WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

BUREAU FOR MEDICAL SERVICES

Certified Community Behavioral Health Clinics Desk Guide

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Bureau for Medical Services

Certified Community Behavioral Health Clinics
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Table of Contents

1.0 Introduction 3
Background 3
Purpose of the West Virginia CCBHC Desk Guide 3
2.0 CCBHC Application and Certification Process 3
Provider Requirements 3
Application Process 3
Decertification Process 5
3.0 Providing CCBHC Services 6
Staffing 6
Privacy and Confidentiality 6
Member Rights and Responsibilities 6
Member Choice 6
Member Rights and Responsibilities 6
Grievance and Complaint Procedures 6
Emergency Preparedness 7
Clinical Policies and Procedures 7
Treatment Planning 7
Evidence-Based Practices 7
Crisis Intervention Procedures 8
Care Coordination 8
CCBHC Targeted Case Management (TCM) 8
Primary Care Screening and Monitoring 8
4.0 Billing and Reimbursement 9
General Information 9
Provider Identification Reporting 9
Client Eligibility and Enrollment 9
Reporting CCBHC Services 9
Use of Billing Modifiers 10
Prior Authorization Requirements 10
Special Billing Considerations 10
Third-Party Liability (TPL) 10
Common Billing Scenario Examples: 10
Quality Incentive Payments 11
5.0 Quality, Data Collection, and Reporting 11
Continuous Quality Improvement (CQI) Plan 11
Data Reporting: Clinic Collected Measures 11
Data Reporting: State Collected Measures 13

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6.0 Managed Care Organizations 15
Role of an MCO in a CCBHC Model 15
Role of CCBHC Provider for Individuals Enrolled in Managed Care 15
CCBHC Provider and MCO Communication 15
Points of Communication 16
7.0 List of Acronyms 16
8.0 Version Change Log 17

1.0 Introduction

Background

In March 2021, the West Virginia Legislature enacted W.Va. Code §9-5-30, directing the Medicaid agency, in partnership with the West Virginia Department of Human Services (DoHS), to establish a state certification process and payment system for Certified Community Behavioral Health Clinics (CCBHCs). Per West Virginia law, 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.

CCBHCs are designed to help ensure access to coordinated, comprehensive behavioral healthcare. 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 requirement includes developmentally appropriate care for children and youth.

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.

Purpose of the West Virginia CCBHC Desk Guide

The CCBHC Desk Guide offers West Virginia Medicaid-enrolled CCBHC providers guidance and resources as they develop policies and practices to implement CCBHC programming requirements, deliver services, and seek reimbursement.

The CCBHC Desk Guide is not intended to be interpreted as Medicaid policy. All Medicaid-enrolled CCBHC providers must be familiar with, and adhere to, West Virginia Medicaid policies and procedures. For Medicaid program CCBHC policy, please refer to the West Virginia Medicaid Policy Manual, *Chapter 503 Licensed Behavioral Health Centers, Appendix 503I.*

The Desk Guide contains links to non-state-operated websites that contain additional information relevant to the topics presented and may be useful to the reader. DoHS' Bureau for Medical Services (BMS) is not able to attest to the accuracy of information provided on the cited third-party websites. The links are provided for reference only and do not constitute an endorsement by the BMS of the sponsors, information, or any products presented on the websites.

The Desk Guide content is subject to change and will be updated as necessary to address new and emerging issues.

2.0 CCBHC Application and Certification Process

Provider Requirements

A CCBHC must meet all of the following minimum requirements:

- Be a nonprofit organization.
- Be a licensed behavioral health center (LBHC) in good standing with DoHS.
- Be enrolled as a Medicaid provider in West Virginia.
- Be an LBHC with a CCBHC certification as determined by DoHS.
- Be compliant with all federal, state, and local regulation, certification, and required auditing processes.
- Participate in the Substance Abuse and Mental Health Services Administration (SAMHSA) behavioral health treatment locator.

