Alabama Department of Mental Health
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Alabama CCBHC FAQ

List of FAQ Categories:

Applications

Q: What is the schedule for new applications beginning now? When is it due?
A: ADMH is currently developing the timeline and process for new applications to be received. Currently Alabama Demonstration entry month is July, however SAMHSA has provided guidance for quarterly entry found here. As Alabama continues to assess provider entry, more guidance may be found on our webpage Certified Community Behavioral Health Clinics – Alabama Department of Mental Health

Q: Will ADMH accept applications on a quarterly basis, particularly for additional sites?
A: ADMH is in the process of developing the timeline and procedure to accept new applications. Please see above.

Q: How will ADMH provide Technical Assistance (TA) for new applicants?
A: TA will be provided by consultants and/or ADMH based on priority needs from surveys. ADMH will also tailor TA to individual provider needs.

Availability and Accessibility of Services

Q: When we extend our hours to include night and weekend availability, do we need to ensure all CCBHC services are provided during those hours?
A: No, the CCBHC does not need to ensure all CCBHC services are provided during extended hours but should arrange for availability of services (including the services offered and the hours they are available) to meet the needs of the people being served, as informed by the Community Needs Assessment and based on input from people receiving services. Please note that people should be able to contact the CCBHC 24 hours a day and that a mobile crisis response should also be provided within 3 hours 24 hours a day.

Q: How will a site be defined? For example, if child and adolescent services are offered in a different building but in the same city/county as the adult services, is that considered one site? Basically, can all the physical locations providing CCBHC services in one city/county be considered to be one site??
A: ADMH is in the process of finalizing its policy and will publish this soon.

Q: When adding additional sites (i.e. satellite offices), can some of the services be available via telehealth or via CCBHC staff from another office coming on-site?
A: ADMH is in the process of finalizing its policy and will publish this soon.

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Care Coordination

Q: Please confirm, that like other states, the minimum qualification for a care coordinator is a high school diploma.

A: Yes, the minimum requirement will be a person with a high school diploma or GED supervised by a Rehabilitative Services Professional with 2 years of experience. It is designed to align with the minimum qualifications in Chapter 105 and with a Qualified Mental Health Provider-Non-Degree.

Q: What is the difference between a Care Coordination partner and a DCO?

A: 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 to deliver one or more (or elements of) the required services as described in criteria 4. The DCO is rendering services on behalf of the CCBHC. The formal relationship between CCBHCs and DCOs creates the platform for seamlessly integrated services delivered across providers under the umbrella of a CCBHC.

DCOs are more than care coordination partners, and there is an expectation that relationships with DCOs will include more regular, intensive collaboration across organizations than would take place with other types of care coordination partners. From the perspective of the person receiving services, services received through a DCO should be part of a coordinated package with other CCBHC services and not simply accessing services through a separate provider organization.

To be a DCO, the organization must have a formal arrangement with the CCBHC (contract, MOU, MOA, or another formal arrangement). The CCBHC assumes clinical responsibility for DCO services provided to CCBHC consumers.

CCBHCs are required to develop a range of care coordination partnerships to ensure that CCBHCs services are coordinated with other health and social services and supports. CCBHCs, as noted in criteria 3, must develop care coordination partnerships with a range of entities and are encouraged to develop these partnerships with other entities depending on their community's needs.

Please reference the certification criteria and/or the National Council CCBHC Contracting and Community Partnerships, updated January 2024.

Carved Out Services

Q: Does "carved out" mean we will bill and be paid as we are today for these services?
A: CCBHC services are billed directly to Medicaid. Only CCBHC services defined by ADMH as "triggering events" will generate the PPS rate. All other services and service codes are considered "carved out," meaning they do not generate a PPS. Some services, such as care coordination, may not generate a PPS payment but the cost of providing those services is included in the PPS rate.

Q: Will Therapeutic Mentoring(H2019) be a triggering event since it is similar to a peer service for children?
A: No, Therapeutic Mentoring is carved-out from CCBHC services.

Claims & Billing

Q: When should billing be submitted for payment?
A: Alabama Medicaid Agency (AMA) requires that all claims for CCBHC services to be filed within one year of the date of service. CCBHCs are expected to submit claims via the Medicaid Portal for payment no later than 120 days after the date of service. Billing to ADMH should be submitted by the 15th of the month in the arrears (ex. September billing should be submitted to ADMH no later than October 15th).

Q: If needed, will Medicaid and DMH agree to make advanced payments (based on historical monthly payments) and then reconcile once CCBHC billing is up and running?
A: No advance payments will be issued.

Q: Who bills for CCBHC services provided by a DCO?
A: The CCBHC is responsible for billing all services provided to consumers of the CCBHC. The CCBHC will reimburse the DCO based on the method included in the formal DCO agreement.

