HFS
Illinois Department of
Healthcare and Family Services

Certified Community Behavioral Health Clinic (CCBHC) Demonstration Program Frequently Asked Questions

Updated: 02/07/2025

Please note that changes and additions to the FAQ are reflected by red text throughout the document.

General

1) Will HFS issue a CCBHC Provider Handbook?

A. Yes. HFS intends to publish a CCBHC Provider Handbook.

2) Does Rule 2060 apply to CCBHCs? (new 2/7/25)

A. Yes, the Illinois Substance Use Disorder (SUD) Act, 20 ILCS 301, makes it unlawful for any person to provide treatment for SUD unless the person is licensed to do so by SUPR. "Treatment" in the SUD Act is defined as "the broad range of emergency, outpatient, and residential care (including assessment, diagnosis, case management, treatment, and recovery support planning) may be extended to individuals with substance use disorders or to the families of those persons."

HFS, SUPR and DMH are working to align payer requirements to reduce duplication and streamline the provision of integrated behavioral health services. SUPR offers monthly CCBHC Office Hours to provide support and technical assistance to providers regarding compliance with Part 2060 requirements.

3) How are the new proposed rules for 2060 going to impact CCBHCs?

A. Each CCBHC site location, and any DCO site location delivering substance use treatment services, is required to maintain a substance use treatment license pursuant to 77 Ill. Adm. Code 2060 (“Rule 2060”). CCBHCs and applicable DCOs will need to maintain compliance with any changes to Rule 2060.

4) Do Community Mental Health Center (CMHC) sites in the CCBHC Demonstration need to be seen by BALC to ensure compliance with Rule 132 and maintain CMHC certification? (new 2/7/25)

A. No. Entities seeking to participate in the CCBHC Demonstration must be able to meet the regulatory requirements found in 59 Ill. Adm. Code 132 or 89 Ill. Adm. Code 140.Table O during the CCBHC Certification process, but most providers

that are certified as a CMHC or a Behavioral Health Clinic (BHC) will have that enrollment provider type end dated for the Demonstration site when they are provisionally certified as a CCBHC.

Some CCBHC sites may be required to retain CMHC or BHC status after being provisionally certified as a CCBHC to ensure the ongoing funding for certain state programs. The State will continue to work towards consolidating these outliers to help simplify provider enrollment and claims processing throughout the State's implementation of CCBHCs.

5) **How will HFS implement ongoing communication with CCBHCs who have been selected for the Demonstration to ensure implementation issues are addressed?**
   A. HFS conducted a CCBHC Kick-Off meeting on July 17, 2024, that included an overview of CCBHC expectations as well as IMPACT enrollment, billing requirements and other information regarding data, reporting and the expectations for participation in the CCBHC National Evaluation. A recording of the webinar and the slide deck have been posted on HFS' website here: Illinois CCBHC FAQs and Webinars. In addition, HFS will be conducting one-on-one technical assistance meetings with each Demonstration CCBHC, offering weekly 1-hour open office hours for CCBHCs to ask questions, and monthly CCBHC operations calls starting in September. HFS has established a dedicated email inbox for questions that arise between meetings: HFS.CCBHC@illinois.gov.

6) **What steps should a CCBHC Demonstration provider take if they will not be prepared to begin offering all Illinois CCBHC Service Requirements by the required timeframes?**
   A. Any CCBHC that has been selected to participate in the CCBHC Demonstration but is not prepared to implement services in accordance with the Illinois CCBHC Service Requirements should contact HFS at HFS.CCBHC@illinois.gov as soon as possible to discuss next steps.

7) **Will HFS be assisting the Demonstration providers with organizations who have been non-responsive for required pieces, such as the VA?**
   A. Yes. CCBHCs who are having difficulty with other community organizations should discuss their engagement strategies with HFS during their one-on-one meetings.

8) How will additional CCBHCs be added to the Demonstration?