Application Process

Step 1. Complete a Community Needs Assessment: The principal purpose of the community needs assessment is to understand what needs exist in the community and what CCBHCs can do to address them. This involves:

- **Data Collection:** Gathering data on the population's behavioral health needs.
- **Stakeholder Engagement:** Consulting with community members, individuals with lived experience, individuals receiving care, healthcare providers, and other stakeholders to identify gaps in services and areas of high need.
- **Analysis:** Analyzing the data to prioritize services and interventions that will address the most pressing community needs.
- **Documentation:** Document the findings and how the organization plans to address the identified needs in their service delivery model.

Step 2. Letter of Intent: Submit a formal letter expressing intent to become a West Virginia CCBHC to the BMS:

West Virginia Department of Human Services
Bureau for Medical Services
Attention: Behavioral Health & Long-Term Care Unit
350 Capitol Street, Room 251
Charleston, West Virginia 25301

Step 3. Submission of Application: Upon receipt of the Letter of Intent, applicants will be provided detailed instructions on how to submit a completed application to the DoHS and the BMS.

Step 4. **Application Review:** The CCBHC Certification Review Committee, which includes staff from the BMS, DoHS's Bureau for Behavioral Health (BBH), and designated representatives, will review the application. Applicants who meet the minimum requirements will be permitted to advance to Step 5 of the application process.

Step 5. Site Review: The on-site review is an essential component of the certification process. During this review, the CCBHC Certification Review Committee will:

- **Meet with Leadership and Staff:** Discuss the CCBHC organization's vision, operations, and readiness for certification.
- **Review Policies and Procedures:** Evaluate the documentation and implementation of policies and procedures.
- **Facility Tour:** Inspect the physical environment to ensure the facility meets the standards for safety, accessibility, and service provision.
- **Additional Activities:** Conduct other necessary activities to evaluate the organization's readiness and compliance with CCBHC standards.

Step 6. Cost Report: Once an application has been accepted, the applicant must prepare a cost report using the SAMHSA federal template. This involves:

- **Data Collection**: Gather financial data related to service delivery, staffing, and operational costs.
- **Report Preparation**: Complete the SAMHSA cost report template with accurate and detailed financial information.
- **Audit and Validation**: The cost report will undergo review and validation to establish the payment rate.

Step 7. Certification Determination: After conducting the on-site review, the CCBHC Certification Review Committee will inform the applicant of their application status. The status may be:

  - Certified: The applicant has demonstrated compliance with all requirements to become a West Virginia CCBHC, pending cost report approval.
  - Not Certified: The applicant currently does not meet the requirements to become a CCBHC. A complete application must be resubmitted.

Step 8. Recertification: After the initial certification, CCBHCs are required to undergo a recertification process every three years to maintain their status and ensure ongoing compliance with all applicable standards and requirements. CCBHCs must submit their application at least 90 days but no more than six months prior to their certification expiration. This includes:

- **Self-Assessment**: Conducting an internal review to ensure continued compliance with CCBHC standards.

- **Application for Recertification**: Submitting documentation and evidence of ongoing compliance.
- **On-Site Review**: Undergoing another review and an on-site visit by the CCBHC Certification Review Committee.

Decertification Process: The BMS reserves the right to terminate certification due to non-compliance of policy, state licensing revocation, or reports of fraud, waste, abuse, or other issues that are indicative of improper practice. A decertified CCBHC may reapply for certification upon receipt and approval by the BMS of a remedial plan that addressed prior deficiencies. The decertification process in West Virginia includes the following steps:

Step 1. Identification of Non-Compliance:
- **Monitor and Evaluation:** Regular monitoring and evaluation are conducted by BMS and BBH to ensure ongoing compliance.
- **Reporting Issues:** Non-compliance may be identified through routine monitoring, audits, stakeholder reports, or complaints.

Step 2. Notification of Non-Compliance:
- **Formal Notice:** The CCBHC will receive a formal written notice detailing the areas of non-compliance.
- **Timeline for Correction:** The notice will specify a timeline within which the CCBHC must address and correct the identified issues.

Step 3. Corrective Action Plan (CAP):
- **Development of CAP:** The CCBHC must develop and submit a CAP outlining the steps it will take to address the non-compliance issues.
- **Approval of CAP:** The CAP must be approved by the CCBHC Certification Review Committee. The CAP must be completed within the timeline specified in the formal written notice of non-compliance.

