



Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

Certified Community Behavioral Health Clinics (CCBHC) Frequently Asked Questions (FAQs) - Cost Reports

Anticipated Costs

1. Will MDH consider removing the cap on raises for existing staff in anticipated costs?

MDH appreciates the concerns shared regarding this approach. After additional review of the approach taken in other states, MDH has determined that within anticipated costs for Demonstration Year (DY1), a limit on anticipated costs for raises for existing staff will be maintained, with some flexibility for the Maryland-specific landscape. Specifically, providers are only permitted to report raises for clinical staff that are 10% or more below the median market value as determined by the [Bureau of Labor Statistics](#); and the maximum raise would be to the median BLS market value. **However, providers may use the higher of the national or Maryland median salary for the relevant [occupational category](#).** This approach is aligned with the discretion that CMS permits states to ensure that anticipated costs are reasonable.

2. Can MDH provide additional clarity on the definition and understanding of “anticipated costs,” and how those are applied in Maryland compared to other states?

Anticipated costs are costs that did not occur in the historic period and are expected to be incurred in the first-rate period to provide required CCBHC services or bring the facility up to CCBHC certification standards. States have broad discretion in what is allowed as anticipated costs. However, CMS has placed expectation on the state that they are reviewed for reasonableness in amount, necessity, and in reasonable relation to anticipated visits when compared to historic costs per visit.

3. What is the allowance for margin/risk buffer and financial reserves under the PPS rate and cost report?

Anticipated costs reported should be reflective of actual costs expected to occur in the first year that are new costs related to becoming a CCBHC. The PPS rate is a cost-based rate, and in future years, will be based solely on historic costs/visits. The inclusion of anticipated costs in the initial rate-setting cost report should be reported as accurately as possible on what is new and expected to occur.



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PRP & RRP Guidelines

4. How are Psychiatric Rehabilitation Programs (PRPs) incorporated into the CCBHC model and cost reports?

In response to questions regarding how to document and allocate costs for psychiatric rehabilitation programs (PRPs) in cost reports due to Myers and Stauffer on May 22, 2026, the Department provides the following guidance:

- Billing codes H2018-U2 and H2018-U3 may be included as a service that triggers the prospective payment (PPS) rate.
 - All other levels of PRP and residential rehabilitation programs (RRP) are excluded as triggering events.
- H2016 is not included as a service that triggers the PPS rate.
- Costs for H2018-U2 and H2018-U3 should be included in the cost report submitted to Myers and Stauffer.

The Department has excluded other billing codes from the cost report as codes that will trigger the PPS daily rate must comply with the federal statute implementing the Demonstration, which prohibits payment for the following non-CCBHC services: inpatient care, residential treatment, room and board, or any other non-ambulatory expenses and to avoid impermissible duplication of services.

For organizations that operate a PRP and RRP with shared staff or other shared infrastructure, we recommend you consult the updated Centers for Medicare and Medicaid Services (CMS) guidance, [Section 223 Certified Community Behavioral Health Clinic \(CCBHC\) Demonstration Prospective Payment System \(PPS\) Guidance](#) (February 2024) and consult with Myers and Stauffer to assist you in determining the percentage salary costs to allocate for CCBHC cost reporting.

5. Can additional clarification be provided on the exclusion of Residential Rehabilitation Program (RRP) participants and billing codes from the CCBHC model?



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In accordance with Federal [statute](#) and [CMS guidance](#), residential services are excluded from the Certified Community Behavioral Health Clinic (CCBHC) model and accompanying prospective payment system (PPS) rate. Consequently, the Behavioral Health Administration (BHA) has determined that individuals receiving residential rehabilitation program (RRP) services will be excluded from Maryland's CCBHC model. For provider cost reports, RRP clients must be excluded, and the following PRP-RRP codes will not be included:

U7-49
U6-49
U5-52
U5-15
U4-52
U4-15

The BHA made the decision to exclude these codes, as the associated codes are designated for participants in RRP.

The PRP fee schedule includes a cascading split (U5-52, U5-15, U4-42 and U4-15) that is intended for residential participants who wish to receive RRP services from one provider and on-site Psychiatric Rehabilitation Program (PRP) services from a different provider. Participants may attend an on-site PRP with a provider that is distinct from where the participant receives off-site residential services ([Carelton Provider Manual, pg 73](#)). This option is exclusively available to individuals participating in a residential program. As such, it will not be incorporated into the CCBHC rate.

