL  
TRANSMITTAL LETTER

January 28, 2020

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CODY L. PHINNEY, DEPUTY ADMINISTRATOR */Cody L. Phinney/*

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

**BACKGROUND AND EXPLANATION**

Revisions to Medicaid Services Manual (MSM) Chapter 2700 – Certified Community Behavioral Health Center Services are being proposed to update language throughout the chapter based on integration of the Certified Community Behavioral Health Center (CCBHC) model within state plan authority. The CCBHC was previously only under the authority of Section 223(a)(2)(F) of Protecting Access to Medicare Act (PAMA). The proposed revisions also include additions to the chapter to clarify an access site and guidance for CCBHCs dually enrolled as Federally Qualified Health Centers (FQHC). Additionally, the proposed revisions include the removal of non-state plan covered services, including Family Peer Support, Supported Employment and Targeted Case Management for individuals with Substance Use Disorder.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: This proposed change affects all Medicaid-enrolled providers delivering services under the Certified Community Behavioral Health Center model, Provider Type 17 Specialty 188.

Financial Impact on Local Government: Unknown at this time.

These changes are effective January 29, 2020.

**MATERIAL TRANSMITTED**

MTL 03/20  
Chapter 2700 – Certified Community  
Behavioral Health Center Services

**MATERIAL SUPERSEDED**

MTL 12/17  
Chapter 2700 – Certified Community  
Behavioral Health Center Services

<b>Manual Section</b>	<b>Section Title</b>	<b>Background and Explanation of Policy Changes, Clarifications and Updates</b>
<b>Throughout Chapter 2700</b>	<b>Throughout Chapter 2700</b>	Certified Community Behavioral Health Clinic has been changed to Certified Community Behavioral Health Center.
<b>Throughout Chapter 2700</b>	<b>Throughout Chapter 2700</b>	Changed CCBHC demonstration to CCBHC program.
<b>2701</b>	<b>AUTHORITY</b>	Added language to clarify the demonstration authority has been extended.  Added Nevada State Plan 4.19-A and Nevada State Plan 3.1-A.  Added CMS 2261-P, Centers for Medicare and Medicaid Services (CMS).
<b>2702(B)</b>	<b>DEFINITIONS</b>	Added language to include authority of state plan.
<b>2702(F)(4)(c)</b>		Remove Supported Employment.
<b>2702(F)(6)(b)</b>		Remove Family Support Services.
<b>2702(H)</b>		Remove Family Support Services definition.
<b>2702(I)</b>		Remove Family Support Specialist definition.
<b>2702(S)</b>		Remove Supported Employment definition.
<b>2703.3(A)(12)</b>	<b>GENERAL PROVISIONS</b>	Clarifying language related to timeline submission of cost report.
<b>2703.7(A)(3)(a-b)</b>	<b>ACCESS TO CARE</b>	Added clarifying language for an access site.
<b>2703.11</b>	<b>SUPERVISION STANDARDS</b>	Adding language to describe source of supervision requirement.
<b>2703.16</b>	<b>SERVICES</b>	Removed link to Allowable Services grid and described where to find it.
<b>2703.16(B)(3)(k)(1)</b>		Removed requirement to include the Child Abuse and Neglect Systems (CANS) in comprehensive assessment.
<b>2703.16(H)</b>		Removed Family Support Services.
<b>2703.16(K)</b>		Removed Supported Employment.

<b>Manual Section</b>	<b>Section Title</b>	<b>Background and Explanation of Policy Changes, Clarifications and Updates</b>
<b>2703.16(L)</b>		Removed Co-occurring Disorders (COD) and recipients with Substance Use Disorders (SUD).
<b>2703.18(C)</b>	<b>UTILIZATION MANAGEMENT</b>	Removed language of the Health Care Guidance Program since it is no longer a program.
<b>2703.22</b>	<b>FEDERALLY QUALIFIED HEALTH CENTERS DUALY ENROLLED AS A CCBHC</b>	Added clarifying language.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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CERTIFIED COMMUNITY BEHAVIORAL HEALTH **CENTER** SERVICES

2700 INTRODUCTION

Nevada Medicaid reimburses for the Certified Community Behavioral Health **CENTER** (CCBHC) model for children and adults under a combination of mental health rehabilitation, medical/clinical and institutional authority. The intent of the CCBHC model is to increase access to high quality, coordinated and integrated care that is outcomes-based across the continuum of care. The services must be recommended by a physician or other licensed practitioner of the healing arts working within their scope of practice under state law. Services are provided for the maximum reduction of a physical and mental disability and to restore the recipient to the best possible functioning level. The services are provided in the least restrictive, most normative setting possible and must be delivered in a CCBHC delivery model. The CCBHC provides developmentally appropriate services that are recovery-oriented, person- and family-centered, strengths-based and trauma-informed in a culturally and linguistically competent manner. The CCBHC delivery model ensures recipient participation in shared decision-making regarding their individualized treatment and recovery plans and engages recipients and their families in active participation in their care. The provision of services occurs within community settings, using a welcoming approach that encourages and supports treatment to occur “beyond the four walls” of a traditional treatment setting, increasing availability and accessibility of care.