Step 4. Follow-Up Review:
- **Implementation Review:** After the CAP implementation period, the CCBHC Certification Review Committee will conduct a follow-up review to assess the effectiveness of the corrective actions.
- **Compliance Verification:** The CCBHC Certification Review Committee will verify whether the CCBHC has successfully addressed the non-compliance issues.

Step 5. Decertification Decision:
- **Evaluation:** If the CCBHC fails to correct the non-compliance issues within the specified timeline or if the corrective actions are deemed insufficient, the CCBHC Certification Review Committee will evaluate the next steps.
- **Final Decision:** The CCBHC Certification Review Committee will make a final decision regarding the decertification of the CCBHC. The possible outcomes include.
- **Maintain Certification:** If compliance is achieved, the CCBHC will maintain its certification status.
- **Decertification:** If non-compliance persists, the CCBHC will be decertified.

Step 6. Notification of Decertification:
- **Written Notification:** The CCBHC will receive a formal written notice of decertification detailing the reasons and effective date.
- **Right to Appeal:** The notice will include information on the CCBHC's right to appeal the decertification decision, including the process and timeline for submitting an appeal.

Additional Resources:

- West Virginia Medicaid Policy Manual, *Appendix 503I Certified Community Behavioral Health Clinics*.
- West Virginia Medicaid Policy Manual, *Appendix 503I.1 Certified Community Behavioral Health Clinics Application*.
- West Virginia Medicaid Policy Manual, *Appendix 503I.2 Certified Community Behavioral Health Clinics Service Codes*.
- National Council for Mental Wellbeing: *Community Needs Assessment Toolkit.*
- U.S. Department of Health and Human Services: *Certified Community Behavioral Health Clinic Cost Report Instructions.*

For further information and guidance on the certification process, applicants can contact the BMS or the BBH.

3.0 Providing CCBHC Services

CCBHC providers are required to provide a comprehensive array of behavioral health and physical health screening and monitoring services as part of their CCBHC designation. A descriptive list of required covered services is described in the West Virginia Medicaid Policy Manual, *Chapter 503, Appendix I, CCBHC* and is also listed in the *CCBHC Service Code Matrix* reference document.

Additional information and guidance related to the provision of these services is provided below.

Staffing

CCBHCs must have a documented staffing plan that is responsive to the community needs assessment and in compliance with state licensure requirements. Staff training plans must incorporate comprehensive new staff orientation, competency training, and ongoing opportunities for staff development and education. CCBHCs are to ensure that individuals providing training to CCBHC staff have the qualifications to do so, as evidenced by their education, training, and experience. CCBHCs are to have policies and procedures indicating how they assess the competencies of staff and maintain staff records of completed trainings.

Additional Resources:

- West Virginia Department of Health: *West Virginia Department of Health Office of Health Facility Licensure & Certification*

Privacy and Confidentiality

CCBHCs must have procedures in place that ensure compliance with the Health Insurance Portability and Accountability Act of 1966 (HIPAA) and 42 Code of Federal Regulations (CFR) Part 2. These procedures include, but are not limited to, requirements specific to minors, the release of SUD treatment records, and meeting all other state and federal privacy requirements. CCBHCs should educate, inform, obtain, and document patient consent at intake and at regular intervals.

Additional Resources:

- The BMS: *HIPAA Resources*
- U.S. Department of Health and Human Services: *Health Information Privacy*
- *42 CFR Part 2*
- SAMHSA: *Substance Use Confidentiality Regulations*

Member Rights and Responsibilities

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 whether the member is receiving some, or all of, their services at a CCBHC. Members covered by a managed care organization (MCO) will use only in-network providers unless prior approval is granted by the member's MCO.

Member Rights and Responsibilities

Individuals have rights and responsibilities related to their Medicaid benefits as outlined in the West Virginia Medicaid Provider Manual, *Chapter 400, Member Eligibility*, and member *Guide to Medicaid*. These rights and responsibilities extend to services associated with CCBHCs. CCBHCs must educate and inform members of the CCBHC model of care as well as member rights and responsibilities and document their efforts at intake and regular intervals. CCBHC staff must provide this information to members in a way that is accessible for the individual, considering reading level, cultural nuances, and language translation needs.

