CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)

Transmittal 217 **Date: March 8, 2024**

SUBJECT: Revisions to the State Operating Manual (SOM) Chapter 2; Community Mental Health Center (CMHC).

I. SUMMARY OF CHANGES: Revisions were made to Chapter 2 of the State Operations Manual, based on new requirements for Intensive Outpatient Services (IOP) released in the Outpatient Prospective Payment System final rule and new personnel qualification.

NEW/REVISED MATERIAL - EFFECTIVE DATE: March 8, 2024
IMPLEMENTATION DATE: March 8, 2024

The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 2/2250/2250A/Citations and Definitions
R	Chapter 2/2250/2250C/Partial Hospitalization Services and Intensive Outpatient Services Provided by CMHCs or by Others Under Arrangements With the CMHC
R	Chapter 2/2251/2251A/Request to Participate
R	Chapter 2/2251/2251B/Processing CMHC Initial Certification Request, SA Role
R	Chapter 2/2251/2251C/Processing CMHC Initial Certification Request, CMS Location Role
R	Chapter 2/2251/2251F/Involuntary Termination

III. FUNDING: No additional funding will be provided by CMS; State activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

State Operations Manual
Chapter 2 - The Certification Process
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(Rev. 217; Issued: 03-08-24)

Community Mental Health Center (CMHC)

2250A - *Citations and Definitions*

(Rev. 217; Issued: 03-08-24; Effective: 03-08-24; Implementation:03-08-24)

Citations

Section 4162 of P.L. 101-508 (OBRA 1990), amended §1861(ff)(3)(A) and §1832(a)(2)(J) of the *Social Security* Act *(Act)* to include *Community Mental Health Centers* (CMHCs) as entities that are authorized to provide partial hospitalization services *(PHP) and intensive outpatient (IOP) services* under Part B of the Medicare program, effective October 1, 1991. Applicable regulations are found at 42 CFR Chapter IV, Parts 400, 410, 424, 485 and 489. The *Conditions of Participation (CoPs)* were published on October 29, 2013 and were effective on October 29, 2014. *Section 4124(b) of the Consolidated Appropriations Act* (*CAA), 2023 established Medicare coverage for IOP effective for items and services furnished on or after January 1, 2024. Section 4124(b)(1)(A) of the CAA, 2023 amended section 1832(a)(2)(J) of the Act to add IOP to the scope of covered benefits provided by CMHCs.*

Definitions

Community Mental Health Center (CMHC), as defined in §410.2*, means* "an entity *that- (1) Provides outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and clients of its mental health service area who have been discharged from inpatient treatment at a mental health facility; (2). Provides 24-hour-a-day emergency care services; (3) Provides day treatment or other partial hospitalization services, or intensive outpatient services, or psychosocial rehabilitation services; (4) Provides screening for patients being considered for admission to State mental health facilities to determine the appropriateness of this admission; (5) Meets applicable licensing or certification requirements for CMHCs in the State in which it is located; and (6) Provides at least 40 percent of its services to individuals who are not eligible for benefits under title XVIII of the Social Security Act."*

Active treatment plan, *as defined in §485.902,* means an individualized client plan that focuses on the provision of care and treatment services that address the client's physical, psychological, psychosocial, emotional, and therapeutic needs and goals as identified in the comprehensive assessment.

Comprehensive assessment, *as defined in §485.902,* means a thorough evaluation of the client's physical, physiological, psychosocial, emotional, and therapeutic needs related to the diagnosis under which care is being furnished by the CMHC.

Initial evaluation, *as defined in §485.902,* means an immediate care and support assessment of the client's physical, psychosocial (including a screen for harm to self or others), and therapeutic needs related to the psychiatric illness and related conditions for which care is being furnished by the CMHC.

Intensive outpatient (IOP) services, *as defined at §410.2, means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting and furnishes the services as described in §410.44. Patients require at least 9 hours per week of therapeutic services.*

Representative*, as defined in §485.902,* means an individual who has the authority under State law to authorize or terminate medical care on behalf of a client who is mentally or physically incapacitated. This includes a legal guardian.

Restraint*, as defined in §485.902,* means (1) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a client to move his or her arms, legs, body, or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a client for the purpose of conducting routine physical examinations or tests, or to protect the client from falling out of bed, or to permit the client to participate in activities without the risk of physical harm (this does not include a client being physically escorted); or (2) A drug or medication when it is used as a restriction to manage the client's behavior or restrict the client's freedom of movement, and which is not a standard treatment or dosage for the client's condition.

Partial Hospitalization Services (PHP)*, as defined in §410.2, means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting and furnishes the services as described in §410.43."*

Day Treatment Services generally include person-centered, culturally and linguistically appropriate, comprehensive, coordinated, structured treatment services and activities. A day treatment program consists of a scheduled series of structured, face-to-face therapeutic sessions organized at various levels of intensity and frequency in order to assist the persons served in achieving the goals identified in their person-centered plans. Day treatment programs are offered four or more days per week, typically with support available in the evenings and on weekends. A day treatment program may prevent or minimize the need for a more intensive level of treatment. It may also function as a step- down from inpatient care or partial hospitalization or, as transitional care following an inpatient or partial hospitalization stay to facilitate return to the community.

