OREGON HEALTH AUTHORITY

# Public notice

## Notice of intent – OHA will add Certified Community Behavioral Health Center (CCBHC) services to the Medicaid State Plan.

**Date:** April 29, 2025[1]

**Contact:** Jesse Anderson, State Plan manager

**Comments due:** 5 p.m. Friday, May 23, 2025

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Oregon Health Authority (OHA) intends to submit a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services. The SPA would add CCBHC services to the Medicaid State Plan, effective Oct. 1, 2025. The services are the same as those currently available under Oregon's Medicaid CCBHC demonstration.

OHA will also submit a request to add these services to Oregon's Alternate Benefit Plan (ABP) so that these services are also covered for adults eligible for Medicaid through the Affordable Care Act.

### Background

Oregon's Medicaid CCBHC demonstration expires Sept. 30, 2025. This change will allow Oregon to continue Medicaid coverage of CCBHC services.

OHA estimates the fiscal impact to be $4,301,279 for Federal Fiscal Year 2026. This is for reimbursement to new clinics expected to participate after Oct. 1, 2025.

[1] Updated April 30, 2025, to add information about aligning State Plan and ABP coverage.

500 Summer St NE E35, Salem OR 97301 | Voice: 503-945-5772 | Fax: 503-947-1119
All relay calls accepted | Oregon.gov/OHA

## Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services

The ABP will continue to provide full access to EPSDT services to all members under age 21 through the coordinated care organization and fee-for-service delivery systems. This includes:

- Informing them that EPSDT services are available and of the need for age-appropriate immunizations.
- Covering screening services and corrective treatment for conditions the screenings identify. This includes any services coverable under the Medicaid program found medically necessary to treat, correct or reduce illnesses and conditions discovered regardless of whether Oregon's Medicaid State Plan covers the services.

## Cost-sharing protections

Oregon does not impose cost sharing on Medicaid beneficiaries, so no exemptions are necessary to ensure cost-sharing protections for Native Americans as required by section 5006(e) of the American Recovery and Reinvestment Act of 2009.

## Obtaining SPA language

The next pages show the new State Plan language in the proposed SPA. You can also view the full State Plan, approved SPAs and proposed SPAs on the OHA website.

## How to comment:

OHA welcomes public review and input. Please send written comments by 5 p.m. Friday, May 23, 2025, to jesse.anderson@oha.oregon.gov.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED CATEGORICALLY NEEDY

DRAFT

13.d. Rehabilitative: Certified Community Behavioral Health (CCBH) services

Certified Community Behavioral Health Center (CCBHC) is an entity that providers integrated, comprehensive health services with a focus on behavioral health. CCBHC services include a comprehensive set of outpatient, community-based behavioral health services, and supports that take an integrated, whole-person approach through coordination with physical health and social service providers. Certification to operate as a CCBHC is provided by the Oregon Health Authority Behavioral Health Division and indicates that the entity meets criteria as established by the Oregon Health Authority.

Service Array

CCBHC services are inclusive of all services outlined in 13.d Rehabilitative: Behavior Rehabilitation Services in addition to services covered elsewhere in the plan as outlined in the below list.

- Crisis behavioral health services that include 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization
- Screening, assessment, and diagnosis, including risk assessment
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning
- Outpatient mental health and substance use services
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk
- Targeted case management
- Psychiatric rehabilitation services
- Peer support and counselor services and family supports

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| CCBHC Service | Service Description | Provider Qualifications |
|---|---|---|
| Crisis behavioral health services that include 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization | As described in 13.d attachment 3.1-A | As described in 13.d attachment 3.1-A |
| Screening, assessment, and diagnosis, including risk assessment | As described in 13.d attachment 3.1-A | As described in 13.d attachment 3.1-A |
| Patient-centered treatment planning or similar processes, including risk assessment and crisis planning | As described in 13.d attachment 3.1-A | As described in 13.d attachment 3.1-A |
| Outpatient mental health and substance use services | As described in 13.d attachment 3.1-A | As described in 13.d attachment 3.1-A |

