# Community Behavioral Health Supports (CBHS)

## *Ask the Expert*

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# BACKGROUND

## Community Behavioral Health Support (CBHS) Services

In 2021, Legislation directed the Health Care Authority (HCA) and Home and Community Living Administration (HCLA) to work with Center for Medicare/Medicaid (CMS) on creating a Medicaid benefit under the HCA behavioral health benefit that would more fully support individuals with mental health needs in long-term care residential settings. The title of this new state plan program, which was implemented in July 2024, is Community Behavioral Health Support Services (CBHS). It is authorized under a 1915(i) State Plan amendment.

> ***CBHS eligibility is determined by the Health Care Authority (HCA), this is not an HCLA authorized program or service.***

You can find more information on the HCA website Community Behavioral Health Support (CBHS) services and on the HCA billing guide.

### Service provided under CBHS

CBHS provides Supportive Supervision and Oversight.

- Supportive supervision provides 1:1/enhanced in person monitoring, redirection, diversion, and cueing of the client to prevent at risk behavior that may result in harm to the client or to others.
- Services are individually tailored to help clients acquire, retain, restore and improve the self-help, socialization and adaptive skills necessary to reside successfully in community-based settings.
- These services assist clients in building skills and resiliency to support stabilized living and integration. Interventions are coordinated as appropriate with other support services, including behavioral health services.
- Interventions are not related to the provision of Personal Care.

### Functional and Financial Eligibility for CBHS

For full CBHS eligibility requirements see WAC 182-561
Individuals may be eligible for CBHS if they:

- Are financial and functional eligible for Home & Community Services (HCS), as defined in WAC 388-106-0010 and
- Interested in residing or living in a long-term care residential setting
- Have a qualifying CBHS diagnosis
- Meet CBHS Risk Criteria

### CBHS Risk Criteria

An individual must meet one or more criteria under Risk Criteria #1, **AND** one or more criteria under Risk Criteria # 2 OR #3 as outlined in the CBHS referral form HCA 13-0124

- Risk Criteria #1: The client's care needs can only be served through CBHS as evidenced by meeting at least one of five risky behaviors over the past year or having a history of them **AND**

- Risk Criteria #2: The client has a history of being unsuccessful in community living settings **OR**
- Risk Criteria #3: The client has past psychiatric history, where significant functional improvement has not been effectively maintained without CBHS

### Residential provider types allowed for CBHS:

- Adult Family Home (AFH)
- Assisted Living Facilities (ALF)
- Enhanced Adult Residential Care Facilities (EARC)
- Adult Residential Care Facilities (ARC)
- Enhanced Services Facilities (ESF)

### Who determines CBHS Eligibility, tiering and authorizes payment for CBHS?

- **Referral**: Home and Community Services case manager completes the referral.
- **Eligibility**: HealthCare Authority determines CBHS eligibility.
- **Tiering**: CBHS level of service (tiering) is determined by Managed Care Organizations (MCOs) for MCO enrollees and HealthCare Authority for Fee-for- Service (FFS) clients.
- **Authorization**: The Managed Care Organization authorizes for MCO enrollees; HealthCare Authority (HCA) authorizes CBHS for Fee for Service (FFS) clients.
- **Payment:** Payment for Supportive Supervision services is divided into six tiers. HCA and the MCOs use the information in the tier guidance table to determine the appropriate level of care.

## CBHS Referral Process

When to submit the CBHS Referral form

- **Initial referral** (clients who are not on CBHS): CBHS referrals should only be submitted at the time of the client's Initial/Re-Apply, Annual and Significant Change CARE Assessment.
- **Renewal referrals** (clients who are on CBHS): CBHS referrals should be submitted at the time of the client's Annual and Significant Change CARE Assessment.

- It is important to review services with the client.
- Does the client appear to meet CBHS eligibility?
- Is the client agreeable to the service?
- Would the client benefit from 1:1 enhanced in person monitoring, redirection, diversion, cueing, or supportive supervision?

