RI CCBHC Cost Reporting – FAQs
Last Updated: 02/15/2023

	Question	Answer
1	PPS-1 vs. PPS-2: Why PPS-2?	The State selected the PPS-2 rate-setting methodology because this structure will allow us to best meet the needs of both Medicaid members and providers. Specifically, PPS-2: • Allows for varying rates for special populations with specific needs; • Is similar in structure to Rhode Island's Health Home Program bundles, IHH and ACT, and was initially proposed in RI's original CCBHC demonstration application, so there is some familiarity among both providers and the State; and • Requires a quality component to incentivize value and pay providers beyond the PPS rate for high quality, aligning the model with value-based care initiatives occurring within RI Medicaid.
2	What if all DCOs haven't been identified by the time of cost report submission? Is there an opportunity for more to be added later?	New DCOs can be added during each annual cost reporting cycle. If a required CCBHC service is provided by a DCO, the cost of that DCO arrangement must be included in the cost report. This means the CCBHC includes the payment rate it has established with the DCO for the agreed upon services (not the underlying costs of the DCO), or the anticipated cost of the service. See CMS Cost Report Instructions and Supplemental Technical Guidance for additional clarification re: how to project and incorporate DCO costs in the cost report.
3	EBP Training/ Coaching/ Fidelity	See Technical Guidance for additional clarification re: allowable EBP training costs. "CCBHCs may adopt additional EBPs beyond the minimum standard. Training and licensing costs for EBPs permitted by BHDDH according to established standards will qualify as an allowable CCBHC cost."
4	MCO Funds Flow/Integration	The PPS-2 rate will be fully incorporated in the Managed Care capitation rates; each MCO will be responsible for paying the provider specific PPS-2 rate to each certified CCBHC according to program specifications.
5	What is the role of the MCO in authorizing services, utilization review and management, outcome measurement, and compliance and quality improvement?	This is under discussion. The CCBHC Interagency Team will release additional guidance/details ASAP.
6	Attribution: What is the process of designating and changing attribution, and/or appealing the decision?	There are two processes: 1. Initial attribution will be based on a combination of BHOLD and claims. BHDDH will send each provider a list of attributed members. Providers will add/update the files and submit back to BHDDH.

		2. Ongoing attribution will be the provider's responsibility in most cases. We will utilize the Gainwell Eligibility Portal (same one used for IHH/ACT today).
7	Allowable Services: Can CCBHCs include the cost of services that are not required but allowed in the cost report, or would there need to be a discussion with BHDDH or DCYF ahead of time? If so, what would be the process?	Yes, however the State will make a determination as to which new costs will be approved in the final cost report.
8	Payment: What constitutes a monthly billable visit?	Page 4, Appendix B of the Cost Report Technical Guidance discusses billable visits. The State also released a FFS Fee Schedule Crosswalk to CCBHC Services.
9	General Population Services: What services would be provided to adults with severe mental illness but who do not meet the high acuity category, as they can generally self-manage their symptoms more adequately than most? Can they be provided case management and care coordination services as part of the general population category if the CCBHC builds that into the staffing level in addition to ACT and ICCT team staffing?	CCBHCs need to provide the required services to all individuals with BH conditions; this includes individuals who do not meet the high-acuity category needing case management and care coordination. The cost of those services need to be accounted for in the General Population rate. Team structure or specific services are not prescribed for the General Population.
10	Should Healthy Transitions (HT) costs be included with High Acuity Adults or High Acuity Children population? Or split across the groups given HT serves individuals 16 to 25 years old?	Individuals receiving Healthy Transition services (and their associated costs) should be included in the high acuity adult group, regardless of age. This exception was added to V2 of the Technical Guidance (dated 1/13).
11	Are there directions for providers completing the cost report who now operate one of the required CCBHC programs that is now partially or fully grant funded, with that grant ending sometime in the near future?	Page 18 of the CMS Cost Report Instructions, Allocation Descriptions Tab, notes that the CCBHC should offset salary costs by applicable revenues, such as grants received. As such, if a grant is expiring, and those revenues are not anticipated to be available in SFY 2024, the associated costs are allowable. If the grant revenues are expected for part of a year, the associated costs would also be allowable for the portion of the year when the grant funding is expired. Note, if applicable, these details should be included in the cost report comments tab, detailing the worksheets and lines in which the costs are included.
12	Can treatment teams blend IHH and ACT services or must teams be delineated based on level of care?	No, teams cannot be blended. ACT is an evidence-based model.
13	What are the fidelity tools for the required evidence-based practices?	The fidelity tools are not yet finalized. The State will work closely with providers on plans to roll-out tools and trainings. Cost report submissions must include anticipated training costs as applicable.

14	Do staff need to be fully certified in best practice areas or will internal training and demonstration of fidelity suffice?	Staff should be sufficiently trained in the evidence-based practices (EBPs) to competently perform that specific clinical practice, initially with coaching and supervision. There is no requirement at present that would require each practitioner be fully certified. The CCBHC's implementation along with practice requirements and standards should be reflected in their plan which will be required as part of the application.
15	What costs are considered "above State-defined threshold" falling into the "outlier" category?	This question is answered in Appendix E "Outlier Thresholds and Allocation Guidance".
16	For group home clients, will the existing daily MHPRR rate be billable in addition to the high acuity PPS-2 rate?	Yes. MHPRR services are not included in the PPS-2 rate.
17	It seems that the state requirements differ from the federal CCBHC model. Can you help clarify the rationale for that difference?	The RI CCBHC Standards comply with all aspects of the current federal model. SAMHSA has proposed changes to the federal certification standards; these are currently out for public comment and will be issued as final in Spring 2023. RI intends to revise its CCBHC Standards to comply with the final Federal Standards.
18	What constitutes the Utilization of a Mobile Crisis Team where in that an unattributed member can get assigned by BHDDH to a CCBHC according to their geographic proximity?	The State is currently developing these guidelines; they will be publicly released on a later date.
19	Please define Clubhouse services - will day program models other than true Clubhouse services be acceptable?	RI Clubhouse services need to comply with the nationally recognized Clubhouse standards. At present, they do not need to be certified. Day program is not an allowable service under the Clubhouse model.
20	In regard to patient Visit Detail request from Appendix F – TPC received extra payments through patient claims for the Workforce Development Grant. Do we include those payments in the "paid amount" column of the cost report, or should we back out those payments from the claims detail?	EOHHS assumes this is in reference to enhanced fee-for-service rates funded by the Workforce Development program. The full enhanced rate received via claims payment should be included in the "Paid Amount" column of the [Detailed Visit Reporting]. Any Workforce Development program funding received outside claims payment (grant, etc.) should be excluded.
21	High Acuity Adults: Need further clarification for eligibility of RI I/DD waiver. What specific Intellectual diagnoses does this include?	CCBHCs must serve all individuals. If providers are uncertain if an individual meets the RI I/DD waiver criteria, they should submit the request for the high-acuity adult population via the Gainwell Eligibility Portal. Additional guidance will be issued by the State on a later date.
22	Concern that this broad eligibility criteria may be inclusive of more severe intellectual developmental diagnosis and ability to participate in CCBHC services.	The Fidelity model to be used is under further discussion by the State addition details will be released ASAP. CCBHC Standards address the staffing patterns and census.
23	Can you confirm the ACT fidelity model-TMACT-staffing pattern, and census numbers? TMACT fidelity refers to 3 hr per month while technical	These details can be found in the draft CCBHC Certification Standards posted 1/11. See Addendum 7. Scope of Services. The ACT service requirements will be added to the final Certification Standards to be released 2/1.