CCBHCs meet the psychosocial and physical health needs of the recipient through the provision of direct services and through effective case management and care coordination. CCBHCs may collaborate with a Designated Collaborating Organization (DCO) that is an extension of the CCBHC delivery model. This innovative and flexible delivery model provides whole person responsive and preventative care to best meet the needs of the recipient. Services assist recipients to develop, enhance and/or retain behavioral and physical health, social integration skills, personal adjustment and/or independent living competencies in order to experience success and satisfaction in environments of their choice and to function as independently as possible. Interventions occur concurrently and begin as soon as clinically possible.

CCBHC providers must ensure that all services are coordinated across the continuum of care and provided under this chapter and according to most recent edition of the relevant Medicaid Services Manuals (MSM) sections to include, but not limited to, Chapters 100, 400, 600, 1700, 1900, 2500, 3400, 3800 and the MSM Addendum. Providers must ensure all services are evidenced-based and accepted as best practices based on the Substance Abuse and Mental Health Services Administration (SAMHSA) Evidenced-Based Practices Guide (reference: <https://www.samhsa.gov/ebp-web-guide>).

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## 2701 AUTHORITY

In 1965, the 89th Congress added Title XIX of the Social Security Act (SSA) authorizing varying percentages of Federal Financial Participation (FFP) for states that elected to offer medical programs. States must offer the 11 basic required medical services. Two of these are inpatient hospital services (42 Code of Federal Regulations (CFR) 440.10) and outpatient hospital services (42 CFR 440.20). All other mental health and substance abuse services provided in a setting other than an inpatient or outpatient hospital are covered by Medicaid as optional services. Additionally, state Medicaid programs are required to correct or ameliorate defects and physical and mental illnesses and conditions discovered as the result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening for children 21 years or younger, whether or not such services are covered under the state plan (Section 1905(a) of the SSA).

Other authorities include:

- Nevada Medicaid Inpatient Psychiatric and Substance Abuse Policy, Procedures and Requirements. The Joint Commission Restraint and seclusion Standards for Behavioral Health.

Health and Human Services (HHS) Sections 2701 through 2763, 2791 and 2792 of the Public Health Service (PHS) Act (42 USC 300gg through 300gg-63, 300gg-91 and 300gg-92), as amended.

(Reference: <https://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf>).

- **Section 223(a)(2)(F) of Protecting Access to Medicare Act (PAMA). This demonstration authority has been extended.**
- Section 2402(a) of the Patient Protection and Affordable Care Act (ACA).
- Section 2403(a) of the ACA: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs.
- **Nevada State Plan Section 4.19-A.**
- **Nevada State Plan Section 3.1-A.**
- **CMS 2261-P, Centers for Medicare and Medicaid Services (CMS) (Medicaid Program; Coverage for Rehabilitative Services).**

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2702 DEFINITIONS

The following definitions are listed for the purpose of this demonstration program only and are specific to the CCBHC delivery model. All other relevant definitions can be found in the appropriate MSM Chapter and the MSM Addendum.

- A. CARE COORDINATION:** Deliberately organizing, facilitating and managing a CCBHC recipient’s care. This includes coordinating all behavioral/mental and physical health activities regardless if the care is provided directly by the CCBHC and it’s DCO or through referral or other affiliation outside of the CCBHC delivery model. Care coordination includes:
1. Ensuring access to high-quality physical health care (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems and employment opportunities as necessary to facilitate wellness and recovery of the whole person. This may include the use of telehealth services.
  2. Having policies and procedures in place that comply with Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2 requirements specific to adults and children, and other privacy and confidentiality requirements of state or federal law to facilitate care coordination.
  3. Having policies and procedures in place to encourage participation by family members and others important to the recipient to achieve effective care coordination, subject to privacy and confidentiality requirements and recipient consent.
  4. Having policies and procedures in place to assist recipients and families of children and adolescents in obtaining appointments and keeping the appointments when there is a referral to a provider outside the CCBHC delivery model, subject to privacy and confidentiality requirements and consistent with the recipient’s and their family’s preference and need.
- B. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTER (CCBHC):** An entity that meets criteria as established by the Substance Abuse and Mental Health Services Administration (SAMHSA) demonstration program and is certified in the State of Nevada by the Division of Public and Behavioral Health’s (DPBH) Health Care Quality and Compliance (HCQC) bureau. CCBHCs provide and contract with DCOs that provide services in accordance with the Protecting Access to Medicare Act of 2014 (PAMA) **if providing service through this authority and with state plan.**
- C. CLINICAL SUPERVISOR:** A licensed behavioral health professional operating within the scope of their practice under state law who has specific education, experience, training,

