

COMAR 10.09.65 Certified Community Behavioral Health Clinics

(CCBHC) Effective Date: July 1, 2027

Comment Period - October 2, 2026 through October 16, 2026

Please send comments to mdh.regs@maryland.gov

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Administrative Services Organization (ASO)" means the entity under contract with the Department to provide utilization management, claims processing, and other administrative services for the Maryland public behavioral health system.

(2) "American Society of Addiction Medicine (ASAM) criteria" means an instrument designed to indicate placement guidelines for admission, continued stay, and discharge of individuals with a substance use disorder.

(3) "Behavioral Health Administration (BHA)" means the administration within the Department that establishes regulatory requirements that behavioral health programs are to maintain in order to become licensed by the Department.

(4) "Certified Community Behavioral Health Clinic (CCBHC)" means a program certified by the BHA that provides a comprehensive range of mental health and substance use disorder services in accordance with federal [Public Law 113–93](#) and state requirements.

(5) "Certified peer recovery support services" means a set of nonclinical activities provided by an individual in recovery from behavioral health concerns, who uses personal, lived experiences and training to support other individuals with behavioral health challenges.

(6) "Cost Report" means the detailed financial and statistical report of a provider's allowable costs and statistical data submitted on forms prescribed by the Department in accordance with federal regulations.

(7) "Core Service" means comprehensive and integrated mental health and substance use service areas that a CCBHC is federally required to provide or arrange.

- (8) *“Chesapeake Regional Information System for Our Patients (CRISP)” means the statewide health information exchange that facilitates the transfer of clinical information between healthcare organizations.*
- (9) *“Department” means the Maryland Department of Health, as defined in [COMAR 10.09.36.01](#), or its authorized agents acting on behalf of the Department.*
- (10) *“Designated Collaborating Organization” means 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 of the required core services.*
- (11) *“Family peer support services” means a set of nonclinical activities provided by an individual with experience as a caregiver of a child with behavioral health challenges or an individual who has experience with state or local services and systems as a consumer who has or had behavioral health challenges, who uses personal, lived experiences and training to support families and caregivers of children with behavioral health concerns.*
- (12) *“Medical Assistance” has the meaning stated in [COMAR 10.09.24.02](#).*
- (13) *“Medically necessary” has the meaning stated in [COMAR 10.09.36.01](#).*
- (14) *“Medicare Economic Index (MEI)” means the inflation adjustment index, calculated by the federal Center for Medicaid and Medicare Services, Office of the Actuary using standard Medicare payment methodology, applied annually to update the CCBHC bundled daily rate.*
- (15) *“Participant” means an individual who is certified as eligible for, and is receiving, Medical Assistance benefits.*
- (16) *“Primary Care Provider” means a physician, or other provider type, who is the primary coordinator of care for the enrollee, and whose responsibility is to provide accessible, continuous, comprehensive, and coordinated health services covering the full range of benefits required by the Maryland Medical Assistance Program.*
- (17) *“Program” has the meaning stated in [COMAR 10.09.36.01](#).*

- (18) *"Prospective Payment System 1 (PPS-1) " means the PPS-1 per-diem reimbursement methodology, an all-inclusive, daily cost-based per-visit rate established by the Department for each CCBHC.*
- (19) *"Provider" means an organization or an individual practitioner furnishing the services covered under this chapter which, through appropriate agreement with the Department, has been identified as a Program provider by the issuance of a provider account number.*
- (20) *"Psychiatric Rehabilitation Program (PRP) services" means the Psychiatric Rehabilitation Program for Adults, in accordance with COMAR 10.63.20; or Psychiatric Rehabilitation Program for Minors, in accordance with COMAR 10.63.21.*
- (21) *"Rebasing" means the periodic recalculation of the CCBHC's base PPS-1 rate using audited cost reports to ensure the rate remains aligned with the actual cost of service delivery.*
- (22) *"Targeted case management" means services which assist participants in gaining access to the full range of behavioral health services, as well as to any additional needed medical, social, financial assistance, counseling, educational, housing, and other support services.*
- (23) *"Triggering services" means the CCBHC services approved by the Department which are eligible for the PPS-1 payment.*

.02 Provider Requirements

To be eligible to participate in the Program as a CCBHC, a provider shall:

- A. Be certified as a CCBHC by BHA in accordance with COMAR 10.63.01.04C;*
- B. The CCBHC shall operate the approved programs or services otherwise licensed under COMAR 10.63.*
- C. The CCBHC shall provide the following core services:*
 - (1) Behavioral health crisis services;*
 - (2) Screening, assessment, and diagnosis services;*
 - (3) Person-centered and family-centered treatment planning services;*
 - (4) Outpatient mental health and substance use disorder services;*

- (5) Outpatient primary care screening and monitoring of key health indicators,*
- (6) Targeted Case Management;*
- (7) Psychiatric Rehabilitation Program services;*
- (8) Certified Peer Recovery Support Services and Family Peer Supports; and*
- (9) Intensive community-based behavioral health care for members of the Armed Forces and veterans.*
- D. Meet all federal and state regulations governing CCBHC service provision;*
- E. Maintain a non-financial Designated Collaborating Organization agreement with a Department approved mobile crisis team provider within the CCBHC's service area to deliver crisis services;*
- F. Meet general conditions for Program participation as set forth in [COMAR 10.09.36.03](#) [COMAR link](#)*
- G. Meet all requirements for licensing and practice as defined in COMAR 10.63.01, COMAR 10.63.02, COMAR 10.63.03, COMAR 10.63.04, COMAR 10.63.05, and COMAR 10.63.06;*
- H. Meet the conditions for participation as described in [COMAR 10.09.59.03](#) and [COMAR 10.09.80.03](#).*
- I. The provider shall maintain evidence-based practices as established in the CCBHC certification standards approved by the Department.*
- J. The provider shall deliver telehealth services in compliance with [COMAR 10.09.49](#) and any guidance issued by the Department.*
- K. The provider shall utilize CRISP to receive alerts of a participant's hospital admission, discharge, or transfer.*
- L. The CCBHC shall establish protocols for transitioning a participant to the community from hospital emergency departments and inpatient settings.*

.03 Covered Services.

- A. The provider shall be reimbursed for services under this chapter that are documented, pursuant to the requirements in this chapter and additional guidance provided by the Department.*

B. The Program shall reimburse behavioral health crisis services when delivered as crisis psychotherapy services by an eligible provider in accordance with [COMAR 10.09.59.04](#) and [COMAR 10.09.59.06](#).

C. The Program shall reimburse for screening, assessment, and diagnosis services when delivered in accordance with COMAR 10.63.04.04.

D. The Program shall reimburse for person-centered and family-centered treatment planning service when:

(1) The participant is present either in person or by telehealth at the time the services are delivered;

(2) The treatment planning documentation is completed in accordance with COMAR 10.63.04.07.

E. The Program shall reimburse for outpatient mental health and substance use services when:

(1) Outpatient mental health services is delivered in accordance with [COMAR 10.09.59.04](#) and COMAR 10.63.16.04; and

(2) Outpatient substance use disorder services is delivered in accordance with [COMAR 10.09.80.05](#) and COMAR [10.09.80.06](#) and meets the following for the ASAM level of care:

(a) Level 1 outpatient substance use disorder services shall comply with COMAR 10.63.17; or

(b) Level 2.1 outpatient substance use disorder services shall comply with COMAR 10.63.13.

F. The Program shall reimburse for outpatient primary care screening and monitoring of key health indicators when the provider reports identified health conditions and needs with the primary care provider and other health providers, as applicable.

G. The Program shall reimburse targeted case management services for mental health or substance use disorder diagnoses when providers deliver services directly to the adult and youth participants and their caregivers.

H. The Program shall reimburse PRP services when:

(1) Delivered to an adult in accordance with COMAR 10.63.20; or

(2) Delivered to a minor in accordance with COMAR 10.63.21.

I. The Program shall reimburse for certified peer recovery and family peer support services when:

(1) Delivered by a peer who is certified by BHA or a BHA-approved certification entity;

(2) Peer services are rendered under the supervision of a certified registered peer supervisor or equivalent peer supervisor approved by BHA or its designee; and

(3) Services are with direct contact with the participant, except in the case of minors wherein contact with the guardian on behalf of the minor is acceptable;

J. The provider shall ensure all services are rendered within the scope of practice by personnel with the necessary certifications, licenses, and training in accordance with State law.

.04 Participant Eligibility.

A. To be eligible for services outlined in Regulation .03 of this chapter, a participant shall:

(1) Meet the Department's medical necessity criteria; and

(2) Have a behavioral health diagnosis listed in [COMAR 10.67.08.02N](#) or COMAR [10.67.08.02O](#).