### *CBHS Referral Workflow:*

When a qualifying CBHS diagnosis is entered in CARE assessment 'medical screen', a message will appear in the Behavior Screen: "*Based on selected diagnosis, client may be eligible for Community Behavioral Health Support Services.*




- Assessor to review CBHS Brochure and CBHS eligibility with client/AREP
- Determine with the client/AREP interest for CBHS services and if they appear to meet risk criteria
- If client is interested in CBHS supportive supervision and appears to meet CBHS eligibility criteria:
- The referring case manager to complete sections 1 and 2 of the CBHS referral form HCA 13-0124
    - If a residential provider is NOT identified in section 1 see CBHS referrals when there is no residential provider identified

**To assist with the CBHS Eligibility process, case managers can add additional information in the comment boxes to questions 2 & 3 to clarify the need for CBHS.**

## *Where to submit CBHS referrals:*

Emails for clients assigned MCO/HCA Medicaid plan can be located on page 1 of the CBHS referral form HCA 13-0124

- Confirm client is active on an LTC Medicaid program
    - Client pending Medicaid due to hospitalization stay: If client is hospitalized (Not in a State Hospital) and financial is awaiting confirmation of the transition to the community before they can turn on Medicaid see Provisional CBHS referrals for clients in an acute/psych hospital or state hospital setting pending Medicaid eligibility.
- Review ProviderOne Details – Managed Care Screen
    - For clients who have a Managed Care plan identified as Fully Integrated Managed Care (FIMC) or Behavioral Health Services Only (BHSO), send the CBHS referral packet to the clients assigned Managed Care Plan using the email identified on page 1 of the CBHS referral form.
    - For clients without an identified FIMC or BHSO program BUT confirmed active on Medicaid in Fee- For- Service (FFS), send the CBHS referral packet to Fee-for Service (FFS) email identified on page 1 of the CBHS referral form.

## *What is submitted with the CBHS referral?*

The HCS/AAA Assessor is responsible for submitting a completed CBHS referral package- see below

- CBHS referral form HCA 13-0124

- CARE Assessment Details
- CARE Service Summary
- Behavior Support Plan (for RSW Behavior Support clients)
- Case Manager to use the CBHS Email Template

If additional clinical information is needed, the MCO/HCA will follow up with the medical provider, residential provider or hospital to obtain required information to determine CBHS eligibility.

- The referring case manager can provide the medical providers' contact information to the MCO/HCA if needed.

> Case Managers ***should not*** be providing third party clinical documentation to the MCO/HCA. HCA/MCO should obtain information directly from medical providers.

### *Referral timeline for CBHS referrals:*

- The MCO or HCA will confirm receipt with the Case Manager in two business days.
  - Clients in an inpatient setting: CBHS referrals will be reviewed and returned within 7 business days. ***Staff to use the Subject line: CBHS Referral – Inpatient [DSHS Secure]***
  - Clients not in an inpatient setting: CBHS referrals will be reviewed and returned within 13 business days. **Staff to use the Subject line: CBHS referral [DSHS Secure]**

### *What additional steps are needed if no provider is identified at the time of the CBHS referral?*

- If an accepting residential provider is not identified at the time of the CBHS referral and client is found eligible for CBHS, Section 5 – CBHS service authorization – will be returned without authorization dates. The assessor must:
- Notify the MCO/HCA once an accepting provider and transition date has been identified via email and request a finalized CBHS form.
- The assessor must provide the facility name, Provider Name, Email, address and phone number AND transition date.
- No Provider Email Template Link
- HCA/MCO will send the completed form back to the referring case manager and to MCOBHOforms@dshs.wa.gov

### *Provisional CBHS referrals for clients in an inpatient setting (state or community hospital) pending Medicaid eligibility.*

For clients who have been assessed and confirmed to meet both the functional and financial eligibility requirements for Home and Community Services (HCS), but whose Medicaid is still pending due to their inpatient status, it is possible for them to request CBHS.