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credentials and licensure to coordinate and oversee an array of behavioral health services and ensure clinical compliance with the requirements of a CCBHC delivery model. The Clinical Supervisor has administrative and clinical oversight of the program and must ensure that services provided are medically necessary, and clinically, developmentally, culturally and linguistically appropriate, and follow an evidence-based model.

- D.** CO-OCCURRING BEHAVIORAL HEALTH DISORDER (COD): Recipients with co-occurring disorders are those who currently, or at any time in the past year (12 continuous month period), have had a diagnosable substance use and a mental health disorder that meets the coding and definition criteria specified in the most current International Classification of Diseases (ICD), that has resulted in a functional impairment which substantially interferes with or limits one or more major life activity. This impairment also hinders their ability to function successfully in several areas including social, occupational and/or educational environments, or substantially interferes with or limits them from achieving or maintaining housing, employment, education, relationships or safety.
- E.** DESIGNATED COLLABORATING ORGANIZATION (DCO): A distinct entity that is not under the direct supervision of a CCBHC, but has a formal contractual relationship with a CCBHC to provide an authorized CCBHC service. The CCBHC must ensure the DCO provides the same quality of care as those required by the CCBHC program. The CCBHC maintains ultimate clinical responsibility for the services provided to CCBHC recipients by the DCO under this agreement. To the extent that services are required 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 the overall coordination of a recipient’s care including services provide by the DCO or those to which it refers a recipient.
- F.** EVIDENCED-BASED PRACTICE (EBP): Services that have specific fidelity measures for proven effectiveness. CCBHCs and DCOs must provide EBP services that meet criteria as best practices and approaches for the purpose of the CCBHC program. The following required EBPs are meant to meet the needs of the broader focus of recipients served throughout their lifespan and set the minimum standard of practice in the application of EBPs. The CCBHC may select more population-specific EBPs listed in the SAMHSAs Evidenced-Based Practices Guide to reflect the unique needs of their communities.
  - 1. Crisis Behavioral Health Services
    - a. Collaborative Management and Assessment of Suicidality
    - b. Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA/CIWA-Ar)
    - c. Clinical Opiate Withdrawal Scale (COWS)



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- d. Targeted Case Management (TCM)
- e. Solution-Focused, Brief Psychotherapy (SBFT)
- f. Wellness Recovery Action Plans (WRAP)
- 2. Screening, Assessment and Diagnostic Services
  - a. Achenbach Children’s Behavioral Checklists
  - b. Ages and Stages Questionnaire-Social Emotional
  - c. CRAFT Screening Test
  - d. Patient Health Questionnaire-9 (PHQ-9)
  - e. DSM-5 Level 1 and 2 Cross-Cutting Symptom
  - f. Child and Adolescent Needs and Strengths (CANS)
  - g. Children’s Uniform Mental Health Assessment (CUMHA)
  - h. Child and Adolescent Services Intensity Instrument (CASII)
  - i. Level of Care Utilization System (LOCUS)
  - j. American Society of Addiction Medicine – Patient Placement Criteria (ASAM)
  - k. World Health Organization Disability Assessment Scale Version 2 (WHODAS 2.0)
- 3. Outpatient Mental Health and Substance Use Treatment
  - a. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
  - b. Cognitive Behavioral Therapies (CBT) including Dialectical Behavior Therapy (DBT) and Acceptance and Commitment Therapy (ACT)
  - c. Family Check-Up and Everyday Parenting
  - d. Motivational Interviewing

