MEDICAID POLICY INFORMATION SHEET

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Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

This policy will implement Michigan's Centers for Medicare & Medicaid Services (CMS) Certified Community Behavioral Health Clinic (CCBHC) Demonstration.

Reason for policy (problem being addressed):

The CCBHC Demonstration will increase access to and quality of behavioral health services in Michigan by requiring CCBHC sites to serve all Michigan residents with a behavioral health need and utilizing a prospective payment system for sustainability. CCBHCs are federally required to provide nine comprehensive behavioral health services, such as 24/7 mobile crisis and medication assisted treatment. Moreover, CCBHCs must meet stringent standards for care coordination, quality and financial reporting, staffing, and governance.

Budget implication:

☐ budget neutral
☒ will cost MDHHS $ 26 million ($4.5 million GF) annually, and is budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

Yes

Does policy have operational implications on other parts of MDHHS?

Yes, the Community Health Automated Medicaid Processing System (CHAMPS) and the Waiver Support Application (WSA) will be impacted.

Does policy have operational implications on other departments?

No

Summary of input:

☐ controversial
☒ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☐ Yes ☒ No If Yes, please provide status: ☐ Approved ☐ Pending Approval ☐ Denied Date: Date:	Public Notice Required: ☐ Yes ☒ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 2122-BHDDA	**Date:** June 16, 2021

Comments Due: July 21, 2021
Proposed Effective Date: October 1, 2021
Direct Comments To: Amy Kanouse
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Policy Subject: Centers for Medicare & Medicaid Services (CMS) Certified Community Behavioral Health Clinic (CCBHC) Demonstration

Affected Programs: Medicaid, Healthy Michigan Plan, MIChild

Distribution: All Providers

Summary: This policy will implement Michigan's CMS Certified Community Behavioral Health Clinic (CCBHC) Demonstration.

Purpose: The CCBHC Demonstration will increase access to and quality of behavioral health services in Michigan by requiring CCBHC sites to serve all Michigan residents with a behavioral health need and utilizing a prospective payment system for sustainability. CCBHCs are federally required to provide nine comprehensive behavioral health services, such as 24/7 mobile crisis and medication assisted treatment. Moreover, CCBHCs must meet stringent standards for care coordination, quality and financial reporting, staffing, and governance.

Cost Implications: $26 million ($4.5 million in general fund), and is budgeted in current appropriation.

Potential Hearings & Appeal Issues:

State Plan Amendment Required: Yes ☐ **No** ☒ **If yes, date submitted:**	**Public Notice Required: Yes** ☐ **No** ☒ **Submitted date:**
Tribal Notification: Yes ☒ **No** ☐ **- Date:**	

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**
Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Proposed Policy Draft

Michigan Department of Health and Human Services
Medical Services Administration

Distribution: All Providers

Issued: September 1, 2021 (Proposed)

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

Effective: October 1, 2021 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

In 2016, the Michigan Department of Health and Human Services (MDHHS) applied to the 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 period begins upon implementation. 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 create a companion operation 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. 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.

II. 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 CCBHC sites. (Refer to the Reporting Requirements section of this policy for additional information.)

B. Beneficiary Eligibility

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

III. Enrollment

Potential CCBHC enrollees will be identified using a multifaceted approach for both Medicaid beneficiaries and non-Medicaid prospective enrollees. MDHHS reserves the right to review and verify all enrollments. The processes below delineate the approach for each prospective enrollee category:

A. Prospective CCBHC Medicaid Enrollees

i. Prepaid Inpatient Health Plan (PIHP) Assignment of Auto-Enrolled Medicaid

MDHHS will provide a generated list of potential Medicaid enrollees from MDHHS administrative claim/encounter data into the Waiver Support Application (WSA). Medicaid beneficiaries will be automatically prospectively enrolled into the CCBHC benefit plan based on having a current mental health and/or SUD diagnosis. Queries will search all available historical claims to identify a recent diagnosis.

