Guidance to Planning Grant States to Apply to Participate in the Section 223 CCBHC Demonstration Program

Introduction

Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014 (P.L. 113-93)[1] authorized the Certified Community Behavioral Health Clinic (CCBHC) demonstration to allow states to test a new strategy for delivering and reimbursing a comprehensive array of services provided in community behavioral health clinics. The demonstration aims to improve the availability, quality, and outcomes of outpatient services provided in these clinics. It also requires states to reimburse CCBHC providers using a Medicaid prospective payment system (PPS) methodology intended to cover the expected cost of providing CCBHC services to Medicaid beneficiaries. In 2016, 24 states received one-year CCBHC planning grants and eight states (Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania were selected by the U.S. Department of Health and Human Services (HHS) to participate in 2-year CCBHC demonstration programs. The Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136) passed in August 2020 which expanded the demonstration to add two new states, Kentucky and Michigan. There have been several extensions to the two-year demonstration program, with the most recent extension and expansion authorized through the Bipartisan Safer Communities Act (BSCA) of 2022 (P.L. 117-259). The BSCA also authorized one-year planning grants, and a total of four years of enhanced Federal Medical Assistance Percentage (FMAP) for up to 10 additional states added to demonstration as early as July 1, 2024, and every two years thereafter. The BSCA also gives Michigan and Kentucky six years of enhanced FMAP in the program.

In March 2023, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded 15 CCBHC state planning grants[2] from which 10 states (Alabama, Illinois, Indiana, Iowa, Kansas, Maine, New Hampshire, New Mexico, Rhode Island and Vermont) were selected for CCBHC demonstration participation on June 2024.

In December 2024, SAMHSA awarded an additional round of one-year CCBHC planning grants to 15 states[3] to prepare these eligible states to apply to join the Demonstration in 2026. These states will be eligible to apply to join the Demonstration in 2026 along with other states that

[1] H.R. 4302, 113th Congress. Protecting Access to Medicare Act of 2014. PL No 113-92; April 2, 2014. https://www.congress.gov/bill/113th-congress/house-bill/4302

[2] On March 16, 2024, the U.S. Department of Health and Human Services (HHS), through the Substance Abuse and Mental Health Services Administration (SAMHSA), awarded 15 states each with $1 million, one-year CCBHC planning grants. This was the first time planning grants were available since the program began in 2015. The 15 selected states were Alabama, Delaware, Georgia, Iowa, Kansas, Maine, Mississippi, Montana, North Carolina, New Hampshire, New Mexico, Ohio, Rhode Island, Vermont, West Virginia.

[3] On January 7, 2025, the U.S. Department of Health and Human Services (HHS), through the Substance Abuse and Mental Health Services Administration (SAMHSA), awarded 15 states each with $1 million, one-year CCBHC planning grants. The 15 states selected were Alaska, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Louisiana, Maryland, Montana, North Carolina, North Dakota, South Dakota, Utah, Washington, and West Virginia.

previously received a CCBHC Planning Grant and have not yet joined the Demonstration, whether in 2016, 2023, or 2024.

Applications will be reviewed by a panel of federal subject matter experts. Based on that review, recommendations for selection will be made to federal officials of the Assistant Secretary for Planning and Evaluation (ASPE), the Centers for Medicare & Medicaid Services (CMS), and SAMHSA for final selection no later than June 2026. This document outlines the application materials that must be submitted and clarifies the evaluation criteria that will be used to select states to participate in the demonstration.

PAMA (P.L. 113-93, 42 U.S.C. 1396a, note), at subsection 223(d)(4)(A) under which the program is authorized, is explicit that preference must be given to selecting demonstration programs where participating CCBHCs will achieve at least one of the following:

- Provide the most complete scope of services as described in the Criteria to individuals eligible for medical assistance under the state Medicaid program; OR
- Improve availability of, access to, and participation in, services described in subsection Criteria to individuals eligible for medical assistance under the state Medicaid program; OR
- Improve availability of, access to, and participation in assisted outpatient mental health treatment in the state; OR
- Demonstrate the potential to expand available mental health services in a demonstration area and increase the quality of such services without increasing net federal spending.

This guidance is provided to clarify the criteria that federal subject matter experts will use to assess which states are most likely to achieve at least one of the above goals during the demonstration program. Other criteria will be considered such as each state's readiness to participate in the program in terms of meeting the expectations of the planning grant, the state's compliance with the updated CCBHC Criteria[4] and conformance of the state's PPS to the updated PPS Guidance.[5]

Planning Grant States must submit applications to participate in the demonstration no later than April 1, 2026, 11:59PM EST. Applications must be submitted by email to CCBHC@samhsa.hhs.gov. States selected to participate in the demonstration program will be announced in June 2026.

[4] The updated criteria, released in March 2023, are available at https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf.

[5] The updated PPS guidance, released in February 2024, is available at https://www.medicaid.gov/medicaid/financial-management/section-223-demonstration-program-improve-community-mental-health-services/index.html

Components of the Application to Participate in the Section 223 Demonstration Program

Applications to participate in the demonstration program will be assessed on the completeness of the application and the score applied by an objective review of applications. There are three parts to this application: 1) Required Attachments, 2) Program Narrative, and 3) Prospective Payment System Methodology Description. The components are described in greater detail below along with the points assigned for each section in parentheses. The total possible score is 100 for the complete application.

Part 1: Required Attachments

You must include all of the following attachments. Attachment 1 will be scored as described under Part 2, item B.

Attachment 1.	Complete the *Certified Community Behavioral Health Clinic (CCBHC) Criteria Compliance Checklist 2023* according to the guidance included in the program narrative section below. This checklist will identify the readiness of the proposed CCBHCs in your state to be compliant with the updated CCBHC Certification Criteria by the proposed start date of your demonstration program. Include the completed checklist as Attachment 1.
Attachment 2	Include a signed statement that verifies that all CCBHCs proposed to be a part of the state's demonstration program will be compliant with the CCBHC Certification Criteria by the proposed start date of the state demonstration program and that, as a part of this, all participating CCBHCs will participate in SAMHSA's treatment locator. The applicant must document that they have provisionally certified at least two CCBHCs in diverse geographic areas including rural and underserved areas. These provisionally certified CCBHCs must substantially meet the criteria and be ready to fully meet the certification criteria by the proposed date of state entry into the demonstration. The applicant will clearly indicate the proposed date of state entry into the demonstration.
Attachment 3.	Include a statement that describes the target Medicaid population(s) to be served under the demonstration program.
Attachment 4.	Include a list of proposed certified community behavioral health clinics including any designated collaborating organizations (DCOs) proposed to work with each CCBHC and what portions of the nine required services they would be providing. Include the address and Unique Entity Identifier (UEI) number for each proposed CCBHC as well as a list of service locations with addresses where the CCBHC anticipates delivering services. All CCBHC service locations that meet criteria for inclusion in

the treatment locator should be included in the SAMHSA treatment locator (by responding to the National Substance Use and Mental Health Services Survey (N-SUMHSS) and opting-in to participate in the treatment locator). This list should provide the name and address of the location as it appears in the SAMHSA treatment locator.