Community Needs Assessment

Q: When does a CCBHC need to complete the comprehensive assessment?
A: CCBHCs must complete the comprehensive assessment within 60 calendar days of the first request for services.

Q: How often will an updated Community Needs Assessment (CNA) be required?
A: ADMH requires an updated needs assessment every 3 years. Anytime there is a substantial change within the community the CCBHC must provide an update to their

CNA, and alert ADMH to such changes.

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

A: Yes. The CCBHC is expected to implement all required CCBHC services.

Comprehensive Treatment Plan

Q: Will the comprehensive patient-centered treatment plan and the SDOH assessment tool replace the SUN-R and case management ISP?

A: Eventually, we will be moving to a comprehensive treatment plan for all CCBHCs, this will be the standard across the department. ADMH has partnered with interest-holders to create a workgroup to update the comprehensive treatment plan to align with the integrated CCBHC model. More information will be disseminated as this process evolves.

Consumer Provider Choice

Q: If the service exists in the catchment area does the CCBHC need a DCO to facilitate the "partnership with existing services" or would a standard MOU suffice?

A: Yes. 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 to deliver one or more (or elements of) of the required services. The contract with the DCO is legally binding with the CCBHC having responsibility for quality oversight and data sharing and leading communication and integrated care services with the DCO. CCBHC services provided through a DCO must conform to the relevant applicable CCBHC criteria. The formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal, legal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized.

Demonstration CCBHCs must have referral/care coordination arrangements in place (in addition to DCO arrangements, if applicable) with all required provider types to facilitate connection to appropriate treatment and services. Refer to the SAMHSA CCBHC Criteria under Criteria 3C. Care Coordination Partnerships for the full list of required provider types.

Core Services (required)

Q: What are the core services CCBHC's are required to provide?

A: CCBHCs are required to provide at least 51% of the following nine core services directly (4.A.1, Page 26):

1. Crisis Behavioral Health Services
2. Screening, Assessment, and Diagnosis
3. Person-Centered and Family-Centered Treatment Planning
4. Outpatient Mental Health and Substance Use Services
5. Outpatient Clinic Primary Care Screening and Monitoring
6. Targeted Case Management Services
7. Psychiatric Rehabilitation Services
8. Peer Supports, Peer Counseling, and Family/Caregiver Supports
9. Intensive, Community-based Mental Health Care for Members of the Armed Forces and Veterans

Crisis Care Services

Q: Does a response via telehealth within 3 hours meet mobile crisis response criteria?

A: No, this would not meet the CCBHC criteria. While there are cases where a telehealth response might be sufficient, the CCBHC needs to have the ability, either directly or through a DCO, to provide the mobile response in person within 3 hours.

Designed Collaborating Organization (DCO)

Q: If CCBHCs make DCO arrangements to provide some of the required services, the CCBHC must be able to provide at least 51% of the services; DCOs can provide at most, 49% of the services. How is this calculated?

A: The requirement is for the CCBHC to provide 51% (or more) of all the encounters across the CCBHC-required services, exclusive of crisis.

Q: Are CCBHCs clinically responsible for services provided by DCOs?

A: Regardless of DCO relationships entered, the CCBHC maintains responsibility for assuring that people receiving services from the CCBHC receive all nine services as needed in a manner that meets the requirements of the CCBHC certification criteria – for a full definition of the DCO relationship see page 53 of the updated criteria (PDF | 1.3 MB).

Integrated Services

Q: What is included in integrated services?

A: Integrated behavioral health and primary care services. Integrated care is defined per the Agency for Healthcare Research and Quality as "the care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."

Joint Commission

Q: Where/when does joint commission fit into the process?

A: Currently, Joint Commission accreditation is not part of the certification process in Alabama.

NOMS

Q: What is the National Outcome Measures (NOMS) requirement and sampling method for the state project?

A: NOMS is not required as part of the CCBHC Demonstration program.

NPI Numbers and Taxonomy Code

Q: If a new NPI number and/or taxonomy code is needed for CCBHC, what can CCBHC Demonstration providers do to begin the process?

A: You can begin applying for a new NPI and/or taxonomy code for CCBHC services via NPPES but until Medicaid and Gainwell complete their work, no further actions can be taken.

Populations Served

Q: What populations are served through a CCBHC?

A: CCBHCs must provide services to anyone seeking help for a mental health or substance use condition regardless of condition, ability to pay, or age.

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Prospective Payment System (PPS)

Q: What is a PPS?

A: A Prospective Payment System (PPS) is a method of reimbursement in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service.

