

Medicaid Billing Readiness: A Practical Guide for Community-Based Organizations Serving People with Behavioral Health Needs

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Community-based organizations (CBOs) play a critical role in expanding access to behavioral health services and supports for Medicaid members, as well as strengthening clinical and community care coordination. In recent years, states have expanded Medicaid coverage and reimbursement pathways for community-based services, including [peer recovery support](#) and [community health worker services](#). As a result, more CBOs have opportunities to receive Medicaid reimbursement either as enrolled providers or through partnerships with managed care organizations (MCOs), health systems, or a network of community organizations.

While these opportunities can support greater sustainability for CBOs, navigating Medicaid enrollment and billing requirements can be complex, time-consuming, and resource intensive.

This tool offers practical planning and implementation guidance to help CBOs assess, prepare for, and build Medicaid billing capacity. Designed for leaders and staff at CBOs — including syringe services programs (SSPs), harm reduction organizations, peer-led programs, and other behavioral health and social service providers — the tool draws on lessons from an initiative that helped CBOs in Wisconsin and SSPs in Michigan build their capacity to bill Medicaid for reimbursable services. It offers a decision-making tool to help CBOs explore and select the billing approach that best fits their goals and capacity, along with recommendations in five areas of particular importance for organizations seeking to build the internal infrastructure needed to bill Medicaid directly.



ABOUT THIS RESOURCE

This tool is part of a series developed by the Center for Health Care Strategies (CHCS) and The McSilver Institute for Poverty Policy and Research at New York University, with support from Vital Strategies. The series draws on technical assistance provided to peer support and harm reduction organizations in Michigan and Wisconsin that sought to build capacity to directly bill Medicaid for services, strengthen partnerships with Medicaid health care providers, and expand access to services for Medicaid members.

Choosing the Right Medicaid Billing Approach

Determining how an organization will access Medicaid reimbursement is a critical decision because it affects the staffing, infrastructure, resources, and operational changes required for implementation. In addition, Medicaid reimbursement can impact organizational culture. The most appropriate Medicaid billing approach will depend on an organization's capacity, resources, desired level of autonomy, and long-term sustainability goals.

The options below outline two approaches for CBOs: **billing Medicaid directly** or **partnering or subcontracting with health care entities or other CBOs**. Each approach presents distinct pathways, considerations, and trade-offs to help organizations identify the model that is best aligned with their needs, capacity, and long-term vision. Smaller or newer organizations without established billing infrastructure may benefit from beginning with the partnership approach. Organizations with greater financial resources, internal capacity, and existing infrastructure may be better positioned to strengthen their systems and pursue direct Medicaid billing. The strategies in the rest of this tool pertain mainly to organizations preparing to bill Medicaid directly.

Option 1: Bill Medicaid Directly

With this approach, a CBO develops the structures, systems, and processes needed to bill Medicaid directly for covered services. The following outlines approaches CBOs can take to build this capacity.

- **Develop internal infrastructure:** This may include investing in an electronic health record (EHR) platform to track and document visits, ensuring staff are properly credentialed and supported by required clinical oversight, and establishing procedures that comply with Medicaid requirements. By taking this approach, a CBO gains greater autonomy and control over its operations, financial management, data collection and reporting, and overall strategic direction. This option often includes upfront costs, such as investments in billing staff and IT infrastructure. It may also involve a steep learning curve as staff across the organization adapt to new workflows and standard operating procedures, such as accurately documenting services, following billing and coding requirements, and observing data privacy rules.
- **Outsource key operational functions:** Instead of developing the internal infrastructure, a CBO obtains Medicaid operational and billing support through third-party vendors or consultants. Under this model, the CBO contracts with an external entity, such as a billing company, to manage billing-related processes and activities, including verifying coverage and submitting visits for payments. The CBO may also outsource other functions to enable faster implementation and provide access to specialized third-party expertise. However, it may also result in less autonomy over billing processes, data management, and reduced revenue due to outsourcing costs, which typically range from seven to 10 percent of collected Medicaid reimbursement. Additionally, the CBO retains primary responsibility for complying with all audit requests and requirements.

