Certified Community Behavioral Health Clinic (CCBHC): Frequently Asked Questions (FAQ)
October 2022

This FAQ document responds to questions received by the Executive Office of Health and Human Services (EOHHS) to date. More detailed guidance is forthcoming through the CCBHC Interagency Team.

#	Question	Answer
1	**Who will certify CCBHCs?**	The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), in coordination with the Executive Office of Health and Human Services (EOHHS), is charged with the certification of select programs and services that are reimbursed by Medicaid, including CCBHCs.
2	**What is the timeline for certifying entities?**	Entities seeking CCBHC program participation starting in Quarter 1 of SFY 2024 must be certified on/before July 1, 2023. Entities seeking CCBHC program participation starting in Quarter 1 of SFY 2025 must be certified on/before July 1, 2024.

3	**Who is eligible to be considered for CCBHC certification for SFY 2024?**	In order to be eligible to apply for certification as a CCBHC, the applicant must meet the following requirements:
		• Be licensed in RI as a behavioral healthcare organization (BHO) or have a pending application for BHO licensure in process at the time of request for certification as a CCBHC.
		• Be accredited by a nationally recognized accreditation body (The Joint Commission, Council on Accreditation of Rehabilitation Facilities or Council on Accreditation) with standards specific to delivery of behavioral healthcare services for mental illness and substance use disorder or have a pending application submitted at the time of request for certification as a CCBHC.
		• Have a minimum 3 years of demonstrated experience providing evidence-based practices for people experiencing serious and persistent mental illness (SPMI), serious mental illness (SMI), and/or serious emotional disturbance (SED) and/or individuals with complex or severe substance use disorders.
		• Demonstrated experience and ability to directly provide the following two services for outpatient behavioral health care.
		  ○ Screening, assessment, and diagnosis, including risk assessment.
		  ○ Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
		• Demonstrated experience and ability to directly provide (not only through a DCO arrangement) the following four services for outpatient behavioral health care.
		  ○ Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
		  ○ Screening, assessment, and diagnosis, including risk assessment.
		  ○ Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
		  ○ Outpatient mental health and substance use services.

		Catchment Areas
		
		BHDDH's goal is to ensure that CCBHCs are ready to meet the needs of all of Rhode Islanders across the life course supported by needs assessment and ongoing evaluation data.
		• BHDDH intends to certify one CCBHC per catchment area unless the data indicate to BHDDH that there is an unmet need for additional services for either youth or adults in that area. Needs assessment data will include but not be limited to:
		  ○ Meeting the timeliness of appointments,
		  ○ Adequate services for all age ranges, etc.
		• CCBHCs should have the ability to provide all nine required CCBHC services throughout the entire catchment area that the vendor is applying to serve.
		• CCBHCs are expected to enter into DCO arrangements sufficient to meet the behavioral prevention and treatment and cultural competency and outreach needs in their catchment area. Other collaborative arrangements will also be necessary, including for 988 services. See the answer to Question 11 for more information.
		• Within their catchment areas, CCBHCs will be required to accept Mental Health Court ordered Civil Court Outpatient Certifications or apply for facility status if they do not currently address these referrals. They must also accept inpatient psychiatric hospital discharges, individuals with co-occurring intellectual or developmental disabilities, and all medically managed (ASAM 4.0) and medically monitored (ASAM 3.7) detoxification service discharges.
		• Individuals seeking services will be free to select a CCBHC (and related DCO) of their choice and are not restricted to the one designated for their community of residence.

4	**How will CCBHCs be certified for SFY 2024?**	BHDDH licensed behavioral health organizations who wish to be certified by BHDDH as CCBHCs will complete an application for certification. Through this application process they will demonstrate compliance with the six program areas detailed in the Protecting Access to Medicare Act (PAMA) of 2014 (PL 113-93). PAMA details 115 separate required standards. BHDDH will enhance these standards with additional, Rhode Island-specific standards. Many of these standards are already incorporated into BHDDH licensure requirements, and in the accreditation requirements of the Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission (TJC) and the Council on Accreditation (COA). As such, compliance with each standard may be demonstrated in one or a combination of the following three ways: 1. Licensure from BHDDH 2. Accreditation by CARF, TJC, or COA 3. Production of relevant documents for review and/or attestation related to complying with the standard. In their CCBHC application, providers will demonstrate their licensure and accreditation through the provision of the relevant documentation. For those criteria for which the provider is not