A. HFS is still finalizing the requirements and process for the addition of CCBHCs starting in Demonstration Year 2. Information will be shared as it becomes available.

Scope of Services

9) What services are included in the CCBHC PPS?

A. The services covered by the CCBHC PPS are described in the Illinois CCBHC Service Requirements and further detailed in the allowable billable detail procedure code list shared with all CCBHCs.

10) What substance use services are covered under the CCBHC PPS? (response updated 2/7/25)

A. The CCBHC PPS rate covers substance use services, including the following:

- Screening, brief intervention and referral to treatment (SBIRT)
- ASAM assessment
- Individual and groups ~~therapy/~~counseling and didactic) (ASAM Level 1, Level 2 and Level 2.5)
- ~~Intensive outpatient individual and group therapy/counseling (ASAM Level 2 and Level 2.5)~~
- Case management
- Peer and recovery support services
- Medication assisted recovery and medication assisted treatment
- Alcohol and/or other drug toxicology testing (collection and handling only)

Please note that other CCBHC covered services (e.g., crisis intervention, psychiatric evaluation, medication monitoring) must also be available to support customers with substance use challenges, as appropriate and medically necessary. For a full description of services, providers should reference the covered services outlined in federal and state CCBHC requirements for specific service information.

11) If the Community Needs Assessment conducted for our service area does not identify a need for additional service capacity for a required CCBHC service, will the CCBHC still be expected to implement the service?

A. Yes, the CCBHC is expected to implement all required CCBHC services. In rare instances, the State may grant a waiver to a CCBHC in the implementation of a particular discrete service if the State determines the community has sufficient demonstrated capacity for that service.

12) **Are there any anticipated changes to the timeline for implementation of all IL required services (e.g., standing up a BH urgent care crisis centers, crisis stabilization units, data reporting requirements).**
    A. The State does not intend to change the timeline for implementation of the Illinois CCBHC Service Requirements. Please refer to the Illinois CCBHC Service Requirements for details regarding required services and the timelines for implementation.

13) **When will the State be releasing more details about requirements for Urgent Care Centers and Crisis Stabilization Units?**
    A. HFS anticipates finalizing guidance for Urgent Care Centers by February 2025 and for Crisis Stabilization Units by March 2025.

14) **Is methadone part of the CCBHC and if it is there any weekly requirements?**
    A. Methadone is an optional service that can be provided by CCBHCs credentialed to deliver methadone and who enroll with the appropriate subspecialty in IMPACT. It is included in the PPS rate for CCBHCs that opt to provide this service. The dispensing and administration of methadone is claimed using the detail billing code of H0020. H0020 represents a weekly episode of care and may only be billed once every 7 days for customers receiving methadone.

15) **What are the requirements for unfunded clients?**
    A. CCBHCs must serve and collect required data points on all customers seeking services, regardless of their ability to pay. There must be no distinction in how a CCBHC serves a customer based on their ability to pay.

16) **Are Certified Alcohol and other Drug Counselors (CADCs) considered equivalent to Mental Health Professionals (MHPs)? (new 2/7/25)**
    A. For the purposes of the CCBHC Demonstration, the Departments have introduced the credential of a Behavioral Health Professional (BHP). A BHP is any individual who meet the qualifications of an MHP as defined in 89 Ill. Adm. Code 140.453(b)(5) or who are a Certified Alcohol and other Drug Counselor (CADC). The CCBHC Billing Code List provides a detail of all service codes a BHP can provide; this would include any service identified as minimally requiring an RSA level staff. Substance use services must adhere to requirements of 77 Ill. Adm. Code 2060 for professional staff requirements.

17) **Can the minimum staff level on the brief emotional/behavioral assessment code (96127) be changed from LPHA to BHP? (new 2/7/25)**

A. The staffing level for 96127 is intentionally set as an LPHA to align with fee-for-service billing guidance. Lower-level staff can bill for standardized screening tools using H2000 – IATP. HFS is reviewing this guidance to determine if a change is necessary for the purposes of improving quality metric reporting. HFS will communicate any guidance changes in writing with a future effective date if a change is determined necessary.

