Billing & Finance

Code List Process

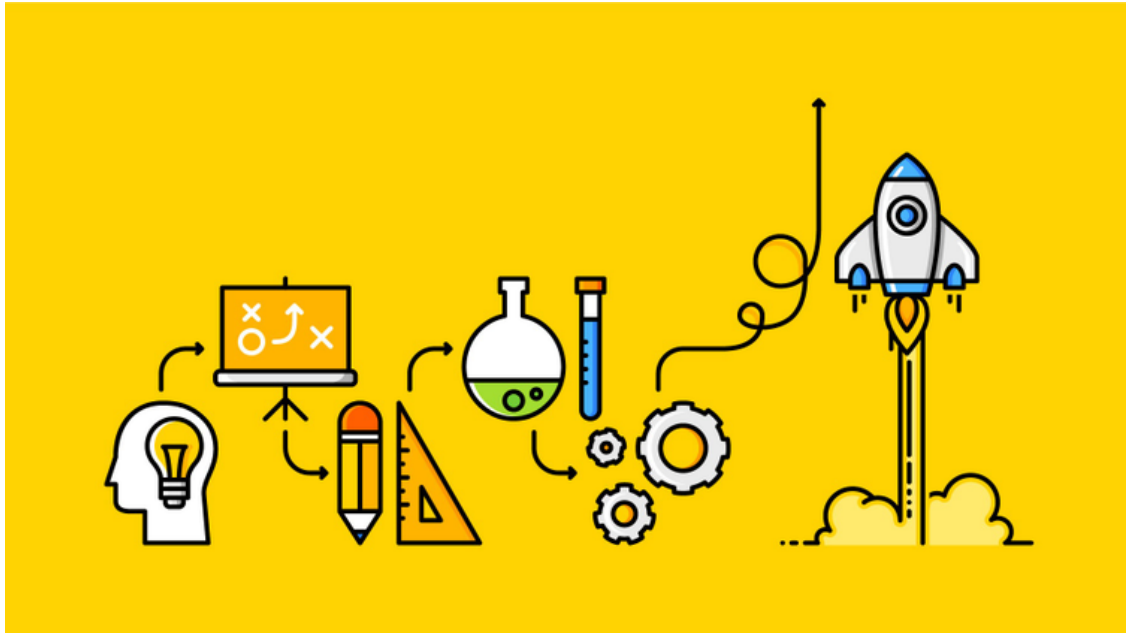
CCBHC Code List: Meeting Goals & Activities

✓ **7/18: Billing Managers [First Run]** ✓ **7/24: Billing Managers [Second Run]** ✓ **8/2: Provider Recommendations due to the State***	Goal: Draft the provider recommendation of all codes that will need to be accessed for billing to account for the costs included in the template. • Review the **draft list** developed by the state team; • Identify and **add missing** codes, **remove unnecessary** codes; • Recommend suggestions for the **qualifying vs. support statuses** for each code. • **Deliver recommendations** to the state by 8/2
✓ **8/22: Clinical Review**	Goal: Articulate the clinical appropriateness and incentives of the included/excluded codes. • Assess the **clinical appropriateness** of the draft code list. • Identify the **incentive structures** that are created by the inclusion/exclusion of codes. • Make any **recommendations** for changes.
✓ **8/28: CFO Review & Costing Considerations**	Goal: Articulate the financial impacts and incentives of the included/excluded codes. • Assess the **financial impact** of the draft code list. • Identify the **incentive structures** that are created by the inclusion/exclusion of codes. • Make any **recommendations** for changes.
✓ **9/30: Final Provider Recommendations***	Goal: Prospective CCBHC providers deliver a final recommendation for the state to decide the final list for DY1 implementation. • **Contingency**: All codes submitted for recommendation are subject to the review and approval of the State of Vermont's certified coders and the alignment with other Medicaid programs.
✓ **10/8: CCBHC Monthly**	Goal: Review the evolved code list with the broader audience. • Review the **vision, process, and timeline**; • Engage **feedback** and provide multiple mechanisms for delivering it**.**
❑ **11/12: CCBHC Monthly**	Goal: Adopt the final code list for DY1 implementation with the broader audience. • Review the **vision, process, and timeline**; • **Adopt** the final code list; • Describe the **process for updating** the included/excluded codes.