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- e. Integrated Dual Diagnosis Treatment; Life Skills Training
- f. Illness Management and Recovery (IMR)
- g. Medication Management
- h. Body Mass Index
- i. Metabolic Monitoring with Atypical Antipsychotics
- 4. Psychiatric Rehabilitation Services
  - a. Basic Skills Training and Psychosocial Rehabilitation
  - b. Life Skills Curriculum
  - c. Assertive Community Treatment
- 5. Behavior Change and Counseling Risk Factors
  - a. Screening, Brief Intervention and Referral to Treatment (SBIRT)
  - b. Nursing Quit-Line
  - c. Chronic Disease Management
- 6. Peer Support, Counselor Services and Family Supports
  - a. Peer Support Services
- G. FAMILY-CENTERED: An approach to the planning, delivery and evaluation of care based on active participation and input from a recipient’s family and the CCBHC. Family-centered care recognizes families as the ultimate decision-makers for their child, with the child encouraged to gradually take on more and more of the decision-making. Services are culturally, linguistically and developmentally appropriate and youth-guided and not only meet the behavioral, mental, emotional, developmental, physical and social needs of the child, but also support the family’s relationship with the child’s health care providers.
- H. INTENSIVE FAMILY INTERVENTION SERVICES: A comprehensive interdisciplinary array of flexible CCBHC services that are expected to improve or maintain a family system to support the recipient’s recovery and functioning level and to prevent an exacerbation of symptoms. Intensive Family **Intervention Services** provide support to the family to connect them to resources, provide mentoring or coaching and assist them with setting recovery

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goals and developing and implementing recovery action plans. These services also help families to solve problems directly related to recovery, including finding sober housing, developing appropriate social interactions, occupying free time, improving job skills or, if needed, assisting the family in traversing criminal or juvenile justice systems.

- I. **LINGUISTIC COMPETENCE:** Meaningful access to services that allow the recipient with Limited English Proficiency (LEP) or language-based disabilities to fully understand and participate in CCBHC services. Linguistic competence includes the use of interpretation/translation services (provided by individuals trained in a medical setting), bilingual providers, auxiliary aids and services that are ADA compliant. Linguistic competence also includes having written forms and signage at the appropriate literacy level for recipients and/or their families and that are available in alternate formats as needed for recipients with disabilities to accommodate functional limitations. CCBHCs and DCOs must also ensure outgoing phone messages/recordings reflect linguistic competence.
- J. **PEER SUPPORT SPECIALIST:** An individual who meets the provider qualifications in MSM Chapter 400 and uses their lived experience of recovery from mental or substance use disorders to deliver Peer Support Services. A Peer Support Specialist is an individual who is currently or was previously diagnosed with a mental and/or behavioral health disorder and who possesses the skills and abilities to work collaboratively with and under the clinical and direct supervision of a CCBHC. A Peer Support Specialist cannot be the legal guardian, spouse or parent.
- K. **PERSON-CENTERED:** Person-centered care involves the recipient to the maximum extent possible and also includes family members, legal guardians, friends, caregivers and others whom the recipient wishes to include. The recipient directs their care and the provider supports the recipient’s goals and wishes in their treatment and their health care goals, objectives and approaches used.
- L. **PERSON-CENTERED PLANNING:** An approach that focuses on the recipient’s goals, desires, strengths and needs for support in the development of an effective plan for treatment and in the provision of services. Services are individualized in partnership with the recipient served to ensure that they and their families (when appropriate) can select and direct meaningful and informed interventions. Services are matched to treatment needs, are outcome-based and designed to maximize each recipient’s independence, capabilities and satisfaction. (Also reference Person-Centered Treatment Planning in the MSM Addendum).
- M. **PRINCIPAL BEHAVIORAL HEALTH PROVIDER (PBHP):** A CCBHC clinician assigned to each recipient. The PBHP must ensure that:
  1. Regular contact is maintained with the recipient as clinically indicated and as long as ongoing care is required;

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2. A psychiatrist reviews and reconciles the recipient’s psychiatric medications on a regular basis;
3. Coordination and development of the treatment plan incorporates input from the recipient (and, when appropriate, the family with the recipient’s consent when the recipient possesses adequate decision-making capacity or with the recipient’s surrogate decision-maker’s consent when the recipient does not have adequate decision-making capacity);
4. Effective communication occurs with the recipient and addresses any of the recipient’s problems or concerns about their care. This includes discussion regarding future mental health care for recipients who are at high risk of losing decision-making capacity;
5. For a recipient who lacks the capacity to make a decision about their integrated treatment plan, that the recipient’s decision-making capacity is formally assessed and documented; and
6. For a PBHP providing services to a veteran recipient (in the case that the Veterans Health Administration (VHA) has not already assigned a PBHP), the PBHP must also:
  - a. Follow the most recent edition of the VHA Handbook; and
  - b. Ensure that collaboration occurs with the Veterans Administration (VA) Suicide Prevention Coordinator (SPC) at the nearest VA facility to support the identification of those who have survived suicide attempts and others at high risk, and to ensure that they are provided with increased monitoring and enhanced care.