18) **What are the medical necessity requirements that must be met to bill for Crisis Stabilization services (T1019)? (new 2/7/25)**

A. For the purposes of the CCBHC Demonstration, Crisis Stabilization services may be authorized following any crisis event experienced by the customer, which may include but is not limited to: a Mobile Crisis Response event; a call to 988; a visit to urgent care, an emergency room, or similar setting for a psychiatric need; a person identified at imminent risk of law enforcement involvement or housing destabilization as a result of a behavioral health need. Crisis Stabilization services must be authorized on the customer's IATP or a Crisis Safety Plan. There is not a specific Crisis Safety Plan template that providers are required to use; however, the Crisis Safety Plan must include the following: 1) a behavioral health diagnosis, demonstrated clinical need, or functional impairment; 2) the agency responsible for delivering Crisis Stabilization service as well as the amount, frequency, and duration of services; and 3) LPHA authorization for the services, as indicated by the LPHA's dated signature.

19) **What are the minimum qualifications a Peer Support Worker (PSW) must meet to bill for Peer Support Services (H0038)? (new 2/7/25)**

A. For the purposes of the CCBHC Demonstration, a Peer Support Worker (PSW) is defined as a person who: delivers services from the peer perspective; works under the supervision of a QMHP; is 18 years of age or older; has individual lived experience, or experience as a caregiver of a child, with behavioral health needs; demonstrates the ability to work within agency structure, accept supervision, and participate as a member of a multi-disciplinary team, when applicable; and has completed a Department-approved peer support training or certification process. The current Department-approved peer support training and certification processes are:

- Certified Recovery Support Specialist (CRSS);
- Certified Peer Recovery Specialist (CPRS);
- Certified Family Partnership Professional (CFPP);

- Certified Veteran Support Specialist (CVSS);
- Family Peer Support training model offered through the Provider Assistance and Training Hub (PATH); or
- Other provider established training curriculums with written approval from the Department.

Please note, the Departments may institute standardized training requirements for PSWs in the future. PSWs hired by CCBHCs prior to 7/1/2025 not meeting the requirements outlined above will be grandfathered in as qualified PSW staff until 6/30/2027; as of 7/1/2027, all PSWs must meet the qualifications of a PSW as outlined by the Department.

Providers are also reminded that when seeking reimbursement from a source other than the Medicaid CCBHC Demonstration, they must comply with the staffing and service requirements outlined by their funder or payer.

20) Can Peer Support services (H0038) be provided before an IM+CANS assessment is completed, specifically for crisis and recovery services? (new 2/7/25)

A. No. Peer Support services are considered medically necessary when they are 1) provided to a customer for maximum reduction of disability and restoration to the best possible functional level and 2) recommended by an LPHA or a professional staff per Part 2060 and as documented on the customer's treatment plan. However, staff serving in a peer role may deliver, or participate in the delivery, of crisis services (e.g., Mobile Crisis Response Team, Crisis Stabilization) that do not require the completion of an IM+CANS prior to service delivery.

21) Can Targeted Case Management (TCM) services (T1016) be provided following a crisis event but before an IM+CANS assessment is completed? (new 2/7/25)

A. No. TCM services must be recommended by an LPHA on the customer's IM+CANS.

22) Is clinical formulation without the client present sufficient activity to trigger a PPS payment under H2000 – Integrated Assessment and Treatment Planning? (new 2/7/25)

A. No. Clinical staff time for the formulation of a client case is collected and built into the PPS Cost Reporting and paid out to CCBHCs with each encounter.