*Indicates a deadline, not a meeting

Vermont CCBHC Billing Guide Overview

- Updates anticipated as the demonstration progresses.
  - Changes may come from participant feedback, healthcare providers, or new directives from CMS/SAMHSA.
  - Always use the latest manual available online. Printed copies are uncontrolled.
  - Initial manual published April 1, 2025.
- Assist certified CCBHCs in billing for services under Vermont's federal CCBHC Demonstration.
  - Does **not** apply to programs with SAMHSA Expansion Grants or any provider not officially DMH/DSU certification.



CCBHC Demonstration Billing Guidelines

Billing Start Date:	Begins on the date of service specified in the DMH/DSU certification letter.
Billing End Date (whichever occurs first):	End of the Vermont demonstration. Certification end date. Three years from the certification approval date.
Certification Requirement:	CCBHCs are only authorized to use demonstration billing codes while maintaining active certification by DMH/DSU.

Introduction to the PPS-1 Methodology

- **PPS-1 Payment Model**:
  - Reimburses CCBHC services through a daily **Prospective Payment System (PPS-1)**.
  - **Rate Calculation**: Clinic's allowable costs ÷ number of qualifying daily encounters.
  - **Supports Expansion**: Enables clinics to serve more clients and offer flexible, client-centered care.
- **Daily PPS Payment**:
  - One payment per day, per client, when a qualifying service is provided.
  - Rate covers the clinic's anticipated yearly costs of delivering care.
- **Unique Rates**:
  - Each CCBHC has an individualized rate based on its care model and population.
  - Ensures appropriate reimbursement while enhancing service flexibility.

Qualifying vs. Support Services

- **Qualifying Services**:
  - Qualifying services qualify as the minimum requirements on a day to trigger the daily PPS-1 payment.
  - Only one payment can be triggered per day, per member.
  - Costs are incorporated in the PPS-1 rate through the cost template.
  - Core Mental Health/Substance Use service
- **Support Services**:
  - "Support" is NOT a clinical reference. Support services *support* the qualifying services.
  - Allowable under the CCBHC program but do not trigger PPS-1 payment on their own.
  - Costs are incorporated into the PPS-1 rate through the cost template.
  - Part of comprehensive care for clients who are receiving core services.
  - Little or no historical data to inform prospective visit estimates impacting the rates.

Finding Balance: This payment model balances flexibility—by reducing the number of payment-triggering services and minimizing service-by-service accountability—with the traditional fee-for-service model, where each individual service triggers a payment and ensures accountability for every service provided.

Examples of Support Codes

- **T1013, Interpreter Services:**
  - Necessary for care.
  - Factored into the PPS-1 rate through the cost template.
  - The interpreter services would be *supporting* the service they were billed with.
- **90833, Psychotherapy, 30 minutes with patient:**
  - Necessary for care.
  - Factored into the PPS-1 rate through the cost template.
  - The additional 30 minutes of therapy services would be extending or *supporting* the service the 60-minute therapy session they were billed with.

The Daily Rate

HCPCS	Long Description	Short Description
T1040	Medicaid CCBHC services, per diem	Comm bh clinic svc per diem
Q2	Demonstration procedure/service	Demo procedure, service

- These codes are essential for ensuring accurate billing and reporting for CCBHC demonstration services.
- In addition to the above, all individual CCBHC services provided during a specific day must be identified as discrete procedure codes on the Medicaid claim.
- All codes billed to the CCBHC program must follow national correct coding standards.

Billing Exceptions & Restrictions

- The below **Exceptions** are billed outside of the CCBHC model. This may include, but is not limited to:
  - The Hub Payment Model services
  - School-based Services
  - The Spoke Payment Model services covered under the Blueprint scope of work.
  - Mental Health Urgent Care Centers
  - Enhanced Mobile Crisis
- **Restrictions**
  - Correctional facilities are a disallowed setting for Medicaid billing under federal law.
  - CCBHC services cannot be reimbursed if they are provided in a setting or as part of a service where mental health and/or substance use care is already included in a bundled payment
  - CCBHC services cannot be billed (under the CCBHC provider number) if they are paid through a separate grant/contract or included in the expectations for an alternative fund source (such as Global Commitment Investments).

