MDHHS Michigan Department of Health & Human Services

Medical Services Administration BULLETIN MSA

Revised language within bulletin 9-2-2021

Bulletin Number: MSA 21-34

Distribution: All Providers

Issued: September 1, 2021

Subject: Centers for Medicare & Medicaid Services (CMS) Certified Community Behavioral Health Clinic (CCBHC) Demonstration

Effective: October 1, 2021

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

In 2016, the Michigan Department of Health and Human Services (MDHHS) applied to CMS to become a CCBHC Demonstration state under Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA). That request was approved on August 5, 2020, when the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 authorized two additional states (Michigan and Kentucky) to join the demonstration. As a result, MDHHS was approved for a two-year demonstration with an anticipated implementation start date of October 1, 2021. The two-year demonstration period begins upon implementation (please note that Congress has continued to extend the demonstration period for the first cohort of states that joined in 2016).

I. CCBHC General Information

A. Overview

The CMS CCBHC Demonstration requires states and their certified CCBHC sites to provide a robust set of coordinated, integrated, and comprehensive services to all persons with any mental illness or substance use disorder (SUD) diagnosis. Moreover, the demonstration requires and emphasizes 24/7/365 crisis response services (e.g., mobile crisis services). Other critical elements include, but are not limited to, strong accountability in terms of financial and quality metric reporting; formal coordination with primary and other care settings to provide intensive care management and transitions; linkage to social services, criminal justice/law enforcement, and educational systems; and an emphasis on providing services to veterans and active-duty service members. To account for these requirements, the state must create a prospective payment system (PPS) reimbursement structure that finances CCBHC services at an enhanced payment rate to properly cover costs and offer greater financial predictability and viability. The PPS is integral to sustaining expanded services, investments in the technological and social determinants of care, and serving all eligible Michigan residents regardless of insurance or ability to pay.

B. Purpose

The purpose of this policy is to define the operational requirements needed to implement the CCBHC Demonstration.

C. CCBHC Demonstration Handbook

MDHHS created a companion operational protocol to this policy for Prepaid Inpatient Health Plans (PIHPs) and CCBHCs called the CCBHC Demonstration Handbook. The CCBHC Demonstration Handbook provides further detail and guidance to execute the provisions of this policy. Collectively, this policy and the CCBHC Demonstration Handbook comprise MDHHS' requirements of the PIHPs and CCBHCs regarding the clinical, financial, and operational facets of the CCBHC Demonstration. The CCBHC Demonstration Handbook can be accessed on the MDHHS CCBHC website.

II. CCBHC Eligibility

A. Site Eligibility

In its 2016 CCBHC Demonstration application, MDHHS named 14 prospective CCBHC demonstration sites (11 Community Mental Health Services Programs and 3 non-profit behavioral health entities). Collectively, the sites currently serve 18 counties, although services are not limited by county of residency. Per CMS directive, the following 14 sites cited in the 2016 application are eligible to become CCBHCs under the demonstration:

- Centra Wellness Network (Benzie and Manistee Counties)
- Community Mental Health and Substance Abuse Services of St. Joseph County
- Community Mental Health Authority of Clinton, Eaton, and Ingham Counties
- Community Network Services (Oakland County)
- Easter Seals (Oakland County)
- HealthWest (Muskegon County)
- Integrated Services of Kalamazoo
- Macomb County Community Mental Health
- Saginaw County Community Mental Health Authority
- St. Clair County Community Mental Health Authority
- The Guidance Center (Wayne County)
- The Right Door (Ionia County)
- Washtenaw County Community Mental Health
- West Michigan Community Mental Health (Lake, Mason, and Oceana Counties)

Prospective CCBHC Demonstration sites must be certified by MDHHS to be designated as CCBHCs. (Refer to the CCBHC Certification Requirements section of this policy [Section IV] for additional information.)

B. CCBHC Recipient Eligibility

Any person with a mental health or SUD International Classification of Diseases (ICD)-10 diagnosis code is eligible for CCBHC services. CCBHCs must serve all individuals regardless of county of residency or ability to pay.

Please note that there are two exceptions to the mental health and/or SUD diagnostic requirement:

- Persons in crisis: People in crisis are eligible to receive CCBHC crisis services even if it is determined during the CCBHC crisis service that the person does not have a mental health or SUD diagnosis.

- Persons being assessed/screened for mental health and/or SUD diagnoses: People without a current mental health and/or SUD diagnosis are eligible to receive CCBHC screening and assessment services even if these services do not result in a diagnosis. If the screening/assessment does not result in a mental health and/or SUD diagnosis, the person is not eligible to receive subsequent CCBHC services unless they are: 1) in crisis as described above; or 2) later found to have a mental health and/or SUD diagnosis.

