Certified Community Behavioral Health Clinics (CCBHCs)

FREQUENTLY ASKED QUESTIONS (FAQ) UPDATED 10.20.2025

General

1. Clarify the definition of a CCBHC client.

   The Iowa CCBHC Provider Guide defines a CCBHC client as "an individual who has received at least one of the nine required CCBHC services from a state-certified CCBHC at any time during the Demonstration period. CCBHC quality measures define specific parameters for inclusion in quality reporting. Attribution to a CCBHC requires one enumerated visit that falls within the CCBHC scope of services regardless of location.

2. Is there any likelihood that IHHS will move the start date of CCBHC implementation? Many of us have already signed leases for additional space, hired staff, etc. to gear up for a July 1st start date. Will CMS allow IHHS to delay implementation?

   No, Iowa HHS does not plan on moving the start date for CCBHC implementation.

Cost Report

3. Will there be additional cost report training?

   Yes, Iowa HHS will continue to provide cost report technical assistance.

4. With 2 CFR Part 200, the federal government increased the de minimus rate to 15% (the increase is explained online - https://www.fema.gov/node/what-de-minimis-rate). Wouldn't the CCBHCs use the 15%?

   If your organization has a negotiated Indirect Cost Agreement, then you are required to use that negotiated rate. If not, your organization can either have the cost report allocate indirect costs, or use the de minimis rate, if they qualify to use the de minimis. We expect the CCBHC guidance and cost report to be revised to reflect the de minimis increase to 15%, but that has not been released yet. If you are considering changing your allocation method to the de minimis option, please let us know and we will get definitive guidance on what percentage should be used.

5. What, if anything, will CCBHCs need to provide for their cost report updates to Iowa HHS to justify their service counts?

   The required documentation will vary based on the change. In general, it would be helpful to have a detailed narrative of each change that includes the assumptions and the reason for the change from the original cost report submission along with any detailed calculations. CCBHCs must show how they

arrived at the new cost amount. For the counts, CCBHCs should describe their method for determining unduplicated visits and providing supporting documentation (w/o PHI) to show the calculation that ties out to the cost report visit count.

6. Previously submitted cost reports included a provisional Federal Indirect Rate effective 1/1/2022 – 12/31/2024 from a letter dated 3/24/2023. If a CCBHC received a new letter with a final 2022 rate and a new provisional rate for 1/1/2023 – 12/31/2025, which rate is the CCBHC expected to use for the revised cost report.

   CCBHCs should use the revised rate as it covers the 2024 cost reporting period.

CCBHC Billing Guide

7. Is Crisis Stabilization Community Based Services (CSCBS) a core service program? These billing codes are in the guide.

   Yes, CSCBS is a threshold service and is eligible for the PPS daily rate.

8. Regarding CPT code H0015, is this billed daily rate or a weekly rate for IOP?

   The PPS is a daily rate.

9. For Intensive Psychiatric Rehabilitation (IPR) S9480, what is the per diem? Monthly, daily, weekly…

   S9480 is Intensive Outpatient Psychiatric not IPR. All services are billed on a daily PPS rate. Intensive Psychiatric Rehabilitation (IPR) is not a threshold service and does not qualify for PPS under CCBHC.

10. What is the mental health clubhouse service per diem (H2031) billable for adults and kids? What are the licensure requirements for the facilitator?

    After additional review H2031 is not valid for Iowa Medicaid and will be removed from the code list for CCBHC. The cost of providing required peer support services should be included in the CCBHC's cost report.

11. CPT code 96101 was discontinued by the APA in 2019 and broken down into four separate codes (those are on the list). 96101 is still on the list of threshold services.

    Iowa HHS will remove CPT code 96101 from the code list for CCBHC.

12. Can we utilize bachelor level clinicians for Functional Family Therapy (FFT) with a master's level therapist as supervisor? (Three bachelor level per master's level supervisor?) If yes, do we use the modifier HN for the bachelor's level of service?

    Iowa Medicaid recently posted proposed State Plan Amendment (SPA) language to update the Multisystemic Therapy (MST) and FFT SPA. During the public comment period, Iowa Medicaid received several suggestions for revisions to help with clarity of the language in the SPA. Iowa Medicaid did take the feedback into consideration and submitted the updated SPA language to CMS who has up to 90 days to review. A decision regarding the appropriate modifier for this level of service will be made once approval has been obtained.

13. Is there a process for any potential future revisions to this guidance or other rules that may occur during the demonstration period?

The CCBHC retains a stakeholder feedback process, and the demonstration has a requirement for evaluation.

14. Can excluded services such as BHIS or CSS be billed using FFS on the same day as a CCBHC threshold service like med management or outpatient therapy?