**N.** RECOVERY: A process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential. CCBHC and DCO providers must utilize SAMHSAs working definition, dimensions and guiding principles of recovery from mental health disorders and substance use disorders in their clinical decisions. Reference <http://www.samhsa.gov/> for the latest best practices.

**O.** RECOVERY-ORIENTED: The recipient’s care is designed to promote and sustain their recovery from a behavioral health condition. Services are strengths-based and support the recipient to optimal functioning and community integration.

**P.** SUBSTANCE USE DISORDER (SUD): An individual with a substance use disorder (SUD) is a person who currently, or at the any time in the past year (12 continuous month period), has had a diagnosable substance use disorder that meets the coding and definition

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criteria specified in the most current ICD that has resulted in a functional impairment which substantially interferes with, or limits, one or more major life activity in several areas such as social, occupational or educational.

- Q.** TRAUMA-INFORMED: An approach to care which “realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, 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.” The six key principles of a trauma-informed approach include: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues (SAMHSA (2014)).

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2703 POLICY

2703.1 CERTIFIED COMMUNITY BEHAVIORAL HEALTH **CENTER** (CCBHC) DELIVERY MODEL

- A. The CCBHC delivery model incorporates the provision of expanded and non-traditional biopsychosocial services in a behavioral health clinic. Services focus on whole person, integrated care and the coordination of quality care for improved health outcomes for recipients with behavioral health disorders. The CCBHC delivery model is designed to increase provider flexibility and improve the responsiveness of services to meet the needs of recipients served.
- B. CCBHCs and DCOs must ensure that services are evidenced-based, address multiple domains, are provided in the least restrictive environment, and involve family members, caregivers and informal supports when considered appropriate per the recipient and/or their legal guardian. CCBHC and DCO providers must collaborate and facilitate full participation from the recipient’s team members including the recipient and their family (when appropriate), to address the quality and progress of the individualized treatment plan. CCBHCs must continuously work to improve services in order to ensure overall efficacy of the recipient’s care.
- C. In the case of child recipients, CCBHC and DCO providers must deliver youth-guided and family-driven effective/comprehensive services and monitor child and family outcomes through the utilization of Child and Family Team meetings. CCBHC and DCO providers must also coordinate care for any child recipient under the jurisdiction of a state or county child welfare agency with the relevant agency. The CCBHC must document this specific coordination in the child recipient’s medical record.
- D. Recipients receiving services from a CCBHC and/or DCO may receive services in conjunction with or independent of other services. Services are based on an on-going review of admission, continuing stay and discharge criteria. All services must be provided according to the Federal requirements of a CCBHC as prescribed by SAMHSA.

2703.2 PROVIDER STANDARDS

CCBHC providers must be certified by the following DPBH bureaus: HCQC and Substance Abuse Prevention and Treatment Agency (SAPTA). CCBHC providers must ensure timely access to integrated, coordinated and responsive care, treatment, interventions and services under an established CCBHC delivery model. This model is based on an integrated system of care that meets the individually assessed biopsychosocial needs of recipients served. The provision of services is based on medical necessity, clinical appropriateness and the emergent, urgent and stabilization needs of each recipient in conjunction with their goals and choices. Individuals must be offered entry into any service needed, regardless of the point of contact. All services must be coordinated

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across the continuum of care and provided under this chapter and according to all relevant MSM Chapters and Addendum.

2703.3 GENERAL PROVISIONS

A. CCBHC providers must:

1. Continuously meet HCQC certification criteria;
2. Ensure recipient’s rights and freedom to choose providers;
3. Ensure recipients have access to the CCBHC grievance procedures outlined in the certification criteria, including CCBHC services provided by a DCO;
4. Address specific sub-populations within their Medicaid populations. These sub-populations include, but are not limited to, recipients involved in the juvenile/criminal justice systems, children in child welfare, recipients at-risk for hospitalization, recipients transitioning from inpatient stays and recipients with co-morbid chronic health conditions;
5. Assign a PBHP to each recipient;
6. Ensure locations are accessible and recipients have a safe and functional environment;
7. Ensure outpatient clinic hours include night and weekend hours to meet the needs of recipients in crisis. This includes informing recipients of these services and how to access suicide/crisis hotlines and warm lines;
8. Provide outreach and engagement activities to assist recipients and their families in accessing services;
9. Coordinate access to transportation through Nevada Medicaid’s non-emergency transportation vendor;
10. Have adequate continuity of operations and disaster plans in place;
11. Maintain records and documentation as required by the CCBHC program to include the monitoring and reporting of the fidelity to selected core EBPs;
12. Submit a cost report at the end of the first year of doing business, or until a rebase is required by the DHCFP;

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13. Submit quarterly reports on the CCBHC and State led measures;
14. Submit ad hoc reports as requested;
15. Ensure all DCO services are evidenced-based and there are formal agreements with their DCOs to obtain access to data needed to fulfill the reporting obligations for the CCBHC program;
16. Comply with requests from the Qualified Improvement Organization (QIO)-like vendor; and
17. **Comply** with the DHCFP’s polices and **agency** review processes.