	guidance also refers to monthly requirements defined by BHDDH. Please clarify.	
24	Will the State consider allowing IHH and ACT enrollments currently in the State portal system to qualify in year 1 to include individuals with the listed diagnosis and DLA scores between 4 and 5, and all individuals with current exceptions already approved? Transition to change in DLA of score of less than 4 in year 2?	Based on the BHOLD reporting, CSP and ACT are automatically in the high acuity population for the initial assignment. No, if they have a DLA score between 4 and 5, they will be assigned to the standard population (general outpatient).
25	Recommend the use of the Modified CGAS assessment over the CANs assessment as a level of care assessment too. There is experience using the tool when the state used it when transitioning to Childrens Intensive Services (CIS) model, which some believe to be the best service delivery system we have had in behavioral health in the last 30+ years. CGAS assessment is nationally recognized, and the RI modified CGAS was developed by colleagues at Yale in conjunction with providers and DCYF, and used exclusively by RI.	The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose assessment tool that was developed for children's services to support decision making, including level of service decisions and care planning, and to facilitate quality improvement efforts and outcomes monitoring. Versions of the CANS are currently used in 50 states for children's behavioral health, child welfare, juvenile justice, and early intervention. The CANS has been in use within Rhode Island since 2013. Overall, the CANS was chosen as a functional assessment tool over the CGAS due to concerns about inter-rater reliability with the CGAS and because the CANS translates easily to practice and has a strong research base and demonstrated validity as a support for long-term treatment planning. Additionally, the person completing the CANS does not need to be a masters-level clinician or higher.
26	There are 21 EBP's listed as required in the Technical Guidance. Having had experience with SAMHSA grants EBP implementation, fidelity tool development, data collection and tracking, analysis and report writing, and the associated staff training time (pulling them away from direct services and other required training), we know this will require a significant expense to implement this many EBP's and fidelities at one time. Managing just 5 or 6 at one time is costly. Can we assume the 21 EBP's noted on the list are EBP's we can pick from to implement? Will there be guidance on fidelity tools and scoring protocols?	All 21 EBP's are required. Please refer to schedule in draft Certification Standards (released 1/11) for implementation deadlines. Many of these EBPs are already being utilized by BHDDH licensed organizations. Yes, there will be guidance on Fidelity tools.
27	Wondering if there is a list out yet of the DCOs that have been awarded? We have several we are	Yes, the State is working to put together a list of DCOs that we can share. You do not have to be awarded the grant to be a DCO.

	partnering with but were hoping to see the complete list.	
28	How do we treat costs currently underwritten by state or federal grants? Are they included or excluded from the expense base?	Page 18 of the CMS Cost Report Instructions, Allocation Descriptions Tab, notes that the CCBHC should offset salary costs by applicable revenues, such as grants received. As such, if a grant is expiring, and those revenues are not anticipated to be available in SFY 2024, the associated costs are allowable. If the grant revenues are expected for part of a year, the associated costs would also be allowable for the portion of the year when the grant funding is expired. The State requests the costs currently underwritten by state or federal grants to be reported in the following manner, consistent with the principles above: • Actual costs incurred in the base year (SFY 2022) are fully included in Compensation and Other (column 1 and column 2 of the [Trial Balance]). • State and federal grants applicable to those costs in the base year are included as an offsetting (negative) value in the Adjustments (column 6 of the [Trial Balance]). Itemize the offsetting grants in Part 2 of [Trial Balance Adjustments], Other Costs Not Allowed (row 22a). • Grants not available in the rate year (SFY 2024) are included as a positive value in Anticipated Costs (column 8 of the [Trial Balance]). Note, if applicable, these details should be included in the cost report comments tab, detailing the worksheets and lines in which the costs are included.
29	My assumption is that such costs can be included in the base. As grant withdrawals may only be done once Medicaid revenue is netted against a cost.	See response to question 28 above.
30	Can we DCO with an agency that is a CCBHC in our same catchment area for services?	CCBHCs have the ability to DCO with any organization meeting the standards providing services in their area. An organization can be a CCBHC and a DCO.
31	What EBPS are you requiring for younger children? There does not seem to be one specified for young children on your list.	None are required at this time. We are leaving it to the discretion of the CCBHC.
32	Can you clarify which services can be DCO'd?	This is addressed in the draft Certification Standards released 1/11.
33	How will you identify/account for the children receiving community-based BH services that are not provided by CMHCs since they are not reported to BHDDH - it seems like you will be counting on the attribution lists from just the CMHCs and there are	If the CMHC becomes a CCBHC/DCO, they will be required to report all of the children receiving services in BHOLD.