23) Can a CCBHC provide services to customers preparing to transition out of a residential treatment setting? Is it ok for these services to be billed on the same day as a residential per diem? (new 2/7/25)

A. Yes, in limited circumstances a CCBHC can provide and bill its PPS rate for certain services (e.g., assessment, targeted case management) provided to customers receiving treatment in an institutional setting, so long as the following conditions are met:

- The purpose of the service is to prepare the customer for transition back into a community-based setting and promote continuity of care;
- The customer is within 30 days of discharge from the facility;
- The service activity is not already covered as part of the facility's per diem rate; and,
- The clinician providing the CCBHC service is attributed to the CCBHC (i.e., the clinician is accounted for in the CCBHC cost report and is not a member of the treatment facility staff).

Designated Collaborating Organizations (DCOs)

24) Can a CCBHC DCO with another CCBHC?

A. No. DCO agreements are not allowed between CCBHCs.

25) Is there any limitation about the services that can be contracted out to a DCO?

A. CCBHCs must deliver at least 51% of all CCBHC encounters directly. Additionally, CCBHCs must have the ability to deliver the following services to any individual seeking services from the CCBHC, regardless of age, residence, gender, or other demographic factors: triage assessment, initial and comprehensive assessment, therapy/counseling, case management, and crisis intervention. This does not prohibit a CCBHC from entering a DCO agreement for the same services, but rather is intended to ensure the CCBHC has the capability of providing a basic set of services to all populations that may seek services.

Interface with Managed Care

26) How will MCOs and CCBHCs interface? Are there particular expectations for networking/contracting, payment, and data/information sharing?

A. MCOs are required to contract with all CCBHCs, to reimburse CCBHCs at the site-specific PPS rate, and to provide technical assistance to CCBHCs regarding credentialing, contracting, and claiming as needed. CCBHC sites should begin discussing their pending change in status, updating contracts, and enrollment information with the MCOs. CCBHCs are expected to work collaboratively with

MCOs and to share information and participate in interdisciplinary care team meetings for any customers receiving MCO care coordination.

27) **How will value-based arrangements in our current MCO contracts be treated?**
   A. MCOs are required to reimbursement CCBHCs at the site-specific PPS rate under the CCBHC Demonstration. Independent value-based agreements between MCOs and CCBHC sites electing to participate in the Illinois CCBHC Demonstration are not allowed.

28) **Will any MCO requirements change on October 1, 2024, or should we expect status quo claim submission, prior authorization, and other processes?**
   A. MCOs will be expected to enroll each CCBHC into their network and to pay the PPS rate for all CCBHC allowable services. MCOs will follow the same billing guidelines established by HFS for CCBHCs. Prior authorization of CCBHC services is prohibited.

29) **What changes do the providers need to make to the rosters for the MCO's?**
   A. Please address this question directly with the MCOs.

<u>Data/Metrics and Other Reporting Requirements</u>

30) **Do CCBHCs have to register CCBHC clients in DARTS and Carelon? (response updated 2/7/25)**
   A. CCBHCs must enter demographic data into DARTS for all Medicaid eligible (whether enrolled in an MCO or the fee-for-service program) clients as well as anyone served for whom the CCBHC is seeking service funding directly from SUPR. CCBHCs must continue to register all customers served in the Carelon system, regardless of payer or insurance status. The Departments are exploring ways to streamline information collection and data sharing.

31) **What specific quality bonus approach (e.g., amount, terms, runout timing) will HFS follow for Demonstration Year 1?**
   A. There will not be a quality bonus payment for Demonstration Year 1.

32) **What will the start date of data measures be? If we are to have everything in place 10/1, will measures have 10/1 start date and report half FY or all calendar year?**
   A. CCBHCs participating in Demonstration Year 1 must collect all required data points beginning October 1, 2024. For each year of the 4-year demonstration, the Demonstration Year (DY) will start on October 1 and will end on September 30. The Measurement Year (MY) will start on January 1 and will end on

December 31. Clinic-collected data is required for 100% of customers served, regardless of payer. CCBHCs should review the SAMHSA Technical Guidance on Data Reporting and Quality Metrics found at this link: SAMHSA Data Reporting and Quality Metrics Guidance. CCBHCs must optimize intake procedures and workflows to ensure Demonstration data reporting requirements are met.

