MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

Director, Bureau of Policy and Strategic Engagement
Health Services Administration

Project Number:	2552-BH	**Comments Due:**	April 21, 2026	**Proposed Effective Date:**	As Indicated

Mail Comments to: Amy Kanouse

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

Affected Programs: Medicaid, Healthy Michigan Plan, MIChild

Distribution: All Providers

Policy Summary: This policy updates enrollment, billing, and reimbursement requirements for the CCBHC demonstration.

Purpose: To update CCBHC policy to reflect the transition from managed care reimbursement to a direct payment model.

Proposed Policy Draft

Michigan Department of Health and Human Services
Health Services

Distribution: All Providers

Issued: May 1, 2026 (proposed)

Subject: Certified Community Behavioral Health Clinic (CCBHC) Demonstration Direct Payment Transition

Effective: As Indicated (proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

The purpose of this policy is to update CCBHC Demonstration requirements related to direct pay. This policy updates provider enrollment, billing, and reimbursement requirements for the CCBHC demonstration related to the payment model transition, effective October 1, 2025.

I. General Information

The Centers for Medicare & Medicaid Services (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. (Refer to the Certified Community Behavioral Health Clinic Demonstration section of the Special Programs chapter within the Michigan Department of Health and Human Services [MDHHS] Medicaid Provider Manual for a detailed description of the CCBHC structure.)

II. Eligibility

A. Site Eligibility

Per the Substance Abuse and Mental Health Services Administration (SAMHSA) and CMS requirements, states must select and certify providers to participate in the CCBHC Demonstration. Sites must meet all requirements as outlined in the CCBHC Demonstration Handbook and be certified by MDHHS and designated as a CCBHC demonstration site.

B. CCBHC Service Recipient Eligibility

Any person with a mental health or SUD International Classification of Diseases (ICD)-10 diagnosis code is eligible for CCBHC services. The mental health or SUD diagnosis does not need to be the primary diagnosis. CCBHCs must serve all individuals regardless of county of residency, insurance coverage, age, severity of need, or ability to pay.

Exceptions to the diagnostic requirement are:

- Persons in crisis: People in crisis are eligible to receive CCBHC crisis services even if it is determined during the CCBHC crisis service that the person does not have a mental health or SUD diagnosis.
- Persons being assessed/screened for mental health and/or SUD diagnoses: People without a current mental health and/or SUD diagnosis are eligible to receive CCBHC screening and assessment services even if these services do not result in a diagnosis. If the screening/assessment does not result in a mental health and/or SUD diagnosis, the person is not eligible to receive subsequent CCBHC services unless they are: 1) in crisis as described above; or 2) later found to have a mental health and/or SUD diagnosis.

III. Enrollment

CCBHCs are required to be certified as a CCBHC Demonstration Site by MDHHS and must be a Medicaid-enrolled provider to seek reimbursement for services rendered to Medicaid beneficiaries. Prospective payment system (PPS) payments for non-Medicaid persons served are not permitted.

To enroll as a CCBHC Provider Type, a CCBHC must have a Type 2 (Group) National Provider Identifier (NPI) specific to CCBHC services and must complete an online application in the Community Health Automated Medicaid Processing System (CHAMPS). CCBHCs must have received certification documentation from MDHHS prior to enrolling as a CCBHC provider type. CCBHCs must enroll under the "specialty programs" enrollment type. No subspecialty is required.

IV. Certification Requirements

CCBHC demonstration clinics must complete the MDHHS certification process to become a CCBHC under the CMS CCBHC Demonstration. During the certification process, CCBHCs will provide justification for meeting SAMHSA and MDHHS-defined CCBHC criteria by submitting supporting documentation verifying that standards have been met. CCBHCs must be recertified every three (3) years, or more frequently, if necessary, to verify new SAMHSA or MDHHS requirements have been met. MDHHS reserves the right to request documentation from the CCBHC to ensure all certification requirements are met. This may include, but is not limited to, updated policies, procedural documents, or revisions to current CCBHC application materials.

