Certified Community Behavioral Health Clinic Services

CCBHC services include a comprehensive and integrated package of mental health and substance use disorder treatment services and supports listed under the Rehabilitative Services benefit, Physician Services, Other Laboratory and X-ray Services, Medical and Remedial Services, Other Practitioner Services, MAT, and services as defined under the EPSDT benefit in Attachments 3.1-A and 3.1-B. The state reimburses CCBHC providers on a per visit basis using a provider-specific bundled daily payment rate. The bundled payment represents the daily cost of providing CCBHC services. A CCBHC provider receives payment for each day CCBHC services are provided to a Medicaid beneficiary. Payment is limited to one payment per day, per CCBHC, per beneficiary for each CCBHC visit. Visits eligible for reimbursement include days on which at least one CCBHC service is provided to a beneficiary.

The CCBHC rate is incorporated in the Managed Care capitation rates. Each managed care organization is responsible for paying the provider-specific rate to each certified CCBHC according to program specifications.

CCBHC Rate Methodology: The payment rate for CCBHC services is based on the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. Allowable costs include the salaries and benefits of Medicaid providers, the cost of services provided per the DoHS, and other costs such as insurance or supplies needed to provide CCBHC services. Indirect costs include site and administrative costs associated with providing CCBHC services. For the purposes of calculating rates, visits include all visits for CCBHC services including both Medicaid and non-Medicaid visits. Allowable costs are identified using requirements in 45 CFR §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement.

CCBHCs must provide data on costs and visits to the Bureau for Medical Services (BMS) or its successor annually using the CMS CCBHC cost report or currently authorized template. Annual CCBHC cost reports based on audited financials shall be submitted to BMS annually. Upon receipt from the CCBHC, the cost reports are reviewed by a Certified Public Accounting firm. Upon acceptance of the CCBHC cost reports from the accounting firm, BMS sets the rates for the following rate year. The rate year follows the calendar year.

Initial Payment Rates: The State will establish a provider-specific bundled daily payment rate using audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period. The initial rates include expected costs and visits that are subject to review by a

Certified Public Accounting firm and the state. The bundled daily rate is calculated by dividing the total annual allowable expected costs of CCBHC services by the total annual number of expected CCBHC Medicaid and non-Medicaid visits.

Initial payment rates for CCBHCs transitioning from the Section 223 Demonstration to the State Plan will be the approved demonstration rates.

Rebasing and Inflation Adjustments: CCBHC payment rates are rebased after an initial rate period and every three years following the last rebasing. Rates are rebased by dividing the total annual allowable CCBHC costs from the CCBHC's most recent 12 month audited cost report by the total annual number of CCBHC Medicaid and non-Medicaid visits during that 12-month time period. The resulting rate is trended from the midpoint of the cost report period to the midpoint of the rate year using the Medicare Economic Index (MEI). Initial payment rates are rebased once the CCBHC submits the first audited cost report including a full year of actual cost and visit data for CCBHC services under the State Plan. Rates are rebased using actual data on costs and visits. Rebased rates take effect the following January, and the State does not reconcile previous payments to cost. Payment rates are updated between rebasing years by trending each provider-specific rate by the MEI for primary care services. Rates are trended from the midpoint of the previous calendar year to the midpoint of the following year using the MEI.

Quality Bonus Payment (QBP): CCBHCs may be eligible for a QBP based on reaching specific numeric thresholds on State-identified performance metrics. Any QBP would be in addition to payments under the bundled payment rate and paid to CCBHCs that achieve specific performance thresholds as identified by the state. CCBHCs would need to achieve thresholds on all identified quality measures in order to be eligible for a QBP. To participate in a QBP program, CCBHCs will need to demonstrate the ability to submit electronic data to BMS in a form, with sufficient detail, and for a defined period of time to determine QBP eligibility. QBPs will be calculated for each CCBHC pursuant to published BMS rule.