33) **How will the patient experience of care survey be disseminated?**
   A. HFS is still determining the process it will use to disseminate and collect responses from the patient and youth/family experience of care surveys. More information will be shared with CCBHCs as it becomes available.

34) **Will there be reports that allow us to view our outcomes in comparison to other CCBHCs in the state?**
   A. HFS is exploring options for the collection and sharing of all required CCBHC data metrics. More information will be shared with CCBHCs as it becomes available.

35) **What methods/specifications will be required by HFS for data reporting and submission?**
   A. HFS is exploring options for the collection and sharing of all required CCBHC data metrics. More information will be shared with CCBHCs as it becomes available.

36) **Will Illinois require CCBHCs to report any additional data elements besides those required clinic-level measures in the CCBHC criteria?**
   A. Currently, the State has opted to only collect and report required clinic and state collected measures. However, the State is actively reviewing the data elements and collection processes across all payers to determine where administrative efficiencies and streamlining can be implemented. This may result in changes to the data elements CCBHCs report to HFS in the future.

Billing

37) **When does HFS plan to provide guidance/instructions for billing for CCBHC services?**
   A. Initial guidance was provided during the CCBHC Kick Off meeting and the allowable billable detail procedure code list has been shared with all CCBHCs. The recorded webinar and slide deck from the kick off meeting are posted on HFS' website here: Illinois CCBHC FAQs and Webinars. Additional guidance will

be provided during an upcoming CCBHC Billing Webinar, the CCBHC Provider Handbook, and ongoing meetings with CCBHCs.

38) **Will CCBHCs continue to bill claims through DARTS and Carelon or will all CCBHC billing be migrated to a single platform?**
   A. For Medicaid customers, all CCBHC claims for services covered under the PPS are to be billed directly to HFS or the appropriate MCO.

39) **What is the timing on billing for and then turn-around on payment for the PPS rate?**
   A. Billing and payment timelines for CCBHCs will follow standard reimbursement processes for both fee-for-service and the MCOs.

40) **Will there be more than one daily bundle code?**
   A. No. CCBHCs must bill for CCBHC services using the code T1040 with the applicable detail service codes included.

41) **What changes do CCBHCs need to make in IMPACT?**
   A. Providers must submit a new application in IMPACT as the CCBHC provider type. In most instances, providers will also need to close out the existing community mental health and substance use treatment provider enrollments at the same site location. Providers should reach out to OMI.IMPACT@uillinois.edu for technical assistance in navigating the IMPACT provider enrollment process.

42) **What level of service must be delivered to trigger a billable PPS encounter?**
   A. An allowable CCBHC code from the qualifying list of procedures must be provided to a Medicaid customer for the CCBHC to receive the daily PPS rate. For an activity to qualify as a billable PPS payment, the CCBHC must deliver a minimum of one (1) unit of service from the qualifying list of procedures to the customer in accordance with the requirements for that service.

43) **Which rendering provider is listed on the daily bundle?**
   A. No rendering provided is required on CCBHC claims.

44) **Are there any authorization requirements or limits on CCBHC services covered under the PPS?**
   A. No.

45) **Will claims be submitted on 837P format?**
   A. Yes.

46) How should CCBHCs bill for clients with a third-party payer (i.e., commercial insurance, Medicare) as primary and Medicaid as secondary?

A. Claims for CCBHC services must be submitted and adjudicated by all third-party liability (TPL) resources before a claim may be submitted to HFS or the MCOs for Medicaid reimbursement. TPL information can be found when verifying a customer's eligibility through MEDI.