	many more children and adolescents receiving BH services not under the BHDDH umbrella.	
34	Need protocol for warm handoff as clients move from one program to another (i.e., related to changes in attribution)	Thank you for your feedback. The State is taking this under advisement.
35	Will children also be attributed/registered?	Yes.
36	Will all populations be managed through the Gainwell Eligibility Portal?	Yes.
37	Which Cost Report Category should Psych Nurse Practitioners be categorized under?	Please reference the attached crosswalk of definitions for the CCBHC cost report line item categories on the [Trial Balance] worksheet based upon provider certification standards when completing the CCBHC cost report. The profession in question should correspond with line 17d in this crosswalk.
38	Can we use a Federally Approved Indirect Cost rate in the indirect cost section instead of listing all costs?	Yes. Please note that the PPS-2 rate will be calculated upon the approved federal indirect rate, and not the provider's listing of each indirect cost reported in the cost report. If provider is using its federal approved rate, provider still must populate the indirect costs portion of the cost report, even though these costs will not directly affect the PPS-2 rate.
39	Are the Part I compensation amounts for employees used such as a psychiatrist the current salary or annualized compensation for FY 7/1/21-6/30/22?	The Part I compensation values should reflect compensation in the base year, 7/1/21 through 6/30/22. Any adjustments to costs (including compensation) to reflect costs that are expected to increase as a result of offering CCBHC services during the rate period that were not captured in the base year may be included in the "Adjustments for Anticipated Cost Changes" column. This may include annualizing the compensation for employees not employed for the full base year. Please note, the PPS-2 rate will include an adjustment for inflationary trend between the base year and rate period based on the Medicare Economic Index (see [CC PPS-2 Rate] worksheet).
40	Want to confirm that Anticipated Costs include the cost of bringing salary levels and benefit packages to market.	Yes, this is correct. This will be reviewed for reasonableness and further guidance may be issued.
41	NMH have completed a federal indirect cost rate submission. We are in the process of being negotiated. Is it allowable to use this rate while we are still in process?	Same question as #38. Providers should itemize all their indirect costs per the current Cost Report Guidance and provided Cost Report Templates.
42	I saw telephones under Indirect costs. What about cell phones that are used by direct CCBHC staff?	After further discussion, we anticipate cell phones would be included in an indirect cost category, such as "Telephone", unless the CCBHC can demonstrate the cell phones meet the direct cost principles outlined in 45 CFR §75.413.
43	Is a de minimus indirect rate (i.e., 10%) allowed rather than detailing out indirect costs?	Same question as #38. Providers should itemize all their indirect costs per the current Cost Report Guidance and provided Cost Report Templates.
44	What is the reporting period should be used for the base year financial statements?	As noted on page 2 of the Supplemental Technical Guidance, SFY 2022 (July 1, 2021 – June 30, 2022) is the base year for cost report data.

45	Do you have all of these schedules completed with sample data so we can understand how it all flows?	The State does not have these schedules completed with sample data. The supplemental reports are generally independent. The CCBHC cost report does "flow", in that the costs input are used to output a PPS-2 rate. Please reach out if there is a specific question on that we can respond to about the flow of the workbook.
46	If a consumer is in a MHPRR, is the MHPRR rate to be included or just the cost of IHH/ACT Health Home? Or is it both the IHH and MHPRR cost as covered and non-covered costs?	Just the cost of IHH. MHPRR services are not included in the PPS-2 rate.
47	How can the CCBHCs identify the outlier clients?	Outlier visits and charges are reported in the [Monthly Visits] and [CC PPS-2 Rate] worksheets. Outlier clients are those with total billed charges in the base year exceeding the annual outlier threshold for the client's population/condition group illustrated in Appendix E of the Cost Report Technical Guidance. If the annual outlier threshold is exceeded for a given client, all charges and patient visit months starting with the month the threshold is crossed should be allocated to the "Visit Months Above the Outlier Threshold" and "Charges or Costs for CCBHC Services Above the Outlier Threshold" columns in the [Monthly Visits] and [CC PPS-2 Rate] worksheets, respectively. Patient visit months and charges incurred in the months prior to the month the outlier threshold was crossed should not be included in these columns. The outlier threshold should not be prorated for clients with less than 12 months of eligibility in the base year.
48	Do you plan to have clinic specific rates as has been done in the CCBHC demo or will there be one rate for all clinics?	Each CCBHC will have its own PPS-2 rates across the 4 population rate categories.
49	When will these standards be distributed?	Draft Certification Standards were posted to the EOHHS CCBHC webpage for public access on 1/11. Final Certification Standards will be released 2/1.
50	Could you explain if the criteria on the Readiness Assessment coordinate with a set of published standards?	The criteria in the Readiness Assessment mirrors the current federal CCBHC standards released by SAMHSA.
51	Does the budget that is due with the Continuation Application reflect our $60,000 award (2 DCO sites) or the possible $740,000?	We will be requesting an accounting of the dollars spent in the initial Phase 1 Grant Allocation. Then, the budget that will be required with the Continuation Application will be for the Phase 2 funding ($760,000 per CCBHC clinic site and $370,000 per DCO site).
52	As an approved but non-funded DCO are we still required to do the DCO - Equity Assessment?	No. This is only a requirement for grantees.
53	How are the requirements of being a DCO being communicated to DCOs?	All potential DCOs are welcome to our Learning Collaborative meetings. DCO requirements are also listed in the draft RI CCBHC Standards released 1/11.

54	You mentioned when we 1st discussed the error we made in our application (failing to request the DCO funding) that another RFP or application may become available is there any update on this?	No, we are sorry, but we will not be able to put forth another DCO RFP application.
55	I am wondering if I can connect with someone at OHHS to discuss our role as a DCO? This is a new process for us. I'd like to be sure that we are able to assist as much as possible to deliver a high quality of care to our patients.	We will be exploring the DCO roles within the Learning Collaborative meetings that will be carried out monthly and we will be able to have additional conversations with potential DCOs upon request.
56	It was mentioned that there should be one cost report per organization. Would this apply to an organization such as Gateway if the intent is to apply as a CCBHC for multiple catchment areas. If there are different DCOs relationships across different catchment area, how do we layer this consideration into the Cost Report?	Yes, there should be one Cost Report per CCBHC. Note, DCO relationships are not specific to a catchment area. The DCO costs and visits should be incorporated into the report in aggregate across all catchment areas, consistent with the CCBHC costs and visits. Please note, the contractual arrangements and DCO cost and visit estimates should be provided in a sufficient level of detail (e.g., separate reporting for each DCO relationship) in the "DCO Support" portion of the required supplemental reporting. See "Appendix F: Supplemental Reports" of the Cost Report Technical Guidance for more information.
57	There is a discrepancy in the RI technical guidance and the CMS Cost Report guidance in regards to Qualifying staff person: a. Is the intent that qualifying services are those staff type listed in the Cost Report? b. We would need a detailed description of each staff type. This is imperative to categorizing qualifying encounter appropriately for both the PPS-2 billing component and the cost reporting data. Example: Nurse Practitioner Staff type?	a. Yes. The State will be sure to align the Staff Type list in the Technical Guidance and Cost Report Guidance. b. The State has developed these details and is working to release them ASAP.
58	In regards to RI technical guidance and qualifying locations: Line 3. "x. Another Community-based site that has been approved by the Department": • What other locations would apply? For example, maybe recovery specialist will meet clients at a Starbucks, or a park. Would those qualify?	We have provided an exclusion list in V2 of the Cost Reporting Technical Guidance (dated 1/13).