    Providers can bill FFS for individuals who are authorized to receive BHIS or CSS using their CMHC or BH provider NPIs on the same day as they bill a threshold service (PPS) using their CCBHC NPI.

15. Are there credentialing modifiers for the service codes related to providing certain screenings?

    Providers should follow standard Medicaid billing practices unless otherwise specified in the CCBHC Billing Guide. If no modifier is listed on the appropriate fee schedule, then there is no credentialing requirement. However, the individual providing the screening / assessment must be trained in the tool and be able to utilize it to fidelity.

16. Will the State have any sort of public comment period as to the new CCBHC rules?

    The changes that have been made regarding IHH and ACT billing are policy decisions. Iowa HHS has not yet begun the rulemaking process related to CCBHC which would include a public comment period.

17. Do Iowa Health and Wellness Plan members need to be medically exempt to receive PPS under CCBHC?

    An IHAWP member does not need to be medically exempt for the CCBHC to claim PPS, unless the service requires it. B3 services, such as Peer Services, require medical exemption to bill PPS.

18. When a patient has Iowa Medicaid secondary, normally providers would bill the primary insurance using the UB-04 form for SUD IOP claims and then send secondary to Iowa Medicaid MCOs using the UB-04 form. Can the State provide guidance on how this will work within CCBHC?

    In the case of Medicare/Medicaid crossover or COBA process claims, the CCBHC would still complete a UB-04 claim for SUD IOP service submission to Medicare. All other claims sent to Medicaid/MCOs including those for SUD IOP need to be submitted on a CMS-1500 form. This includes direct billings to Medicaid, third-party claims where the CCBHC has received payment from the primary payor and is submitting to Medicaid/MCOs as the secondary payor source, as well as corrections to Medicare claims that are sent directly to MCOs.

19. Are CCBHCs able to bill PPS for individuals with Medicaid who receive care/case management with the MCOs?

    Yes, if an individual has a type of Medicaid that is eligible the CCBHC can bill PPS for individuals receiving case/care management from the MCOs or TCM.

20. Are CCBHCs to adhere to the Medicaid 15-minute rounding methodology as specified in ARC 0710C, page 2 which states that “for a 15-minute unit of service 7 or fewer minutes

are rounded down to a zero unit, and 8-14 minutes of service are rounded to a full billing unit?"

CCBHCs are to follow standard Medicaid billing practices including utilizing the rounding rule, when appropriate.

21. There are certain services, such as mobile crisis response, that Medicare does not cover and will not pay. Prior to CCBHC, providers would have submitted these claims directly to Medicaid for payment. Will this be the same for CCBHCs?

    CCBHC providers are to follow the same current billing practice of submitting "bypass" claims directly to Medicaid for specific services not covered by Medicare. These "bypass" services include mobile crisis, crisis stabilization community-based services (CSCBS), assertive community treatment (ACT), and peer services. It is important to note that if the claim includes a Medicare covered service, such as therapy or medication management these claims cannot be submitted directly to Medicaid and must follow standard billing guidance for dual or third-party liability billing for individuals with Medicare primary and Medicaid secondary.

22. There are certain providers that Medicare will NOT credential and therefore will not pay for services rendered by these providers. Prior to CCBHC, providers would have submitted these claims directly to Medicaid for payment. Will this be the same for CCBHCs?

    Medicaid will be issuing guidance related to this topic for all Medicaid providers.

23. Will the State have any sort of public comment period as to the new CCBHC rules?

    The changes that have been made regarding IHH and ACT billing are policy decisions. Iowa HHS has not yet begun the rulemaking process related to CCBHC which would include a public comment period.

Mobile Crisis

24. Can a CCBHC bill a PPS rate for Mobile Crisis Response when it is not followed up with another CCBHC service? If not, would these be funded through the BH-ASO or another entity?

    If the CCBHC is the state sanctioned mobile crisis provider they are required to bill PPS for Medicaid-enrolled individuals, either as primary or secondary, in a qualifying plan. The individual does not need to receive an additional clinical service with the CCBHC to be eligible for PPS for the mobile crisis encounter. If mobile response is provided by a DCO, and an individual indicates they are NOT already receiving services through a CCBHC and are NOT interested in follow up CCBHC services, these individuals should not be referred to the CCBHC. They would not be considered clients of the CCBHC and therefore not eligible for PPS. The service should then be billed directly, as appropriate, by the mobile crisis provider.

25. Has the state considered that Mobile Crisis patients may already be engaged in outpatient services at a non-CCBHC and not want to transfer services to the CCBHC?

    See answer to #24.

26. Does the CCBHC Mobile Crisis Team collect different information and expectations for billable CCBHC clients and non-CCBHC?