B. A participant is eligible for PRP services when the criteria in [COMAR 10.09.59.05](#) is met.

.05 Limitations.

A. The Program may not reimburse a provider for the following :

(1) Services which are not medically necessary;

(2) Services rendered but not appropriately documented to the level of service;

(3) Services not designated by the Department as triggering services;

(4) Investigational or experimental drugs and procedures;

(5) Housing services, including residential rent and utility payments;

(6) Respite care;

(7) Childcare services;

(8) Afterschool and camp programs;

(9) Elder Care services;

(10) PRP service on a day when that service is the only triggering service for a participant, who has received six or more PRP services in the month; and

(11) Targeted Case Management if the participant is receiving a comparable care coordination service under another Program authority.

B. The Program may not reimburse for CCBHC services when a participant is concurrently receiving the following:

(1) Health Home services;

(2) Residential Treatment Center services;

(3) Services that are provided in a hospital inpatient or in an intermediate care facility except on the date of admission;

(4) Residential Substance Use Disorder Programs except on the date of admission;

(5) Mental Health Partial Hospitalization Program or Psychiatric Day Treatment services; or

(6) A service in Regulation .03 when the same service is delivered by another provider.

.06 Authorization Requirements.

A. For services outlined in Regulation .03 of this chapter, the provider shall notify the ASO and obtain authorization to provide services from the ASO.

B. The ASO agent shall authorize services that are:

(1) Medically necessary; and

(2) Of a type, frequency, and duration consistent with expected results and cost-effectiveness.

C. Payment may not be rendered for services not authorized by the Department or its designee.

.07 Payment Procedures.

A. Effective July 1, 2027, the Department shall reimburse a CCBHC for covered services according to the daily PPS-1 rate established for each CCBHC by the Department.

B. The PPS-1 shall be billed once per day by a CCBHC for each day on which one or more triggering services is provided to a participant according to the Department's billing requirements.

C. Cost Reporting and Retention.

(1) The indirect costs shall be determined by the following methods according to [2 CFR §200.414](#):

(a) A rate agreement with the U.S. Department of Health and Human Services;

(b) A de minimis rate of up to 15 percent of modified total direct costs, available only to a CCBHC that has never received a negotiated indirect cost rate and meets eligibility requirements per [2 CFR §200.414](#);

(c) If no other methodologies are reasonable, then the provider may utilize an alternative allocation methodology approved by the Department; and

(d) The appropriate methodology shall be applied to all facility and administrative costs included in the cost report.

(2) The provider shall accurately document and submit zero-dollar claims for all procedure codes for services as described in §B in order to bill the PPS-1 procedure code.

(3) The provider shall submit annual cost reports, and the Department shall review the reports and establish the reimbursement rate, in accordance with the Centers for Medicare and Medicaid Services cost principles under [2 CFR Part 200](#) and [42 CFR Part 413](#) and state requirements.

(4) The provider shall keep all financial and statistical records available for inspection for six years.

D. Rate Adjustments and Penalties.

(1) Rates shall be adjusted annually by the MEI at the beginning of each fiscal year.

(a) The MEI shall be applied first to the interim rate in the fiscal year in which the rebased rate is being finalized.

(b) The rebased rate shall be applied retroactively for the entire fiscal year.

(c) Rate rebasing shall occur at least once every three years by the Department.

(2) The Department shall reduce the provider's current prospective rate by 20 percent if:

(a) A cost report is not received within six months of the fiscal year; or

(b) A clinic-collected quality measures report is not received within six months after the end of the fiscal year.

E. General policies governing payment procedures that are applicable to all providers are set forth in [COMAR 10.09.36.04](#).

F. Billing time limitations for claims submitted under this chapter are set forth in [COMAR 10.09.36.06](#).

.08 Recovery and Reimbursement.

Recovery and reimbursement are as set forth in [COMAR 10.09.36.07](#).

.09 Cause for Suspension or Removal and Imposition of Sanctions.

Causes for suspension or removal and imposition of sanctions are as set forth in COMAR [10.09.36.08](#), COMAR 10.63.38 and COMAR 10.63.39 as appropriate.

.10 Appeal Procedures for Providers.

Appeal procedures for providers are as set forth in [COMAR 10.09.36.09](#).

.11 Appeal Rights — Denial of Services.

Appeal procedures for applicants and participants are as set forth in [COMAR 10.01.04](#).

.12 Interpretive Regulation.

State regulations are interpreted as set forth in [COMAR 10.09.36.10](#).