Billing Exceptions & Restrictions

- **Restrictions**
  - Service provision is limited to discharge planning activities in the following settings, as outlined in more detail below:
    - Nursing homes
    - Inpatient hospitals
    - Institutes of Mental Disease (IMDs)
    - 24-hour intensive residential facilities (i.e., any placement that is not categorized as home-and-community-based settings)
    - Psychiatric Residential Treatment Facilities (PRTFs)
    - Crisis Beds
    - Intermediate Care Facilities
  - If CCBHC staff provide services as part of care coordination to facilitate transitions from these non-carceral institutional settings, the activity may be billable under the following conditions:
    - The services must be furnished **pursuant to a written plan of care**.
    - The services must be considered **outside the scope of both the setting and the specialized services** provided by that setting.
    - The services must be **specific to discharge planning**.
- Allowable services include those aligned with the nine required CCBHC demonstration services that are necessary for transitioning individuals into their own households. These may include:
  - Assessing needs post-discharge,
  - Identifying and setting up mental health and substance use services the person will require after discharge,
  - Accessing community-based services,
  - Non-medical transportation, and
  - Other related services and supports necessary to ensure a successful transition.

Annual Code Review & Update*

Current and prospective CCBHCs submit list of codes (including rationales for adding) to the State for review as new allowable costs.

Aug.

Sep.–Nov.

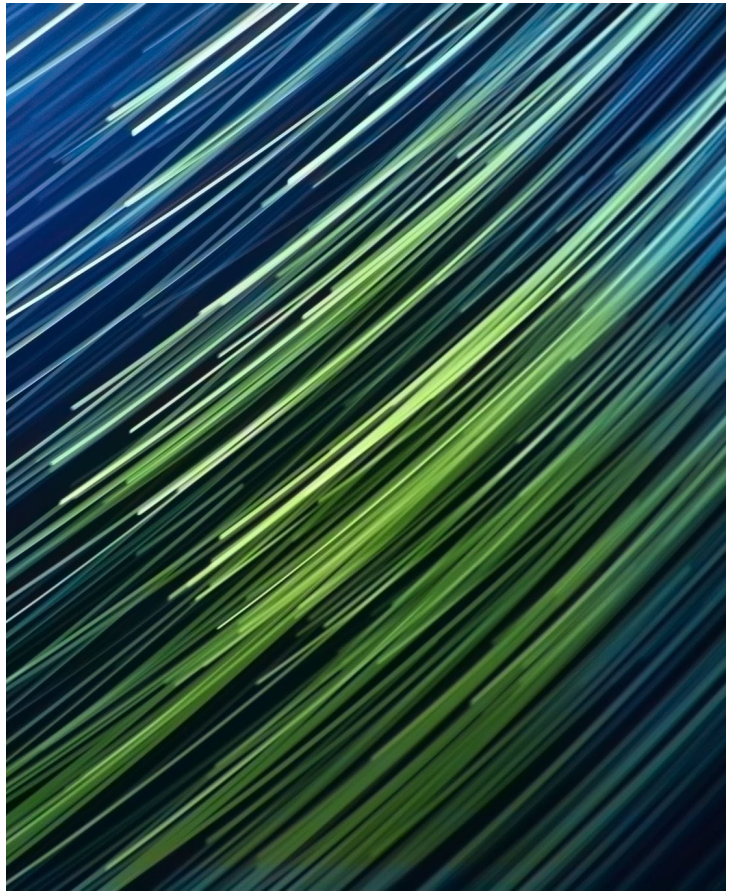
State reviews and provides written feedback.

If necessary, a meeting will be held.

[If applicable] State adopts an updated code list.

Implementation on the Calendar Year

Dec - Jan



*The state is dedicated to making every effort to adhere to this timeline. However, this timeline is not legally binding. The state retains final authority over the code list, ensuring reasonable opportunities for feedback are provided.