Option 2: Partner or Subcontract with CBOs or Health Care Providers

With this option, a CBO contracts with an established Medicaid provider or other CBOs that have the billing systems and infrastructure needed to support the delivery of Medicaid-covered services.

- **Partner with other CBOs:** CBOs may come together to create a centralized infrastructure organization, usually referred to as managed services organizations or administrative services organizations. Under this approach, participating organizations may form a new entity that pools their resources to provide centralized support for Medicaid billing, including billing operations, documentation systems, contracting, credentialing, quality improvement and compliance functions. This may be cost-effective for CBOs because they share costs and resources with a broader pool of providers, that may include access to EHR and billing platforms.
- **Partner with a Medicaid Billing Organization:** In this option, a CBO contracts with an established Medicaid provider, such as a [Certified Community Behavioral Health Clinic \(CCBHC\)](#), [federally qualified health center \(FQHC\)](#), hospital, or other Medicaid billing organization, to deliver services on its behalf. Because the partner already has the necessary billing infrastructure in place, the CBO may be able to deliver Medicaid services without developing its own billing system. The CBO typically uses the partner organization's EHR, billing system, credentialing, and other administrative capacity.

Preparing for Medicaid Billing

If a CBO decides to pursue direct Medicaid billing, developing an implementation roadmap can help address billing requirements for eligible services and identify the organizational, operational, and administrative components necessary for success. Key planning efforts include:

1. [Leadership, Board, and Staff Engagement](#)
2. [Infrastructure and Staffing Capacity](#)
3. [Internal Policies and Procedures](#)
4. [Billing and Financial Management](#)
5. [Documentation Standards for Medicaid Billing](#)

1. Leadership, Board, and Staff Engagement

Staff and board engagement are essential for a successful transition to Medicaid billing and overall organizational readiness. Effective engagement helps foster culture change and strengthen alignment across governance, operational, clinical, and administrative functions. Board members may bring valuable experience from working with health care organizations or other Medicaid-enrolled providers and can offer informed perspectives on whether and how the organization should pursue Medicaid billing. Board members and organizational leaders can help assess the risks and benefits of Medicaid participation, including financial sustainability, compliance requirements, and operational impacts. Engaging leadership, board members, and staff throughout the process supports informed decision-making, effective resource allocation, and the potential for long-term sustainability in Medicaid participation.

The following recommendations can help CBOs build internal support for Medicaid billing and assess its financial implications.

Recommendations

- **Engage early.** When appropriate, engage board members early to support strategic decision-making and secure formal approval for Medicaid participation. It is equally important to begin conversations with staff early to explore how Medicaid billing may affect the organization. Early engagement can help clarify responsibilities, build buy-in, and strengthen accountability as the organization moves from planning to implementation.
- **Develop clear and consistent messaging.** Acknowledge and address staff concerns about the operational and administrative changes that may result from becoming a Medicaid-enrolled provider. Medicaid billing may change how staff work, how the organization operates, and the level of clinical integration and oversight required. These changes could conflict with the organization's current service delivery model and affect staff's day-to-day responsibilities. Consistent messaging can help staff understand that Medicaid billing can create an additional revenue stream and increase opportunities to expand and grow services.
- **Evaluate the financial implications.** Medicaid can provide a more stable source of recurring revenue than grant funding, but it also requires increased infrastructure and administrative capacity. Conduct a financial analysis to estimate the volume of potentially billable services and revenue needed to offset new and ongoing costs, such as software, billing staff, and other administrative expenses. Review your state Medicaid agency's website or provider portal for provider manuals, fee schedules, and procedure code lists that identify covered services and reimbursement rates. In many Medicaid managed care environments, reimbursement rates are generally established by state Medicaid requirements. Organizations should first review applicable state Medicaid fee schedules and reimbursement guidance to understand the rates for covered services. Rates may also be available in provider manuals, shared during contracting discussions, or negotiated through the contracting process.



2. Infrastructure and Staffing Capacity

Medicaid billing and managed care contracting require specialized knowledge and expertise to navigate program requirements and billing rules. Reimbursement of services may also require clinical supervision, review or authorization by a licensed clinician/physician, and secure systems for collecting, storing, and managing client information. Organizations should assess whether they have the infrastructure and staffing capacity to meet these requirements and maintain ongoing compliance.