A provisional approval does not guarantee authorization of services or service level for CBHS services. Instead, it indicates that the client is *functionally eligible* and may receive CBHS services once Medicaid becomes active. Final service authorization is contingent upon Medicaid approval. See process below:

### State hospital clients:

- Confirm client is financially eligible from Public Benefits Specialist (PBS) and functionally eligible.
- Case manager to send CBHS referral to the client's assigned managed care plan using the email identified on the referral form. (i.e. Your client is pending transition from a State Hospital)

### Acute/Community Psych hospital clients:

- Confirm client is financially eligible from Public Benefits Specialist (PBS) and functionally eligible.
- Case manager to send CBHS referral for clients who have not been assigned a managed care plan to HCA using the email identified on the referral form.

## How does HCA determine CBHS eligibility dates?

### New Referrals (Initial/Re-Apply CARE Assessment)

- For new referrals received by the 20th day of the month, the effective date is the first day of the month in which the referral was received.
    - Example: If HCA receives the CBHS referral for a new CBHS client on March 15th, CBHS eligibility will begin March 1st.
- CBHS eligibility is authorized for 12 months at a time.

### Annuals or Significant Change CARE Assessment (CBHS renewals)

- CBHS referrals submitted, CBHS eligibility start date effective the first day of the following month.
    - Example: The CBHS referral is submitted on March 12th, CBHS is approved, CBHS eligibility will start the following month on April 1st.
- Exception: If CBHS eligibility ends before the first of the following month, the eligibility date will be the first of the month after CBHS eligibility ends.

### *CBHS Approvals – What constitutes a completed CBHS referral*

A CBHS referral is fully approved when

CBHS eligibility (Section 4) has:

- "Meets Functional Eligibility" AND "Meets Financial Eligibility" selected AND
- 1915i Eligibility dates are identified

**AND**

CBHS service authorization (Section 5) has

- Supportive Supervision tier selected AND
- Service Authorization dates identified AND

- Signature and date

## Steps to take when a CBHS referral is approved

- Notify client/AREP and send the completed CBHS approval form to the residential provider along with the CARE Assessment details and Service Summary.
- Add CBHS treatment: *Supportive Supervision and Oversight* to the CARE Assessment in treatment section.
    - Frequency: QD (once daily)
    - Provider: Assign to residential provider
- Send the completed CBHS referral form to DMS via dshs.altsadms@dshs.wa.gov
- Set a reminder (CARE tickler) for at least 30 days before the end of the CBHS approval period (*end date noted in Section 4 of CBHS form*).
- Document approval in an SER note using "CBHS/1915i" purpose code.
    - SER sample "*Received authorization for CBHS services from [HCA or MCO plan name*] *Client has been approved for supportive supervision and oversight at Tier _ (1-6). Approval dates ___ to ____."*

## Steps to take when a CBHS referral is provisionally approved

A provisional approval does not guarantee authorization of services or service level for CBHS services. Instead, it indicates that the client is *functionally eligible* and may receive CBHS services once Medicaid becomes active. Final service authorization is contingent upon Medicaid approval.

Once client's Medicaid is active and client has transitioned to a residential LTC setting:

- Case manager reviews for MCO assignment
- Case manager sends the following via email to client's assigned MCO for tier level determination and finalized form:
    - CBHS provisional approval
    - Assessment Details and Service Summary
- Steps to take when a CBHS referral is approved.

The MCO and HCA will finalize sections 4 & 5 of the CBHS referral and send the completed form back to the case manager.

## Steps to take when a CBHS approval is pending identifying a residential provider

If an accepting residential provider is not identified at the time of the CBHS referral and client is found eligible for CBHS, Section 5 – CBHS service authorization – will be returned without authorization dates. Once an accepting residential provider is identified the assessor must:

- Notify the MCO/HCA once an accepting provider and transition date has been identified via email and request a finalized CBHS form.

- The assessor must provide clients name, ProviderOne, the facility name, Provider Name, Email, address and phone number AND transition date.
- No Provider Email Template Link
- HCA/MCO will send the completed form back to the referring case manager and to MCOBHOforms@dshs.wa.gov
- Steps to take when a CBHS referral is approved.