The relevant PIHP will identify and assign these beneficiaries to the pertinent CCBHC site within the WSA. This includes verifying beneficiary consent to share information (particularly regarding beneficiaries with an SUD only diagnosis). Once enrolled in the WSA, the WSA roster file is sent to the Community Health Automated Medicaid Processing System (CHAMPS) for Medicaid CCBHC benefit plan assignment, which affords CCBHC services and commensurate reimbursement.

ii. CCBHC Recommendation of Prospective CCBHC Medicaid Enrollees

For Medicaid beneficiaries not automatically enrolled by MDHHS, CCBHCs are permitted to recommend potential enrollees for the CCBHC benefit to the PIHP via the WSA. CCBHC providers must provide documentation that indicates a potential CCBHC enrollee meets eligibility for the CCBHC benefit, including diagnostic verification and obtaining consent to share information. The PIHP must review and process all recommended enrollments in the WSA. The PIHP is responsible for verifying that the CCBHC has completed the enrollment and attested to the diagnostic eligibility but cannot deny enrollment of an individual with a qualifying diagnosis.

B. Prospective Non-Medicaid CCBHC Enrollees

Both the PIHP and the CCBHC will recommend individuals for enrollment via the WSA. Unlike the Medicaid beneficiaries enrolling in the CCBHC, these individuals will not be assigned a benefit plan in CHAMPS. Rather, the WSA and CHAMPS will be leveraged to track the volume of non-Medicaid CCBHC enrollees.

IV. 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.

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.

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 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 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.

VI. Certification Requirements

CCBHCs must meet the minimum certification criteria defined by Substance Abuse and Mental Health Services Administration (SAMHSA) and 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 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 have the capacity to 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.

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.).

VII. 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. 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 a QUARTERLY cost report with supporting data to the PIHP. Cost reports are based on the CCBHC financial records and must follow the templated 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 be issued per federal guidance (estimated to be released by spring 2022).

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.

VIII. Responsibilities of PIHPs

A. Enrollment

PIHPs will review auto-enrolled CCBHC Medicaid beneficiaries and assign beneficiaries to CCBHCs by conferring with the beneficiary and the prospective CCBHC site. Beneficiaries recommended by CCBHC sites for CCBHC enrollment/assignment will be

reviewed and processed by the PIHPs. PIHPs will also enroll non-Medicaid beneficiaries as identified by CCBHC sites. For all enrollments, the PIHP must verify and complete all enrollment steps, including the verification of diagnostic eligibility, in the WSA.

B. Outreach

PIHPs will 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.

C. Payment

PIHPs are responsible for reimbursing CCBHCs for each valid CCBHC service encounter.

D. Reporting

PIHPs will review, edit, and send final draft CCBHC cost reports and quality metrics to MDHHS for MDHHS review and submission to CMS. Access data 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.

E. Grievance Monitoring

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

IX. 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 core CCBHC services. MDHHS will provide augmented prospective PIHP capitation payments for anticipated CCBHC Demonstration enrollees, predicated upon historical utilization of CCBHC-eligible services at the anticipated uptake rate of 25%. In turn, the PIHP will reimburse a CCBHC Demonstration Site the full PPS-1 amount less the QBP portion, and the portion allowed to be retained by the PIHP for its role in executing the CCBHC. Reconciliation of the supplemental payments will take place annually, based on a retrospective review of the actual number of valid CCBHC encounters submitted to CHAMPS by the PIHP. MDHHS will provide PIHPs with reconciliation payments based on the difference between the initial supplemental payments and the actual supplemental payments required. 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 for Demonstration Year 1

Per federal guidelines, MDHHS will utilize pertinent cost and utilization data and guidance on allowable costs to develop the PPS-1 rates for Demonstration Year 1. This includes direct costs related to a collaborative care staffing model with proper administrative management, care coordination, training for cultural competence, enabling services, and information technology; it also includes indirect costs for allowable administrative overhead. MDHHS will maintain a fee schedule for the PPS-1 rate on the MDHHS CCBHC website, in the CCBHC Demonstration Handbook, and in the Behavioral Health Developmental Disabilities Administration (BHDDA) Service Encounter Coding Chart.

B. PPS-1 Rates for 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.

C. Quality Bonus Payments

MDHHS will afford QBPs 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 will be 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.

X. Metrics, Assessment, and Distribution

The methodology for metrics, specifications, and distribution will be maintained on the MDHHS CCBHC website and in the CCBHC Demonstration Handbook.