The following recommendations can help CBOs assess and build the staffing, technology, and administrative infrastructure required for Medicaid billing.

Recommendations

- **Assess and address staffing needs.** Inventory current staff positions, licenses, and credentials to identify which roles can support Medicaid-billable services and where additional staffing, credentialing, or supervision may be required. For example, billing for peer recovery support services may require a licensed mental health professional to provide supervision and review treatment plans. Assess which functions can be supported by existing staff and where additional capacity may be needed, including provider credentialing and enrollment, billing, quality assurance, finance management, compliance, legal support, and utilization management or prior authorization.



- **Manage credentialing and provider enrollment.** Credentialing verifies that individual providers, supervisors, agencies, organizations, and contracted staff meet requirements to deliver Medicaid-billable services. This may be required by both the state Medicaid agency and each MCO with which the organization contracts. The process may include reviewing licensure, certification, education, training, scope of practice, work history, liability coverage, and Medicaid participation eligibility. Establish a process to manage staff credentials and maintain key documentation, such as operating licenses, tax ID/EIN, and liability insurance. This should include procedures for monitoring expiration dates of licenses and certification, and maintaining current documentation on file to avoid any liability issues.
- **Address technology infrastructure.** Assess whether the organization's current technology systems can support Medicaid enrollment, billing, service documentation, and other administrative requirements. This may include implementing or upgrading an EHR system that can collect insurance information, document services, assign appropriate billing codes, and securely maintain required records.

Resources to Support Learning and Implementation

- [National Provider Identifier Standard \(NPI\)](#): Describes what an NPI is, how it is used and provides related resources for obtaining an NPI. (*Centers for Medicare & Medicaid Services (CMS)*)
- [National Practitioner Data Bank](#): A repository of federal data that contains reports on certain adverse actions and medical malpractice payments involving health care practitioners and organizations. It can be used to verify practitioners' professional backgrounds and support the credentialing process. (*U.S. Department of Health and Human Services (HHS)*)
- [Provider Enrollment and Credentialing in Medicaid](#): Provides an overview of federal requirements, processes, and common provider challenges related to Medicaid enrollment and credentialing. (*Medicaid and CHIP Payment and Access Commission*)
- [CBO Clinical Services Expansion Playbook](#): A comprehensive toolkit informed by readiness assessments conducted with three Illinois CBOs, providing guidance and checklists on third-party billing setup, coding and collections, credentialing and payer contracting, and technology upgrades to support billing operations. (*Illinois Department of Public Health/Illinois Public Health Association*)
- [Data Elements to Support Documentation, Track Funding Sources and Meet Funder Requirements](#): Explains the key differences between data systems for services (e.g., EHRs, health information exchanges) and common data elements to track for billing. (*California Health Care Foundation*)

Common Provider Credentialing Requirements

As part of the provider credentialing process, organizations are frequently asked to submit the following:

- Operating certificates/licenses
- Tax ID/EIN
- Liability insurance
- Policies and procedures
- Compliance program documentation
- Individual qualifications (e.g., degrees, licenses, certifications)

Adapted from a presentation by the McSilver Institute for Poverty Policy and Research at New York University.

3. Internal Policies and Procedures

Becoming a Medicaid provider may require significant administrative changes, including developing and implementing new policies and procedures. Medicaid providers must comply with the [Health Insurance Portability and Accountability Act \(HIPAA\)](#), which establishes national standards for protecting health information,

and, when applicable, [Title 42 of the Code of Federal Regulations \(CFR\) Part 2](#), which protects the confidentiality of individuals receiving substance use disorder education, prevention, training, treatment, rehabilitation or participating in research.

Medicaid providers are also expected to maintain a compliance program that meets applicable federal and state requirements related to [fraud, waste, and abuse](#). The goal of a compliance program is to ensure that providers have the structures and systems needed to minimize risks, address improper payments and billing errors, and protect the integrity of the Medicaid program.

As CBOs prepare to implement Medicaid billing, they should integrate these and other Medicaid policies, procedures, and compliance requirements into their operations. The following recommendations outline key steps CBOs can take to support this process.