Grievance and Complaint Procedures

The CCBHCs must have a formal policy and procedure to help ensure members receiving services are fully informed of, and have access to, CCBHC grievance procedures and independent advocacy services, including for CCBHC services are provided by a designated collaborating organization (DCO). Information about grievance procedures must be provided in an intake package for people receiving services and posted in CCBHC waiting

areas and websites. This information must be written in a way that is accessible for the individual, considering reading level, cultural nuances, and language translation needs.

Additional Resources:

- West Virginia: *Guide to Medicaid*
- West Virginia *Office of the Mental Health Ombudsman*

Emergency Preparedness

CCBHCs are required to have a continuity of operations/disaster plan. The plan will help ensure the CCBHC is able to effectively notify staff, people receiving services, and healthcare and community partners when a disaster/emergency occurs, or services are disrupted. The CCBHC, to the extent feasible, should have identified alternative locations and methods to sustain service delivery and access to behavioral health medications during emergencies and disasters. The plan must also address health information technology (IT) systems security/ransomware protection and backup and access to these IT systems, including health records, in case of disaster.

Additional Resources:

- SAMHSA: *SAMHSA Disaster Behavioral Health Planners Resource Portal*

Clinical Policies and Procedures

Treatment Planning

All members receiving services from 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, intake, 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.

Care, treatment, and service goals should be individualized and reflect the member's own words. They should be measurable and reviewed at specific time frames as required. Members should be involved in the decision making for treatment planning.

Treatment plan progress should be documented in such a way that CCBHCs can aggregate progress across services and the program to be able to report on effectiveness of services. For example, providers should be able to calculate the percentage of members who meet one or more treatment plan goals within a year or what percentage of treatment plan goals are met within a year, on average.

Evidence-Based Practices

CCBHC selection of evidence-based practices should be guided by the needs assessment, needs of the community being served, and state requirements and regulations. CCBHCs should develop and document plans for ensuring fidelity to the model for the evidence-based practices used in their clinical settings. Fidelity to the model should include a measurement of effectiveness and health outcomes that the CCBHC can demonstrate at the individual and aggregate levels across the program to evaluate if the Evidence-Based Practices program is having a positive impact on individuals' health.

As a provider resource, the DoHS developed the BBH Clearinghouse, which is a repository of prevention, early intervention, treatment, and recovery programs that have been systematically reviewed for evidence of effectiveness for children and young adults with behavioral health needs and their families. The clearinghouse is intended to give West Virginia service providers and stakeholders an array of evidence-based options for program implementation. It is not an exhaustive review of all available resources.

Additional Resources:

- West Virginia Department of Human Services – *BBH Clearinghouse*
- National Council for Mental Wellbeing – *CCBHC Evidence-Based Practice Reference Guide*
- SAMHSA *Evidence-Based Practices Resource Center*

Crisis Intervention Procedures

CCBHCs must have policies and procedures to ensure immediate, clinically directed action, including crisis planning and subsequent follow-up if the screening or other evaluation identifies an emergency or crisis need.

Additional Resources:

- West Virginia Medicaid Policy Manual, *Appendix 503H Community-Based Mobile Crisis Intervention Services*
- *SAMHSA: SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit*

Care Coordination

CCBHCs must 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 health outcomes.

Additional Resources:

- National Council for Mental Wellbeing – *CCBHC Care Coordination Toolkit*

CCBHC Targeted Case Management (TCM)

CCBHC's 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.

CCBHCs are required to provide CCBHC TCM for children and adults with significant needs who meet CCBHC TCM criteria. CCBHCs must follow requirements under *Chapter 503 Appendix I, CCBHC,* and may not bill for services under *Chapter 523, Targeted Case Management* policy manual.

Primary Care Screening and Monitoring

A CCBHC is responsible for ensuring that screening and monitoring of primary health indicators and risks, including prevention measures, is conducted. CCBHCs should coordinate with primary care providers to support integrated provision of primary and behavioral healthcare. If the individual's primary care provider conducts the necessary screening and monitoring, the CCBHC is not required to do so if it has a record of the screening and monitoring and the results of any tests that address the health conditions included in the CCBHC's screening and monitoring protocols.