    The information gathered should meet the needs of all billing sources.

27. If the CCBHC later learns the crisis client had another IHH, will the CCBHC be expected to pay back for the service?

    If a CCBHC later learns that the crisis client was enrolled in an IHH they would not have to pay back for the service.

Assertive Community Treatment

28. The definition for face-to-face services in the CCBHC Billing Guide under ACT do not appear to include telehealth, yet it was commented verbally on 1/17/2025 that it would. Will CCBHC PPS payment abide by Iowa Code 514c.34?

    Yes, CCBHC PPS payment will abide by Iowa Code 514c.34. Direct services (e.g., med management, outpatient therapy, crisis response, etc.) within ACT that qualify for PPS can also be received via telehealth per client choice and current Medicaid rules.

29. Are telehealth meds and therapy billable?

    Yes, direct services, including med management and therapy within ACT that qualify for PPS can also be received via telehealth per client choice.

30. Are therapy phone calls or phone crisis intervention billable?

    Iowa Medicaid has a list of approved telehealth service codes with a column that notes if they are eligible for audio-only. While ACT isn't specifically referenced, service components of ACT are and could be provided as audio only if this is the only option and it is documented. This includes services such as therapy and crisis intervention calls.

31. Are pre-authorizations for ACT required under CCBHC?

    Any service, including ACT, which currently requires pre-authorization will continue to require pre-authorization within CCBHC.

32. Is ACT considered duplicative of Home Habilitation?

    Yes, this is still policy. Habilitation and ACT are considered duplicative.

33. Can CCBHCs combine the time spent with an individual over separate encounters during a day of service to ensure they meet the minimum number of minutes for ACT?

    No, there should be a minimum of 15 continuous minutes of service to be able to bill PPS.

34. Are CCBHCs limited to seeing individuals enrolled in ACT to 10 times a month?

    CCBHCs are not limited to seeing individuals enrolled in ACT to a prescribed number of times per month. CCBHCs are limited to ten PPS billings for ACT

threshold encounters. The costs for ACT services are included in the overall PPS rate and CCBHCs should provide ACT services as needed and consistent with ACT fidelity standards.

35. How will CCBHCs document ACT services they are not able to bill for?

    CCBHCs should document all ACT services provided whether or not they are billable as part of their documentation process in their EHR. CCBHCs may need to determine a process to manually count ACT service encounters for cost reporting or other reporting purposes.

Care Coordination/Case Management

36. Are CCBHCs required to serve individuals who only want care coordination and receive no direct services from the CCBHC?

    CCBHCs may serve individuals who only want care coordination services, however, CCBHC may not be the best fit for individuals who have high care coordination needs but no other connection to the CCBHC. The CCBHC should work with the referring entity to identify the individual's needs and determine the appropriate type of coordination for that individual.

Peer Services

37. Are group peer services a billable threshold service within CCBHC?

    While the costs associated with group peer activities can be included in CCBHC costs there is no code for peer group services under threshold services in the CCBHC Billing Guide making it ineligible for PPS reimbursement. However, there are two peer support codes eligible for PPS reimbursement. Both codes are for services provided on an individual basis.

Integrated Health Home (IHH)

38. Can Certified Community Behavioral Health Clinics (CCBHCs) bill and be paid the Prospective Payment Service (PPS) for individuals enrolled in an Integrated Health Home (IHH)?

    No, an individual enrolled in any IHH at any tier is not eligible for reimbursement of the PPS under CCBHC.

39. If not, can the CCBHC bill the current fee-for-service rate for any services?

    Yes, CCBHCs can bill the current fee-for-service rate for services provided to an individual enrolled in an IHH. Claims must be billed under one of the organization's other NPIs (e.g., Community Mental Health Center NPI).

40. Does this count for people enrolled in another provider's IHH program?

    Yes, individuals enrolled in any IHH at any level are not eligible for PPS under CCBHC.

41. How does the CCBHC know who is enrolled in an IHH program?

Iowa Medicaid is working with the MCO Plans to develop a method for checking IHH enrollment.

42. If a list of individuals enrolled in an IHH program is provided, how will this list be communicated moving forward?

    See answer to #41

43. How does the CCBHC know how many of their current clinical patients are enrolled in an outside IHH program?

    See answer to #41

44. What services can CCBHC not bill the PPS for if the individual is enrolled in an IHH?

    A CCBHC cannot bill PPS for any individual enrolled in an IHH for any service other than mobile crisis.

45. Does this apply to individuals enrolled in Intensive Case Management (ICM)-IHH, or non-ICM IHH, or both?

    Yes, all tiers of IHH are ineligible for PPS under CCBHC.

46. If the CCBHC's mobile crisis team is out on a call, how will they know if the individual is already enrolled in an IHH?