Recommendations

- **Establish a compliance**

program. Integrate the program into the organization's day-to-day operations and ensure it is supported by senior leadership and the governing body. Compliance responsibilities may be assigned to appropriately trained existing staff or managed by a standalone department or dedicated staff with specialized expertise. Consult the appropriate state agencies and review applicable requirements to ensure that the organization's compliance program aligns with state policies and standards. Each state establishes its own operating standards and designates an entity to oversee compliance and conduct audits, often through the state's Office of Inspector General. Design and implement policies and procedures that support accurate billing, the prompt identification and correction of billing errors, improper conduct, and inappropriate payments. The compliance program should also establish disciplinary standards for violations of organizational policies or legal requirements. Beyond meeting legal and regulatory requirements, an effective compliance program can improve organizational effectiveness, demonstrate a strong record of compliance, and identify issues early. Early detection helps minimize financial losses to the Medicaid program and reduces the organization's exposure to repayment obligations, civil damages, and penalties such as sanctions and termination and exclusion of provider enrollment in the Medicaid program.



Key Components of an Effective Compliance Program

At a minimum, a compliance program must meet all applicable state requirements and should include the following elements:

- Written policies, procedures, and standards of conduct
- A designated compliance officer and compliance committee
- Compliance program training and education
- Clear channels for communication and reporting concerns
- Consistent disciplinary standards
- Routine auditing and monitoring
- Processes for investigating and responding to compliance issues
- Ongoing staff education and training

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- **Implement privacy and confidentiality policies.** Review applicable HIPAA and, if relevant, 42 CFR Part 2 requirements, and develop internal guidance to support compliance. Train staff on HIPAA and

42 CFR Part 2, as applicable, and obtain legal consultation to help staff navigate issues such as information sharing, record retention, and confidentiality.

- **Determine how the organization will conduct utilization reviews.** Utilization review is an ongoing quality assurance and compliance process that assesses the necessity, appropriateness, effectiveness, and efficiency of health care services, procedures, settings or programs. It can be incorporated into an organization’s broader quality improvement efforts and conducted throughout the service delivery lifecycle. Although a formal utilization review program is not a general requirement for all Medicaid providers, internal reviews can help CBOs confirm that services delivered are medically necessary, properly authorized, adequately documented, and billed correctly. They can also help prepare for audits, identify potential fraud, waste, and abuse risks, address operational or documentation gaps, and strengthen the delivery of Medicaid-billable services. Consider developing a written utilization review plan that defines roles and responsibilities, frequency of reviews, documentation procedures, oversight mechanisms, and corrective action processes.

Resources to Support Learning and Implementation

- [Office of Inspector General Compliance Resources](#): Provides guidance, training materials, and tools to help health care organizations comply with federal program requirements and prevent fraud, waste, and abuse. (*U.S. Department of Health and Human Services, Office of Inspector General*)
- [Uses and Disclosures for Treatment, Payment, and Health Care Operations](#): Explains when protected health information may be used or disclosed under HIPAA for treatment, payment, and operations. (*HHS*)
- [Understanding Confidentiality of Substance Use Disorder \(SUD\) Patient Records or “Part 2”](#): Explains 42 CFR Part 2 requirements for protecting the confidentiality of SUD patient records. (*HHS*)
- [Understanding Changes to 42 CFR Part 2](#): Reviews recent changes to 42 CFR Part 2 and their implications for the confidentiality of substance use disorder records. (*Legal Action Center*)
- [HIPAA for Professionals](#): Outlines federal standards for protecting the privacy and security of health information and provides detailed guidance and resources to support implementation. (*HHS*)
- [Medicaid Integrity Program - Educational Resources](#): Provides guidance, tools, and training materials on preventing fraud, waste, abuse, and improper payments. (*CMS*)

4. Billing and Financial Management

Effective billing and financial management processes ensure that CBOs submit accurate claims, effectively manage contracts with MCOs, monitor reimbursement, and maintain financial stability. Organizations should assess whether they have the infrastructure, staff expertise, and workflows needed to manage the revenue cycle and address any identified gaps.

Revenue cycle management (RCM) is the process of tracking a client’s services and related payments, from verification of coverage and authorization through claim submission, payment, and reporting. Because there may be a significant delay between delivering a service and receiving payment, organizations should plan for cash-flow gaps. Effective RCM helps ensure services are accurately captured and fully reimbursed.