Attachment 5. Include a signed statement that verifies that the state has agreed to pay for CCBHC services at a rate established under the prospective payment system and a list of the provisional DY1 PPS rates for each CCBHC listed in Attachment 4.

Attachment 6. Include a description of the scope of services required by the state in compliance with the CCBHC Criteria, Scope of Services, provided by/through CCHBCs in your state, available under the state Medicaid program, and that will be paid for under one of the selected PPS methodologies tested in the demonstration program. This is meant to be a verification of the scope of services that the state has required in order to comply with the CCBHC Criteria, including any additional services required through state discretion and evidence-based practices.

Attachment 7. Include a completed cost report and explanatory narrative from a CCBHC listed in Attachment 4, with that provider's CCBHC cost and visit data that demonstrates the rate for DY1. States may use either the CMS CCBHC cost report or a state-developed cost report that CMS has approved for use in the Demonstration. The CMS CCBHC cost reporting templates and instructions are available at: https://www.medicaid.gov/medicaid/financial-management/certified-community-behavioral-health-clinic-ccbhc-demonstration/ccbhc-cost-reporting.

Part 2: Program Narrative

In the Program Narrative, you will describe your state's readiness to participate in the demonstration program and project the impact of participation. The Program Narrative will be scored up to a total of 80 points and may not exceed 30 pages. Each of the sections will be scored as listed below. More detailed guidance is provided in the next section.

A. Solicitation of input by stakeholders in developing CCBHCs (10 points)
B. State Capacity to Support CCBHC and Certification of clinics as CCBHC (30 points)
C. Development of enhanced data collection and reporting capacity (10 points)
D. Participation in the national evaluation (15 points)
E. Projection of the impact of the state's participation in the Demonstration program (15 points)

Part 3: Prospective Payment System Methodology Description

Please complete Part 3 Prospective Payment System Methodology Description, the form that is attached later in this guidance. Part 3 will be scored up to a total of 20 points. Using this form, you will describe the following:

1. CCBHC PPS Rate-Setting Methodology Options
2. Quality Bonus Payments (QBPs)
3. Payment to CCBHCs that are FQHCs, Clinics, or Tribal Facilities
4. Cost Reporting and Documentation Requirements
5. Managed Care Considerations
6. Identifying CCBHC Claims and Service Level Encounter Detail
7. Funding Questions

Part 2: Program Narrative

In the Program Narrative, you will describe your state's readiness to participate in the demonstration program and project the impact of participation. This part will be scored up to a total of 80 points and may not exceed 30 pages.

A. (10 points – approximately 3 pages) Solicitation of input by stakeholders with respect to the development of such a demonstration program from people with lived experience of mental health and substance use conditions, people being served by potential CCBHCs, family members, providers, tribes, and other key stakeholders. Please provide the following:

- A description of the steering committee or use of an existing committee, council, or process composed of relevant state agencies, providers, individuals with lived experience and family members (e.g., representatives of peer or family-run programs or stakeholder organizations), service recipients, community-based programs and health agencies, and other key stakeholders to guide and provide input throughout the grant period.
- A description of the outreach, recruitment, and engagement of the population of focus including adults with serious mental illness and children with serious emotional disturbances and their families, and people with or in recovery from severe substance use disorders, as well as others with mental illness and substance use disorders in the solicitation of input.
- A description of the coordination with other local, state, and federal agencies and tribes to ensure that services are accessible and available.

B. (30 points – approximately 11 pages) State capacity to support CCBHCs and certification of CCBHCs for purposes of participating in a demonstration program, using the updated CCBHC criteria. Reviewers will examine the state's submission of the *CCBHC Criteria Compliance Checklist 2023* attachment (https://www.samhsa.gov/sites/default/files/ccbhc-compliance-checklist-july-2023.pdf). This compliance checklist includes the updated criteria required for the CCBHCs and their Designated Collaborating Organizations (DCOs) which together form the CCBHC. For any criteria that falls in categories other than "ready to implement" (1), include a description of the current status and the plan to become fully compliant is required and plans for remediation with any issues by the proposed start date. Only include clinics proposed for the initial entry of the Demonstration. For each of the criteria on the checklist, please indicate the number of clinics in your state that fall within each of the following categories:

1. Ready to implement

    - The CCHBC fully satisfies all elements under this Program Requirement Criteria.

2. Mostly ready to implement

    - The CCBHC satisfies almost all elements under this Program Requirement Criteria although some minor adjustments are currently in process to fully satisfy. The CCBHC has a plan to come into compliance within the required timeframe.

3. Ready to implement with remediation

    - The CCBHC satisfies some elements but must make significant improvements in other elements to fully satisfy this Program Requirement Criteria. The CCBHC is responsive to implementing the needed changes and has begun to do so. The CCBHC has a plan to come into compliance within the required timeframe.

4. Unready to implement

    - The CCBHC has not demonstrated capacity to meet the elements under this Program Requirement Criteria and will be unable to come into compliance within the required timeframe.

In addition, please provide the following:

- A description of the state's current readiness and history implementing the CCBHC program, including any current CCHBC Expansion grants in the state as well as the efforts to support the CCBHC Demonstration program; CCBHC initiatives under Medicaid state plan or waiver; any support of CCBHCs through other funding sources managed by the State; and the State's capacity and infrastructure established to support the CCHBC Demonstration program in areas such as certification, technical assistance, data systems, and payment.
- A description of the selection processes and review procedures that you used to select and certify clinics as CCBHCs that demonstrates attention to quality of care, access and availability of services. While CCBHCs may serve multicounty areas, the CCBHC must have the capacity to meet the requirements of the 2023 CCBHC Certification Criteria, including the following: (a) ensure access for communities and populations living within the CCBHC service area, (b) address geographic and transportation barriers, (c) ensure timely provision of the nine (9) required services, and (d) ensure representation of communities and populations served in the governance of the CCBHC. State certification and ongoing monitoring processes should be structured to ensure CCBHC capacity for meeting these requirements.
- A description of the different types of CCBHCs including geographic area, population density, underserved areas or other data.
- Cite documentation, including medically underserved area (MUA) designations, that at least one CCBHC is located in a rural and/or underserved area.
- A description of how the state has worked with selected CCBHCs to improve the delivery of high-quality behavioral healthcare, such as support for evidence-based

practices, workforce development, development of interdepartmental partnerships, recovery-oriented and trauma-informed models of care, and other related areas as well as a description of plans to continue support CCBHCs in these areas as a part of the demonstration program.