59	Could you provide or direct us to a specific definition of CCBHC/ non-CCBHC services that are included in/ excluded from the "in-scope" portion of the cost report?	CCBHC services are all those required to meet the Certification Standards, including the 9 required services. Whether a CCBHC directly provides a required service, or partners with a DCO to do so, these costs should be included in the Cost Report.
60	Could you provide or direct us to examples of "Telehealth" costs that need to be carved out? These may be unspecified costs in our internal records and likely scattered among several expense accounts.	This includes all costs associated with implementing, operating, and sustaining a telehealth system (not already paid for) should be included in the Cost Report. E.g., hardware or software costs, consulting services, technical assistance, IT lines, etc.
61	The non-CCBHC portion of the "Trial Balance" tab indicates the need to carve-out Medicaid from non-Medicaid costs. What is an acceptable allocation method for determining the separation given our internal costs aren't necessarily separated in that manner?	Allocation methodologies should be consistent with *45 Code of Federal Regulations (CFR) §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for the U.S. Department of Health and Human Services (HHS) Awards* and *42 CFR §413 Principles of Reasonable Cost Reimbursement*, such as a Random Moment Time Study performed under a CMS-approved methodology. Starting at 45 CFR 75.420, these regulations also define unallowable costs such as lobbying, advertising, and bad debts. All unallowable costs should be included in the non-Medicaid portion of the cost report.
62	Similar to the question above, if staff have more than one licensure (LICSW, LCDP, LMHC, etc.) needing to be separated between more than one personnel category on the "Trial Balance" tab and encounter data cannot distinguish between the services, what is an acceptable alternative allocation methodology? How much leeway is there to using different allocation methods?	As indicated by the question, the FTE and costs should be allocated between the line items based on an allocation methodology. The allocation methodology should follow the principles in the above federal guidance.
63	What constitutes the utilization of a Mobile Crisis Team where in that an unattributed member can get assigned by BHDDH to a CCBHC according to their geographic proximity?	A member will be assigned to a CCBHC when the member receives a mobile crisis service. It is the responsibility of the mobile crisis service provider to advise the CCBHC to attribute the member to the CCBHC based on the member's residence or choice.
64	If there's a significant clinical reason why a member should not be attributed to a specific CCBHC due to geographic proximity alone, what attribution adjustments/considerations will be taken?	Consumer choice and existing exceptions (e.g., reassignment from one treatment center to another due to violent behavior) will be respected. The State will issue further guidance on reattribution on a later date.

65	The cost report requires a fiscal year of 7/1-6/30 and needs to be able to tie back to our audited financial statements. The problem is our fiscal year is 10/1-9/30. How should we proceed? What time period should we report?	The reconciliation should start with the audited financial statements covering the base year, so FYE 9/30/21 and FYE 9/30/22 in this scenario. Additional steps should then illustrate: • The impact of limiting these financial statements to the base year time period. • The combination of these time periods.
66	We are in the middle of our cost report and have an important question that we need answered before we can move on. Should we be basing our cost report on costs needed to accomplish everything that is required in the certification standards or just what is realistically feasible for year 1? For example, we might need 100 new staff to accomplish all requirements but for year one it is more realistic that we will be able to hire 30 staff. Should we do our cost report based on all 100 staff or the 30 staff for year 1? Will we be able to adjust our rate each year to account for the additional staff that will be needed to meet all of the requirements?	Before an organization can be fully certified as a CCBHC, it must substantially comply with all 115 criteria of the CCBHC certification standards. It is unreasonable to expect however that the CCBHC will be able to fully meet all the needs of Populations of Focus and of the Priority Populations in year one. Cost reports should be completed based on what is realistically feasible for year 1, but providers will also need to ensure they are able to meet required criteria. The State intends to rebase after year 1 given this exact issue and will also issue guidance on recouping unrealized cost on a later date.
67	We are having discussions with youth providers now about being DCOs for Thrive but it is unclear which services for youth we should be putting in the CCBHC. Also, stated is that there will be guidance and a methodology provided on youth mobile crisis. Could you please provide more direction on youth services so we can better prepare our cost report?	CCBHC's are required to meet directly (or through a DCO) all the behavioral health needs for all ages and address many of the factors pertaining to social determinants of health. DCO's are seen providing any of those services under a specific DCO agreement with the CCBHC. Services could also include outreach and engagement activities. Specific services for youth in the high acuity category are listed in the RI CCBHC draft Certification Standards released 1/11 for comment. Services not listed can also be proposed in the cost report if seen as being necessary to comply with service needs of youth.
68	Could you please clarify what "ACT" for Teen ACT stands for? It is unclear if the acronym is Assertive Community Treatment or Acceptance and Commitment Therapy.	Assertive Community Treatment. However, please note the CCBHC Interagency Team has determined that Teen ACT will not be a required EBP for CCBHCs.
69	The cost report does not list Master's Level Clinicians as a specified position - should we put that under "other"?	Please refer to the Trial Balance Crosswalk for additional guidance. See 'Trial Balance Line' = 17a.
70	We operate an IHH site outside of our catchment area. If a client chooses to remain at our site, will	The State will honor client choice. If a client choses to remain at a specific provider site outside of their CCBHC catchment area, the State will attribute them to that CCBHC/provider.

	they be attributed to the CCBHC associated with the site or the CCBHC of geographic proximity?	
71	Is true that a specialized ACT team may operate outside of the CCBHC catchment area as long as it is a specialized ACT team? If so, what are the standards that define a team as specialized?	We are not certain what you mean by 'specialized' ACT Teams, but the components of the ACT model are listed in the RI CCBHC Certification Standards; these must be met with fidelity.
72	Would you be able to provide a little more information about Teen ACT? Composition/qualifications of the team, staffing, etc. What would the age group be, 16-18? I understand SAMHSA has something using the abbreviation ACT - Acceptance and Commitment Therapy. Is there any relation to this?	When we say Teen ACT, we are referring to Assertive Community Treatment. Please note, the State has removed Teen ACT as a required evidence-based practice (EBP).
73	My staff may have already reached out to you with this question. Do you have any program material on the model of Teen Act that you are recommending? We are having a hard time finding a fidelity scale and good program description. We are also needing to choose an evidence-based practice(s) to address the needs adolescents and younger children with serious emotional disorders such as MST, FFT, MDFT etc. Is there any preference from DCYF for additional enhanced outpatient level of care evidenced based practices in addition to Teen Act? Intensive in-home Children's services are one of biggest service gaps. Teen Act only addresses part of the Enhance Outpatient Service needs of the children in our area and we prefer to use a more robust EBP rather than a generic EOS model in addition to Teen ACT. Any thoughts would be appreciated.	See response to question 72. DCYF is interested in additional evidence-based practices (EBPs). Providers are required to contact DCYF with EBPs they wish to implement for children.
74	Depending on the ACT fidelity tool chosen by the state, could TPC blend treatment teams if fidelity to the ACT model were able to be demonstrated for the clients receiving ACT care?	ACT teams and services will need to comply with the fidelity to the model described in the RI CCBHC guidance. The fidelity measure will need to be completed at least every 6 months. We don't how you define blended treatment teams. Blending ACT teams staffing with other non ACT teams would not comply with the requirement.