Screening protocols are to be 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 quality measures and reporting, per state and federal criteria

Additional Resources:

- U.S. Preventive Services Task Force *A & B Recommendations*
- West Virginia *HealthCheck*

4.0 Billing and Reimbursement

General Information

CCBHCs are reimbursed using a per diem Prospective Payment System (PPS-1) model. The CCBHC Service Code Matrix reference document will assist providers in identifying the CCBHC services that "trigger" a PPS-1 payment. Service codes that are indicated with a "Yes" in the "PPS trigger service (Yes/No)" column of the Service Code Matrix will trigger a PPS per diem payment to the CCBHC during claims adjudication:

- Only one PPS-1 per diem payment can be reimbursed each calendar day.
- For instances where multiple "trigger" services are delivered on a date of service, only one PPS per diem payment will be reimbursed.
- It is expected that all services rendered are reflected in the claim and documented by the provider. This includes all CCBHC "trigger" and "non-trigger" services.

Provider Identification Reporting

It is recommended that LBHCs use the currently enrolled National Provider Identifier (NPI) rather than requesting a new NPI for CCBHC provider enrollment.

- Requesting a new NPI will require the provider to enroll the new NPI, this includes submitting a new provider enrollment application and waiting on the provider enrollment approval process.
- Using the current NPI may be less burdensome on the providers and allow for a quicker system setup, letting the CCBHC start billing once certified.

When a provider submits a CCBHC application, the provider should include the current LBHC NPI. Once the application is approved, the BMS will send the approval notification to Gainwell to add the CCBHC provider specialty to the provider's NPI. Newly certified CCBHC providers are required to update their West Virginia Health PAS-OnLine provider enrollment account to update their provider specialty. CCBHCs will submit claims with the NPI indicated on the approved CCBHC application.

If a CCBHC provider has not previously submitted a UB-04 claim electronically to Medicaid, the provider may be required to submit testing files prior to being able to formally submit claims for payments. CCBHCs should contact the Electronic Data Interchange departments of the MCOs and Gainwell Technologies for additional information.

BMS will not require a specific taxonomy code for CCBHCs.

Client Eligibility and Enrollment

CCBHCs are responsible for verifying an individual's eligibility before billing. Prior to billing, providers must also determine whether the member is enrolled in an MCO or if they are fee-for-service (FFS). CCBHCs should verify if the individual has other private health insurance and bill the other insurance, including Medicare, prior to billing Medicaid.

Reporting CCBHC Services

CCBHC providers are to bill their services using the uniform billing form, UB-04, with a 76X Bill Type. Revenue codes are required on a UB-04. The UB Code Editor provides standard coding guidance on types of bill and revenue codes. To define the X of the three-digit type of bill, providers may also reference the guidance provided for the UB-04, Inpatient/Outpatient Billing Instructions maintained at Health PAS-OnLine - Billing-Instructions (wvmmis.com) for selecting the most appropriate bill type code values for billing services and for reporting claim corrections.

To receive a CCBHC PPS-1 rate for services, providers must submit a UB-04 claim with:

- The CCBHC daily per diem encounter procedure code T1040 – **AND**
- At least one of the procedure codes from the CCBHC Service Code Matrix list designated as a PPS trigger service.

Additional billing guidelines include:

- All CCBHC required and allowed services rendered on the date of service are to be reported whether included in cost reporting or not.
- CCBHC providers are to report all services from a single date of services on one UB-04 claim; a UB-04 claim with multiple dates of service is not permitted.
- When reporting multiple service codes for a date of service, the code T1040 is to be reported on the first line of the claim.
- Providers can submit their encounter charges on the UB-04 for each line item; however, the only code that will receive payment is the T1040. The itemized services will pay $0.
- A facility-type NPI cannot be used in the attending provider field of the UB-04 claim. If used, the claim will be denied . It must be an individual-type NPI.
- Crisis Stabilization Unit (CSU), Children with Serious Emotional Disorders (CSED), Assertive Care Treatment (ACT), and SUD residential services are carved out of the CCBHC daily PPS encounter rate. Providers will bill the carved-out services on the uniform billing form, CMS-1500, as is the current process.
- Carved-out services will be reimbursed in accordance with existing Medicaid policy and reimbursement methodology.