- A description of how CCBHCs will be working with other community organizations, including the 988 Suicide & Crisis Lifeline, and state mental health and substance use crisis response systems.
- A description of how the CCBHC needs assessments have been used to identify behavioral health needs and resources in the service areas of included CCBHCs across the lifespan, to include the impact the CCBHC needs assessment will have on staffing, language and culture, services, locations, service hours, and evidence-based practices, while identifying and addressing barriers and increasing access to healthcare.
- A description and justification of the evidence-based practices[6] that the state has required. The state should identify and explain why the evidence-based practices were identified based on the needs of the state.
- For each proposed CCBHC, provide the definition of the CCBHC service area using recognized geographic boundaries, such as municipal or county borders, zip codes, or census tracts.
- A description of the guidance to CCBHCs regarding the CCBHC's organization governance that ensures meaningful input by people with lived experience of mental health and substance use conditions, people being served, persons in recovery, and family members, including caregivers of both children and adults receiving services.
- A description of any other areas that the state is exercising their discretion to place additional requirements that go beyond the minimum expectations set in the CCBHC criteria, using the State Discretion Guidance.
- A description of the planned process for bringing additional CCBHCs into the State CCBHC Demonstration program over time, if the state is planning to add additional CCBHCs over the course of the 4-year demonstration program (note: states may describe a process without identifying specific CCBHCs).

C. (10 points – approximately 4 pages) Development of enhanced data collection and reporting capacity. Please provide the following:

- A description of the ways in which the state and CCBHCs have developed or enhanced data collection and reporting capacity in support of meeting PPS requirements, quality reporting requirements, and demonstration evaluation reporting requirements listed under Criteria Program Requirement 5: Quality and Other Reporting in the Criteria.

[6] For more information about evidence-based practices for mental and substance use conditions, please visit the SAMHSA Evidence-Based Practices Resource Center: https://www.samhsa.gov/resource-search/ebp

- A description of the designed or modified and implemented data collection and reporting systems-including but not limited to registries or electronic health record functionality that report on access, quality, scope of services, and costs and reimbursement for behavioral health services. A description of how the state assisted CCBHCs with preparing to use data to inform and support continuous quality improvement processes within CCBHCs, including fidelity to evidence-based practices, and person-centered, and recovery-oriented care during demonstration. A description of how the state plans or has developed processes by which it can provide timely input to CCBHCs on interim results of stated-collected quality measures.
- A description of how the state will work with CCBHCs to ensure that the CCBHCs are billing for CCBHC services correctly using the federal CCBHC, or state developed demonstration billing codes, in a way that results in proper payment of the PPS and captures service level detail of CCBHC services delivered under the claim.
- A description of the format of all data described in this section and when and how evaluators will be able to access this data.

D. (15 points – approximately 6 pages) Participation in the national evaluation of the Demonstration Program. Please provide the following:

- A description of the capacity and willingness to assist HHS to access data related to the cost, quality, and scope of services provided by CCBHCs and the impact of the demonstration programs on the federal and state costs for a full range of mental health and substance abuse services (including inpatient, emergency, and ambulatory services paid for through sources other than the demonstration program funding).
- The status of requests or planned requests for an Institutional Review Board's approval to collect and report on process and outcome data (as applicable and necessary).

E. (15 points – approximately 6 pages) Project the impact of the state's participation in the Demonstration program. Please project the impact of CCBHCs in your state to achieve at least one of the goals listed below during the four-year demonstration program. Use the following guidance to develop your narrative.

- Select one or more goals from the four listed below to project the impact of CCBHCs in your state. Explain the process by which you selected the goal(s) and why it is important to your state and CCBHC communities. Include a description of the impact from established State CCBHC efforts, if applicable.
- List specific measures, selected from CCBHC Criteria: Appendix B, that will show the impact on the population served by CCBHCs over the four-year

demonstration program period.[7] Explain how these measures are related to the goal(s) selected.

- Provide baseline data on selected measures from the planning grant period, if data has been previously collected. Note: Some of the quality measures are newly added and therefore not all states have been able to collect baseline data on all the quality measures. It is recommended to report on the data available as the baseline.
- Describe your plan for data collection, documentation, tracking of outcomes, and analysis to measure progress in achieving the outcome.
- Using the selected measures, project the impact on the target population from baseline to the completion of the demonstration program and justify your projections. Include any data that was collected based on State CCBHC efforts already implemented on the target population, if applicable.

Goal 1. Provide the most complete scope of services required in the CCBHC Criteria to individuals who are eligible for medical assistance under the state Medicaid program.

Goal 2. Improve availability of, access to, and participation in, services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program.

Goal 3. Improve availability of, access to, and participation in assisted outpatient mental health treatment in the state.

Goal 4. Demonstrate the potential to expand available mental health services in a demonstration area and increase quality of such services without increasing net federal spending.

[7] CCBHC Criteria - Appendix B: https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

Part 3: Prospective Payment System Methodology Description

Using the following format, describe the state's prospective payment system (PPS) methodology. This part of the Guidance will be scored up to a total of 20 points and your response may not exceed 30 pages. Each section of this part of the application corresponds to the same section of the CCBHC PPS Guidance. Sections 1-5 of this form pertain to fee-for-service prospective payment; managed care payment is addressed in section 6. Section 7 pertains to mechanisms for identifying claims and service level information, while Section 8 pertains to funding the CCBHC demonstration. For Part 3 of this application, refer to the February 2024 release of the "Section 223 Certified Community Behavioral Health Clinic Demonstration Prospective Payment System Guidance" (PPS Guidance).

Section 1: Introduction

Section 223 of the PAMA, requires payment using a PPS for CCBHC services provided by qualifying clinics and related satellite sites established prior to April 1, 2014. The Centers for Medicare & Medicaid Services (CMS) offers a state the option of using one of four (4) PPS payment methodologies. States may select from among the daily Certified Clinic PPS rate (CC PPS-1), the monthly Certified Clinic PPS rate (CC PPS-2), the daily Certified Clinic PPS rate that includes special crisis services (CC PPS-3), and the monthly Certified Clinic PPS rate that includes special crisis services (CC PPS-4). The rate selected by the state must be used demonstration-wide for payments that are either fee for service (FFS) or made through managed care payment systems. CMS updated the PPS Technical Guidance in 2024 which outlines details specific to the available PPS options currently available under the CCBHC demonstration.