III. PIHP Responsibilities of the CCBHC Demonstration

A. CCBHC Oversight and Support

PIHPs share responsibility with MDHHS for ensuring continued access to CCBHC services. PIHPs must contract with all CCBHC demonstration sites in their region and ensure access to CCBHC services for their enrollees. PIHPs must also assist CCBHCs with meeting certification requirements, developing training and technical assistance activities that will support CCBHCs in effective service delivery, and providing technical support to CCBHCs related to Health Information Technology, including WSA, CareConnect360, Electronic Health Records (EHRs), and Health Information Exchanges (HIEs).

B. CCBHC Enrollment and Assignment

PIHPs review MDHHS-identified, CCBHC-enrolled Medicaid beneficiaries and assign beneficiaries to CCBHCs by conferring with the beneficiary and the prospective CCBHC. Beneficiaries recommended by CCBHCs for CCBHC enrollment/assignment will be reviewed and processed by the PIHPs. PIHPs will also review and assign MDHHS identified non-Medicaid CCBHC-eligible recipients to CCBHCs and process CCBHC assignment requests. For all assignments and enrollments, the PIHP must verify and complete all steps in the WSA as outlined in Section IV below.

C. Coordination and Outreach

PIHPs work in partnership with MDHHS and CCBHCs to coordinate outreach efforts. This includes defining target populations, including the uninsured and underinsured, and sharing responsibility for building a community referral network and increasing awareness of CCBHC services. PIHPs must also coordinate crisis and other referral services with the Michigan Crisis and Access Line (MiCAL), when available.

D. Payment

PIHPs are responsible for reimbursing CCBHCs at the site-specific PPS-1 rate for each valid CCBHC service encounter (note: the PPS-1 payment may only be paid once per day regardless of the number of CCBHC service encounters reported for a given day) in accordance with the CCBHC Payment Methodology section of this policy (Section VIII). The full PPS-1 payment amount must be received by the CCBHC within 60 days following the month in which the service was rendered. PIHP contracts with CCBHCs must reflect the CCBHC scope of services and ensure compensation for CCBHC services equates to clinic-specific PPS-1 rates. Finally, PIHP contracts with CCBHCs must permit subcontracting agreements with DCOs and credentialing of DCO entities and/or practitioners. Further operational details and requirements may be found in Section VIII below and detailed further in the CCBHC Demonstration Handbook.

E. Reporting

1. Required Cost and Quality Metric Reports

PIHPs must review, edit, and send final draft CCBHC cost reports and quality metrics to MDHHS for MDHHS review and submission to CMS. Data reflecting access to care will be collected and reported to MDHHS quarterly and should include, by CCBHC, the number of individuals requesting services and the number of individuals receiving their first service. PIHPs must send all reports to MDHHS in accordance with state and federally defined timelines.

2. Grievance Monitoring

PIHPs must monitor, collect, and report grievance, appeal, and fair hearing information, and report details, by CCBHC, to MDHHS quarterly.

3. Other Required Reports

PIHPs must submit other MDHHS-required reports, including Financial Status Reports (FSRs), pursuant to MDHHS-defined instructions and timelines with further requirements specified in the CCBHC Demonstration Handbook

IV. CCBHC Certification Requirements

CCBHCs must complete the MDHHS certification process to become a CCBHC under the CMS CCBHC Demonstration. The certification will be documented and monitored through the Behavioral Health Developmental Disabilities Administration (BHDDA) Customer Relationship Management database. Potential CCBHCs must provide justification of meeting CCBHC criteria and upload supporting documentation verifying that standards have been met. Certifications are valid for two years. MDHHS can issue a provisional certification for a CCBHC that does not fully meet all the program requirements. Provisional certifications are term-limited and the CCBHC must provide MDHHS with a plan for meeting the full certification requirements to maintain certification. CCBHCs can receive the PPS payment while provisionally certified.

MDHHS will conduct at least one site visit to each certified CCBHC during the demonstration period to verify that program requirements are being met and implemented in practice. MDHHS staff will review documentation and client records and offer feedback on CCBHC practices.