The following recommendations highlight key processes and tools CBOs can establish to manage Medicaid eligibility, billing, reimbursement, and revenue effectively.

Recommendations



- **Establish processes for verifying coverage.** Integrate the collection and verification of Medicaid insurance information into intake and enrollment workflows. Ideally, coverage information should be confirmed before services are delivered and periodically throughout the individual's engagement in care and services. If a client's Medicaid coverage is inactive, establish referral pathways to connect the client with appropriate assistance to apply for or reinstate coverage. Collecting this information may represent a significant change for the organization and the people it serves, particularly if the organization is accustomed to providing low-barrier services without collecting personally identifiable information. Clearly communicate the reasons for this change to new and existing program participants, and train staff to explain the requirements with transparency and sensitivity. Establish processes for:

- Obtaining and securely storing copies of Medicaid ID cards;
- Accessing state eligibility systems, Medicaid, MCO portals, or EHR systems to verify insurance coverage;
- Confirming MCO requirements, such as whether prior authorization is required by one MCO but not another; and
- Identifying coverage changes.

- **Ensure that effective revenue cycle management processes are in place.**

Develop workflows that integrate administrative, clinical, billing, compliance, quality assurance, and operational teams to accurately capture, manage, and collect revenue. Establish formal processes for each phase of the revenue management cycle, from obtaining authorizations before a visit to reviewing performance data and identifying opportunities for quality improvement.

- **Create a chargemaster that lists all billable services and associated charges.** A chargemaster is a centralized source for billing codes, rates, and service definitions. A well-maintained chargemaster can support accurate claim submission and reimbursement, reduce billing errors and claim denials, and improve revenue capture by ensuring that all billable services are identified and billed appropriately. When developing the chargemaster, involve representatives from the organization with knowledge and/or expertise in finance, billing, operations, and programming. Although an organization may not have dedicated departments or roles for each area, cross-functional representation from staff familiar with its operations, service delivery, and finances can support effective chargemaster development and management.

Tips for Successful Revenue Cycle Management

To support accurate and timely reimbursement:

- Review revenue cycle performance regularly, rather than semiannually or annually, to monitor claim status, denials, appeals, payments, and outstanding balances.
- Keep EHR and billing systems current with applicable regulatory and payer requirements.
- Review claims reports regularly and promptly to address rejected or denied claims.
- Correct errors and resubmit claims within required time frames.
- Promptly review payer remittance advice, which explains how claims were processed and paid, to allow time for corrections, resubmissions, and appeals.

Adapted from a presentation by the McSilver Institute for Poverty Policy and Research at New York University.

Resources to Support Learning and Implementation

- [Community Based Organization Workflow: Community Health Integration Codes](#): Although specific to Medicare billing, this resource provides a useful workflow for understanding billing preparation and the claims submission process. (*Minnesota Department of Health*)
- [Community Care Hub IT Playbook](#): Details operational processes that support collaboration between CBOs and health care partners on Medicaid billing, including revenue cycle management, claims processing, and billing procedures. (*Administration for Community Living*)
- [New Jersey DMHAS Code and Rate Table](#): Provides an example that CBOs can use as a model when developing their chargemasters. (*New Jersey Division of Mental Health and Addiction Services*)
- [Medicaid Integrity Program - Educational Resources](#): Provides guidance, tools, and training materials on preventing fraud, waste, abuse, and improper payments. (*CMS*)

5. Documentation Standards for Medicaid Billing

Documentation serves multiple purposes, including tracking an individual's progress toward their goals, facilitating communication among providers, and demonstrating compliance with requirements for Medicaid reimbursement. Providers must document all billable services in accordance with applicable Medicaid program requirements and behavioral health provider standards. As CBOs prepare to become Medicaid providers, they have the opportunity to foster a culture in which documentation is a shared responsibility and an integral component of service delivery. This approach can support the consistent application of documentation practices and the timely billing of services.

The following recommendations can help organizations develop documentation standards that comply with Medicaid requirements while supporting individuals in their recovery and progress toward their goals.