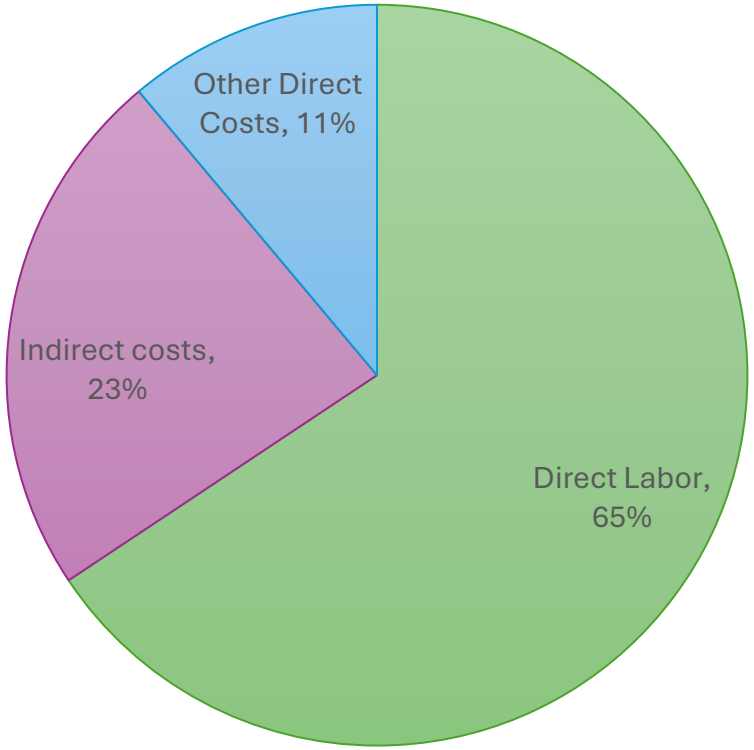
CCBHC Cost Templates

Will Medicaid funding for CCBHCs be subject to a cap?

- Medicaid funding for CCBHCs does not have a federal funding cap but is subject to available state matching fund appropriations. Under the CCBHC model, certified organizations receive prospective payment system (PPS) rates, which are designed to cover the full cost of services, provided they meet the following criteria (as determined by the state):
  - **Reasonable**: Is the cost necessary and reflective of market value?
  - **Allowable**: Is the cost permissible under state and federal regulations?
  - **Allocable**: Does the cost benefit the program, or can it be reasonably distributed to the program using an appropriate cost center?
  - **Consistently Treated**: Are costs for similar purposes treated uniformly?
- The Daily Rate (i.e., PPS-1) would provide the same rate for all clients, regardless of level of complexity/need and would therefore not vary with the number or intensity of services provided in one day.
- Although there is no formal cap on Medicaid funds under the prospective payment model, funding constraints could emerge due to broader state or federal budget decisions. Such decisions could necessitate reassessing eligibility or services to ensure compliance with PPS criteria.

Cost Distribution in CCBHCs

- Direct labor costs: 65% of total allowable costs (outpatient care centers: 68%)
- Indirect costs: 23%
- Other direct costs: 11%
- Consistent across states



Labor Costs

- **Salary Ranges**:
  - **Basis for Calculation**: Salary ranges based on 25-75% of Bureau of Labor & Statistics current data.
  - **State Ceiling**: Vermont has implemented a maximum limit of 75% of the BLS data for all CCBHC staff salaries.
  - **Supplementing Salaries**: Agencies can utilize donations and private funding to enhance salaries or offer bonuses. These supplements would be non-reimbursable.
- **Exemption Process**:
  - **Application for Exemption**: Agencies may apply for individual position exemptions. An agency may not apply for a agency-wide exemption.
  - **Requirements**: Each exemption request must be accompanied by a narrative justification and any pertinent data to support the case.
  - **Evaluation of Reasonable-ness:** The state must consider the broad range of health care provider stability when evaluating requests for exemptions that may disrupt the market value.