Minimum certification criteria are defined by Substance Abuse and Mental Health Services Administration (SAMHSA) and the MDHHS minimum standards as detailed in the CCBHC Demonstration Handbook. Certification criteria address the following components:

A. Staffing Requirements

Staffing requirements include criteria that staff have diverse disciplinary backgrounds, have necessary state required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population. (Refer to the Michigan Prepaid Inpatient Health Plan [PIHP]\Community Mental Health Services Program [CMHSP] Provider Qualifications Per Medicaid Services & Healthcare Common Procedure Coding System [HCPCS]\Current Procedural Terminology [CPT] Codes document for additional information.) CCBHCs must provide an interdisciplinary team-based set of services to ensure the totality of one's needs (physical, behavioral, and/or social) are met through the provision of CCBHC services.

B. Availability and Accessibility of Services

Availability and accessibility of services includes crisis management services that are available and accessible 24 hours per day, the use of a sliding scale for payment, and no rejection for services or limiting of services based on an individual's ability to pay or county of residence. There is no limit on the amount or duration of services offered, provided the individual meets standards for medical necessity as indicated by the CCBHC and services are provided in accordance with the individual's treatment plan. CCBHCs must also meet standards for timeliness as defined in the CCBHC Demonstration Handbook.

C. Care Coordination

Care coordination includes requirements to coordinate care across settings and providers to ensure seamless transitions for individuals across the full spectrum of health services, including acute, chronic, and behavioral health needs. Care coordination requirements shall include partnerships or formal contracts.

D. Scope of Services

The CCBHC scope of services includes provision (in a manner reflecting person-centered care) of the nine core CCBHC services outlined in the CCBHC Service Requirements section of this policy. Services may be provided directly by the CCBHC or through formal relationships with DCOs. Required Evidence Based Practices and expectations around service delivery are outlined in the CCBHC Demonstration Handbook.

E. Quality and Other Reporting

CCBHCs must collect, report, and track encounter, outcome, and quality data, including but not limited to data capturing: consumer characteristics; staffing; access to services; use of services; screening, prevention, and treatment; care coordination; other processes of care; costs; and consumer outcomes. Measures and specifications for reporting are listed in the CCBHC Demonstration Handbook.

F. Organization Authority, Governance, and Accreditation

The CCBHC must meet one of the following criteria:

- a non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code;
- a part of a local government behavioral health authority (which includes all forms of CMHSPs);
- an organization operated under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 United States Code [USC] 450 et seq.); or
- an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (25 USC 1601 et seq.).

V. Designated Collaborating Organization (DCO)

A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. Persons receiving CCBHC services from DCO personnel under the contract are CCBHC recipients. The CCBHC must adhere to the following DCO provisions:

A. CCBHC Agreements with DCOs

CCBHCs must establish formal agreements if they choose to utilize a DCO. A formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized. CCBHCs are required to submit all DCO agreements to MDHHS. Detailed requirements regarding CCBHC agreements with DCOs are cited in the CCBHC Demonstration Handbook.

B. CCBHC Clinical and Financial Responsibility for DCOs

CCBHCs must maintain clinical and financial oversight of CCBHC services provided by DCOs. This includes the responsibility for billing CCBHC services rendered under contract by a DCO. This also includes ensuring a DCO meets all clinical parameters required of CCBHCs. Detailed requirements for the responsibilities are cited in the CCBHC Demonstration Handbook.

C. CCBHC Payment for DCOs

Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. Payment will be provided directly to the DCO from the CCBHC based on agreed upon contractual service rates. These rates must be reflective of fair market value.

VI. Identification, Enrollment, and Assignment of CCBHC Recipients

Eligible CCBHC recipients are identified using a multifaceted approach described in the CCBHC Demonstration Handbook. MDHHS reserves the right to review and verify all enrollments and assignments.

A. MDHHS Identification/Enrollment of CCBHC-Eligible Recipients

MDHHS uses administrative data from the MDHHS Data Warehouse to identify CCBHC-eligible recipients in counties with a CCBHC Demonstration Site based on having a recent mental health and/or SUD diagnosis. All Medicaid beneficiaries eligible for CCBHC are automatically enrolled in the CCBHC benefit plan in Michigan's Medicaid Management Information System (MMIS), known as the Community Health Automated Medicaid Processing System (CHAMPS).

B. PIHP Assignment of CCBHC-Eligible Recipients

MDHHS will provide PIHPs with a list of CCBHC-eligible recipients for their region in the timeframe and manner specified in the CCBHC Demonstration Handbook. PIHPs must work with CCBHCs to assign individuals to the pertinent CCBHC within the WSA. The assignment must include an attestation that the Consent to Share Behavioral Health

Information (MDHHS-5515) or other approved consent form (if held to more stringent requirements under federal law) has been signed by the CCBHC-eligible recipient.

