HFS
Illinois Department of
Healthcare and Family Services

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CERTIFIED PUBLIC ACCOUNTANTS

Illinois Medicaid Certified Community Behavioral Health Clinic (CCBHC) Initiative

Frequently Asked Questions

October 17, 2022[1]

General Questions

1. What is a CCBHC?

Enacted under Section 223 of the 2014 Protecting Access to Medicare Act (PAMA) (PL 113-93), CCBHCs are a new type of behavioral health organization and a new Medicaid provider type. They differ from traditional behavioral health organizations in that they must meet rigorous established criteria for care coordination, service delivery, crisis response, and are evaluated by a common set of quality measures.

The statute specifies that CCBHCs must provide nine categories of comprehensive services to address the complex needs of individuals with mental health or substance use disorders (SUD). CCBHCs may deliver these services directly or through formal relationships with Designated Collaborating Organizations (DCOs). CCBHCs serve all individuals in need of care, regardless of residency or ability to pay. In exchange, CCBHCs receive an enhanced prospective payment system (PPS) rate based on the costs of expanding services to meet the identified mental health and SUD treatment needs in their communities.

Required CCBHC Services:

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
- Screening, assessment, and diagnosis, including risk assessment.
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
- Outpatient mental health and substance use services.
- Outpatient clinic primary care screening and monitoring of key health indicators and health risks (e.g., BMI, blood pressure, tobacco use, HIV/Viral Hepatitis).
- Targeted case management.
- Psychiatric rehabilitation services.
- Peer support, counselor services, and family support.
- Intensive, community-based mental health services for members of the armed forces and veterans.

[1] Responses provided as of October 17, 2022 are based on information available based on the current demonstration guidance, and may be modified dependent upon the release of any new grant guidance.

Section 223 of PAMA includes the statutory criteria for certifying CCBHCs. These criteria, which establish a basic level of service at which a CCBHC should operate, fall into six key program areas:

1. **Staffing** – Staffing plan driven by local needs assessment, licensing, and training to support service delivery.
2. **Availability and Accessibility of Services** – Standards for timely and meaningful access to services, outreach and engagement, 24/7 access to crisis services, treatment planning, and acceptance of all patients regardless of ability to pay or place of residence.
3. **Care Coordination** – Care coordination agreements across services and providers (e.g., Federally Qualified Health Centers, inpatient and acute care), defining an accountable treatment team, health information technology, and care transitions.
4. **Scope of Services** – Nine required services, as well as person-centered, family-centered, and recovery-oriented care.
5. **Quality and Other Reporting** – 21 quality measures, a plan for quality improvement, and tracking of other program requirements.
6. **Organizational Authority and Governance** – Consumer representation in governance, appropriate state accreditation.

CCBHCs are also required to serve any individual in need of care including, but not limited to, those with serious mental illness, serious emotional disturbance, long-term chronic addiction, mild or moderate mental illness, and substance use disorders.

Note: The Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services (HHS) set policy and provides guidance on behavioral health programs including CCBHCs. Additional SAMHSA guidance on CCBHCs can be found at: https://www.samhsa.gov/certified-community-behavioral-health-clinics.

2. What is the difference between the CCBHC Medicaid Demonstration and the SAMHSA CCBHC grants available directly to providers?

There are two distinct funding streams associated with the CCBHC program:

- **SAMHSA Grants**
  CCBHC Expansion Grants: Issued directly to community-based providers over three separate funding opportunities in Federal FY2018, FY2020, and FY2021. SAMHSA has full oversight of these grants. There is no requirement for state coordination with providers, but providers were required to self-attest that they meet the baseline CCBHC criteria.
  CCBHC PDI and IA Grants: The Planning Development and Implementation (PDI) grant is for new providers to plan for, and develop services necessary, to become a CCBHC. The Improvement and Advancement (IA) grant is for existing CCBHC sites. SAMHSA has oversight of these grants. Providers are required to obtain a letter of support from the State Mental Health Authority and self-attest that they meet the baseline CCBHC criteria. The state has no direct involvement in the oversight or implementation of this funding.
- **CCBHC Medicaid Demonstration**
  The Centers for Medicare and Medicaid Services (CMS) CCBHC Medicaid Demonstration is administered by the state Medicaid agency and uses a prospective payment system (PPS) rate to reimburse providers for services. In order for a state

to apply for and participate in the demonstration, they must first be awarded a SAMHSA CCBHC planning grant which is intended for states to plan and prepare for the demonstration. If the state is not awarded this planning grant, then they cannot participate in the demonstration. Under the Medicaid Demonstration, the state is responsible for overseeing the program, including the state-based certification process, reimbursement, and compliance with federal reporting requirements.

3. How will the award of the SAMSHA grants affect providers receiving those awards if Illinois becomes a CCBHC Medicaid Demonstration state?