75	Does the CCBHC certification application process include an application process for DCO's?	We ask you to identify the DCOs, but there's not a separate application for them. Certification is governed by the CCBHC. CCBHCs are responsible for the DCOs. The relationship is between the CCBHC and DCO. Application is from the CCBHC. Certification Standards includes an Appendix that sets forward guidelines for CCBHC and DCO relationships.
76	Do you have technical assistance resources to help prospective CCBHC's develop DCO's?	Learning Collaborative resources will be provided to help CCBHCs identify and create potential partnerships with DCOs.
77	Please explain the needs assessment process. Will the state provide the initial needs assessment?	A needs assessment for the purpose of identifying appropriate staffing and services for the area served by the CCBHC is required every 3 years, at a minimum. The state conducts a Needs Assessment to meet requirements of the SAMHSA Combined Substance Use and Mental Health Block Grant. The Block Grant Needs Assessment Report describes the unmet service needs and critical gaps within the current system as well as any advances that have been made. The data provided is state level aggregate data and identifies priority needs related to the provision of behavioral health services. For the purposes of the initial CCBHC application period, this will serve as the state needs assessment. See: fy2022-2023-combined-mental-health-and-substance-abuse-block-grant-application-behavioral-health-assessment-and-plan.pdf (ri.gov), Block Grant Needs Assessment Reports pp.269-294. The needs assessment process utilized can be adapted for use within a catchment or service area. Applicants who have not completed a needs assessment or those who have a needs assessment that is over three years old will be expected to complete a needs assessment within a year of certification.
78	Will there be any more technical assistance on suggested evidenced based practices and information on the fidelity standards? Particularly seeking guidance on children's evidence-based practices as Teen Act only covers apportion of developmental stages and service needs.	See response to Question 73. At this time the State will not require specific EBPs beyond TF-CBT and DBT for youth and children. We recommend consulting the updated RI CCBHC Certification Standards, California Evidence-Based Clearinghouse, and other national EBP summary websites for additional EBPs information. The State recommends that potential CCBHCs assess the populations they serve in order to identify what services would be appropriate for their specific catchment areas.
79	One of the great things about CCBHC is they allow for the clinics to determine which programs are needed in the areas they serve and the staff needed to deliver those programs. The Certification Standards state that the State will determine staffing needed according to a needs assessment that the state will be conducting. Also, the Certification Standards require an additional 18 evidence based programs to be implemented in years 1 & 2. This is a lot for clinics to be doing in addition to implementing the 11 core services. In	The State has taken this feedback into consideration and amended the RI CCBHC Certification Standards on EBPs to reflect the additional time needed to implement and ensure staff participation.

	my opinion, the CCBHC should focus on getting the CCBHC fully operational with the staff needed to meet the needs of the community and the growing capacity that has been seen with the Demonstration clinics. Think we should focus on 11 core services, then thinking about expansion of EBPs after in a phased approach. All this in year 1-2 is a lot.	
80	Is staffing pattern something we can do in partnership with the State? E.g. for non ACT programs.	Discussion of staffing patterns in the CCBHC Certification Standards are specific to the IHH/ACT program – State will clarify language in the final draft of the Standards (to be released 2/1).
81	Will additional quality measures be posted?	Please review Addendum 9, the table entitled "CCBHC Federally Required Quality Measures, Data Source and Party Responsible for Providing the Data. This table describes the nine clinic-reported measures, the source of the data and the party responsible for reporting the data.
82	For DCOs, are they required to provide all core services? Or can some of these be done by the DCOs?	Parts or all of Standards 5-9 can be DCO-ed out (see 1/7 Public Meeting PPT deck, slide 9). The CCBHC is the central point of contact and responsible party; should provide bulk of services but can partner with DCOs to supplement.
83	Will the CCBHC Certification Application be submitted through the new RI State Grants Management System?	No, it will be submitted to BHDDH electronically. A submission protocol will be shared out by the State ASAP.
84	Is what is required for cyber security insurance included in the draft Certification Standards? Just need to go out to brokers if higher then what is already required.	Due to the nature of the CCBHC services, access to confidential information (including but not limited to HIPAA and/or PII information) is required. There should be cyber security insurance coverage in the amount of $5 million per occurrence and $5 million in the annual aggregate.
85	TPC has previously been approved by BHDDH to provide ACT and IHH services within the same team. This allows TPC to increase/decrease services to clients as indicated by their needs without further dysregulating the client by assigning them new treatment teams at times of psychiatric instability. Will this no longer be approved?	See answer to Question 12. In order to meet fidelity to the ACT model, IHH and ACT teams may not be integrated.
86	I could not find any reference to the Definition of "Line of Business". This term is used in Schedule F under Detailed Visit Reporting Worksheet.	Please reference Appendix F in the Cost Report Technical Guidance for additional detail on the requested key fields. For 'Line of Business', values should be "Medicaid", "Commercial", or "Other" (with description provided on the [Notes] worksheet). These values represent the source of insurance coverage for the individual.