C. CCBHC Recommendation of CCBHC-Eligible Recipients

For individuals not automatically identified and enrolled by MDHHS, CCBHCs are permitted to recommend eligible recipients for enrollment into the CCBHC via the WSA. CCBHC providers must provide documentation that indicates a potential CCBHC enrollee meets eligibility for the CCBHC benefit, including diagnostic verification and the completion and attestation of the MDHHS-5515 or other approved consent form (if held to more stringent requirements under federal law). The PIHP must review and process all recommended enrollments in the WSA. The PIHP is responsible for verifying eligibility criteria but cannot deny enrollment of an individual with a qualifying diagnosis. Assignment procedures are described in the CCBHC Demonstration Handbook.

Please note that CCBHC services can be provided before being assigned to a CCBHC in the WSA. However, as soon as appropriate, the CCBHC and PIHP shall assign the person into the CCBHC via the WSA. The assignment will be utilized to monitor and analyze CCBHC-service encounters for both the Medicaid and non-Medicaid populations.

VII. CCBHC Service Requirements

In accordance with PAMA, CMS requires CCBHCs, directly or through designated collaborating organizations, to provide a set of nine comprehensive services to address the complex and myriad needs of persons with mental health or SUD diagnoses services. These services include the following:

1. Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
2. Screening, assessment, and diagnosis, including risk assessment.
3. Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
4. Outpatient mental health and substance use services.
5. Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
6. Targeted case management.
7. Psychiatric rehabilitation services.
8. Peer support and counselor services and family supports.
9. Intensive, community-based mental health care for members of the Armed Forces and veterans, particularly those members and veterans located in rural areas.

VIII. CCBHC Payment Methodology

A. Selection of Prospective Payment System 1 (PPS-1)

MDHHS utilizes the prospective payment system 1 (CC PPS-1) methodology in which CCBHCs receive a daily clinic-specific rate based on the average expected daily cost to deliver core CCBHC services.

B. PPS-1 Rates for Demonstration Year 1

1. Demonstration Year 1

Pursuant to federal requirements, the PPS-1 rate for Demonstration Year 1 is based on the CCBHC Cost Reports submitted to CMS in 2016. These rates may be updated based on FY19 clinic data and/or the appropriate Medicare Economic Index (MEI) adjustment. Any updates to the rates must be approved by MDHHS and CMS.

2. Demonstration Year 2

Pursuant to federal requirements, the PPS-1 rate for Demonstration Year 2 will be rebased according to the actual costs of providing the nine core CCBHC services, including the costs of serving the uninsured and underinsured. As such, Demonstration Year 2 PPS-1 rates will be based on the CCBHC Cost Reports submitted for Demonstration Year 1.

MDHHS will post CCBHC PPS-1 rates on the CCBHC website, in the CCBHC Demonstration Handbook, and in the Behavioral Health Developmental Disabilities Administration (BHDDA) Service Encounter Coding Chart.

C. Payment Operations

1. MDHHS to PIHPs – CCBHC Capitation Payment

MDHHS operationalizes the PPS-1 through the PIHPs, specifically those PIHPs that have CCBHC Demonstration Sites within their service areas. MDHHS will prospectively provide PIHPs a CCBHC per member per month (PMPM) capitation payment based on Medicaid beneficiaries enrolled in the CCBHC benefit plan. The CCBHC PMPM payment is comprised of the anticipated utilization of CCBHC services at the PPS-1 rate and an administrative amount to reflect the additional duties MDHHS is requiring of the PIHPs in executing the CCBHC Demonstration. MDHHS will reconcile with the PIHPs the actual costs of CCBHC Demonstration services to CCBHC capitation payments per the terms cited in the CCBHC Demonstration Handbook.

2. PIHPs to CCBHC Demonstration Sites

MDHHS requires the PIHP to reimburse a CCBHC at its clinic-specific PPS-1 rate for each qualifying CCBHC service (note: the PPS-1 payment may only be paid once per day regardless of the number of CCBHC services provided on a given day). PIHPs must reimburse a CCBHC the full PPS-1 payment amount within 60 days following the month in which the service was rendered.