The receipt of SAMHSA CCBHC grant funds does not prevent or automatically qualify a provider from participating in the Medicaid Demonstration. Instead, any provider, regardless of whether they have received SAMHSA CCBHC grant funding, must meet the CCBHC Certification Criteria through the state-based certification process in order to participate in the Medicaid Demonstration.

4. How is a CCBHC different from a Behavioral Health Center (BHC), a Community Mental Health Center (CMHC), a Federally Qualified Health Center (FQHC), and Rural Health Center (RHC)?

While all of these provider types deliver overlapping types of services, CCBHCs have very strict requirements for care coordination and integrated care, core services, reimbursement, data collection and quality reporting. The nuances of each provider type require greater detail than the scope of this FAQ and will be detailed at a later date.

The table below from the National Council for Mental Wellbeing describes key differences between the CCBHC delivery model and traditional behavioral health models.

	Traditional Delivery Models	CCBHC Service Delivery Model
Access to Care	Workforce shortages, inability to recruit and retain qualified staff and limited capacity to meet the demand for treatment resulting in clinics turning away patients or placing them on long waiting lists.	CCBHCs are required to serve everyone, regardless of geographic location or ability to pay. Nationally, 100% of CCBHCs have hired new staff including 72 psychiatrists and 212 staff with addiction specialty focus expanding their capacity to meet the demand for treatment. As a result, CCBHCs report an aggregate increase of 25% in patient caseload.
Wait Times	Wait times from referral to first appointment average 48 days nationally at community based behavioral health clinics.	For routine needs, 46% of CCBHCs offer same day access to services and 94% offer access within 10 days or less.
Evidence-based Practices (EAPs)	No standard definition of services that requires evidence-based practices. Services vary widely between clinics with little guarantee that clients will have access to high quality, comprehensive care. Array of services and staff training is dependent upon grant funds.	CCBHCs are required to provide a comprehensive array of services including 24/7 crisis services, integrated health care, care coordination, medication-assisted treatment (MAT), peer and family support and care coordination. Across CCBHCs, 75% have expanded capacity to provide crisis care, 73% have adopted innovative technologies to support care,

	Traditional Delivery Models	CCBHC Service Delivery Model
		57% have implemented same-day access protocols and 64% have expanded services to veterans.
Quality Measures	Quality measures are inconsistent across states, communities and grant programs.	Clinics are required to report on standardized quality metrics, while states report on additional quality and cost measures. Nationally, 79% of CCBHCs reported using quality measures to change clinical practice.
Crisis Services	Crisis services provide necessary assessment, screening, triage, counseling, and referral services to individuals in need but vary nationally.	All CCBHCs offer 24/7 access to crisis care, including mobile crisis teams, ensuring individuals of all ages receive the care they need and avoid unnecessary hospitalizations. A CCBHC in Oklahoma reported a 64% reduction in psychiatric hospitalizations as a result of its crisis response activities and improved care transitions with the hospital.
Care Coordination	Traditional delivery models do not include incentives for care coordination services; therefore, physical and behavioral health conditions are seldom diagnosed and treated simultaneously.	CCBHCs are required to coordinate care with hospitals, schools, criminal justice agencies and other providers to improve health outcomes and reduce use of emergency room and inpatient facilities. Estimated savings of guiding one high-resource-user to care coordination is estimated to be $39,000 per year. These activities are incorporated into the reimbursement rate.
Medication Assisted Treatment (MAT)	Nationally, only 36% of substance use treatment facilities offer access to one or more types of MAT, due in part to barriers that prevent hiring prescribers.	92% of CCBHCs offer MAT due to state-driven requirements and a reimbursement rate that supports prescriber hiring and training.
Payment	Services are supported by grant funding that is limited in scope and not sustainable.	CCBHCs establish a sustainable payment model that ends reliance on time-limited grants.
Source: National Council for Mental Wellbeing. Certified Community Behavioral Health Clinics Moving Beyond "Business as Usual" to Fill the Addiction and Mental Health Treatment Gap. https://www.thenationalcouncil.org/wp-content/uploads/2021/12/080520_NCBH_CCBHCFactSheet_v2.pdf		

5. Will the implementation of CCBHCs eliminate other provider types or programs?

No, the goal is to expand the behavioral health continuum and offer a more robust service array. CMHCs, BHCs, SUPR Providers and other related programs will not be eliminated.

6. What if Illinois is not chosen for the Planning Grant?

Illinois is committed to pursuing the CCBHC model to advance the goals of the state and will proceed with a path forward that is the best fit for the state, providers, and beneficiaries.