2703.4 RECIPIENTS IN THE U.S. MILITARY OR VETERANS

- A. CCBHCs must ensure services to U.S. Military and Veterans. CCBHCs must ask all recipients inquiring about or requesting services whether they have ever served in the U.S. Military. For those individuals who respond positively, the CCBHC must:
  1. Either direct them to care or provide the needed care;
  2. Offer assistance enrolling in the VHA programs;
  3. Ensure veterans and active duty military receive the required CCBHC services;
  4. Assign a PBHP with specific cultural competence in military and veteran’s culture to every veteran, unless the VHA has already assigned a PBHP;
  5. Provide care and services for veterans that are recovery-oriented, and adhere to the guiding principles of recovery as defined by the VHA and other VHA guidelines;
  6. Ensure all staff who work with military or veteran recipients are trained in cultural competence, and specifically military and veteran’s culture; and
  7. Ensure the individualized treatment plan complies with VHA requirements.

2703.5 STAFF COMPETENCIES

- A. CCBHCs and DCOs must ensure staff are competent and capable to provide CCBHC services that are developmentally, culturally and linguistically appropriate as documented by:



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1. Written policies and procedures to describe the methods used for assessing the skills and competencies of providers;
2. A list of in-service trainings and educational programs provided that includes documentation of the qualifications of the in-service trainers for each training topic as evidenced by their education, training and experience; and
3. Documentation of the completion of training and demonstration of competencies to provide CCBHC services within each staff's personnel record.
  - a. This documentation must include verification to show that each staff has completed the trainings required under the CCBHC program.

2703.6 CARE COORDINATION

- A. CCBHCs and DCOs must work on behalf of recipients in the coordination and management of their care to ensure effective outcomes. This includes all providers of behavioral/mental and physical health care and other agencies serving a joint recipient.

CCBHCs must have policies that ensure:

1. Coordination of care for recipients who present to the local emergency department (ED) or who are involved with law enforcement when in a crisis;
  2. A reduction in any delays in the initiation of services during and after a recipient has experienced a psychiatric crisis;
  3. Coordination with all State of Nevada Department of Health and Human Services programs to maximize benefits to recipients served, eliminate duplication of efforts, streamline processes and improve access to available community supports; and
  4. Effective and timely care coordination by having appropriate consents in place that meet HIPAA and 42 CFR Part 2 requirements.
- B. To ensure effective and timely care coordination, CCBHCs must also have agreements in place which describe the mutual expectations and responsibilities related to care coordination for each of the following providers unless the service is provided directly by the CCBHC:
1. Federally Qualified Health Centers (FQHCs);
  2. Rural Health Clinics (RHCs), when relevant;

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3. The recipient's primary care provider and other recipient providers of health care to ensure physical health care needs are addressed;
4. Ambulatory detoxification, medical detoxification, post detoxification step-down services and residential program(s) to include the ability to track the recipient's admission and discharge to these facilities;
5. Emergency departments which includes having protocols for transitioning recipients from emergency departments and other emergency settings to a safe community setting, including the transfer of medical records, prescriptions, active follow-up, a plan for suicide and homicide prevention and safety, where appropriate, and the provision of peer services;
6. Acute-care and psychiatric hospitals, including, outpatient clinics and urgent care centers;
7. Local law enforcement, criminal justice agencies and facilities including drug, mental health, veterans and other specialty courts;
8. Indian Health Services (IHS) and tribal programs;
9. Specialty providers of medications for treatment of opioid and alcohol disorders;
10. Homeless shelters/housing agencies;
11. Employment services systems;
12. Services for children e.g., schools, child welfare agencies, juvenile justice programs, youth regional treatment centers and state licensed and nationally accredited child placement agencies for therapeutic foster care service, when relevant;
13. Services for older adults, such as Aging and Disability Services Division (ADSD);
14. The nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center or other VA facility; and
15. Local human services programs (e.g., domestic violence centers, pastoral services, grief counseling, ACA navigators, food and transportation programs and other social and human services programs as identified by the recipient and/or their family as integral to their stabilization and/or recovery success).