A Medicaid per-encounter rate is set based on a cost report that documents a clinic's allowable costs and qualifying patient encounters (either on a monthly or daily basis) over a year. The costs are divided by the number of qualifying encounters to arrive at a single rate which is paid to the clinic each time a monthly or daily encounter occurs, regardless of the number or intensity of services provided.

CCBHCs complete a cost report including both current costs and anticipated future costs associated with complying with the CCBHC certification criteria.

Q: How do PPS payments flow through to the DCOs?

A: CCBHCs incorporate any DCO services into their cost report so that DCO costs are captured in the PPS rate. The CCBHCs receive the PPS payment when a DCO provides a CCBHC service. The CCBHC must negotiate their payment arrangements with the DCO and include this in their contract.

Q: How will PPS rates apply to non-Medicaid members?

A: CCBHCs will bill traditional reimbursement mechanisms (e.g., Medicare, private insurance) for services provided to non-Medicaid members. CCBHCs must provide services to anyone seeking help for a mental health or substance use condition regardless of one's ability to pay.

Q: Is the PPS rate inclusive of the costs of serving the uninsured?

A: Yes. The PPS-1 daily rate is based on the expected costs of all CCBHC demonstration services irrespective of payer, including the costs of serving individuals who are uninsured. Please reference the CMS CCBHC Cost Report Instructions here for more information about what should be included in your Cost Report."

Q: Are all costs included in the cost report for all encounters across payers?

A: CCBHCs will adhere to the guidance in Certified Community Behavioral Health Clinic Cost Report Instructions published by CMS on February 1, 2024 here . Additional state guidance will be disseminated as the demonstration evolves.

Q: Will there be more than one rate for adults or children?
A: No.

Q: As additional sites are added, will the PPS be re-calculated or use the one already in effect?
A: The provider will use the PPS rate already in effect.

Q: If an FQHC is currently contracted with a CCBHC to provide primary care services on their site ("reverse integration") and currently bills at their PPS rate, will they need to change to billing through the CCBHC?
A: Yes.

Q: If the PPS rate is based on all agency allowable costs including proposed staff increases, how will this be handled for those staff who are not part of the CCBHC cost center? The PPS rate will not be applied to all services/staff which might result in a two-tiered pay scale if additional resources are not available.
A: The PPS-1 rate is calculated from the Total Allowable CCBHC Costs (the sum of lines 18, 21, and 28 on the Trial Balance tab) plus the Indirect Cost applicable to CCBHC Services (line 16 on the Indirect Cost Allocation tab), divided by the Total CCBHC visits. Therefore, you are correct that the PPS rate calculation will not account for the costs related to staff who are not part of the CCBHC cost center (outside of those who are identified as part of your indirect costs). Please refer to the CMS Cost Report guidance (here) for more information. Agencies will need to consult with their actuary on agency specific questions.

Q: Are EPSDT services in or out of the CCBHC PPS?
A: All EPSDT services are carved out of PPS.

Rebasing

Q: Do you have to conduct a new Needs Assessment when you rebase?
A: No, you do not have to conduct a new Needs Assessment when rebasing.

Q: How is the rebasing timeline established?
A: ADMH follow the guidance of CMS on rebasing found here.

Screening and Monitoring Measures

Q: In the Role of the Rule of the Medical Director Bulletin: It notes that protocols for HIV and Hepatitis screenings are recommended. Can you confirm that by "screening" you mean "questionnaire" and not the actual lab test?

A: Yes, screening can be completed via a questionnaire.

Q: Regarding the CCBHC Clinic Reporting Requirements Bulletin (DY-1/Clinical-24-15): It was noted in the past that we are only collecting the minimum required measures this first year. Only Items 1-5 as required clinic-collected and 6-10 are optional according to SAMHSA's criteria. However, under Section 3.2 all items 1-10 are listed and read as if they are all required. Can you please confirm that Measures I-SERV, DEP-REM-6, ASC, CDF-CH, CDF-AD, and SDOH are the only SAMHSA-required clinic-collected measures?

A: These are the only required measures at this time. Please refer to the SAMHSA CCBHC Quality Measure Technical Specifications Manual for additional information about these measures. In the future, ADMH may add additional measures in a phased approach.

Q: Has a decision been made on the DLA-20?

A: ADMH will not be engaging with use of the DLA-20 at this time.

Q: Will ADMH develop the health screening questionnaire??

A: ADMH will develop the required components for the EHR to track. There is a policy in place for Primary Care Screenings that can be found here.

Special Populations

Q: Is there any further information/clarification about caring for patients with Autism Under CCBHC?

A: CCBHCs must provide services to anyone seeking help. After the assessment has been completed, the CCBHC will coordinate appropriate care for the individual (i.e. referrals, etc.). ADMH will keep you informed as more guidance becomes available. Please refer to CCBHC Criteria 4.a.2.