## Steps to take when the CBHS referral is denied:

- Notify client of CBHS decision.
- Document denial in a SER note using "CBHS/1915i" purpose code
- Send the denied referral form to DMS dshs.altsadms@dshs.wa.gov
- Send the denied CBHS referral form to the residential LTC provider.
- Document denial in a SER note (include explanation of client not meeting CBHS eligibility found in section 4 of the referral form)

**NOTE:** Financial does not need to be notified of CBHS being opened or closed.

## Required Notifications to MCOs and HCA for CBHS approved clients

**Notifications are required to the MCO/HCA, via a Change of Circumstance form (16-275), when:**

- The client is planning or has already moved to a different residential LTC setting.
- Client is hospitalized and will not be returning to LTC residential setting.
- The MCOs and HCA open and close authorizations for CBHS. Client/AREP/Guardian is no longer interested in receiving CBHS service.
- Client's LTC services are closing.
- Client passed away

**Steps for Case Managers completing Change of Circumstance form:**

- Communicate to the MCO/HCA with the Change of Circumstance form: Community Behavioral Health Supports (CBHS) DSHS Form 16-275
- Send copy of 16-275 to DMS dshs.altsadms@dshs.wa.gov
- If CBHS is no longer needed due to reasons above, CM will:
    - Document the closure in a SER under the CBHS service code.

- For CBHS ending mid-plan period: Update the assessment to remove supportive supervision treatment and send the provider the updated CARE Assessment and Service Summary.

## CBHS Re-tiering Guidance

Residential providers in consultation with clients can submit the Supportive Supervision re-tiering request form (CBHS) (HCA 13-0126) to request an increase or decrease in the client's CBHS Supportive Supervision tiering.

- The requestor (Provider or client) must support, with data, any increase or decrease in the client's behaviors that result in the need for change in the client's one-on-one support.
- Re-tiering requests are requested by the LTC residential provider, *not the HCS/AAA case manager* and determined by the MCO and HCA for FFS clients.
- The LTC provider should remain in contact with the MCO/HCA (FFS) when a re-tiering request is made.

## Can clients receive Residential Support Waiver and CBHS services concurrently?

- CBHS is the first program of consideration for 1:1/enhanced staffing in a residential setting consistent with the requirement of state plan services authorized before waiver services
- **If eligible for both programs (CBHS and RSW), clients must access CBHS for the 1:1/enhanced staffing, as CBHS supportive supervision is a state service plan**.
- If CBHS is denied, clients can access RSW (SBS, CSS, ESF) for their 1:1/enhanced staffing needs.
- Clients who decline CBHS 1:1/enhanced staffing may access supplementary behavioral support through ECS
- **Declining a referral for 1:1/enhanced staffing through CBHS will also be a decline for the 1:1/enhanced staffing referral through RSW (SBS, CSS and ESF).**

See LTC Manual Chapter 7F – Residential Support Waiver to review criteria and services under RSW

# RESOURCES

## Related WACs and RCWs

- Community Behavioral Health Supports WAC 182-561
- Community Behavioral Health Supports Eligible diagnosis WAC 182-561-0700
- LTC Functional and Financial Eligibility WAC 388-106-0010

## Acronyms

| | |
|---|---|
| AAA | Area Agency on Aging |
| ACES | Automated Client Eligibility System |
| CBHS | Community Behavioral Health Support |
| CFC | Community First Choice |
| CMS | Centers for Medicare and Medicaid Services |
| COPES | Community Options Program Entry System |
| DSHS | Department of Social and Health Services |
| D-SNP | Dual Special Needs Plan |
| FAQ | Frequently Asked Questions |
| FFS | Fee-for-Service |
| FIMC | Fully Integrated Managed Care |
| HCA | Health Care Authority |
| HCS | Home and Community Services |
| HRSN | Health-Related Social Needs |
| IBSS | Intensive Behavioral Supportive Supervision |
| ILOS | In Lieu of Service |
| LTSS | Long-Term Services and Supports |
| MAGI | Modified Adjusted Gross Income |
| MCSC | Managed Care Systems Consultant |
| MCO | Managed Care Organization |
| NFLOC | Nursing Facility Level of Care |
| PBS | Public Benefits Specialist |
| PCCM | Primary Care Case Management |
| PCM | Primary Case Manager |
| SSI | Supplemental Security Income |

