Michigan Medicaid Policy | MMP

BULLETIN

BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICES ADMINISTRATION

MDHHS

Bulletin reissued 11-20-2023 to correct language on page 2.

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Distribution: All Providers

Issued: October 2, 2023

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

Effective: November 1, 2023

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

The purpose of this policy is to define operational changes necessary to implement the CCBHC demonstration and provide for coverage and reimbursement of CCBHC services. In addition, MDHHS will develop and continuously update a companion operational guide for providers called the CCBHC Demonstration Handbook, which will be posted on the MDHHS CCBHC website.

I. General Information

The CMS CCBHC Demonstration requires states and their certified 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. Refer to the Certified Community Behavioral Health Clinic Demonstration section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter within the MDHHS Medicaid Provider Manual for detailed description of the CCBHC structure.

II. Eligibility

A. Site Eligibility

Per CMS directive, states have the flexibility to determine which behavioral health providers can participate in the CCBHC Demonstration. Sites must meet all requirements as outlined in the CCBHC Demonstration Handbook and be certified by MDHHS to be designated as a CCBHC demonstration site.

B. CCBHC Service 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, insurance coverage, age, severity of need, or ability to pay.

Exceptions to the diagnostic requirement are:

- 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 and/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. Enrollment

All eligible Medicaid beneficiaries will be automatically enrolled in the CCBHC benefit plan. CCBHCs and Prepaid Inpatient Health Plans (PIHPs) have the authority to add additional beneficiaries as appropriate. Non-Medicaid individuals are not automatically enrolled in the CCBHC benefit plan but should be tracked using encounter reporting and other methods outlined in the CCBHC Demonstration Handbook.

MDHHS reserves the right to review and verify all enrollments.

IV. Certification Requirements

CCBHC demonstration clinics must complete the MDHHS certification process to become a CCBHC under the CMS CCBHC Demonstration. During the certification process, CCBHC clinics will provide justification of meeting CCBHC criteria defined by Substance Abuse and Mental Health Services Administration (SAMHSA) and MDHHS by submitting supporting documentation verifying that standards have been met.

In accordance with the Protecting Access to Medicare Act of 2014 (PAMA), certification criteria address the following broad elements:

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.

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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.

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, at minimum, partnerships or formal contracts with: federally-qualified health centers (FQHCs) (and, as applicable, rural health clinics [RHCs]) to provide FQHC services (and, as applicable, RHC services) to the extent such services are not provided directly through the CCBHC; inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs, other community or regional services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, state licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services; Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the department as defined in section 1801 of title 38, United States Code; and inpatient acute care hospitals and hospital outpatient clinics.

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 designated collaborating organizations (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, and other data as federally required or requested by MDHHS. 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:

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- 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 Community Mental Health Services Programs [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.).

A detailed description of all certification requirements and standards can be found in the CCBHC Demonstration Handbook.

V. Service Requirements

CCBHCs, directly or through DCOs, must 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.

VI. Designated Collaborating Organization

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.

A. Agreements with CCBHCs

A formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal arrangements describing

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the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized. The CCBHC maintains clinical responsibility for the services provided for CCBHC consumers by the DCO.

B. Payment for DCO

Payment for DCO services is included within the scope of the CCBHC prospective payment system (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.

VII. Payment Methodology

MDHHS will utilize 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 CCBHC services. MDHHS will also employ a Quality Bonus Payment (QBP) that will reward CCBHCs based on attainment of outcomes.

CCBHCs must submit valid CCBHC Encounter Codes cited in Appendix A of the CCBHC Demonstration Handbook with a corresponding T1040 service encounter code to receive payment.

A. PPS-1 Rates

MDHHS will utilize pertinent cost and utilization data from the submitted annual Cost Report to develop clinic-specific PPS-1 rates. Rates may be updated each demonstration year based on Cost Report data, the appropriate Medicare Economic Index (MEI) adjustment, or as otherwise permitted under federal guidance. Rate updates will be documented in applicable rate certification materials.

B. Quality Bonus Payments

MDHHS will afford Quality Bonus Payments (QBPs) based on providers meeting CMS-defined quality benchmarks. The QBP will be based on five percent of the total Demonstration Year Costs as reported by the CCBHCs. The methodology, specifications, and distribution will be maintained in the CCBHC Demonstration Handbook.

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VIII. Reporting Requirements

CCBHCs are responsible for the reporting of encounter data, clinical outcomes data, quality data, and other data as federally required or requested by MDHHS. 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. MDHHS will require the PIHP to collect, maintain, and organize CCBHC reporting data; MDHHS will also require the PIHP to send all reports to MDHHS in accordance with state and federally defined timelines.

A. Cost Reporting

CCBHCs must submit an annual cost report with supporting data to the PIHP and MDHHS. Cost reports are based on CCBHC 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 metrics are defined per federal guidance and detailed in the CCBHC Demonstration Handbook. 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.

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.

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

Approved

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