7. What does the 24/7 crisis intervention requirement include?

Per current SAMHSA guidance:

- The CCBHC provides crisis management services that are available and accessible 24 hours a day and within three hours.
- The CCBHC policies and procedures must be publicly available and clearly describe the methods for providing a continuum of crisis prevention, response, and follow up services.
- Individuals who are served by the CCBHC are educated about crisis management services, Psychiatric Advanced Directives, and accessing crisis services, including suicide or crisis hotlines and warmlines, at the time of the initial evaluation. This includes individuals with limited English proficiency or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels).
- CCBHCs will maintain a working relationship with local emergency departments. Protocols are established for CCBHC staff to address the needs of CCBHC consumers in psychiatric crisis who come to those emergency departments.
- Protocols, including for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a psychiatric crisis.
- Following a psychiatric emergency or crisis involving a CCBHC consumer, in conjunction with the consumer, the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises for the consumer and their family.
- Detailed CCBHC criteria is available at: https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

8. Is there a maximum number of CCBHCs that will be chosen for grant participation?

No maximum cap has been determined at this time. Quality of applications and geographic prevalence of services will drive the selection process.

Questions related to Certification

9. If SAMHSA has accepted my organization's CCBHC Certification Attestation, does that mean we are automatically considered a CCBHC eligible to participate in the Medicaid Demonstration?

No, in order to participate as a CCBHC in the Medicaid Demonstration, all providers must meet the CCBHC Certification Criteria through the state-based certification process and be selected by the state to participate in the program.

10. What are the provider requirements to be eligible to apply to be a CCBHC?

Section 223 of the PAMA requires that a CCBHC be one of the following entities:

- A nonprofit organization.
- Part of a local government behavioral health authority.
- An entity operated under authority of the IHS, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS pursuant to the Indian Self-Determination Act.
- An entity that is an urban Indian organization pursuant to a grant or contract with the IHS under Title V of the Indian Health Care Improvement Act (PL 94-437).

Eligible providers for the Medicaid Demonstration must also meet the CCBHC Certification Criteria through the state-based certification process.

11. Can facilities be certified as both a CCBHC and CMHC? Will the CCBHC initiative eliminate CMHC programs?

Yes, facilities can be certified as both a CCBHC and a CMHC. CMHC programs will not be eliminated.

12. Will there be a new provider type created for CCBHCs?

Yes, CCBHCs will be a new provider type under Medicaid for those organizations that meet state-based CCBHC certification criteria and are selected to participate in the Medicaid Demonstration.

13. If Illinois receives the planning grant, what would be the earliest date the state would be ready for CCBHC provider certification?

It is anticipated the state-based CCBHC certification process would begin in early 2024.

14. What are the data reporting requirements or metrics and where can they be found?

At a minimum, consumer and service-level data should include a unique consumer identifier, unique clinic identifier, unique claims CPT code identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. This data must be reported through MMIS/T-MSIS in order to support the state's claim for enhanced federal matching funds made available through this demonstration program. For each consumer, the state

must obtain and link the consumer level administrative Uniform Reporting System (URS) information to the claim (or be able to link by unique consumer identifier).

CCBHCs are required to report on quality measures as outlined in the demonstration. CCBHCs must also submit a cost report with supporting data within six months after the end of each demonstration year to the state Medicaid agency. The state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each demonstration year to CMS.

For additional information refer to SAMHSA CCBHC Criteria: https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

15. Where can I find information on the CCBHC quality measures?

Please refer to https://www.samhsa.gov/section-223/quality-measures

16. What will the staffing requirements be for CCBHCs?

As part of the upcoming planning process, HFS, in partnership with DHS, will perform a needs assessment to inform the development of the CCBHC staffing requirements that will be covered in the state-based CCBHC certification process. The needs assessment will cover cultural, linguistic, and treatment needs.

SAMHSA requires that CCBHC staffing be compliant with state licensure and the state-based CCBHC certification. The clinical and non-clinical staff must be appropriate for serving the consumer population in terms of size, composition, and required services. SAMHSA requires that the CCBHC executive management include a Chief Executive Officer (CEO) and a Medical Director. The Medical Director must be able to prescribe and provide substance abuse treatment. Clinicians must have necessary licensure and credentialing and meet cultural and linguistic requirements.

Once certified, the CCBHC will update the needs assessment and the staffing plan, including both consumer and family/caregiver input. The needs assessment and staffing plan will be updated regularly, at least every three years.

Additional detail on the SAMHSA staffing requirements is available at: https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

17. Since staffing is one of the CCBHC requirements, are smaller nonprofits going to be ineligible to apply if they don't meet that criteria? Would having a waitlist make them ineligible to apply?

Once the state issues the CCBHC staffing requirements, providers interested in being certified as a CCBHC should assess their ability to comply and provide services as required.

18. What are the requirements for a Designated Collaborating Organization (DCO)? Are there criteria outlined somewhere if an organization wants to be a DCO to be able to provide services?