This approach mitigates the potential for confusion concerning services rendered to residential participants and ensures the CCBHC rate aligns with CMS guidance. Furthermore, this action reduces the risk of service duplication between the established CCBHC code and the existing Public Behavioral Health System (PBHS) codes.

As a reminder, attendance at an onsite PRP program is not a prerequisite for the participant to receive RRP services and may not be mandated ([Carelton Provider Manual, pg. 73](#)). Providers caring for individuals receiving RRP would still be reimbursed as they currently are in the PBHS.



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6. Can MDH clarify the rationale for keeping PRP as a monthly service under the daily PPS rate, and how CMS/SAMHSA has approved this? How does this approach compare to that of other states' PPS billing?

Many states have continued to have providers bill weekly or monthly bundles under a daily visit PPS as they were today (i.e. weekly or monthly). This is most commonly done in states that have weekly or monthly bundled rates for medication assisted treatment (MAT) or targeted case management (TCM), respectively. If a change is made, it would not only require updates to state billing logic and practices but also create inconsistency with how a service is billed within the state depending upon the provider type billed.

In response to additional concerns regarding how PRP services are counted as daily visits in the cost reports due to Myers and Stauffer on May 22, 2026, the MDH recently provided updated guidance regarding the accompanying daily visits supporting documentation to be submitted for cost reports. Specifically:

- Supporting documentation should include claims detail for both the monthly (H2018) and encounter (H2016) billing codes.
 - *Note: There should be an indication on the H2016 services whether the service is related to a H2018-U2 or H2018-U3 bundled service.*
- Two daily visit counts should be included in the supporting documentation.
 - Daily visit count that assumes H2018-U2 and H2018-U3 are the billing codes that trigger the prospective payment (PPS) rate.
 - Daily visit count that assumes the H2016 billing code triggers the PPS rate.
- Submitted cost reports should report the daily visit count that assumes H2018-U2 and H2019-U3 are the billing codes that trigger the PPS rate.

At this time, the MDH has not made the decision to alter existing guidance on how daily visits will be counted for PRP services. However, after much feedback, it has been determined that additional information should be collected with the cost report submissions to make the most informed decision possible.

Scope of Services and Activities

7. The Scope of Services and Activities (SOSA) include codes for non-EBP (mobile treatment services), but does not include EBP Assertive Community Treatment (ACT) codes. Should providers include ACT information in the cost report and call it mobile treatment? Will ACT be part of the PPS?



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If the SOSA reflects that a service is PPS-triggering, the costs and visits should be included in the cost report. If the SOSA shows that a service is not PPS-triggering and is cost-only, the costs would be considered CCBHC costs and should be included in the cost report; but no visits should be included. Services that are not listed in the SOSA should be categorized as non-CCBHC costs in the cost report.

- 8. It has already been mentioned that Targeted Case Management (TCM) in Maryland has a different definition than the Federal CCBHC TCM definition. Are you assuming that we will use the Maryland definition?**

The SOSA includes codes that have been designated as PPS-triggering for CCBHC Targeted Case Management (TCM), including Maryland TCM codes (T1016 and T1017) and other codes. If the SOSA reflects that a service is PPS-triggering, the costs and visits should be included in the cost report. The definition of care coordination for federal certification is broader so includes a larger array of activities than the Maryland definition.

- 9. Can we include the cost of staff who provide allowable CCBHC services that are not cost triggering? For example, nurses who provide enhanced case management that does not have a billable code in the SOSA.**

Yes, these costs should be included in the CCBHC cost report. Cost of care coordination activities can be included in the cost report.

Miscellaneous

- 10. The state has said that we can only use a designated collaborating organization (DCO) for Mobile Crisis. We are not the state-sanctioned Mobile Crisis provider in our county. Would a DCO with them include a PPS rate even though they are already paid for by the County? Would some sort of memorandum of understanding (MOU) suffice in lieu of a DCO payment plan?**



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The Department is requiring CCBHC providers to establish non-financial DCO arrangements with the state-sanctioned mobile crisis team in their county. Therefore, the DCO arrangement does not include a PPS and there will be no billing. An MOU will be sufficient to establish that relationship.