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2703.7 ACCESS TO CARE

- A. CCBHC and DCO providers must ensure access to high quality behavioral and physical health care. This includes having policies in place that ensure:
1. Services cannot be refused due to the recipient’s residence which include protocols to address services for those living out of state;
  2. Initial services will not be denied to those who do not live in the CCBHC catchment area (where applicable), including the provision of crisis services and other services, and coordination and follow-up with providers in the recipient’s catchment area. Telehealth services may be provided;
  3. Services are available for recipients living in the CCBHC catchment area including those residing in remote areas of the CCBHC’s location;
    - a. An access site (or point) is a location where a CCBHC recipient can receive CCBHC services within the current service area. However, an access point is not intended to provide all of the required services under the CCBHC model.
    - b. A CCBHC offering more than four of the required services at this facility would be classified as a “satellite clinic” and would need to be certified as a CCBHC.
  4. Communication is made to the public of the availability of CCBHC services; and
  5. For access to higher levels of care, CCBHCs must:
    - a. Have procedures and services for transitioning recipients from emergency departments and these other settings to CCBHC care, for shortened lag time between assessment and treatment, and for transfer of medical records, prescriptions and active follow-up;
    - b. Have provisions for tracking recipients admitted to and discharged from these facilities (unless there is a formal transfer of care from the CCBHC);
    - c. Have care coordination agreements for recipients presenting to the facility at risk of harm to themselves or others which includes the coordination of consent for follow-up within 24 hours and continuing until the recipient is linked to services or is assessed as being no longer at risk; and

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- d. Have in place procedures that make and document reasonable attempts to contact all recipients discharged from these facilities within 24 hours of discharge.

2703.8 HEALTH INFORMATION TECHNOLOGY (HIT)

A. CCBHC providers must have HIT systems in place that:

1. Include Electronic Health Records (EHRs);
2. Capture demographic information, diagnoses and medications lists;
3. Provide clinical decision support;
4. Electronically transmit prescriptions to the pharmacy;
5. Allow reporting on data and quality measures required by the CCBHC program;
6. Allow the system to conduct activities such as population health management, quality improvement, disparity reduction, outreach and research; and
7. If the HIT is newly established, can also send and receive the full common data set for all summary of care records to support capabilities including transitions of care, privacy and security and to meet the *Patient List Creation* criterion (45 CFR 170.314(a)(14)) established by the Office of the National Coordinator (ONC) for ONC’s Health IT Certification Program.

2703.9 QUALITY ASSURANCE

A. CCBHCs must have in place a HCQC approved written Continuous Quality Improvement (CQI) Plan. CCBHCs must:

1. Comply with this plan and all other HCQC requirements to ensure on-going quality care;
2. Ensure the plan includes a description of how the public is made aware of the availability of CCBHC services;
3. Submit all required and requested data, quality and fidelity measures reports to comply with the requirements of the CCBHC program timely; and
4. Provide oversight and monitoring of all their DCOs to ensure services provided meet the requirements of the CQI plan; they are enrolled as an Ordering,

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Prescribing or Referring (OPR) provider, if relevant; they are compliant with the requirements of this chapter and all relevant MSM Chapters and Addendum; and the DCOs submit all required data reports timely which includes both CCBHC and State led measures.

2703.10 BOARD OF DIRECTORS

- A. CCBHCs must operate under established bylaws and have board members that are representatives of the individuals being served in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age and sexual orientation. In terms of representation of behavioral health disorders, CCBHCs must incorporate meaningful participation by adult consumers with mental illness, adults recovering from substance use disorders and family members of CCBHC consumers i.e., 51 % of the board are families, consumers or people in recovery from behavioral health conditions to provide meaningful input to the board about the CCBHC’s policies, processes and services.
- B. CCBHCs must provide the board:
  - 1. An annual financial audit and correction plan with the relevant management letter to address any deficiencies; and
  - 2. The following reports to verify timely access to care:
    - a. Recipients seeking an appointment for routine needs are provided an initial evaluation within 10 business days of the request;
    - b. Recipients seeking an appointment for an urgent need are seen and initial evaluation completed within one business day; and
    - c. Recipients with an emergency or crisis need receive immediate and appropriate action.

2703.11 SUPERVISION STANDARDS

CCBHC providers must ensure all services are provided under medical and clinical supervision as prescribed by this chapter and **within CCBHC certification criteria**. Non-compliance will result in the DHCFP provider termination and/or suspension without cause.