SAMHSA defines a DCO as "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. 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. The CCBHC maintains clinical responsibility for the services provided for CCBHC consumers by the DCO. To the extent that services are required that cannot be provided by either the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for care coordination including services to which it refers consumers. Payment for those referred services is not through the PPS but is made through traditional mechanisms within Medicaid".

- In the context of scope of services and the relationships between the CCBHC and DCOs, a formal relationship is based on 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 used.
- All CCBHC providers who furnish services directly, and any DCO providers that furnish services under arrangement with the CCBHC, are legally authorized in accordance with federal, state and local laws, and act only within the scope of their respective state licenses, certifications, or registrations and in accordance with all applicable laws and regulations, including any applicable state Medicaid billing regulations or policies. Pursuant to the requirements of the statute (PAMA § 223 (a)(2)(A)), CCBHC providers have and maintain all necessary state-required licenses, certifications, or other credentialing, with providers working toward licensure, and appropriate supervision in accordance with applicable state law.
- Whether delivered by the CCBHC or by a DCO, the CCBHC is ultimately responsible for all care provided.
- The CCBHC ensures all CCBHC services are consistent with the consumer's freedom to choose providers within the CCBHC and its DCOs.
- DCO-provided services for CCBHC consumers must meet the same quality standards as those provided by the CCBHC

For further detail, please see the SAMHSA CCBHC/DCO Criteria at https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

19. Will the state help match organizations who want to collaborate with other organizations as they can provide some services but are not set up to provide all of the services?

No, the state will not match organizations looking to collaborate as a DCO.

20. How will stakeholders be included in the data analysis and design of the Prospective Payment System?

Stakeholder input will be included in surveys and in the steering committee meetings during the planning process. In addition, provider cost and unit data will be collected throughout the process to help support the methodology for determining the PPS rate.

21. Will CMHCs who operate under DCFS criteria be rolled into being demonstration providers or only open to providers credentialed under DHS?

The CMHCs who wish to participate in the demonstration grant must meet all SAMHSA certification criteria to participate in the Medicaid Demonstration, whether certified by DHS or DCFS.

22. What will the model look like after the demonstration project?

This decision will be made once CCBHC outcomes data is available toward the end of the four year demonstration.

23. To be eligible for the planning grant, do organizations need to be accredited by the Joint Commission/Council on Accreditation etc., and if so, by whom?

Accreditation will not be a requirement to participate in the demonstration grant.

Questions related to Payment

24. How does the CCBHC prospective payment system (PPS) reimbursement work?

Medicaid reimburses CCBHCs using a provider specific prospective payment that accounts for the costs of service expansion and providing services to all persons who seek care. The PPS rate is intended to sufficiently cover costs and offer improved financial predictability. The PPS is calculated as the total costs of allowable services divided by the total visits for allowable services. Inflation is also applied for the applicable rate period. Providers will receive the PPS rate for eligible services billed for **Medicaid** members.

25. How can a provider best prepare for Prospective Payment System (PPS) rate setting?

Providers should maintain data on their costs and units to share with the state. Additionally, planning and consideration for costs of staff, supplies, and services that may need to be added to meet the CCBHC criteria should be considered. Information will be requested in the form of a cost report or cost survey. Determinations of utilizing a per day PPS or a per month PPS have not yet been made. Providers can review existing claims information to consider how combining daily or monthly services into one reimbursement unit may impact cash flow and reporting. For further information on CCBHC cost reports go to: https://www.medicaid.gov/medicaid/downloads/ccbhc-cost-report-instruction.pdf.

26. How will CCBHC services be reimbursed by managed care organizations (MCOs)? Will organizations be required to seek reimbursement through the MCOs during the demonstration? What might it look like after the demonstration project?

Yes, managed care organizations will be required to cover CCBHC services during the Medicaid Demonstration. HFS will reimburse the services by building the full PPS amount into the MCO capitation rate with the MCOs then reimbursing the CCBHC. Or, HFS will use additional payments to reimburse the CCBHCs the difference between the reimbursement received from the MCOs and the PPS rate.

In terms of what reimbursement might look like after the Medicaid Demonstration, that will depend upon the performance outcome of the project.

27. If the state receives the planning grant, where do the funds go?

SAMHSA specifies that the planning grant funds can only be used by states to plan for participation in the Medicaid Demonstration. This includes the completion of a needs assessment, the development and implementation of the CCBHC certification process, program oversight, rate setting, and program procedures.

28. Will organizations be able to receive multiple reimbursement types during the demonstration?

Yes, eligible services that are not covered under the Medicaid demonstration PPS rate can be claimed for reimbursement.

Additional questions can be submitted by email at HFS.CCBHC@illinois.gov

Please continue to monitor the FAQ for more information.