		deemed compliant as a result of their licensure and/or accreditation, they will need to provide documentation, attestation, or demonstration of compliance. BHDDH will put forth a CCBHC application by early Spring 2023. The application will include criteria for certification and relative scoring for each. Upon receipt of the application, BHDDH will conduct a desk audit of the documentation provided. If BHDDH deems the documentation to be complete, BHDDH will conduct an on-site audit. Following the on-site audit, applicants will be determined as having achieved one of three designations: 1. **"Certified**" as meeting all the standards of a qualified CCBHC, eligible to participate in the CCBHC PPS program for a two-year period. **2. "Provisionally Certified"** as sufficiently meeting standards to participate in the CCBHC PPS program, with commitments to continue to address identified gaps within the six-month period of the Provisional Certification. At the end of the six-month Provisional Certification, providers will (dependent on their progress) be determined either Certified, Not Certified, or as receiving one additional six-month Provisional Certification period. At the end of the second six-month Provisional Certification period, providers will (dependent on their progress) be determined as either Certified or Not Certified. 3. **"Not Certified"** and required to make specified enhancements prior to participating in the CCBHC program.
5	**What are the categories of Certification Standards?**	BHDDH intends to follow SAMHSA criteria for certification, including the following six program areas, with some state specific enhancements (under development): 1. Staffing 2. Availability and accessibility of services 3. Care coordination 4. Scope of services 5. Quality and other reporting 6. Organizational authority, governance and accreditation
6	**How long are CCBHCs certified?**	Any entity who is Provisionally Certified will be required to demonstrate progress against specified deficiencies in accordance with an agreed upon project plan in order for the CCBHC to continue to be eligible to participate in the PPS payment model. Eventually, CCBHCs who have demonstrated that all of the requirements have been fully met will be designated as "Fully Certified." Fully Certified entities would be subject to recertification every two years. Recertification will occur at the same time as licensing renewal, which is also required every two years. Newly certified will be recertified after one year. As noted in the answer to Question 4, provisionally certified agencies will be reviewed 6 months after provisional certification and will be determined either Certified, Not Certified, or as receiving one additional six-month Provisional Certification period. At the end of the second six-month Provisional Certification period, providers will (dependent on their progress) be determined as either Certified or Not Certified.

7	**Have the geographic service areas/ catchment areas been defined?**	Yes, CCBHCs will be selected to serve eight designated service areas. They are currently the eight areas designated to the CMHCs. • CCBHCs will be certified by catchment area. • Organizations with sites in multiple catchment areas will need to apply by catchment area. • Applicants will need to meet all of the CCBHC standards in each catchment area for which they are applying. • Applicants must submit a separate application and cost report for each catchment area for which they are applying. • If a behavioral health provider organization providing services in a specific catchment area chooses NOT to apply as a CCBHC in that catchment area, they may either: o Contract with another CCBHC applicant serving that catchment area as a DCO, and therefore be included in the application of the partner CCBHC; OR o Continue to be paid Fee-for-Service in accordance with existing contracts/agreements for services provided in that catchment area for a limited time
8	**Will the selected CCBHCs be assigned to unique catchment areas or will overlap be allowed in geographic areas?**	As noted above in Question 3, some catchment areas may have more than one provider in order to enhance access. This will be assessed through certification, based on demonstrated need in the community, and the capacity of overlapping providers to offer the full array of CCBHC services within any catchment area they are serving. Providers that do not qualify as a CCBHC in a catchment area outside of their designated catchment area may continue to bill Fee-for-Service in that area for a limited time.
9	**What services will CCBHCs be required to deliver?**	CCBHCs will be required to deliver the nine services below in accordance with key criteria and program requirements established under The Protecting Access to Medicare Act (PAMA) § 223. 1. Crisis Response 2. Screening, Evaluation and Diagnosis 3. Person-Centered and Family-Centered Treatment Planning 4. Outpatient MH and SUD Services 5. Primary Care Screening and Monitoring 6. Peer and Family Support 7. Psychiatric Rehabilitation 8. Targeted Case Management 9. Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans The following service enhancements will also be required: 1. Screening for Hepatitis A, B and C and HIV 2. ACT The CCBHC will be required to provide these services in a manner that is appropriate for the population of their catchment area, for people with illnesses of every severity including people with Serious Emotional Disturbance, Serious Mental Illness and significant Substance Use Disorders, and to all Rhode Islanders regardless their age, race, ethnicity, disability, sexual orientation, gender expression, developmental ability, correctional system involvement, housing status, or ability to pay. CCBHC's are to specifically address

		the behavioral health and related needs of the following targeted populations: Adults with severe mental illnesses; children and youth with severe emotional disorders; under-resourced populations; health equity disparities; individuals who are homeless; justice involved individuals; and transition age youth. Additionally, CCBHCs will be required to adopt a minimum set of evidence-based practices; these are detailed in **Appendix A**.
10	**Traditionally in Rhode Island only Community Mental Health Centers have been able to offer ACT services, will the CCBHC implementation process allow for other agencies to build ACT teams?**	Yes. Any CCBHC will be authorized to provide ACT services either directly or through a Designated Collaborating Organization (DCO) contractual relationship. As with all other services, the CCBHC is ultimately clinically responsible for all care provided by a DCO.
11	**Mobile Crisis – How will CCBHCs interface with 988, BH Link, and Children's Mobile Response and Stabilization Services (MRSS)?**	The State is seeking to align all Mobile Crisis services as seamlessly as possible to ensure that we have one system of care; additional guidance is forthcoming as to how the existing children's mobile crisis services will align with CCBHC mobile crisis services, and how CCBHCs will integrate with 988. While we previously stated that no DCO relationships will be required, an exception is being made for the administrative costs of operating the 988 crisis line including dispatching mobile crisis teams. RI will develop and document an appropriate methodology to ensure that specific costs are allocated in a manner compliant with Medicaid administrative claiming principles and distributed across all CCBHC's cost reports.
12	**What are the criteria and process to be approved as a DCO?**	CCBHCs must deliver all services outlined in the CCBHC criteria, either directly or via a contractual relationship with a Designated Collaborating Organization (DCO). • For Medicaid reimbursable services, a CCBHC can partner with a DCO that is licensed or certified to provide that Medicaid reimbursable service. There is no required process for state approval of the DCO itself, rather the DCO service delivery would be approved as part of the CCBHC application and certification process. • The state anticipates seeking authority for CCBHC allowable services that are not currently Medicaid reimbursable (i.e., outreach) under the CCBHC model. DCOs will not be required to be licensed or certified by Medicaid to provide these services. Please note that the CCBHC will be responsible for ensuring that the that DCO meets all requirements associated with the specified service they have been designated to provide. In addition, the CCBHC will be clinically responsible for the care and treatment provided by DCOs.
13	**What are the expectations for CCBHC and DCO partnerships?**	Guidelines pertaining to the CCBHC/DCO relationship: a. Attestation that DCO has at least three years of experience providing a particular service type or treatment modality.