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13.d. Rehabilitative: Certified Community Behavioral Health (CCBH) services

| CCBHC Service | Service Description | Provider Qualifications |
|---|---|---|
| Outpatient clinic primary care screening and monitoring of key health indicators and health risk | Physician Services<br>Laboratory Services | As described in 5.a and b |
| Targeted case management | As described in Supplement 1 to Attachment 3.1-A of this state plan | As described in Supplement 1 to Attachment 3.1-A of this state plan |
| Psychiatric rehabilitation services | As described in 13.d attachment 3.1-A | As described in 13.d attachment 3.1-A |
| Peer support and counselor services and family supports | As described in 13.d attachment 3.1-A | As described in 13.d attachment 3.1-A |
| Tobacco Cessation | As described in attachment 3.1-A, sec 13.c | As described in attachment 3.1-A, sec 13.c |

CCBHC entities may provide services directly or through contract with Designated Collaborative Organization (DCO) that provide aspects of those services. Designated Collaborative Organizations (DCO) is a distinct entity that is not under direct supervision of a CCBHC but has a formal contractual relationship with a CCBHC to provide an authorized CCBHC service.



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The CCBHC must ensure the DCO provides the same quality of care as those required by the CCHC certification. The CCBHC maintains ultimate clinical responsibility for the services provided to CCBHC recipients by the DCO under this agreement. To the extent that services are required that cannot be provided by either the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for the overall coordination of a recipient's care including services provided by the DCO or those to which it refers a recipient. Providers within the DCO's utilize pre-existing provider qualifications outlined in the State Plan.

Medically necessary rehabilitative services are provided without limitation in amount, duration, and scope in accordance with clinical treatment guidelines, indications, and usage.

Provider Eligibility

Organizational providers of CCBHC services must be not for profit or a part of a local government behavioral health authority or operate under the authority of the Indian Health Service, an Indian Tribe, or Tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self Determination Act, or an urban Indian organization pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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13.d. Rehabilitative: Certified Community Behavioral Health (CCBH) services

The Medicaid Program will provide coverage for a bundle of medically necessary rehabilitation services provided by practitioners employed by, or associated with, provider entities to be known as Certified Community Behavioral Health Centers (CCBHC). CCBHCs are provider entities certified by the Oregon Health Authority as meeting the state's qualifications for a CCBHC. The state agency will reimburse CCBCHs a clinic-specific fee schedule rate applicable to providers affiliation with the CCBHC. These cost-based rates reflect the center's unique costs. Only providers affiliated with the CCBHC who are designated as the principle behavioral health provider and holds the plan of care will be issued a facility-specific bundled daily rate.

The clinic specific CCBH Rehabilitative Services fee schedule is effective for CCBH rehabilitative service provided on or after October 1, 2025.

*Interim bundled daily rate for new clinics for year one*
To determine the interim bundled daily rate for the first year of CCBHC operations, the State will establish a rate based through cost reporting methods below or based on payments to the nearest center with a similar caseload in the event such methodology is more appropriate.

The state will allow the use of anticipated allowable cots to determine first year bundled daily rates. Additionally, the state will:

- Utilize the CCBHC Cost report as reviewed by the Centers for Medicare and Medicaid Services (CMS) to calculate the bundled per visit rate by dividing total allowable anticipated CCBHC services by total anticipated CCBHC visits.
    - Allowable CCBHC cost include total direct cost of CCBHC services plus indirect cost applicable to CCBHC services.
        - Direct CCBHC cost include the actual salaries and benefits of Medicaid qualified providers, cost of services provided under agreement, and other direct CCBHC costs such as medical supplied or professional liability insurance specific to the CCBHC program.

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The CCBHC will also be required to identify the costs of providing "non-CCBHC" services that a community behavioral health provider might provide including psychiatric residential treatment programs and habilitative services for developmentally disabled individuals.

- Indirect costs include site and administrative costs associated with providing all clinics services, including both CCBHC and non-CCBHC services. Indirect costs may also include the cost of the technology and data systems needed by the CCBHC to track and measure outcomes and other data the State requires to be tracked or measured.

- Total CCBHC visits include all visits for CCBHC services, including both Medicaid and non-Medicaid visits. A CCBHC "visit" or "encounter" for the purposes of reimbursing CCBHC services is defined as face-to-face contact with one or mor qualified health professional that take place on the same day with the same patient.