Section 2: CCHBC PPS Rate-Setting Methodology Options

CMS offers a state the option of the CC PPS-1, CC PPS-2, CC PPS-3, or CC PPS-4 methodology for use demonstration-wide. The state chooses the following methodology (select one):

- ☐ Certified Clinic PPS-1 Methodology (CC PPS-1) (Continue to and complete Section 2.1)
- ☐ Certified Clinic PPS-2 Methodology (CC PPS-2) (Continue to and complete Section 2.2)
- ☐ Certified Clinic PPS-3 Methodology (CC PPS-3) (Continue to and complete Section 2.3)
- ☐ Certified Clinic PPS-4 Methodology (CC PPS-4) (Continue to and complete Section 2.4)

Section 2.1: Certified Clinic PPS-1 Methodology (CC PPS-1)

The CC PPS-1 methodology is implemented as a fixed daily rate that reflects the expected cost of all CCBHC services provided on any given day to a Medicaid beneficiary. This is a cost based, per clinic rate that applies uniformly to all services rendered by a CCBHC and qualified satellite facilities established prior to April 1, 2014. The state has the option of offering Quality Bonus Payments (QBPs) that are to be paid in addition to the PPS rate to any certified clinic that achieves on state established thresholds for payment in accordance with Section 3: Quality Bonus Payments (QBPs) of the updated PPS Guidance.

Section 2.1.a Components of the CC PPS 1 Rate Methodology

Demonstration Year One (DYl) Rate Data

In the box below explain the source(s) of cost and visit data used to determine the DYl rate. Detail any estimates that the state used to determine allowable cost and the appropriate number of daily visits to include in the rate calculation. If more space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

Section 2.1b Updates to the PPS-1 Rates

CC PPS-1 Annual Rate Updates

For years where rebasing is not required (i.e.: between DY1 and DY2), states have the option to annually update their PPS rates between DYs by trending them by the MEI or using actual cost and visit data from submitted cost reports to rebase the rates. Please explain which method the state will use to annually update the CC PPS-1 rates between DYs that are not required to be rebased (select one):

- ☐ Annually update CC PPS-1 rates by the Medicare Economic Index
- ☐ Annually update CC PPS-1 rates by rebasing, using one year of actual cost and visit data from provider submitted cost reports; no interim rate.

For states selecting the option to rebase without an interim rate above, please indicate the time period of the cost report that will be used to rebase rates and the effective DY for the rebased rates (i.e.: state intends to use cost reports from two DYs prior to rebase rates, 2024 cost report used to rebase rates effective 2026).

- ☐ Annually update CC PPS-1 rates by rebasing, using one year of actual cost and visit data from the prior DY cost report; includes interim rate.

For states who selected rebasing using an interim rate please describe the timeframe of the cost report being used to rebase the rates, what interim rate the state will pay providers, when the final PPS rate would be calculated for that DY, and how the state intends to reconcile claims for that DY to ensure that all CCBHC service encounters provided in that DY are paid that DY's rebased PPS rate.

CC PPS-1 Required Rate Rebasing

PPS rates are required to be rebased after DY2, effective for DY3, and at least every 3 years from the last DY in which the rates were rebased using actual costs and visits from the provider's CCBHC cost report.

☐ Please check the box confirming the state will rebase CC PPS-1 rates for DY3 using actual DY2 cost and visit data from cost reports submitted to the state.

In the box below, please describe the methodology the state intends to use to rebase PPS-1 rates to align with section 2.5(b) of the PPS guidance, requiring PPS rates to be rebased for all CCBHCs at least every 3 years from the last DY in which their rates were rebased using actual costs and visits from the provider's CCBHC cost report[8]. As part of the methodology, please include the timeframe of the cost report being used for rebasing, when the final PPS rate would be calculated for that DY, and if applicable, the interim rate the state will pay providers and how the state intends to reconcile claims for that DY to ensure that all CCBHC service encounters provided in that DY are paid that DY's rebased PPS rate[9].

If Section 2.1 is completed, skip Sections 2.2, 2.3, and 2.4 and continue to Section 3.1.

[8] If the state intends to use cost and visit data from the prior DY data to rebase rates that are effective in the subsequent DY, the state will need to pay an interim PPS rate until the PPS rate(s) are finalized for that DY.

[9] A state will need to pay an interim rate when current DY data will not be available to the state in time to analyze and rebase the rate for the upcoming DY payment.

Section 2.2: Certified Clinic PPS-2 Methodology (CC PPS-2)

The CC PPS-2 methodology is implemented as a fixed monthly rate that reflects the expected cost of all CCBHC visits provided within any given month to a Medicaid beneficiary. This is a cost-based, per clinic rate that applies uniformly regardless of the number of services rendered within the month by a CCBHC and qualified satellite facilities established prior to April 1, 2014. Under this methodology, separate rates are developed for both the base population and if elected to implement by the state, clinic users with certain conditions, or special populations (SP). In addition, the CC PPS-2 methodology includes outlier payments that are required to be paid for costs exceeding state- defined thresholds and the implementation of QBPs in accordance with Section 3: Quality Bonus Payments of the PPS guidance.

Section 2.2a Components of the CC PPS 2 Rate Methodology

DYl Rate Data

In the box below explain the source(s) of cost and visit data used to determine the DYl rate. Detail any estimates that the state used to determine allowable cost and the appropriate number of monthly visits to include in the rate calculation. If more space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

CC PPS-2 Annual Rate Updates

For years where rebasing is not required (i.e.: between DY1 and DY2), states have the option to annually update their PPS rates between DYs by trending them by the MEI or using actual cost and visit data from submitted cost reports to rebase the rates. Please explain which method the state will use to annually update the CC PPS-2 rates between DYs that are not required to be rebased (select one):

- ☐ Annually update CC PPS-2 rates by the Medicare Economic Index
- ☐ Annually update CC PPS-2 rates by rebasing, using one year of actual cost and visit data from provider submitted cost reports; no interim rate.

For states selecting the option to annually update rates by rebasing without an interim rate above, please indicate the time period of the cost report that will be used to rebase rates and the effective DY for the rebased rates (i.e.: state intends to use cost reports from two DYs prior to rebase rates, 2024 cost report used to rebase rates effective 2026)

☐ Annually update CC PPS-2 rates by rebasing, using one year of actual cost and visit data from the prior DY cost report; includes interim rate.