3. CCBHC Service Encounter Coding Requirements

CCBHCs must submit CCBHC encounter codes to the PIHP to receive payment for providing a qualified CCBHC service. In turn, the PIHP will submit all encounters to MDHHS via CHAMPs in accordance with the provisions below:

a. Required CCBHC Service Encounter Codes

CCBHCs must submit to the PIHP valid CCBHC Encounter Codes reflecting qualifying CCBHC services as cited in Appendix A of the CCBHC Demonstration Handbook with a corresponding T1040 service encounter code. The combination of the T1040 code and the CCBHC Encounter Code must be submitted for the service to be recognized as a CCBHC service and is required to trigger the PPS-1 payment. Omitting either the T1040 code or the CCBHC Encounter Code will preclude payment at the PPS-1 rate.

b. Reporting Detail of CCBHC Service Encounter Codes

All CCBHC service encounters, whether provided directly or through a DCO, must be submitted to the PIHP with the CCBHC as the Billing National Provider Identifier (NPI). For Medicaid beneficiaries, the CCBHC must submit the encounter with the beneficiary's Medicaid ID; for non-Medicaid recipients, the CCBHC must submit the encounter with the PIHP's Consumer ID assigned to the recipient. In turn, PIHPs must submit all CCBHC service encounters to MDHHS via CHAMPS consistent with the preceding requirements.

c. Timely and Complete CCBHC Service Encounter Code Submission

CCBHCs and PIHPs must submit timely and complete CCBHC Service Encounters in accordance with federal managed care rules and pursuant to the requirements specified in the CCBHC Demonstration Handbook.

d. Third-Party Reimbursement/Coordination of Benefits

CCBHCs must first bill for CCBHC services, whether provided directly or through a DCO, any applicable third-party payors, including Medicare, prior to submitting the encounter to the PIHP for CCBHC payment*. In addition, for non-Medicaid CCBHC recipients, CCBHCs must use all applicable federal or state grant funding (including but not limited to SAMHSA CCBHC Expansion grant funding) prior to submitting the encounter to the PIHP for CCBHC payment.

After payment from an applicable third-party payor and/or applicable federal or state grant funding is accounted for, the CCBHC must submit the encounter to the PIHP a claim amount reflecting the difference between its clinic-specific PPS-1 rate and the sum of any third-party payment received or federal or state grant funding utilized. For any given CCBHC service, the collective reimbursement among all payor sources may not exceed a site's specific PPS-1 rate.

(*Note: There are cases where certain third-party payors may not allow the CCBHC to bill on behalf of a DCO. In this case, the DCO must provide any payment received from the third-party payor to the CCBHC. Further details are provided in the CCBHC Demonstration Handbook.)

D. Quality Bonus Payments (QBPs)

QBP may be issued based on providers meeting CMS-defined quality benchmarks. To receive a QBP, a CCBHC must achieve or exceed the threshold for all QBP-eligible measures as specified by CMS. The QBP is based on 5% of the total Demonstration Year Costs as reported by the CCBHCs in their annual cost report. QBP for Demonstration Year 2 will also be calculated at 5% but will be based on sites that exceed the QBP benchmarks established in Demonstration Year 1. The methodology for metrics, specifications, and distribution will be maintained on the MDHHS CCBHC website and in the CCBHC Demonstration Handbook.

IX. CCBHC Reporting Requirements

CCBHCs are responsible for the reporting of encounter data, clinical outcomes data, quality data, and other data as federally required. Data will be used to assess the impact of the demonstration on access to services, quality and scope of services, and costs of providing a comprehensive array of behavioral health services.

A. Cost Reporting

CCBHCs must submit periodic cost report with supporting data to the PIHP in accordance with the CCBHC Demonstration Handbook. Cost reports are based on the CCBHC's financial records and must follow the template provided by the state. When reporting costs, the CCBHC must adhere to the 45 Code of Federal Regulations (CFR)

§75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for the U.S. Department of Health and Human Services (HHS) Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement. The CCBHC records must be detailed, orderly, complete, and available for review or audit.

B. Quality Metric Reporting

CCBHCs are required to collect a core set of quality metrics as defined by CMS. Specifications for the required metric set will reflect federal guidance. Reporting requirements for CCBHC quality metric reporting are detailed in the CCBHC Demonstration Handbook.

C. Reporting by DCOs

CCBHCs must report data on individuals served by DCOs. It is the responsibility of the CCBHC to arrange for access to data required for reporting purposes as part of a CCBHC's agreement with a DCO as cited in Section V above. Reporting requirements for CCBHC services rendered by DCOs are in the CCBHC Demonstration Handbook.

D. Other Required Reports

CCBHCs must submit other MDHHS-required reports, including the Financial Status Reports (FSRs), pursuant to MDHHS-defined instructions and timelines with further requirements specified in the CCBHC Demonstration Handbook.

Manual Maintenance

Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 1-800-292-2550. Atypical Providers may phone toll-free 1-800-979-4662.

An electronic version of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Approved

Kate Massey, Director
Medical Services Administration