In accordance with the Protecting Access to Medicare Act of 2014 (PAMA), certification criteria address the following broad elements:

A. Staffing Requirements

Staffing requirements include criteria that staff have diverse disciplinary backgrounds, have necessary state-required licensure and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population.

B. Availability and Accessibility of Services

Availability and accessibility of services include 24-hour crisis management, a sliding-scale payment option, and no rejection or limitation of services based on ability to pay or county of residence.

C. Care Coordination

Care coordination requires coordinating care across settings and providers to ensure seamless transitions across the full spectrum of health services, including acute, chronic, and behavioral health needs. Care coordination requirements shall include, at minimum:

- Partnerships or formal contracts with: federally qualified health centers (FQHC) (and as applicable, rural health clinics [RHC]) to provide FQHC services (and as applicable, RHC services) to the extent such services are not provided directly through the CCBHC;
- Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs, other community or regional services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities, Indian Health Service (IHS) youth regional treatment centers, and other social and human services;
- Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the department as defined in section 1801 of title 38, United States Code; and
- Inpatient acute care hospitals and hospital outpatient clinics.

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 CCBHC Service Requirements section of this policy. Services may be provided directly by the CCBHC or through formal relationships with designated collaborating organizations (DCO). Required Evidence-Based Practices and expectations around service delivery are outlined in the CCBHC Demonstration Handbook.

E. Quality and Other Reporting

CCBHCs must collect, report, and track service, outcome, and quality data and other data as federally required or requested by MDHHS. Measures and specifications for reporting are listed in the CCBHC Demonstration Handbook.

F. Organization Authority, Governance, and Accreditation

The CCBHC must meet one of the following criteria:

- Is a non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code;
- Is part of a local government behavioral health authority (which includes all forms of CMHSPs);
- Is operated under the authority of the IHS, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS pursuant to the Indian Self-Determination and Education Assistance Act (25 United States Code [USC] 450 et seq.); or
- Is an urban Indian organization pursuant to a grant or contract with the Indian Health Service (IHS) under Title V of the Indian Health Care Improvement Act (25 USC 1601 et seq.).

A detailed description of all certification requirements and standards is available in the CCBHC Demonstration Handbook. CCBHCs must notify the MDHHS CCBHC Certification Monitoring and Oversight section within seven (7) days of any significant change in policy or practice that would impact a clinic's ability to meet certification, and/or a significant change to the cost report.

V. Service Requirements

CCBHCs, directly or through DCOs, must provide a set of nine comprehensive services to address the complex and myriad needs of persons with mental health or SUD diagnoses. Prior authorization for CCBHC services is not required under the CCBHC Demonstration when services are eligible and determined medically necessary by a qualified provider. 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, 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.

CCBHCs are required to provide the majority (51 percent or more) of CCBHC services directly rather than through contracted DCOs. This requirement excludes crisis services, as defined in the CCBHC Demonstration Handbook. Calculation of the 51 percent threshold is based on daily visits identified by the T1040 Healthcare Common Procedure Coding System (HCPCS) code and includes claims for all payer types, including private insurance and the uninsured.

VI. Designated Collaborating Organization

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. DCO Agreements

A formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or other formal arrangements that describe the parties' mutual expectations, establish accountability for services to be provided, and specify funding to be sought and utilized. Agreements must be approved by MDHHS before the DCO initiates delivery of services and must meet the DCO agreement requirements outlined in the CCBHC Demonstration Handbook. DCOs and their providers must be eligible to provide Medicaid services in Michigan. CCBHCs must also notify the MDHHS CCBHC Certification Monitoring and Oversight section of changes to or termination of a DCO agreement. The CCBHC remains responsible for ensuring the DCO complies with CCBHC requirements, including contracted services delivered and the financial components of the demonstration. A DCO Lead must be designated to act as the liaison between the CCBHC and the DCO provider, and to serve as the primary point of contact with MDHHS about all DCO relationships. CCBHCs may enter DCO agreements with other CCBHCs participating in the demonstration for purposes of meeting specific certification requirements detailed in the CCBHC Demonstration Handbook.