For states who selected rebasing using an interim rate please describe the timeframe of the cost report being used to rebase the rates, what interim rate the state will pay providers, when the final PPS rate would be calculated for that DY, and how the state intends to reconcile claims for that DY to ensure that all CCBHC service encounters provided in that DY are paid that DY's rebased PPS rate.

CC PPS-2 Required Rate Rebasing

PPS rates are required to be rebased after DY2, effective for DY3, and at least every 3 years from the last DY in which the rates were rebased using actual costs and visits from the provider's CCBHC cost report.

☐ Please check the box confirming the state will rebase CC PPS-2 rates for DY3 using actual DY2 cost and visit data from cost reports submitted to the state.

In the box below, please describe the methodology the state intends to use to rebase PPS-2 rates to align with section 2.5(b) of the PPS guidance, requiring PPS rates to be rebased for all CCBHCs at least every 3 years from the last DY in which their rates were rebased using actual costs and visits from the provider's CCBHC cost report[10]. As part of the methodology, please include the timeframe of the cost report being used for rebasing, when the final PPS rate would be calculated for that DY, and if applicable, the interim rate the state will pay providers and how

[10] If the state intends to use cost and visit data from the prior DY data to rebase rates that are effective in the subsequent DY, the state will need to pay an interim PPS rate until the PPS rate(s) are finalized for that DY.

the state intends to reconcile claims for that DY to ensure that all CCBHC service encounters provided in that DY are paid that DY's rebased PPS rate[11].

PPS-2 Identification of Populations with Certain Conditions, or Special Populations (SP)

Under the PPS-2 Methodology states have the option to develop a monthly PPS rate for populations with certain conditions, or Special Populations (SP). The state chooses to (select one):

- ☐ Implement SPs and develop monthly SP PPS Rate(s) as part of the PPS-2 Methodology
- ☐ Not implement SPs, therefore no monthly SP PPS Rate(s) will be developed as part of the PPS-2 Methodology (Continue to Section 2.2a, PPS-2 Outlier Payments)

In the box below, identify populations with certain conditions for which separate PPS rates will be determined by the state and explain the criteria used to identify them. If more space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section. Note: the populations listed below should match those shown on the sample cost report submitted by the state.

PPS-2 Outlier Payments

Outlier payments are reimbursements to clinics in addition to PPS rates for participant costs that exceed a state-defined threshold to ensure that clinics are able to meet the costs of serving their users.

- ☐ Please check this box to confirm that the state has outlier payments in reserve

[11] A state will need to pay an interim rate when current DY data will not be available to the state in time to analyze and rebase the rate for the upcoming DY payment.

In the box below provide a description of the outlier payment methodology including an explanation of the threshold for making payment and how much of total allowable cost is set aside for outlier payment; how often outlier payment is calculated; and, how often certified clinics receive outlier payment. If more space is needed, please attach and identify the page that pertains to this section.

If Section 2.2 is completed, skip Sections 2.1, 2.3, and 2.4 and continue to Section 3.2.

Section 2.3: Certified Clinic PPS-3 (CC PPS-3)

The CC PPS-3 methodology is implemented as a fixed daily rate that reflects the expected cost of all CCBHC services provided on any given day to a Medicaid beneficiary. This is a cost based, per clinic rate that applies uniformly to all services rendered by a CCBHC and qualified satellite facilities established prior to April 1, 2014. Under this methodology, separate rates are developed for both the base population and for at least one of the categories of special crisis services (SCS). In addition, under this methodology the state has the option of offering Quality Bonus Payments (QBPs) that are to be paid in addition to the PPS rate to any certified clinic that achieves on state established thresholds for payment in accordance with Section 3: Quality Bonus Payments (QBPs) of the updated PPS Guidance.

Section 2.3.a Components of the CC PPS-3 Rate Methodology

Demonstration Year One (DYl) Rate Data

In the box below explain the source(s) of cost and visit data used to determine the DYl rate. Detail any estimates that the state used to determine allowable cost and the appropriate number of daily visits to include in the rate calculation. If more space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

CC PPS-3 Annual Rate Updates

For years where rebasing is not required (i.e.: between DY1 and DY2), states have the option to annually update their PPS rates between DYs by trending them by the MEI or using actual cost and visit data from submitted cost reports to rebase the rates. Please explain which method the state will use to annually update the CC PPS-3 rates between DYs that are not required to be rebased (select one):

- ☐ Annually update CC PPS-3 rates by the Medicare Economic Index
- ☐ Annually update CC PPS-3 rates by rebasing, using one year of actual cost and visit data from provider submitted cost reports; no interim rate.

For states selecting the option to rebase without an interim rate above, please indicate the time period of the cost report that will be used to rebase rates and the effective DY for the rebased rates (i.e.: state intends to use cost reports from two DYs prior to rebase rates, 2024 cost report used to rebase rates effective 2026)

- ☐ Annually update CC PPS-3 rates by rebasing, using one year of actual cost and visit data from the prior DY cost report; includes interim rate

For states who selected rebasing using an interim rate please describe the timeframe of the cost report being used to rebase the rates, what interim rate the state will pay providers, when the final PPS rate would be calculated for that DY, and how the state intends to reconcile claims for that DY to ensure that all CCBHC service encounters provided in that DY are paid that DY's rebased PPS rate.

CC PPS-3 Required Rate Rebasing

PPS rates are required to be rebased after DY2, effective for DY3, and at least every 3 years from the last DY in which the rates were rebased using actual costs and visits from the provider's CCBHC cost report.

☐ Please check the box confirming the state will rebase CC PPS-3 rates for DY3 using actual DY2 cost and visit data from cost reports submitted to the state.

In the box below, please describe the methodology the state intends to use to rebase PPS-1 rates to align with section 2.5(b) of the PPS guidance, requiring PPS rates to be rebased for all CCBHCs at least every 3 years from the last DY in which their rates were rebased using actual costs and visits from the provider's CCBHC cost report[12]. As part of the methodology, please include the timeframe of the cost report being used for rebasing, when the final PPS rate would be calculated for that DY, and if applicable, the interim rate the state will pay providers and how the state intends to reconcile claims for that DY to ensure that all CCBHC service encounters provided in that DY are paid that DY's rebased PPS rate[13].