Staffing

Q: Can the medical director of a CCBHC be fully remote?

A: The purpose of a medical director is to provide guidance to foster the integration and coordination of behavioral health and primary care and to ensure the quality of broader clinical practice at the CCBHC. This is accomplished through a combination of

consultation and protocol development as well as building and maintaining relationships with clinical and administrative staff. The medical director is expected to be a meaningful part of the behavioral health clinical service team at the CCBHC, and this requires working with the CCBHC staff on site, with interspersed virtual attendance in administrative and clinical activities. Therefore, the Medical Director needs to be on-site at least some of the time to support these functions.

Q: Do clinicians providing SUD treatment services for CCBHCs need to be licensed substance use counselors?

A: The CCBHC must have clinicians on staff who are licensed substance use counselors (Criteria 1.b.2), but there is not a requirement that all counselors providing SUD services be licensed SUD counselors. Per Alabama Rule 580-9-44.02, entities must use Qualified Substance Abuse Professionals (QSAP) to provide treatment for substance use disorder.

Substance Use Disorder Treatment Services

Q: When prescribing Medications for Opioid Use Disorder and other substance use disorders, what services can be provided by a DCO and what must be delivered directly by the CCBHC?

A: The CCBHC must have licensed addiction counselors and people who can prescribe medication for Opioid Use Disorder and Tobacco Use Disorder on their staff. They need to maintain an internal capacity to treat SUD but may provide SUD treatment services through a DCO agreement as well. Specifically, criteria 1.b.2 requires that CCBHC staff must include a medically trained behavioral healthcare provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other FDA-approved medications used to treat opioid, alcohol, and tobacco use disorders. In addition, criteria 4.f.1 states that the CCBHC directly, or through a DCO, provides outpatient behavioral health care, including psychopharmacological treatment. This would not include methadone, unless the CCBHC is also an Opioid Treatment Program (OTP).

Q: Are smoking cessation services required?

A: Yes. Criteria 4.f.1 states, "that SUD treatment and services shall be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 and include treatment of tobacco use disorders." In addition, 1.b.2 requires that CCBHCs have medically trained staff who can prescribe medications for the treatment of tobacco use disorders. CCBHCs are also required to screen from tobacco use disorders as a part of the comprehensive evaluation (Criteria 4.d.4).

Q: What substance use services are covered under the CCBHC PPS?

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

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

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

Training

Q: Will the Relias training modules for Trauma-Informed Care be acceptable to ADMH??

A: Yes, the Steering Committee voted and approved this training. ADMH to provide more details soon.

Triggering Event

Q: Can a triggering event be added for monitoring outpatient commitment patients by bachelor's/master's-level staff?

A: No. Outpatient monitoring is an allowable CCBHC activity. It alone does not trigger payment of the PPS rate. However, it is a cost that's integrated and accounted for in the Cost Reporting process and thus built into the PPS rate.

Q: Are we identifying triggering events and inserting a t-code and then billing all other services to Chapters 105, 106? Or are we billing all services on the triggering list, rolled up into a T-code and only billing non-triggering events to Ch 105,106?

A: Yes. All triggering events should be identified using the T1040 code. The services listed outside of the T1040 code should be included as a service activity which is a built-in

cost of the PPS rate and therefore must not be billed separately due to risk of duplicative billing.

Q: Regarding information from the "Scope of Services" Bulletin (DY-1/Clinical-24-2): ACT is listed as one of the four required items for additional capacity. It also states, "While under Section 223 Medicaid Demonstration, these services will be available under CMS and will be paid for through a PPS-1 payment model structure." Can we get clarification specifically around ACT (required item #4), because in the final Triggering Event List, ACT was not listed as being a triggering event and billable under the PPS model.

A: ACT is not an approved triggering event. ACT is not billable under CCBHC and will continue as fee for service. CCBHCs are required to offer a connection to ACT for individuals who may need a higher level of care.

Q: The HICC monthly code is a triggering event, but the current rate is higher than the triggering event rate. Can we bill this to Chapter 106 and not with a T-code?

A: No, this HICC has been included in your PPS rate, and as such it will need to remain for this year.

Q: At what point will the triggering events list be re-visited?

A: As the ADMH moves through Demonstration Year 1, we will review options for updating our list of triggering events for Demonstration Year 2.

Q: For telehealth services, is the trigger based on where the provider is when providing that service?

A: No. Under CCBHC, telehealth services can accompany a triggering event, however the provider **must** use the T1040 code for billing.

Note: CCBHCs do not meet the specialty type of 931-Telemedicine Services.

For agency specific questions, please contact the Office of CCBHC at ccbhc.dmh@mh.alabama.gov