Psychosocial Rehabilitation Services (PSR) are activities aimed at reintegrating the individual back into society by improving their functioning and ability to comply with rules and expectations of the community and are consistent with the identified goals or objectives of the client's active treatment plan. This includes the fullest possible integration of the client as an active and productive member of his or her family, community, and/or culture with the least amount of structured professional

intervention. Services may be provided individually or in a group setting.

Seclusion, *as defined in §485.902,* "means the involuntary confinement of a client alone in a room or an area from which the client is physically prevented from leaving."

Children *refers to an unmarried person younger than 22 years old. See https://www.medicare.gov/basics/children-and-end-stage-renal-disease for further information.*

Elderly refers to an individual who is aged 65 years and older.

***Employee of a CMHC**, as defined in §485.902, means an individual— (1) Who works for the CMHC and for whom the CMHC is required to issue a W–2 form on his or her behalf; or (2) For whom an agency or organization issues a W–2 form, and who is assigned to such CMHC if the CMHC is a subdivision of an agency or organization.*

***Volunteer**, as defined in §485.902, means an individual who is an unpaid worker of the CMHC; or if the CMHC is a subdivision of an agency or organization, is an unpaid worker of the agency or organization and is assigned to the CMHC. All volunteers must meet the standard training requirements under §485.918(d).*

2250C - Partial Hospitalization *and/or Intensive Outpatient* Services Provided by CMHCs or by Others Under Arrangements With the CMHC

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Per section 1866(e)(2) of the Act CMHCs are recognized as Medicare providers only with respect to providing partial hospitalization services and under regulations at 42 CFR §489.2(c)(2) CMHCs may only enter into provider agreements under Medicare to furnish *PHP and IOP*. If during the course of a survey it is determined that the CMHC does not provide *PHP or IOP*, the surveyor should document this finding in the CMS-2567 "Statement of Deficiencies and Plan of Correction" under Tag 000 "Initial Comments." The survey should be completed, despite this finding. The surveyor should include in their documentation all information collected to confirm that the provider is not providing PH*P*, including documentation from records reviewed and interviews. Even if the CMHC is found to be in compliance with the CoP in *"*§485.918 Organization, Governance, Administration of Services, Partial Hospitalization Services, *and Intensive Outpatient Services,"* the CMHC may not enter into, or continue, a provider agreement with CMS unless the CMHC chooses to provide *PHP and/or IOP*. If the CMHC does not choose to either provide *PHP and/or IOP*, or to voluntarily terminate its Medicare provider agreement, CMS may exercise its authority to terminate the provider agreement pursuant to §489.53.

2251A - Request to Participate

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The CMHC notifies the State Survey Agency (SA) that it wishes to participate. The SA ensures that the CMHC submits a CMS 855A to the Medicare Administrative Contractor (MAC) and forwards information to the applicant concerning the procedure for Office of Civil Rights clearance. Once the MAC has completed its review, including a review of the facility certification statement that at least 40% of the CMHC's items and services are provided to non-eligible individuals, it will forward an approval recommendation notice to the appropriate CMS *Location* and the SA. The SA will schedule an initial survey for the CMHC according to the CMS Mission and Priority Document (MPD).

2251B - Initial Survey/Certification-SA Role

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The SA evaluates whether the applicant meets the CoPs and applicable licensing requirements in the State through an on-site survey. Include within the survey process, the requirements as stated in section 2250C of the SOM. A CMHC may be certified with Standard level deficiencies as long as an acceptable plan of correction is submitted. However, a CMHC may not be certified with a Condition level deficiency, or if it does not provide PH*P or IOP*. The SA will forward its recommendation for certification or denial of certification to the *CMS Location*. The SA will process the certification packet pursuant to applicable instructions in §§2760-2776.

2251C - Initial Certification-*CMS Location* Role

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The *CMS Location* will make a determination on the CMHC's request to be a participant in the Medicare program. The *CMS Location* will evaluate the information and recommendation received from the SA regarding a CMHC's initial certification application including whether or not PH*P and/or IOP* are being provided; either agree or disagree with the SA recommendation for initial certification or denial based upon provider agreement requirements; and notify the applicant of its decision. The *CMS Location* will forward a CMS 2007 to the MAC whether the applicant is approved or denied for certification. If approved, a CCN and provider agreement are issued.

2251F - Involuntary Termination

(Rev. 217; Issued: 03-08-24; Effective: 03-08-24; Implementation:03-08-24)

A CMHC's provider agreement will be involuntarily terminated if the CMHC is not in compliance with the CoPs or does not provide PH*P and/or IOP*. The SA will follow the guidance in SOM §§3005, 3005A, 3005B and 3005D in processing the termination. All CMHCs must comply with the CoPs.