To correct claims, providers are to follow existing Medicaid billing policies and procedures. The provider must void the paid claim and submit a corrected claim to account for any changes. If the claim is denied, a new claim may be resubmitted.

Use of Billing Modifiers

Modifiers are required as indicated in the CCBHC Service Code Matrix reference document. For services rendered via telehealth, modifiers are to be reported at the service code line (not the T1040 code) following existing Medicaid telehealth policy.

Prior Authorization Requirements

Providers may reference the *CCBHC Service Code Matrix* for information related to prior authorization requirements.

If any trigger code service requires prior authorization and the prior authorization is not included on the claim, the T1040 will deny for not having a valid prior authorization.

Special Billing Considerations

- If a CCBHC provides services through a DCO arrangement, the CCBHC must bill for the services.
- Co-payments: co-payments apply according to the current Medicaid co-pay policy (no changes).

Third-Party Liability (TPL)

Medicaid will process claims with TPL following third-party policy in *Chapter 600 Reimbursement Methodologies*.

All providers must ask Medicaid members if they have other public or private insurance or if there is potential that another entity may be liable for the service expense. Once identified, the provider must bill the third party. After receipt of payment or notice of denial for services rendered, the provider may then bill the claim to Medicaid with an attached copy of the Explanation of Benefits from the primary payer. Medicaid will then reimburse the lesser amount of the remainder of an approved claim up to the Medicaid allowable amount or the coinsurance and/or deductible amount.

Claims subject to third-liability rules may be submitted to Medicaid electronically with primary payer information. Providers are to report the third-party-liability information at the header level on the UB-04 claim form.

Common Billing Scenario Examples:

1. Provider renders multiple CCBHC services on a date of service, one that is a trigger service and one that is not.
    - Providers are to report the CCBHC encounter code T1040 and all CCBHC codes for services rendered, whether they trigger a PPS payment or not. One PPS payment will be made for the date

of service. The T1040 will pay the PPS encounter rate, all other service codes will pay $0 and not deny.

2. Provider renders a CCBHC service that does not trigger a PPS payment on a date of service and does not provide a CCBHC trigger service.
    - Providers are to report all CCBHC service codes, including those that do not trigger a payment. Providers are to report the CCBHC encounter code T1040 at $0. The reported non-trigger service code lines on the claim will pay $0.
    - The BMS expectation is that all CCBHC systems are configured by March 31, 2025.
3. Provider renders a CCBHC service that requires prior authorization, and prior authorization is not obtained or is not reported on the claim.
    - When a CCBHC trigger service requires prior authorization and the prior authorization is not reported on the claim, service code T1040 will deny.

Additional Resources:

- BMS: *CCBHC Service Code Matrix*
- West Virginia Medicaid Management Information System: *UB04 Billing Instructions*

Quality Incentive Payments

A quality incentive payment system will be established to achieve specific thresholds on performance metrics that BMS identifies after October 2024. Such quality incentive payments shall be in addition to the bundled prospective daily rate. Additional information will be provided at a future date.

5.0 Quality, Data Collection, and Reporting

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 DoHS 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.

Continuous Quality Improvement (CQI) Plan

CCBHCs must have a written CQI Plan, with a focus on improving behavioral and physical health outcomes and quality of care, reducing emergency department use, rehospitalization, and repeated crisis episodes.

CQI plans must be reviewed and approved by the DoHS Certification Committee upon application for CCBHC certification. CCBHCs are required to update their CQI plans and annually report to the 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, screening, and integration with primary care.

The CQI plan addresses priorities for improved health outcomes, 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:

- Suicide deaths or suicide attempts by the person receiving services.
- Fatal and non-fatal overdoses.
- All-cause mortality among people receiving services.
- 30-day hospital readmissions for psychiatric or substance use reasons for the person receiving services.
- Quality of care issues, including monitoring for metabolic syndrome, movement disorders, and other medical side effects of psychotropic medications.

Data Reporting: Clinic Collected Measures

CCBHCs are required to report on the following measures:

- Percentage of referrals that were accepted for assessment, evaluation, and outpatient services.
- Percentage of new people receiving services, with initial evaluation provided within 10 business days of first contact.

- All five SAMHSA required CCBHC measures listed below (Please refer to the *SAMHSA Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual*).