## Glossary (if needed)

| WORD | DEFINITION |
|---|---|
| **Long-Term Services and Supports** | A wide variety of services and supports that help people with functional impairments meet their daily needs for assistance in qualified settings and attain the highest level of independence possible. LTSS includes both Home and Community-Based Waiver Services and Medicaid Personal Care Services. |
| **Managed Care** | A prepaid, comprehensive system of medical and health care delivery.<br>- *Medical*: Includes preventive, primary, specialty care and ancillary health services<br>- *Integrated***:** Includes Medical services PLUS behavioral health and long-term services and supports. |
| **Fee-For-Service** | A service delivery system where health care providers are paid for each service separately (e.g. an office visit, test, or procedure). |

| | |
|---|---|
| **Community Behavioral Health Supports** | CBHS under 1915 (i) State Plan WAC 182-561-0400 covers one-on-one supportive supervision for clients enrolled in Long-Term Care Services who have complex behaviors related to a qualifying mental health diagnosis. CBHS eligibility is determined by the Health Care Authority. |
| **Intensive Behavioral Supportive Supervision** | IBSS is an In Lieu of Service that provides funding for one-on-one supportive supervision. IBSS is a service of last resort that supports people with cognitive impairment and complex behaviors in community residential settings. IBSS is available for clients enrolled under HCLA for both HCS and DDCS clients. |

## REVISION HISTORY

| DATE | MADE BY | CHANGE(S) | MB # |
|---|---|---|---|
| 9/3/2026 | Laura Botero; Genevieve Boyle; Jennifer Torres-Salas | New Chapter 22d | H26-015 |
| 7/15/2026 | Laura Botero, Jennifer Torres-Salas; Genevieve Boyle | Formatting and grammatical corrections<br>Clarified processes for policy for CBHS approvals, denials, provisional & pending provider approvals. | |

## OTHER MANAGED CARE ORGANIZATION (MCO) FUNDING

### Appendix I Behavioral Health Wraparound Supports (BHWS)

Behavioral Health Wraparound Support (BHWS) provides additional personal care hours in addition to the CARE generated hours for in-home clients only with a primary diagnosis of a serious mental health diagnosis. The client's behavior(s) or symptom(s) of the mental health diagnosis(es) are the primary reason for the client's need for assistance with personal care.

BHWS information can be found in the LTC Chapter 22a.

### Appendix II Intensive Behavioral Supportive Supervision (IBSS)

Intensive Behavioral Supportive Supervision (IBSS) is a voluntary In Lieu Of Service (ILOS) available to Apple Health (Medicaid) clients enrolled with a Managed Care Organization (MCO). ILOS is managed by

the MCOs, in coordination with Health Care Authority (HCA). Providers are contracted and paid directly by the MCOs.

IBSS should only be considered after all other state plan and waiver program (CBHS, RSW etc.) have been explored by the case manager.

Residential providers will need to communicate directly with MCOs and MCOs will need to assist residential providers with the contracting and billing processes. Once the MCO receives the IBSS referral, it is their responsibility to complete the clinical review to determine IBSS eligibility and tiering.

**Where to find additional information for IBSS:**

- HCA Webpage

**HCS/AAA Case Managers role when IBSS is approved:**

- Case manager (CM) will document in a Service Episode Record SER regarding IBSS approval using purpose code "Information & Referral".
- Document that the client was approved for IBSS and by which MCO.
- CM to add "other" under treatments in the medical screen in CARE; Frequency: QD (once daily)".
- Assign residential provider "other" treatment in CARE Support Screen.
- Document that the client was approved for IBSS and by which MCO.