*Reconciliation of bundled daily rate following year one*
After the first year of operation, the CCBHC will be required to submit a cost report inclusive of all actual costs to provide services for the first year of operations to calculate the bundled per visit rate by dividing total allowable CCBH services by the total CCBH visits. Cost and visit data vary based on CCBHC size, location, economy, and scope of services offered and must adhere to 45 Code of Federal Regulation (CFR) 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for the US Department of Health and Human Services (HHS) Awards and 42 CFR 412 Principles of Reasonable Cost Reimbursement.

OHA will conduct a settlement based on the difference in the anticipated costs used to inform the interim year one rate and the actual year one costs as determined by the cost report. The settlement will apply to all claims from the first day of services until the day the new rates is determined, which could result in a payout or a recoupment.



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CCBHCs will continue to be reimbursed at the year one rate until the determination of payment or recoupment is determined and the final bundled daily rate is calculated. Reconciliation will be completed within 18 months of deeming the cost report complete.

Once the daily bundled rate has been calculated using actual costs on the CCBHC cost reported submitted after the end of year one, the rate effective date will be aligned with the start date of year two.

*Rate adjustment for changes in scope*
CCBH providers may request a rate adjustment for change in scope expected to change individual CCBH provider payment rates by 5 percent or more. The provider must submit information to the state regarding changes in the scope of services, including changes in the type, intensity, or duration of services, the expected cost of providing the new or modified services, and any projected increase or decrease in the number of visits resulting from the change. Projections are subject to review by a Certified Public Accounting firm and the state. Provider-specific rate adjustments for changes in scope are permitted once per year and take effect with annual rate updates.

Following an approved period of incremental cost to address changes in scope, the State will rebase clinics on actuals.

*Rebasing and Inflation Adjustments*
CCBH payments rates are rebased after the initial rate period, following a rate adjustment for a change in scope, and two years following the last rebasing. Payment rates are updated between rebasing years by tending each provider-specific rate by the Medicare Economic Index (MEI) for primary care services. Rates are trended from January 1st of the calendar year to December 31st of the same calendar year.



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CASE MANAGEMENT SERVICES

Targeted Case Management: Certified Community Behavioral Health (CCBH) services

Target Group:

Medicaid eligible adults and children with mild, moderate or serious mental illness, mild or moderate or long-term substance use disorders.

For case management services provided to individuals in medical institutions:

☐ Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

Definition of services:

Targeted case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted case Management includes the following assistance:

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CASE MANAGEMENT SERVICES

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*Comprehensive assessment and periodic reassessment* of individual needs*,* to determine the need for any medical, educational, social or other services. These assessment activities include:

These annual assessment (more frequent with significant change in condition) activities include:

- taking client history;
- identifying the individual's needs and completing related documentation; and
- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

*Development (and periodic revision) of a specific care plan that* is based on the information collected through the assessment that;

- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual.

*Referral and related activities* (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:

- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and



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*Monitoring and follow-up activities:*

Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. The activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:

- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers. Targeted case management may include contact with non-eligible individuals, that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

☐ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
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Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Provider qualifications are as described in attachment 3.1-A, sec 13.d CCBCH

Freedom of Choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of the any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
☐ Target group consists of eligible individuals with developmental disabilities Program or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures that:

- Targeted case management services will not be used to restrict an individual's access to other services under the plan; [section 1902(a)(19)]
- Individuals will not be compelled to receive target case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902(a)(19)]
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.



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Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows:
(i) The name of the individual;
(ii) The dates of the case management services;
(iii)The name of the provider agency (if relevant) and the person providing the case management service;
(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences of, coordination with other case managers;
(vii) A timeline for obtaining needed services;
(viii) A timeline for reevaluation of the plan.

Limitations:

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

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Targeted Case Management: Certified Community Behavioral Health (CCBH) services

Limitations (Cont):

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

- FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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Targeted Case Management: Certified Community Behavioral Health (CCBH) services

Targeted Case Management (TCM) services provided to Medicaid eligible adults and children with mild, moderate or serious mental illness, or mild ,moderate or long-term substance use disorders.

Reimbursement Methodology:

Reimbursement for Targeted Case Management for this Target group is as described in Attachment 4.19-B, Section 13.d. Rehabilitative: Certified Community Behavioral Health (CCBH) services.

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