Recommendations

- **Become knowledgeable about and follow documentation requirements for all billable services.** Consult the provider portal, relevant policy manual, or state Medicaid agency website to identify documentation requirements for each Medicaid-covered service. For example, for reimbursement for community health worker services, the client's record may need to describe the nature and duration of the services provided and include the required recommendation or authorization. Medicaid may also require the service note to be reviewed, signed, and dated by the licensed clinician supervising the community health worker to serve as acceptable documentation of the service and its medical necessity.
- **Develop clear documentation guidelines and workflows.** Create guidelines to ensure that staff understand and consistently meet documentation requirements, and clear workflows that define staff roles and responsibilities. For example, providers should document the care and interventions delivered; supervisors, including clinical supervisors if required by Medicaid, should review documentation for quality and provide required approvals; quality improvement teams, when applicable, should monitor records for trends and compliance; and billing staff should verify accurate coding before submitting claims. Overall, documentation should demonstrate a cohesive narrative that links a participant's assessment, service and treatment plan, and progress notes from initial needs to interventions and outcomes.



- **Provide staff training and individualized support to promote high-quality documentation.**

Documenting client services for billing purposes may be a new process for the organization and its staff. Provide organization-wide training and one-on-one support as staff implement new documentation practices. Training should place particular emphasis on documenting medical necessity, including how to clearly demonstrate why each service is necessary to address an identified condition and how the individual's diagnosis and symptoms relate to their functional challenges and the services provided. Ensuring high-quality documentation supports timely payment and reduces the risk of claim denials, payment delays, or recoupments.

Documenting Medical Necessity

Demonstrating medical necessity is essential for Medicaid reimbursement. The examples below illustrate the difference between documentation that clearly supports medical necessity and documentation that is insufficient for billing purposes.

Does Not Adequately Demonstrate Medical Necessity	Demonstrates Medical Necessity
Individual is upset and needs counseling	Individual presents with persistent anxiety interfering with sleep and ability to focus at work. Weekly psychotherapy is needed to reduce symptoms and restore daily functioning.
Individual attends group therapy weekly	Individual participates in weekly group therapy to build coping skills and reduce isolation, supporting progress toward treatment goals.
Individual refuses medication	Individual declines prescribed medication at this time. Ongoing therapy is necessary to manage depressive symptoms and prevent hospitalization.
Individual needs support with life stress	Individual reports difficulty managing stress related to job loss, resulting in increased panic attacks. Services are needed to stabilize symptoms and improve coping.

Adapted from a presentation by The McSilver Institute for Poverty Policy and Research at New York University.

Resources to Support Learning and Implementation

- [Documentation Matters Toolkit](#): Includes resource guides, fact sheets, training materials, and case studies to support complete, accurate, and timely documentation of patient encounters. (CMS)
- [Strengthening Effective Peer Support Documentation Practices](#): Explains the connection between assessments, treatment or service plans, and progress notes. It also discusses medical necessity and highlights necessary components to include in progress notes to meet Medicaid billing requirements for peer recovery support services. (Peer Support Services Technical Assistance Center)

Conclusion

Becoming a Medicaid provider is more than a financial decision. It is an organizational transformation that can affect a CBO's culture, staffing, and operations. Although Medicaid reimbursement can create new financial opportunities, it comes with increased administrative responsibilities, compliance obligations, staffing and expertise requirements, technology costs, and the need for new or revised policies and processes.

There is no one-size-fits-all approach to building the infrastructure for Medicaid billing. CBOs should select a pathway that aligns with their service model, financial resources, workforce, and administrative capacity. Their approach may evolve as internal capacity and resources grow or as changes in Medicaid policy create new coverage, contracting, or reimbursement opportunities. Organizations can use this tool to establish implementation priorities and adapt their Medicaid strategy as their resources, organizational needs, and the broader policy environment evolve.

Additional Resources from CMS

- [Managed Care Landing Page](#): Offers a detailed explanation of the managed care delivery system and how it operates, along with related resources and state-specific data on managed care program components.
- [Managed Care Enrollment by Program and Plan](#): A dataset with state-level information on Medicaid managed care programs such as the plan names, parent organizations, geographic service areas, and enrollment.
- [State Medicaid Agency Directory](#): A directory with contact information for each state and territory's Medicaid agency.



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The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit www.chcs.org.