SAMHSA Required CCBHC Measure *Name, Designated Abbreviation, and Brief Description*	**Steward**	**Centers for Medicare & Medicaid Services (CMS) Core Set (2023)**	**SAMHSA Technical Specification Resource Manual (February 2024) Reference**
Time to Services (I-SERV): The I-SERV measure calculates the average time for members to access three different types of services at behavioral health clinics. The I-SERV measure is comprised of three sub-measures of time until provision of: 1. Initial evaluation, 2. Initial clinical services, and 3. Crisis services.	SAMHSA	n/a	Page 31
Depression Remission at Six Months (DEP-REM-6): The DEP-REM-6 measure calculates the percentage of members (12 years of age or older) with major depression or dysthymia who reach remission six months (+/- 60 days) after an index event date.	Minnesota Community Measurement	n/a	Page 40
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling: The Unhealthy Alcohol Use: Screening and Brief Counseling measure calculates the percentage of members aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months AND who received brief counseling if identified as an unhealthy alcohol user.	National Committee for Quality Assurance (NCQA)	n/a	Page 51
Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD): Percentage of members aged 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.	CMS	Adult and Child	Pages 70 and 77
Screening for Social Drivers of Health (SDOH): The SDOH measure calculates the percentage of members 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.	CMS	n/a	Page 61

CCBHCs must also track and report to the 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.

CCBHCs must collect, track, and report the following data on individuals receiving CCBHC services who receive residential treatment center (RTC) services and all people receiving services with SUD:

- Percentage of inpatient detox episodes that have a seven-day follow-up.
- Percentage of outpatient detox episodes that have a seven-day follow-up.
- 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.

Data Reporting: State Collected Measures

SAMHSA Required CCBHC Measure *Name, Designated Abbreviation, and Brief Description*	**Steward**	**CMS Medicaid Core Set (2023)**	**SAMHSA Technical Specification Resource Manual (February 2024) Reference**
Patient Experience of Care Survey: This measure uses the State's annual completion and submission of the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey.	SAMHSA	n/a	Page 121
Youth/Family Experience of Care Survey: This measure uses the State's annual completion and submission of the Youth/Family Services Survey for Families (YSS-F) Experience of Care Survey.	SAMHSA	n/a	Page 124
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD): Percentage of members ages 18 and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.	CMS	Adult	Page 140
Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD): Percentage of discharges for members aged 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: 1. Percentage of discharges for which the member received follow-up within 30 days after discharge. 2. Percentage of discharges for which the member received follow-up within 7 days after discharge.	NCQA	Adult	Page 193
Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH): Percentage of discharges for members ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: 1. Percentage of discharges for which the member received follow-up within 30 days after discharge. 2. Percentage of discharges for which the member received follow-up within 7 days after discharge.	NCQA	Child	Page 197
Initiation and Engagement of Substance Use Disorder Treatment (IET-AD): Percentage of new SUD episodes that result in treatment initiation and engagement. Two rates are reported: 1. Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.	NCQA	Adult	Page 179

SAMHSA Required CCBHC Measure *Name, Designated Abbreviation, and Brief Description*	Steward	CMS Medicaid Core Set (2023)	SAMHSA Technical Specification Resource Manual (February 2024) Reference
2. Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.			
Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD): Percentage of discharges for members, both children and adults, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: 1. Percentage of discharges for which the member received follow-up within 30 days after discharge. 2. Percentage of discharges for which the beneficiary [client] received follow-up within 7 days after discharge.	NCQA	Adult & Child	Pages 193 and 197
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD): Percentage of emergency department (ED) visits for members, both children and adults with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported: 1. Percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days) 2. Percentage of ED visits for which the member follow-up within 7 days of the ED visit (8 total days)	NCQA	Adult & Child	Pages 214 and 219
Plan All-Cause Readmissions Rate (PCR-AD): For members ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	NCQA	Adult	Page 149
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH): Percentage of children newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: initiation phase and continuation and maintenance phase.	NCQA	Child	Page 162
Antidepressant Medication Management (AMM-AD): Percentage of members aged 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported:	NCQA	Adult	Page 129