2703.12 RECIPIENT SATISFACTION OF CARE

CCBHC and DCO providers must demonstrate satisfaction of care by their recipients under the CCBHC delivery model by ensuring this satisfaction is measured and any dissatisfaction is responded to. This includes a satisfaction survey and the review of recipient responses by their

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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

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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;



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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



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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

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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.
- 1. 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).

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- 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 or 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

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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

#### 2703.17 DOCUMENTATION REQUIREMENTS

- A. CCBHCs must comply with the MSM Chapter 400 documentation requirements and must also document:
  1. The medical necessity and clinical appropriateness of services prescribed on an integrated and individualized person- and family-centered treatment plan;
  2. The coordination of care for recipients with all providers of behavioral and physical health care and, when relevant, with the VHA;
  3. How services are individualized and developmentally, culturally and linguistically competent for each recipient; and
  4. The tracking of and response to recipient’s accessing higher levels of care which includes discharge planning, implementation and coordination.

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2703.18 UTILIZATION MANAGEMENT

- A. The CCBHC delivery model expands access to crisis evaluation, ambulatory detoxification services and outpatient stabilization for recipients who are appropriate for such services. For recipients with needs that exceed outpatient treatment, CCBHCs are required to provide coordinated referrals to higher levels of care in the community.
- B. The role of the CCBHC includes follow-up after hospitalization for behavioral/mental health issues within seven and 30 days. CCBHCs are required to focus care coordination efforts towards recipients transitioning from inpatient behavioral health care to outpatient community treatment settings.
- C. The CCBHC must provide utilization management and oversight of all services performed by a DCO.

2703.19 COVERAGE AND LIMITATIONS

- A. Nevada Medicaid reimburses for all CCBHC services listed in this chapter based on the prospective payment system (PPS) rate methodology.
- B. The CCBHC is responsible for submission of claims including those on behalf of the DCO. Payments for DCO services will be made directly to the CCBHC.

2703.20 NON-COVERED SERVICES

- A. The following services are not covered under the CCBHC program for Nevada Medicaid and Nevada Check Up (NCU):
  1. Services under this chapter for a recipient who does not have a covered, current ICD diagnosis;
  2. Therapy for marital problems without a covered, current ICD diagnosis;
  3. Therapy for parenting skills without a covered, current ICD diagnosis;
  4. Therapy for gambling disorders without a covered, current ICD diagnosis;
  5. Custodial services, including room and board;
  6. Social model support group services (Peer Support Services are based on a medical model);
  7. More than one provider seeing the recipient in the same therapy session; and

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8. Respite.

2703.21 PROVIDER RESPONSIBILITIES

- A. CCBHCs must ensure recipients are informed of services, choices and their rights and responsibilities prior to the provision of services.
- B. Providers are also responsible for:
  - 1. Verifying Medicaid eligibility on a monthly basis.
  - 2. Submitting appropriate billing reflecting accurate procedure and code usage.

2703.22 **FEDERALLY QUALIFIED HEALTH CENTERS DUALY ENROLLED AS A CCBHC**

- A. FQHCs dually enrolled as a CCBHC should determine the appropriate model to bill medically appropriate rendered services. The FQHC and the CCBHC must have internal policies regarding the appropriate placement for treatment for their respective recipients. Medical necessity and clinical appropriateness as determined by the clinical professionals, under care coordination are required and should be taken into consideration when services overlap both within the FQHC and/or the CCBHC scope of services. This is to determine which encounter (FQHC or CCBHC) is appropriate to request reimbursement. Care coordination is required to prevent duplicative billing for the same service occurring at the same time.
- B. Services that are covered under the CCBHC model are identified on the services grid located in the CCBHC billing guide. Recipients that are accessing services that are primarily CCBHC and not an exclusively FQHC service will bill the CCBHC PPS rate. Services that are primarily FQHC specific and not exclusively CCBHC services will bill the FQHC encounter rate.
- C. The Medicaid Surveillance and Utilization Review unit (SUR) will monitor in a retrospective review for any duplication of billing between the two delivery models.

2703.23 RECIPIENT AND/OR FAMILY RESPONSIBILITIES

- A. Recipients or their legal guardians (when applicable) must:
  - 1. Participate in the development and implementation of their individualized treatment plan;
  - 2. Inform their Medicaid providers of any changes to their Medicaid eligibility; and

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3. Provide their Medicaid card to their service providers.

**2703.24 AUTHORIZATION PROCESS**

- A. Prior Authorizations are not required under the CCBHC model.
- B. The CCBHC has the ultimate clinical responsibility for all services including those provided by the DCO and must ensure the medical necessity and clinical appropriateness of the services.

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2704 HEARINGS

Please reference MSM Chapter – 3100, Hearings, for hearings procedures.