If the total payment from TPL is less than the CCBHC's PPS rate, the CCBHC should submit a secondary claim to the appropriate Medicaid payer (i.e., HFS or an MCO) for adjudication, including all appropriate TPL information. TPL coding resources can be found on the HFS Provider Handbook landing page under "Additional Resources for Providers." Medicaid payers will compare the amount of the payment made by TPL to the CCBHC's PPS rate and will reimburse the difference to the CCBHC (i.e., total TPL payment + Medicaid payment = the CCBHC's PPS rate).

Additional information on Medicaid third-party liability (TPL) policies and processes can be found in the Chapter 100 General Policy and Procedures Provider Handbook.

47) 99212-15 are codes we use to bill psychiatric medication management services provided by our doctors and NPs, but on the list of codes, the description for 99212-15 only says "Primary Care Screening and Monitoring."

A. The CCBHC billable code list categorizes allowable detail codes into the 9 service categories required for CCBHCs. CPT codes 99212-99215 are evaluation and management codes used by medical professionals to seek reimbursement for a wide range of office and outpatient visits and are therefore mapped to the "Primary Care Screening and Monitoring" category of services. CCBHCs should follow the guidelines outlined in the CPT coding guidelines to determine the appropriate detail billing codes for the services delivered.

48) Should services delivered to non-Medicaid SASS clients be billed using the CCBHC NPI or the CMHC NPI? (new 2/7/25)

A. Services provided to non-Medicaid SASS eligible clients should continue to be billed using the provider's CMHC enrollment / NPI.

49) Is the NTE segment required on 837 claims for CCBHC services? (new 2/7/25)

A. No, the NTE segment is not required for CCBHC-related 837 claims.

50) Will there be flexibility on the order of claim lines, with the T1040 code first followed by service details? (new 2/4/25)

A. CCBHC encounter claims must be submitted with the T1040 identified on the first service line of the claim for each daily encounter being billed; the service coding detail must follow in any order on subsequent service lines.

51) Under the CCBHC Demonstration, how should the 30, 60, and 90-Day Continuing Stay Review requirement be billed? (new 2/7/25)

A. The Continuing Stay Review (CSR) for SUD is required pursuant to the established timeframes in 77 ILAC 2060.423 should be billed with the detail code H2000.

52) Can Medication Assisted Treatment (H0020) be billed with other detail codes or can it only be billed by itself with the T1040 encounter code? (new 2/7/25)

A. Yes, Medication Assisted Treatment (MAT) can be billed with other detail codes on the same day, so long as the other detail codes are not duplicative of the H0020 (e.g., providers shouldn't also bill Medication Administration - T1502 for the dispensing of methadone). T1040 is billable only once per customer per day, so all PPS covered services rendered on the same day must be billed as detail codes under T1040.

53) What CCBHC service codes are correct for activities done under 2060.419 assessment for treatment planning? What about for activities done under 2060.417 assessment for patient placement? (new 2/7/25)

A. Assessment services conducted pursuant to requirements of 77 Ill. Adm. Code 2060 are to be billed as follows:

- The time spent completing the ASAM assessment should be billed with the detail code H0002.
- All other assessment and treatment planning activities for CCBHC customers under the Demonstration should be billed using the detail code H2000.

54) What CCBHC service codes are correct for billing gambling screening? (new 2/7/25)

A. Gambling screening activities should be billed as part of the appropriate assessment code (e.g., H0002 if conducted as part of the ASAM assessment or H2000 if conducted as part of the customer's IATP).

Payment and Funding

55) Which PPS daily rate approach was part of the state's Demonstration approval?

A. HFS has chosen to utilize PPS-1 rate methodology, which is a daily, all-inclusive encounter rate.

56) Will there be more than one rate for adult or child?

A. No. Each CCBHC site will have one PPS rate.

57) Will there be start-up funds for creating a Behavioral Health Urgent Care Center?

A. No, beyond the use of anticipated costs within the CCBHCs cost report, there is not start-up funding available for Urgent Care Center services.