    Iowa HHS has determined that the IHH exclusion does not apply to mobile crisis under CCBHC.

47. If a CCBHC provides mobile crisis as a Designated Collaborating Organization (DCO) for another CCBHC and responds to a call, is that other CCBHC still obligated to pay the negotiated rate they have with the DCO if the individual is found to be enrolled in an IHH? If the CCBHC denies as they are unable to bill the PPS due to IHH enrollment, can the DCO bill the FFS even though the individual isn't their client?

    See answer to #46

48. Can a CCBHC drop the non-ICM IHH level of care and enroll those people in CCBHC care coordination?

    To continue to provide IHH the provider must provide care coordination to both non-ICM and ICM populations. A member always has a choice in what service they choose.

49. Can a CCBHC provider only offer ICM IHH moving forward?

    See answer to #48

50. Can a CCBHC keep the ICM level of IHH and not provide IHH to non-ICM IHH individuals?

    See answer to #48

51. Will IHH members continue to be retroactively attributed to an IHH for the first of the current month? If so, how will CCBHCs know a patient was retroactively enrolled in an IHH program?

A member can only be enrolled in an IHH on the first day of the month and disenrolled on the last day of the month. FFS does not allow for backdating. Iowa Medicaid is in discussions with MCO Plans about this issue.

52. If a person was not enrolled in an IHH at the time a CCBHC service was delivered and the CCBHC billed the PPS rate, and then later the individual was added to an IHH roster, does the CCBHC have to pay back the difference?

    See answer to #51

53. If so, how will this reconciliation work?

    Payment systems are being configured to deny PPS for individuals enrolled in an IHH.

54. If an individual is not enrolled in IHH but is receiving case management through a Managed Care Organization (MCO), is that case management considered "IHH" and therefore disqualifying for a CCBHC to receive the PPS for other services?

    A CCBHC may bill the PPS for any threshold services provided to an individual with MCO case management.

55. If the CCBHC terminates IHH, what prevents another agency from establishing an IHH in the CCBHC's service area?

    There is no prohibition on an agency choosing to offer IHH.

56. If the CCBHC terminates the provision of IHH, who takes responsibility of the required Targeted Case Management (TCM) for CMHW? Are the MCOs prepared to take over responsibility and to what level?

    Iowa Medicaid would work with the IHH to ensure that all members have necessary case management.

57. If CCBHCs choose to discontinue providing IHH will these members lose eligibility for HCBS for the Children's Mental Health Waiver and Habilitation without an IHH in place?

    No, those members would not lose eligibility but would have the choice to move to another IHH or to a case manager within their assigned MCO.

58. Will agencies be allowed to provide IHH on a smaller scale – offer only ICM level rather than both levels, be allowed to have a wait list, only offer it in certain counties? Or is it an all or none option – do full scale IHH or not at all?

    This question is outside the scope of CCBHC and will be diverted to IHH policy staff. Providers should direct all IHH specific questions to healthhomes@hhs.iowa.gov.

59. Agencies cannot take the financial risk of losing clients in IHH prior to June 30th and then transferring all IHH ICM clients to an MCO who would be expected to pick up cases all over the state right on July 1st. This could cause disruptions to clients receiving Habilitation services. Will there be an allowed overlap period of 90-12 days to ensure better handoffs?

This question is outside the scope of CCBHC and will be diverted to IHH policy staff. Providers should direct all IHH specific questions to healthhomes@hhs.iowa.gov.

60. Will the CCBHC know if a patient is an IHH attributed member going forward? Is this information available via the Eligibility and Verification Information System (ELVS)?

    A CCBHC can ask the member if they are enrolled with an IHH or for information regarding who they work with on a regular basis. Eligibility and Verification Information System (ELVS) shows IHH enrollment for Fee-for-Service (FFS) members only.

61. Why did the state change both IHH and ACT services so significantly for CCBHCs?

    The requirements for ACT remain the same as in Iowa Administrative Code 441-78.45. Billing procedures for ACT were changed to be consistent with the CCBHC payment model requiring a threshold service for payment of PPS. Iowa HHS has determined that CCBHC care coordination and IHH care coordination are duplicative in the following ways. SED and SMI populations are both target populations for CCBHC and IHH. Care coordination is a key function of both CCBHC and IHH. Iowa Medicaid cannot justify duplicate payments for individuals served in both programs.

62. It is understood that CCBHC could be seen as providing duplicate services within the IHH program and case management. However, the support services (outpatient mental health or substance use, peer, etc.) are not duplicative. Why is HHS deciding not to allow CCBHCs to bill the PPS rate for the other CCBHC services?

    The CCBHC is allowed to bill for these services outside of the PPS.