B. Payment for DCO

Payment for DCO services is included within the scope of the CCBHC PPS, and DCO services will be treated as CCBHC services for purposes of the PPS. Payment will be provided directly to the DCO from the CCBHC based on agreed-upon contractual service rates.

VII. Payment Methodology

MDHHS uses the Certified Clinic Prospective Payment System – 1 (CC PPS-1) methodology, under which CCBHCs receive a daily clinic-specific rate based on the

average expected daily cost to deliver CCBHC services. Costs for providing CCBHC services are factored into rates regardless of payer, but the PPS rate is only paid for Medicaid-eligible beneficiaries. Prior authorization for CCBHC services is not required under the CCBHC Demonstration when services are eligible and determined medically necessary by a qualified provider. MDHHS will also employ a Quality Bonus Payment (QBP) that will reward CCBHCs based on meeting required benchmarks.

A. PPS-1 Rates

MDHHS will utilize pertinent cost and utilization data from the submitted annual Cost Report to develop clinic-specific PPS-1 rates. The PPS rate methodology and rebasing will follow applicable federal requirements. Given the different timelines of sites joining the demonstration, rate rebasing methodology may differ amongst CCBHC sites. Rate updates will be documented by MDHHS and shared with CCBHC sites.

CCBHCs are not reconciled to actual costs. Per federal guidance, states are prohibited from making additional payments to CCBHCs at the end of the demonstration year if actual costs are higher than the amount received via PPS rate. CCBHCs are at risk for all services provided throughout the demonstration period.

PPS rates for the current demonstration year are posted on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Certified Community Behavioral Health Clinics.

B. Quality Bonus Payments (QBP)

MDHHS will provide QBPs to providers who meet quality benchmarks. QBPs will be calculated based on five percent (5%) of total Demonstration Year costs. The QBP methodology, performance specifications, and distribution process will be outlined and maintained in the CCBHC Demonstration Handbook. All QBPs are subject to post-payment audit and validation. Any falsification of quality data will be considered a false claim in accordance with the provisions of the Social Welfare Act.

C. Claims Reporting

To receive PPS reimbursement, CCBHCs must submit a claim to CHAMPS for processing. CCBHC claims must be submitted in accordance with policies, rules, and procedures stated in the Billing & Reimbursement for Professionals chapter of the MDHHS Medicaid Provider Manual.

Claims must include a T1040 HCPCS code and be submitted utilizing the Medicaid ID number of the person served. The combination of the T1040 HCPCS code, the qualifying CCBHC HCPCS or Current Procedural Terminology (CPT) code, and a qualifying diagnosis must be submitted for a service to be recognized as a CCBHC service.

Claims for services delivered by a DCO must be submitted to MDHHS with identifying DCO information, using loop 2310C or 2420C.

Additional provisions for claim reporting are detailed in the CCBHC Demonstration Handbook. Qualifying CCBHC HCPCS and CPT codes can be found at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Certified Community Behavioral Health Clinics.

D. Reimbursement Limitations

Per the Protecting Access to Medicare Act of 2014, Section 223.b.2.A, no payment will be made for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, as determined by the U.S. Department of Health and Human Services (HHS) Secretary through CMS.

CCBHCs may not bill for services provided to individuals without an eligible diagnosis even when provision of those services is required (see exceptions to the diagnostic requirement in the CCBHC Service Recipient Eligibility section of this policy).

CCBHCs must only bill the PPS rate at certified CCBHC locations or in the community using the CCBHC-specific billing NPI. CCBHCs may not bill for DCO services prior to MDHHS approval of the DCO agreement.

VIII. Reporting Requirements

CCBHCs are responsible for reporting service, clinical outcomes, quality, and other data as required or requested by MDHHS. Data will be used to assess the demonstration's impact on access to services, the quality and scope of services, and the costs of providing a comprehensive array of behavioral health services.

A. Cost Reporting

CCBHCs must submit an annual cost report with supporting data to MDHHS. Cost reports and supporting data are based on the CCBHC's audited financial records and must follow the templates provided by MDHHS. 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 HHS Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement. 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 metrics are defined per federal guidance and detailed in the CCBHC Demonstration Handbook. 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.