87	Will the State provide guidelines on staff salaries to ensure we're not in competition with each other?	Yes, the Interagency Team is working on this in collaboration with Milliman. Additional guidance will be release post 2/15, taking into account salary information provided within the submitted Cost Reports and additional industry wage data.
88	Where should Care Coordinators be captured in the Cost Report?	We think of care coordination as a service, as opposed to a specific position. See Trial Balance Crosswalk posted to the EOHHS CCBHC webpage on 1/17 for additional guidance.
89	"On-call emergency services (ES)" is its own subcategory now. Originally, the ES clinicians were categorized within the LICSW category. How would you categorize the ES Clinicians?	Separate out full-time salary vs. additional costs for after hours on-call work.
90	There are Providence Center clients in a health home team in Pawtucket that will be attributable to our Pawtucket/Central Falls CCBHC through a DCO arrangement with them. I'm not sure how that will be captured. They(TPC) also had a question about attributing clients they have on a health home team in East Greenwich that reside in Washington County. I assume that since they are serviced in Kent County that they would not be attributable to our Washington County team. Can you help with that issue?	We are attributing clients based on who they're enrolled with now. More guidance on this will be issued in the future.
91	On the trial balance crosswalk where do we capture admin or additional staff such as: • Intake Coordinator • Outreach Worker • Front Desk Staff • Data Entry Specialist • Billing Coordinator • SBIRT Screener • Project Manager • Nurse Care Manager • Registered Nurse • Medical Assistant • Practice Manager • Care Coordinator	The professions in question should crosswalk as described below, based upon whether staff are performing CCBHC services. Additional detail on the PART2B detailed administrative professions is included in Appendix F in the Cost Reporting Technical Guidance document. • Intake Coordinator – PART1A: General practice (performing CCBHC services) • Outreach Worker – PART1A: General practice (performing CCBHC services) • Front Desk Staff – PART2B: Program/Management • Data Entry Specialist – PART2B: IT/EHR • Billing Coordinator – PART2B: Billing • SBIRT Screener – PART1A: General practice (performing CCBHC services) • Project Manager – PART2B: Program/Management • Nurse Care Manager – PART1A: Psychiatric nurse (or credential-appropriate category) • Registered Nurse – PART1A: Psychiatric nurse • Medical Assistant – PART1A: General practice (performing CCBHC services) • Practice Manager – PART2B: Executive • Care Coordinator – PART1A: Case manager

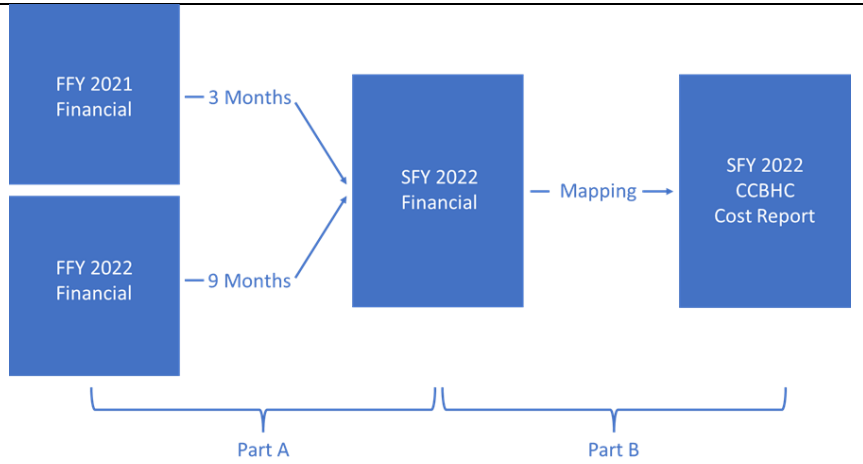
92	Is the continuation application available yet? We are working on the Readiness and Equity assessments and would like to build our implementation plan to address gaps in the Continuation application.	The Infrastructure Grant Continuing Application will be released by 1/27 at the latest.
93	How do you enter the "On Call Emergency Services (ES)" and the "Daytime ES"? Are they considered in the same category or are the separated?	Refer to response for Question 89.
94	Is there an updated version of the cost report regarding the staffing categories. Specifically, line 17? Will there be additional categories added?	See Appendix F and Trial Balance Crosswalk posted to EOHHS CCBHC webpage: https://eohhs.ri.gov/initiatives/behavioral-health-system-review. Advise looking at two documents in tandem.
95	When can we expect the cost reporting guidance to be completed?	Guidance for cost report due 2/15 to State has been finalized. See: Cost Report Technical Guidance (posted 1/13/23).
96	Are we able to establish a DCO relationship with an agency for services not currently funded by Medicaid if those services are in line with CCBHC scope? If yes, is there special guidance for incorporating these costs in the cost report?	CCBHCs need to provide all required services either directly or through a DCO partnership. Input cost or rate currently in use outside of Medicaid (e.g. rate used by DCYF for specific grant-funded child services). Remember this must a BH service, not a medical service (with exception of outpatient primary care screening of key health indicators).
97	Question on the list of allowable services. Are we just including those allowable services on the eligible/ attributed CCBHC populations? For example, we have Healthy Families America (HFA). Would we only include if the service was provided to an attributed client or is the expectation that all of HFA will be rolled into CCBHC and if so which population would they land as they are currently not in BHOLD system?	Include all applicable behavioral health related services delivered. Recommend being more inclusive now; we can parse/pull out specific costs down the road as needed.
98	How should IHH and ACT shadow claims be costed? There are some services that do not crosswalk to a charge for example CM services 15 min and 5 min service and are the per diem charges not to be included? Concerned that charges for these services reported will not reflect the total of the per diem charge.	For **direct (face-to-face) Case Management**: Providers should include H0036 ($21.25 per 15 minutes) in their charges submitted in the PPS-2 worksheet and encounter data. For **indirect (not face-to-face) Care Coordination services**: Do not include in charges submitted in the PPS-2 worksheet but do include in encounter data. EOHHS / BHDDH will develop a crosswalk of CCBHC services to procedure code / modifier and fee amount for use in encounter data submission in the future.