PPS-3 Special Crisis Services (SCS) Rates

Under the PPS-3 Methodology states are required to develop a daily PPS rate for at least one of the three categories of Special Crisis Services (SCS). The state chooses to implement the following SCS categories (select ***at least*** one):

☐ CCBHC mobile crisis services meeting the requirements of section 9813 of ARP

☐ CCBHC mobile crisis services that do not meet the ARP section 9813 requirements

☐ On-site CCBHC crisis stabilization services

In the box below, please describe what demonstration services the CCBHC will provide under each category of SCS service the state intends to implement. If more space is needed, please provide additional information via separate attachment and identify the page(s) that pertains to this section. Note: the categories listed below should match those shown on the sample cost report submitted by the state.

[12] If the state intends to use cost and visit data from the prior DY data to rebase rates that are effective in the subsequent DY, the state will need to pay an interim PPS rate until the PPS rate(s) are finalized for that DY.

[13] A state will need to pay an interim rate when current DY data will not be available to the state in time to analyze and rebase the rate for the upcoming DY payment.

If Section 2.3 is completed, skip Sections 2.1, 2.2, and 2.4 and continue to Section 3.1.

Section 2.4: Certified Clinic PPS Alternative (CC PPS-4)

The CC PPS-4 methodology is implemented as a fixed monthly rate that reflects the expected cost of all CCBHC visits provided within any given month to a Medicaid beneficiary. This is a cost-based, per clinic rate that applies uniformly regardless of the number of services rendered within the month by a CCBHC and qualified satellite facilities established prior to April 1, 2014. Under this methodology, separate rates must be developed for both the base population and at least one of the categories of special crisis services (SCS). Additionally, states have the option to elect separate rates developed for clinic users with certain conditions, or special populations (SP). In addition, the CC PPS-4 methodology requires outlier payments that are paid for costs exceeding state- defined thresholds and also requires the implementation of QBPs in accordance with Section 3: Quality Bonus Payments of the PPS guidance.

Section 2.4.a Components of the CC PPS-4 Rate Methodology

DYl Rate Data

In the box below explain the source(s) of cost and visit data used to determine the DYl rate. Detail any estimates that the state used to determine allowable cost and the appropriate number of monthly visits to include in the rate calculation. If more space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

CC PPS-4 Annual Rate Updates

For years where rebasing is not required (i.e.: between DY1 and DY2), states have the option to annually update their PPS rates between DYs by trending them by the MEI or using actual cost and visit data from submitted cost reports to rebase the rates. Please explain which method the

state will use to annually update the CC PPS-4 rates between DYs that are not required to be rebased (select one):

- ☐ Annually update CC PPS-4 rates by the Medicare Economic Index
- ☐ Annually update CC PPS-4 rates by rebasing, using one year of actual cost and visit data from provider submitted cost reports; no interim rate.

For states selecting the option to rebase without an interim rate above, please indicate the time period of the cost report that will be used to rebase rates and the effective DY for the rebased rates (i.e.: state intends to use cost reports from two DYs prior to rebase rates, 2024 cost report used to rebase rates effective 2026)

- ☐ Annually update CC PPS-4 rates by rebasing, using one year of actual cost and visit data from the prior DY cost report; includes interim rate.

For states who selected rebasing using an interim rate please describe the timeframe of the cost report being used to rebase the rates, what interim rate the state will pay providers, when the final PPS rate would be calculated for that DY, and how the state intends to reconcile claims for that DY to ensure that all CCBHC service encounters provided in that DY are paid that DY's rebased PPS rate.

CC PPS-4 Required Rate Rebasing

PPS rates are required to be rebased after DY2, effective for DY3, and at least every 3 years from the last DY in which the rates were rebased using actual costs and visits from the provider's CCBHC cost report.

- ☐ Please check the box confirming the state will rebase CC PPS-4 rates for DY3 using actual DY2 cost and visit data from cost reports submitted to the state.

In the box below, please describe the methodology the state intends to use to rebase PPS-1 rates to align with section 2.5(b) of the PPS guidance, requiring PPS rates to be rebased for all CCBHCs at least every 3 years from the last DY in which their rates were rebased using actual costs and visits from the provider's CCBHC cost report[14]. As part of the methodology, please include the timeframe of the cost report being used for rebasing, when the final PPS rate would be calculated for that DY, and if applicable, the interim rate the state will pay providers and how the state intends to reconcile claims for that DY to ensure that all CCBHC service encounters provided in that DY are paid that DY's rebased PPS rate[15]. If more space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

PPS-4 Identification of Populations with Certain Conditions, or Special Populations (SP)

Under the PPS-4 Methodology states have the option to develop a monthly PPS rate for populations with certain conditions, or Special Populations (SP). The state chooses to (select one):

- ☐ Implement SPs and develop monthly SP PPS Rate(s) as part of the PPS-4 Methodology
- ☐ Not implement SPs, therefore no monthly SP PPS Rate(s) will be developed as part of the PPS-4 Methodology (Continue to Section 2.4a, PPS-4 Special Crisis Services)

In the box below, identify populations with certain conditions for which separate PPS rates will be determined by the state and explain the criteria used to identify them. If more space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section. Note: the populations listed below should match those shown on the sample cost report submitted by the state.

[14] If the state intends to use cost and visit data from the prior DY data to rebase rates that are effective in the subsequent DY, the state will need to pay an interim PPS rate until the PPS rate(s) are finalized for that DY.

[15] A state will need to pay an interim rate when current DY data will not be available to the state in time to analyze and rebase the rate for the upcoming DY payment.

PPS-4 Special Crisis Services (SCS) Rates

Under the PPS-4 Methodology states are required to develop a monthly PPS rate for at least one of the three categories of Special Crisis Services (SCS). The state chooses to implement PPS rates for the following SCS categories (select ***at least*** one):

- ☐ CCBHC mobile crisis services meeting the requirements of section 9813 of ARP
- ☐ CCBHC Mobile Crisis services that do not meet the ARP section 9813 requirements
- ☐ On-Site CCBHC crisis stabilization services

In the box below, please describe what services the CCBHC will provide under each category of SCS service the state intends to implement. If more space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section. Note: the categories listed below should match those shown on the sample cost report submitted by the state.

PPS-4 Outlier Payments

Outlier payments are reimbursements to clinics in addition to PPS rates for participant costs that exceed a state-defined threshold to ensure that clinics are able to meet the costs of serving their users.

- ☐ Please check this box to confirm that the state has outlier payments in reserve

In the box below provide a description of the outlier payment methodology including an explanation of the threshold for making payment and how much of total allowable cost is set aside for outlier payment; how often outlier payment is calculated; and, how often certified clinics receive outlier payment. If more space is needed, please provide additional information via separate attachment(s) and identify the page that pertain to this section.