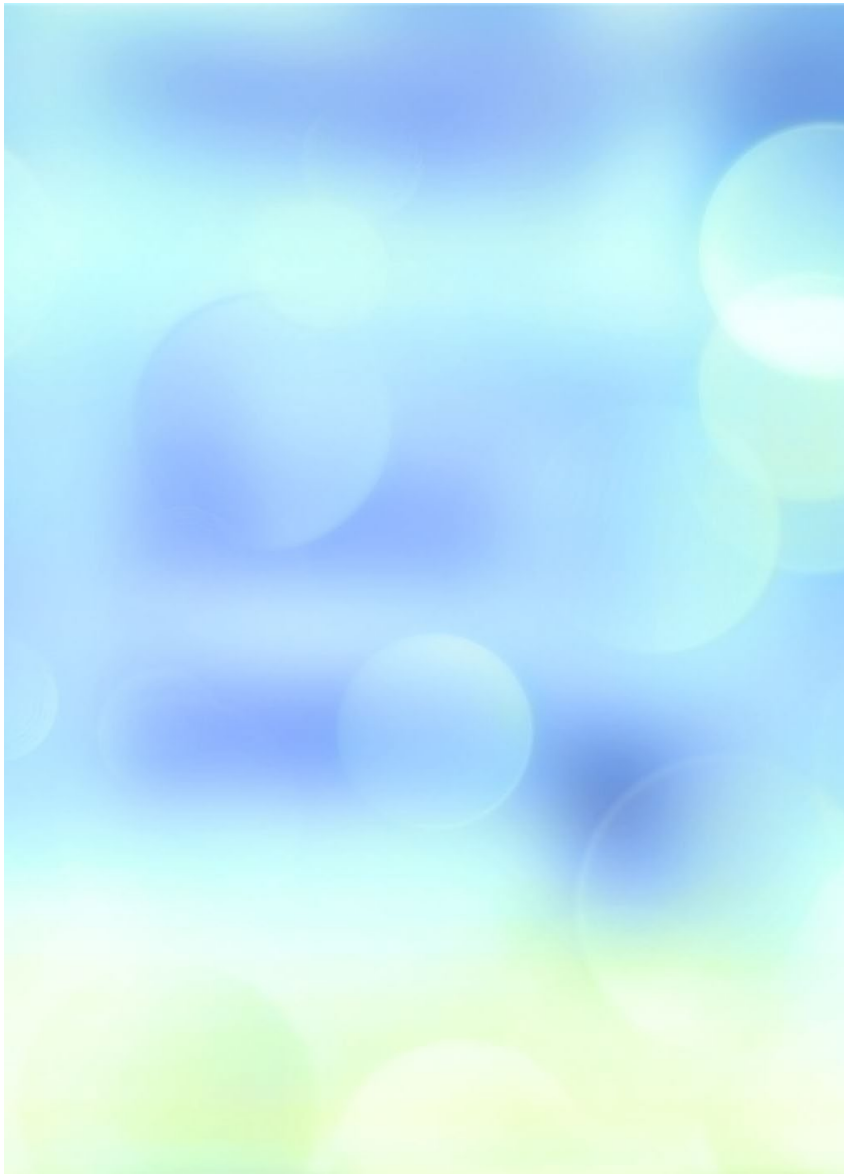
Work Phases

Phase 1: Sept thru Dec

- Staffing salaries and definitions
- Direct, Indirect, Non-reimbursables
- Anticipated Costs (Year 1)

Phase 2: Jan thru Apr

- Residentials
- Crisis Beds



CCBHC Financing: Meeting Goals & Activities

✓ 9/25: Draft the Workplan	Goal: Draft the workplan for arriving at shared definitions for how to account for the costs included in the template. • Review the **draft plan** developed by the state team; • Distinguish between the items that need to be addressed in **Phase One vs Phase Two**. • **Decide** on the final draft plan.
❑ 10/16: Staffing: Definitions (90 minutes)	Goal: Define all staff to be included in the cost template. • Develop **state definitions for positions** included in Part 1A – CCBHC Staff Costs. • Decide on **stratification** of staff in the template. • Instruct on **placement of costs** (e.g., separation of benefits from compensation)
❑ 10/23: Staffing: Salaries (30 minutes)	Goal: Establish salary parameters all staff to be included in the cost template.. • Use of **BLS data**, and how to submit requests for salaries that are greater than 75%. • Expectations for staff salary increases for **established staff** that already exceed parameters.
❑ 11/20: Direct, Indirect, Non-Reimbursable (90 minutes)	Goal: Establish expectations for submitting Other Direct, Indirect, and Non-reimbursables. • Establish parameters for **depreciation costs** allocated to the cost template. • Outline expectations for other items include: insurance, medical supplies, transportation. • Define **services and costs that are not reimbursable** or would be considered duplicative.
❑ 11/27: Anticipated Costs (30 minutes)	Goal: Review the regulations for anticipated costs to ensure a shared understanding. • Examine how **"new hires" and attributed number of hours** we will be evaluated by the state for reasonable-ness. • Review DA and State information that will be informing how **daily visits** are determined and evaluated.
❑ 12/18: CCBHC Monthly	Goal: Adopt the PPS-1 financing plan list for DY1 implementation with the broader audience. • Review the **vision, process, and timeline**; • **Adopt** the defining features; • Describe the **process for future changes** to the template guidance.