		These services and their utilization will be used to calculate outlier payments, so consistency between reporting years and outlier payment is crucial to retain the integrity of the base data and assumptions.
99	When we are verifying a client's PPS2 Program what DLA score do we use most recent or the DLA score in FY22?	If available, the DLA score in FY22 is preferable.
100	Are we to include the per diem for IHH/ACT clients in the service cost report? If we exclude these services, our highest acuity clients may come at the lowest cost.	Page 19 of the Cost Reporting Technical Guidance notes that, "Charges for IHH and ACT servicers should reflect the charges for the actual services provided, as opposed to the bundles rates. The charges assigned to the services provided via IHH and ACT should be consistent with the fee schedule for all other charges."
101	What if there are 2 CCBHCs in one catchment area? How would those clients get attributed from Mobile Crisis or Court ordered?	A protocol will be developed by the State as needed prior to formal launch.
102	Is it our referrals to the DCO that are our clients, or do all clients the DCO serves in the catchment area a CCBHC client? a. If the latter, then billing for all of these clients flows through us, the CCBHC? b. Are DCOs responsible for sharing/reporting all quality measure data, etc. for these clients to the CCBHCs?	Typically, the referral goes from the CCBHC to the DCO, and the CCBHC takes lead on care coordination. There are instances however, where referrals could go in the other direction (for contracted services between the CCHBC and DCO only). a. Once the referral is made, the treatment plan is agreed to, and the treatment is provided, the billing request goes from the DCO to the CCBHC. b. Yes.
103	We have seen a template for DCO budget. Was this provided by the State?	No.
104	Crisis Service Definitions: • "24-hour mobile crisis teams" are teams that provide mobile crisis response off-site from the CCBHC. • "Emergency services" means "crisis response services provided on-site at a CCBHC." • "Crisis stabilization" means "resolution of a crisis whether off-site by a mobile crisis response team or on-site at a CCBHC Questions	a. See definitions for distinctions between each of these three services. Key differences are underlined. There should be sufficient staffing to provide the crisis services in your catchment area. The level of staffing needed is to be determined by each CCBHC. b. Yes, all mobile crisis for adults and children must have a qualified mental health professional (QMHP) as a minimum requirement, as established by the RI CCBHC Certification Standards. This is a not a requirement of the FSRI/Tides State Grant. BHOs can apply for their qualified staff to be certified as a QMHP through BHDDH: https://bhddh.ri.gov/mental-health/provider-and-professional-information/qmhp-application.

	a. Discuss these distinctions and the staffing requirements for each, in particular the QMHP b. Discuss Tides Mobile Crisis Services – QMHP requirement? How will this be facilitated? Was this a requirement of the FSRI/Tides State Grant?	
105	Fidelity. Discussion regarding pricing out requirements – what will State be covering vs what do we need to cover? The State has said training – logistics can be tough (location, new hires, etc.). Hopefully there will be multiple training offerings with virtual training as an option?	The State will be providing some support through a Technical Assistance vendor, however, providers are encouraged to integrate all anticipated costs for trainings, logistics, etc. into their Cost Reports to ensure sufficient funding/resources to meet this need.
106	Confirming the fidelity tools will be chosen by the CCBHC?	No. The State welcomes suggestions from CCBHCs but will ultimately approve the fidelity tools.
107	Reporting and Analysis – noted URI reference source (we have many of these via working with URI and SAMHSA grants. Is the State contracting with URI for analysis and reporting? Or do we have to include this in the cost report?	The State will be providing some support through a Technical Assistance vendor, however, providers are encouraged to integrate all anticipated costs for trainings, logistics, etc. into their Cost Reports to ensure sufficient funding/resources to meet this need.
108	I have a question regarding the allowable relationship between OTP's and the CCBHC's. I understand that referral and care coordination arrangements are permitted and encouraged. But are DCO arrangements between CCBHC's and OTP's allowable or permitted?	In Year 1, a DCO arrangement between CCBHCs and OTPs is not permitted for methadone treatment or Health Home services. However, they can DCO for buprenorphine or naltrexone treatment.
109	Continuation Application: Length for narrative section?	You can use up to a maximum of 10 pages double spaced, but applications can certainly be shorter.
110	What is the window of time for Infrastructure Grant for budget?	The State will respond within 30 days of the Phase Two Contract Renewal request. Budgets should be for a maximum of one year of work and can start when the organization receives a new Purchase Order from the state.
111	Can you clarify how an agency that is not currently a hospital or CMHC is able to have staff meet the criteria to be a QMHP? Both of the current children's mobile crisis providers are not CMHC's and the definition of a QMHP and the application both require that the individual be employed and receive	All mobile crisis for adults and children must have a qualified mental health professional (QMHP) as a minimum requirement, as established by the RI CCBHC Certification Standards. All BHOs can apply for their qualified staff to apply to be certified as a QMHP via BHDDH: https://bhddh.ri.gov/mental-health/provider-and-professional-information/qmhp-application. This requirement is under further legal review at BHDDH.

	training at either a CMHC or hospital. Since this is a certification requirement for mobile crisis will agencies who are not CMHCs be able to train their staff to be QMHPs?	
112	We have been in discussions internally about how to present our High Acuity Kids. As you would likely surmise, we have not "tracked" or provided a specific program for this subset in the past. Thus our current BEHOLD looks like the following for the FY2022 base year: **Row Labels** / **Count of ssn** General 560 MHAdult 1428 SUD 49 **Grand Total 2037** My question to you is, should be breaking the High Acuity Kids in the base year even though we have not actually provided a program to this subgroup?	Yes, you should include all kids who meet the criteria that's been outlined in the CCBHC Cost Report Guidance (see page 7). You don't need to have previously provided services to this subgroup in the base year.
113	Does the HIV/Hepatitis screening need to be completed by a Medicaid provider (can it be DCO'd to a non-Medicaid provider like outreach and engagement)?	HIV/Hepatitis screening is a required CCBHC service. This service may be provided by the CCBHC itself, or by a DCO partner. In either case, the CCBHC and DCO must be a Medicaid provider. See RI CCBHC Certification Standards, Addendum 3 (page 87).
114	The RI CCBHC Certification Standards require BHO for all clinical services, however for children's mental health, BHDDH does not license. If children's mental health services are DCO'd, does this BHO requirement stand? Will we be aligning DCYF licensing process and how will that be reflected in certification?	Addendum 3 of the RI CCBHC Certification Standards (pg. 87) states that "A DCO is required to be licensed as a BHO and enrolled in Medicaid to provide clinical services". If a DCO is not providing clinical services such as outreach and engagement, then a BHO license is not required for that function. BHO requirement is applicable to DCO's who provide Adult or Children clinical services. There will be additional instructions and guidelines when DCYF licensing standards are enacted.
115	Can you clarify - the High Acuity Adult population needs to be served by either ACT or ICCT, or is it just for SPMI requirement? The question pertains to clients who meet exclusion criteria (i.e. homeless)	• ACT and ICTT services fall within the High Acuity Adult PPS2 rate. • The clinical and other related criteria for ACT and ICTT are detailed in the RI CCBHC Certification Standards, Addendum 5. Request for exceptions to those criteria is also listed in that Addendum.