If Section 2.3 is completed, skip Sections 2.1, 2.2, and 2.3 and continue to Section 3.2.

Section 3: Quality Bonus Payments (QBPs)

Section 3.1: Optional QBPs (CC PPS-1 and CC PPS-3)

When using the CC PPS-1 or CC PPS-3 methodology, a state may elect to offer a QBP to any CCBHC that has achieved on the state-defined threshold for a measure in accordance with Section 3: Quality Bonus Payments, of the PPS guidance. No incentive payment shall be made solely on the basis of reporting on measures and shall only be paid for CCBHC performance improvement at or above the measure threshold. The state can make a payment for optional QBP quality measures provided in the PPS Guidance and may propose its own additional QBP quality measures. Any additional state-proposed measure must be approved by CMS.

The state chooses to (select one):

- ☐ Not offer QBP(s) (Continue to Section 4)
- ☐ Offer OBP(s)

In the box below provide a list of the quality measures that will be used in addition to the required comparative QBP measures listed in Section 3 of the PPS guidance. Please note any measure that is state-defined and provide a full description of the measure including the full measure name, a brief description/purpose of measure, the measure numerator and denominator, the measure steward, and whether the measure will be state, or clinic collected. States proposing additional measures for QBP inclusion that are CMS adult-child core set measures only need to provide the full measure name. If more space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

In the box below describe the QBP methodology, specifying (1) the state-developed thresholds that trigger payment, (2) the methodology for calculating the payment, (3) the amount that will be paid for each measure, and (4) how often the payment is made to CCBHCs. Also provide an annual estimate of the amount of QBP payment by demonstration year (DY) for all clinics expected to be certified, including an estimate of the percentage of QBP payment to be made through the PPS rate. If more space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

In the box below, please specify how the state-developed thresholds were developed in such a way where QBPs made to providers are reflective of performance improvement, the provision of a higher quality of care or improvement of beneficiary health. Please also explain how state needs assessments, priorities, and goals were used to determine the thresholds for the QBP quality measures. If more space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

Section 3.2: Required QBPs (CC PPS-2 and CC PPS-4)

Under the CC PPS 2 and CC PPS-4 methodologies, a state must offer a QBP to any CCBHC that has achieved the state-defined threshold for a measure in accordance with Section 3: Quality Bonus Payments, of the PPS Guidance. No incentive payment shall be made solely on the basis of reporting on measures and shall only be paid for CCBHC performance at or above the measure threshold. The state can make a QBP for optional QBP quality measures provided in the PPS guidance and may propose its own additional QBP quality measures. Any additional state-proposed measures must be approved by CMS.

In the box below provide a list of the quality measures that will be used in addition to the required comparative QBP measures (QBP measures #1-7) listed in Section 3 of the PPS guidance. This may include optional QBP quality measures (QBP measures #8-15) or a state-proposed quality measure. Please note any measure that is state-proposed and provide a full description of the measure including the full measure name, a brief description/purpose of measure, the measure numerator and denominator, the measure steward, and whether the measure will be state, or clinic collected. States proposing additional measures for QBP inclusion that are CMS adult-child core set measures only need to provide the full measure name. If more space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

In the box below describe the QBP methodology, specifying (1) the state-defined thresholds that trigger payment, (2) the methodology for calculating the payment, (3) the amount that will be paid for each measure, and (4) how often the payment is made to CCBHCs. Also provide an annual estimate of the amount of QBP payment by demonstration year (DY) for all clinics expected to be certified, including an estimate of the percentage of QBP payment to be made through the PPS rate. If more space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

In the box below, please specify how the state-defined thresholds were developed in such a way where QBPs made to providers are reflective of performance improvement, the provision of a higher quality of care or improvement of beneficiary health. Please also explain how state needs assessments, priorities, and goals were used to determine the thresholds for the QBP quality measures. If more space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

Section 4: Payment to CCBHCs that are FQHCs, Clinics, or Tribal Facilities

In some instances, a CCBHC may already participate in the Medicaid program as a Federally Qualified Health Center (FQHC), clinic services provider or Indian Health Service (IHS) facility that receives payment authorized through the Medicaid state plan. In these instances, the state should refer to the PPS guidance for how these Medicaid providers would be paid when a clinic user receives a service authorized under both the state plan and this demonstration. The state must select and attest to the following statement:

☐ The state will require each certified clinic on its CCBHC cost report to report whether it is dually certified as a FQHC, clinic services provider or IHS facility.

Section 5: Cost Reporting and Documentation Requirements

In order to determine CCBHC PPS rates, states must identify allowable costs necessary to support the provision of services.

Section 5.1: Treatment of Select Costs

CMS provides additional guidance for the state regarding how to treat select costs, including uncompensated care, telehealth, and interpretation or translation service costs.

☐ The state excludes the cost of bad debt expense for uncompensated care from its calculation of the CCBHC PPS rate(s). Note that all costs for providing services, such as salaries and wages, staff benefits, other direct costs and indirect costs regardless of payer should be included in rate calculation but unallowable costs such as bad debt expense, lobbying costs, entertainment expenses and charitable contributions must be excluded from direct CCBHC expenses and indirect costs. The visits for CCBHC services should also be included in the rate calculation regardless of payer.

Section 5.2: Cost Report Elements and Data Essentials

Cost Reporting

- ☐ The state will use the CMS CCBHC cost report and has attached a sample completed CCBHC Cost Report form plus an explanatory narrative from a CCBHC listed in Attachment 7, with that provider's CCBHC cost and visit data that demonstrates the rate for DY1.
- ☐ The state will use its own cost report and has attached a sample completed CCBHC Cost Report form plus an explanatory narrative from a CCBHC listed in Attachment 7, with that provider's CCBHC cost and visit data that demonstrates the rate for DY1 and the cost report instructions.

The attached state-developed cost report template includes following key elements as specified in section 4.2 of the PPS guidance:

- ☐ Provider Information
- ☐ Direct and Indirect Cost-Identification
- ☐ Direct and Overhead Cost-Allocations
- ☐ Number of Visits
- ☐ Rate Calculations

Section 6: Managed Care Considerations

The statute requires payment of PPS and allows payment to be made through FFS and/or through managed care delivery systems for CCBHC demonstration services. The managed care delivery system for CCBHC demonstration services may include Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), or Prepaid Ambulatory Health Plans (PAHPs), collectively referred to as Managed Care Plans (MCPs). If the state chooses to include CCBHC service coverage in their risk-based managed care contracts, CCBHCs must still receive the full PPS payment.