SAMHSA Required CCBHC Measure *Name, Designated Abbreviation, and Brief Description*	Steward	CMS Medicaid Core Set (2023)	SAMHSA Technical Specification Resource Manual (February 2024) Reference
1. Effective acute phase treatment. 2. Effective continuation phase treatment.			
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD): Percentage of members ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed a Food and Drug Administration (FDA)-approved medication for the disorder during the measurement year.	CMS	Adult	Page 135
Hemoglobin A1c Control for Patients with Diabetes (HBD-AD): Percentage of members ages 18 to 75 with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: ● HbA1c control (<8.0%) ● HbA1c poor control (>9.0%)	NCQA	Adult	Page 170

Additional Resources:

- SAMHSA *Quality Measures for Behavioral Health Clinics, Technical Specifications and Resource Manual*

6.0 Managed Care Organizations

Role of an MCO in a CCBHC Model

CCBHC providers are required to serve all members who have a need for behavioral health services and supports through the CCBHC model regardless of residence, income level, and Medicaid/Medicare eligibility.

To strengthen a CCBHC provider's ability to serve members, MCOs are expected to assist CCBHCs with information necessary to allow CCBHC providers to best meet the needs of members and to enhance the coordination of care. Examples of MCO support can include sharing the clinical history of members as appropriate, such as admission, discharge, and transfer (ADT) data, leveraging MCO networks to provide any needed referrals, and assisting with updating medication lists.

Role of CCBHC Provider for Individuals Enrolled in Managed Care

To facilitate active engagement of MCOs in supporting CCBHC service delivery, the CCBHC provider is responsible for communicating with the MCO once intake has been completed. The DoHS envisions that the CCBHC care coordination staff are responsible for communicating with the MCO. In the event that an individual is receiving CCBHC TCM, the CCBHC TCM provider is responsible for communicating with the MCO.

CCBHC Provider and MCO Communication

The steps outlined below are examples of ways CCBHCs and MCOs will collaborate around member needs. It will be at the discretion of the MCO and CCBHC to determine the best ways outreach and communication can occur:

- CCBHC staff determine if the individual is enrolled in an MCO.
- CCBHC staff contacts the MCO's member services department, care management, or utilization management representative to notify of the member's engagement and find out whether the member has been assigned an MCO care manager.
- If the individual has been assigned a care manager by the MCO, the CCBHC is responsible for contacting the MCO care manager and developing a plan for future communications (e.g., when the CCBHC or MCO will communicate with one another; what the preferred method and frequency for communication is).

Points of Communication

To the extent possible, MCOs are expected to support CCBHC providers around the changing needs of members. As a best practice, the DoHS anticipates that MCOs provide CCBHCs with regular analytic reports that offer insight into service utilization for members served under the CCBHC.

Other areas that could warrant bidirectional communication between CCBHC providers and MCOs include:

- Member begins receiving services from a CCBHC.
- Member begins receiving TCM or services from an external provider.
- Referral for a new service provider.
- Change in living situation/address.
- Member is decompensating and likely to need hospitalization or residential services.
- Hospital admission or discharge.

7.0 List of Acronyms

Acronym	Definition
ACT	Assertive Care Treatment
ADHD	Attention-Deficit Hyperactivity Disorder
ADT	Admission, Discharge, And Transfer
BBH	Bureau for Behavioral Health
BMS	Bureau for Medical Services
CAP	Corrective Action Plan
CCBHC	Certified Community Behavioral Health Clinics
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CQI	Continuous Quality Improvement
CSED	Children with Serious Emotional Disorders
CSU	Crisis stabilization unit
DCO	Designated Collaborating Organization
DoHS	West Virginia Department of Human Services
ED	Emergency department
FFS	Fee-for-service
LBHC	Licensed Behavioral Health Centers
MCO	Managed care organization
MHSIP	Mental Health Statistics Improvement Program
NPI	National provider identifier
NCQA	National Committee for Quality Assurance
OUD	Opioid Use Disorder
PPS	Prospective Payment System
RTC	Residential Treatment Center
SAMHSA	Substance Abuse and Mental Health Services Administration

SDOH	Social Drivers of Health
SUD	Substance Use Disorder
TCM	Targeted Case Management

8.0 Version Change Log

Version	Update Description	Effective Date
1.0	New	October 1, 2024