58) How and when will rebasing of the PPS rate occur?

A. CCBHCs will have their PPS rate rebased for Demonstration Year (DY) 2, DY3, and then at least once every 3 years thereafter. CCBHCs are required to complete an annual cost report covering the DY period; cost reports are due 6 months after the end of each DY. The DY2 PPS rate will be established using the CCBHC's DY1 cost report and will be effective retroactive to the start of DY2 (October 1, 2025). CCBHCs will be paid a DY2 interim PPS rate until the site's official DY2 PPS Rate is established. DY2 interim PPS rates will be constituted by taking a site's DY1 PPS rate and applying the appropriate Medicare Economic Index (MEI). HFS intends to complete an adjustment on DY2 CCBHC claims to reflect the finalized DY2 PPS once established.

59) Does the State have any plans to implement an 'uncompensated care pool' for individuals who must be served by a CCBHC, but who are not Medicaid enrollees (e.g., those who are uninsured)?

A. There are not currently plans to implement an uncompensated care pool for CCBHCs. However, CCBHCs may use a combination of other resources (e.g., local funds, grant funds, sliding scale fees) to fund services delivered to non-Medicaid customers.

60) Can non-Medicaid SASS case management services be billed to grant funding if they don't qualify as targeted case management? (new 2/7/25)

A. No, TCM services delivered to non-Medicaid SASS eligible clients should be billed directly to the HFS fee-for-service program under the provider's CMHC enrollment / NPI, consistent with the guidelines outlined in the CBS Handbook.

61) Can CCBHCs bill their SUPR grant for SBIRT services? (new 2/7/25)

A. No.

62) Can a CCBHC or DCO bill their SUPR grants for services provided to Medicaid customers that are not covered under the CCBHC PPS? (response updated 2/7/2025)

A. With the exception of non-medical transportation, CCBHC Demonstration sites should not bill services provided to a Medicaid eligible customer to a SUPR-funded grant or contract. CCBHCs maDirecy not receive duplicate payment for any costs covered under the CCBHC PPS rate reimbursed by the Medicaid program. All organizations funded by SUPR, including CCBHCs, must use state and federal grant funds as the payer of last resort and cannot substitute other funding for substance use service programs (eCFR :: 45 CFR 96.123 -- Assurances. and 305 ILCS 5/5-1.3). Providers are encouraged to reach out to DOIT.SUPRHelp@illinois.gov if there are questions about allowable usage of the provider's specific grant funding.

63) Can a CCBHC bill their DMH grants for services provided to Medicaid customers that are not covered under the CCBHC PPS?

A. Yes. CCBHCs may not receive duplicate payment for any costs covered under the CCBHC PPS rate reimbursed by the Medicaid program, but CCBHCs may continue to utilize DMH grant funding for customers or costs not covered by Medicaid or another payer source. Examples where grant funds may continue to be utilized will be non-Medicaid customers, services to Medicaid customers not covered by the PPS, and expenses not included in the CCBHC site's cost report. Providers are encouraged to reach out to their DMH program contact if there are questions about allowable usage of the provider's specific grant funding.

64) Can a CCBHC bill their DHS grants for services provided to non-Medicaid customers?

A. Yes, CCBHCs and DCOs may continue to utilize SUPR and DMH grant funding for customers not covered by Medicaid or another payer source.

65) How is DHS grant funding to a CCBHC DCO affected by the PPS rate?

A. Grant funds are to be utilized as the payer of last resort. DCOs may not receive duplicate payment for services reimbursed to the DCO through their arrangement with the CCBHC. This means the DCO should not utilize grant funds for any service that meets all the following: 1) is provided by the DCO pursuant to its arrangement with the CCBHC; 2) is provided to a CCBHC

customer; and 3) is provided to an Illinois Medicaid customer. DCOs may continue to utilize DMH or SUPR grant funding for customers or services that are not otherwise reimbursable by Medicaid or another payer source.