- ☐ Please check the box if all CCBHC demonstration services will be delivered through fee-for-service and will be excluded from managed care. (Continue to Section 7); OR
- ☐ Please check the box if some or all CCBHC demonstration services will be delivered through the state's managed care delivery system.

Section 6.1: Managed Care Service Delivery and Capitation CCBHC PPS Rate Methodology

- ☐ Please check the box to affirm that the PPS methodology selected in Section 2 will apply to CCBHC demonstration services delivered in both managed care and FFS.

Section 6.2: Building CCBHC PPS Rates into Managed Care Capitation

CMS offers states the option of using either one of the following methodologies for incorporating the CCBHC rate into the managed care payment methodology (select one):

☐ Fully incorporate the PPS payment into the managed care capitation rate and require the MCPs to pay the full PPS rate to the CCBHC.

Explain how the state will provide adequate oversight to ensure CCBHCs receive the actual PPS rates, including provisions for special populations and outlier payments, as applicable (PPS-2 and PPS-4). If additional space is needed, please attach and identify the page that pertains to this section.

OR

☐ Require the managed care plans **MCPs** to pay a rate to the CCBHCs that other providers would receive for similar services, then use a state **wrap around payment** to ensure payment to CCBHCs is equal to the PPS.

Explain how the state will conduct adequate oversight of, and will reconcile, managed care payments with full PPS rates, including provisions for special populations and outlier payments, as applicable. If additional space is needed, please provide additional information via separate attachment and identify the page(s) that pertains to this section.

Explain the frequency and timing of the wraparound payment used by the state:

Section 6.3: Managed Care Delivery System Operational Considerations

Strategies for avoiding duplication of payments: There is significant variation of how services are delivered through Medicaid managed care. Several states contract with Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health plans (PAHPs) that specialize in behavioral health services. Medicaid enrollees may be members of a PIHP or PAHP and Managed Care Organization (MCO) at the same time. As such, a CCBHC may not be aware which MCP is responsible for payment of behavioral health services. Please indicate the MCP contractual arrangement(s) that will be in place when delivering services under the demonstration:

☐ CCBHC demonstration services will be delivered by multiple managed care plans (MCOs, PIHPs, PAHPs.)

OR:

☐ The state will require all CCBHC services to be delivered under the contract for one managed care plan.

Describe which MCPs will be responsible for providing CCBHC demonstration services, any regional variations for CCBHC service delivery, and identify any services in other managed care plans that may duplicate the CCBHC demonstration services.

Explain how managed care capitation rates will be changed, the timing and process the state will used to determine that the new managed care rates are actuarially sound; and how the state will ensure that payments are not duplicated. If additional space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

If a state chooses not to include all CCBHC demonstration services under a single MCP, describe how coverage responsibility for the demonstration service array is distributed across multiple MCPs. If this distribution requires a change to managed care capitation rates, explain how rates will be affected, the timing and process for determining that the new managed care rates are actuarially sound, and how the state will ensure that payments are not duplicated. If additional space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

Section 6.4: Data Reporting and Managed Care Contract Requirements

Describe the data reporting polices and processes, including specific data deliverables to be reported by each entity, how data will be collected, the timing of reporting, and the contract language governing data reporting. Explain how the state will validate encounter data and ensure timely reporting. If additional space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

Explain how the state will ensure MCP contracts reflect the scope of CCBHC demonstration services and how the state will ensure access to CCBHC demonstration services from MCPs, particularly how it will address out-of-network access to CCBHCs. Indicate whether the state plans to develop quantitative network adequacy standards specific to CCBHCs (note: this is recommended but not required). If additional space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

Section 6.5: Identification of Expenditures Eligible for Enhanced Federal Matching Percentage (FMAP)

Describe how the state will ensure proper claiming of enhanced FMAP for CCBHC demonstration services, including how it will identify the portion of the capitation payment(s) applicable to the services and populations that are eligible for the enhanced match. States should reference SMD #23-005 CMS issued in August 2023 on Medicaid managed care claiming methodologies. If additional space is needed, please provide additional information via separate attachment and identify the page(s) that pertain to this section.

Section 7: Identifying CCBHC Claims and Service Level Encounter Detail

States participating in the CCBHC demonstration must have a mechanism for identifying claims attributable to the CCBHC demonstration as well as service level detail of the CCBHC services provided during the encounter. The CMS Alpha Numeric Healthcare Common Procedure Coding System (HCPCS) File & Code Sets contain dedicated 223 demonstration encounter "T" billing codes that are for CCBHCs to bill solely for demonstration encounters and a Q2 billing code modifier that can be used for billing service-level data associated with each demonstration encounter.

The State will use one of the following mechanisms to identify claims attributable to the CCBHC demonstration (select one):

- ☐ T1040 Medicaid certified community behavioral health clinic services, per diem demonstration billing code
- ☐ T1041 Medicaid certified community behavioral health clinic services, per month demonstration billing code
- ☐ Another state-developed mechanism for identifying CCBHC claims, as described below.

The State will use one of the following mechanisms to identify the service level detail associated with each demonstration encounter (select one):

- ☐ Q2 Demonstration procedure/service modifier
- ☐ Another state-developed mechanism for identifying service level detail associated with each demonstration encounter, as described in detail below.

Section 8: Funding Questions: Section 223 Behavioral Health Demonstration

The questions below should be answered relative to all payments made to CCBHCs reimbursed pursuant to Section 223 of P.L. 113-93 Protecting Access to Medicare Act of 2014[3] and the methodology described in the state's application to participate in the demonstration program.

CMS requests the following information about the source(s) of the non-federal share of payment made for demonstration services.

1. Section 1902(a)(2) stipulates that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

a. Describe how the non-federal share of each type of Medicaid payment (e.g., basic PPS rate, outlier payment and quality bonus payments) is funded.

b. Describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through an IGT. In this case, please also identify the agency to which the funds are appropriated.

c. If any of the non-federal share of payment is being provided using IGTs, fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

d. For any payment funded by IGTs, please provide the following information:

i. A complete list of the names of entities transferring funds;
ii. The operational nature of the entity (state, county, city, other);
iii. The total amounts transferred by each entity;
iv. Clarify whether the transferring entity has general taxing authority: and,
v. Whether the transferring entity received appropriations (identify level of appropriations)

2. Do CCBHC providers receive and retain the total Medicaid expenditures claimed by the state for demonstration services (includes PPS and quality bonus payments) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization?

   If providers are required to return any portion of payments, provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, who they return the funds to (state, local governmental entity, or any other intermediary organization), the amount or percentage of payments that are returned, and the disposition and use of the funds once they are returned (e.g., general fund, medical services account, etc.).