	that are not SPMI do they need to be served as part of the ICCT model. Certification standard only refers to SPMI Service structure under High acuity adult. In other words, can we prorate Teams (e.g. Safe Haven Health Home Team), and what do we do when a Team is too small to prorate?	• In Addendum 7, section pertaining to ICTT, #3.d states that "Providers would have the option to propose to BHDDH the establishment of ICCT teams serving 100 individuals with prorated FTE staffing." Prorated teams due to special circumstances as mentioned would have to be presented and approved by BHDDH.
116	What is the budget start and end date for the EOHHS Infrastructure Grant budget that current Phase 1 grantees will be putting together in the Phase 2 Continuation Application process?	The time period of the planning budget is 12 months. • Start date = upon notification of an approved Continuation Application (or approval with conditions). End date = 12 months from start date. • See RFP: CCBHC Infrastructure Grant Program, pg. 12 for funding distribution timeline.
117	Follow-up to Question 113. Is it HIV/Hep B screening or testing that is required?	Screening is required. See RI CCBHC Certification Standards, pg. 5.
118	Follow-up to Question 65. We do not know what time to period to report as our financial statements are not on a State Fiscal Year (SFY). a. Can we interpret that using the Federal Fiscal Year (FFY) end of Sept. 30 is acceptable? b. Does our attribution data need to correspond to the FFY end of Sept. 30, or the SFY end of June 30?	a. No, using the FFY end of Sept. 30 is not acceptable. Reporting by the SFY (July 1 – June 30) is required. You should use your audited statements (which will likely involve two years of FFY statements to derive the costs for the SFY). In this specific instance, information utilized in the completion of FFY 2021 and FFY 2022 financial statement will be needed to populate the SFY 2022 CCBHC cost report. One of the supplemental reporting requirements includes providing additional detail via a detailed financial statement reconciliation (Appendix F: Item C). Within the guidance provided for this item, there is a graphic that utilizes a FFY financial reporting basis as an example.

		 The overall purpose of the requested additional detail is to understand: • Part A: Where applicable, how multiple financial statements are combined to form a state fiscal year (SFY) reporting basis. • Part B: How the audited financial statement financial categories are mapped and adjusted as needed to the CCBHC cost report expense categories. b. Attribution data needs to correspond to SFY 2022 (July 1, 2021 – June 30, 2022).
119	Can you clarify for 4.c.1 around Children's Mobile Crisis standards? The current programs funded by EOHHS require the ability to offer 30 days of follow-up if necessary for children and youth to connect them to services. Will this expectation be continued? It is not clear in either the CCBHC Certification Standards or the DCYF Emergency Certification standards.	Additional requirements to the RI CCBHC Certification Standards (4.c.1) can be imposed by the State, as long as they don't conflict with the standard. This does not appear to be the case in the example given. While this 30-day follow up is not currently required in the RI CCBHC Certification Standards, current child mobile crisis programs funded by EOHHS do require this. Research has shown better outcomes for children in crisis who receive continued support post-crisis, including lower rates of hospitalization. This recommendation supports the goal of the CCBHC model to ensure those in need are provided with timely access to high quality care. Further guidance will be forthcoming.
120	Could you please define the "Conditions" as we are entering for the Monthly Visits Tab of the Cost Report template?	"Conditions" refer to the specialty populations. See Appendix E and C of the Cost Report Technical Guidance for additional details.
121	RE: Phase 2 Contract Renewal Request (applicable only to current Infrastructure Phase 1 Grantees)	a. No, it is $370,000 per site, if the amount is approved. In your request, please make a distinction between what each site would be carrying out for each allocation of

	a. On the first page it states that "the maximum award amount will be $370,000 per DCO." We are reading this to mean that Child & Family, as a DCO, will be awarded a max of $370,000, regardless of having 2 sites. Is that accurate? b. On the second page, at the end of the paragraph about the workplan, it states: "In addition, request must include documented community feedback that shows that the proposed DCO is representative of the community being served through the submission of no more than 2 letters clearly identifying the DCO's key role as a partner, community leader, or equity partner." Since we are proposing to be a DCO in 2 sites, Providence and Middletown, would we need 2 letters total or 2 for each site, so 4 total? c. Can you define these 3 roles (partner, community leader, and equity partner)? Or are these roles defined in another document/set of standards we can refer to?	$370,000. Based on the request, the review committee will approve up to $370,000 per site. b. Yes, you can submit no more than 2 letters per site if you choose. If you submit letters that comment on the organization as a whole, you can choose to submit only two for your entire application. c. A partner is an organization with which you work closely to carry out program activities. A community leadership is someone who is known in the community and who knows you. For example, this could be an active parent in the local schools, a faith leader, or an elected official. An equity partner would be an organization or entity either led by members of the BIPOC, LGBTQ+, or disability communities, for example, or an organization specifically dedicated to advance an equity agenda or eliminating disparities.
122	Follow-up to Question 112. 'The kids are included. The question is should we show them? Right now, they are in general.'	If you provided services to high-acuity kids in SFY22, include them in your Cost Report, parsed out from the 'General' category.
123	The PPS-1 tab of the Cost Report template automatically populates. Do we need to complete this form and if yes, on Line #7 (MEI), what would is the percentage and/or the "mid-point"?	See RI Cost Report Instructions. You do not need to fill out the PPS-1 tab. For future reference, if you *did* have to complete this tab, see **Page 29. Line 7**: Enter the applicable Medicare Economic Index (MEI). The MEI should trend the costs from the midpoint of the cost period to the midpoint of the rate period. The MEI may be found here by downloading "actual regulation market basket updates" file that provides applicable rates: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html.
124	EBCAP is a CMHC and FQHC, which NPI number should we indicate on the cost report?	Put both, just specify which is the CMHC NPI and which is the FQHC NPI.

125	If we are certified as a CCBHC, can we choose which services to bill the CCBHC rate for vs. which services we bill the FQHC rate for? E.g., bill PPS-2 rate for specific services and use the encounter rate for outpatient services?	No, you cannot pick and choose. All services are inclusive in the CCBHC. An organization cannot pick and choose which required services they provide. There's not a bundled rate and an FFS rate. You have to have all costs bucketed and bill accordingly.
126	If I'm reading the PPS-2 calculation tab, Part 2, line 10 correctly, the boxes for Certain Condition are pulling from row 14, not row 16 on the Monthly Visits tab. It is correct in column C and in the summary, only the certain conditions seem inconsistent.	As previously instructed by the State, please use the Cost Report template provided by CMS with updated macros which was emailed out to all on 01/03/2023. The formula issue flagged here was previously detected and corrected by CMS.
127	Can you walk through the 'Allocation Descriptions' tab one more time so I can be sure I did it correctly?	For additional information, see: **CCBHC Cost Reporting Overview by Milliman (Public Meeting 1/4/2023)** presentation, slide 17.