		b. A formal written agreement (MOU or contract) with a DCO needs to be established describing each party's mutual expectations, deliverables, and establishing accountability of services to be provided including compliance with confidentiality and privacy laws. Formal agreement clearly articulates CCBHC function in developing treatment plan development, care coordination and continued clinical responsibility. DCO is required to serve all individuals referred by the CCBHC, according to the eligibility guidelines established in the CCBHC/DCO agreement and in compliance with CCBHC standards on access and regardless of place of residence or ability to pay. c. CCBHCs and DCOs must have agreements in place and processes for sharing protected health information (PHI) in compliance with HIPAA, HITECH, and 42 CFR Part 2. d. CCBHC training plans must address training of DCO staff e. CCBHCs monitor DCOs' use of EBPs including fidelity compliance. f. DCO staff must be appropriately licensed, certified, registered and credentialed as required. g. DCO services must be trauma informed, person centered, recovery based and culturally appropriate. h. Individuals receiving services from DCOs must have access to CCBHC grievance procedures. DCOs will be required to collect and maintain all documentation necessary for CCBHC data collection and reporting.
14	**Will selected CCBHCs be allowed to form alternative (to DCOs) relationships with partner agencies who otherwise meet SAMSHA (or State) credentialing requirements?**	Yes.
15	**Will participating CCBHCs and DCOs be required to meet any specific insurance requirements?**	CCBHCs and their designated DCOs must meet the insurance requirements as specified by the State (e.g. general liability, workers compensation, and cyber security). These requirements will be included as a part of the CCBHC application.
16	**How can potential CCBHC applicants prepare their cost report if the state has not provided the necessary PPS-2 guidance?**	The state recognizes that potential CCBHC applicants will need PPS-2 guidance in order to complete their cost reports and is working to release that guidance as quickly as possible in order to enable potential applicants to complete the cost reports within the required timelines. While that guidance is being prepared, potential applicants should review the cost reporting tool and associated CMS guidance, prepare their data for processing and procure any consultative, actuarial, and/or accounting support they will require to complete the cost report.

Appendix A: Required Evidence Based Clinical Practices or Programs

A. All Populations (Adults and Children)

1. Motivational Interviewing/Motivational Enhancement Therapy -- *Required of all direct service staff with 50% trained by end of year 1 and 90% trained by end of year two. Maintain level of 90% trained/75% for MET provided for consumers with substance use disorder.*

2. Cognitive Behavioral Therapy (CBT) Age/population appropriate -- *Required of all (direct service staff and clinical staff with 30% trained by end of year 1 and 60% trained by end of year 2. Maintain minimum level of 60% trained*

3. Family Psychoeducation (FPE)/ Family to Family -- *Required of clinical staff with 50% being trained by end of year 1 and 50% by end of year 2. Maintain a minimum level of 75% trained.*

4. Integrated Treatment for Co-Occurring Disorders -- *Required of clinical staff with 50% being trained by end of year 1 and 50% by end of year 2. Maintain a minimum level of 75% trained.*

5. Medication Treatment, Evaluation and Management (MedTEAM) -- *This service/program may be required as a condition of application. If not, then ACT needs to be implemented fully within year 1 and staff trained appropriately according to plan developed by CCBHC and approved by BHDDH.*

6. Screening, Brief Intervention, and Referral to Treatment (SBIRT) -- *Implement service by end of year 1 with all staff trained*

7. Trauma informed care (population and age appropriate) appropriate training for staff at clinical levels -- *Basic training in trauma for all staff and additional specialized training for all direct service staff (50% by end of year 1 and 90% by end of year 2. Maintain 90% level of training.*

8. Coordinated Specialty Care/ Healthy Transitions (CSC/HT) -- *Establish team and service by end of year 1 with all staff trained.*

9. Zero Suicide -- *Implement protocols and processes by end of year 1 with 50% staff trained. 90% of staff trained by end of year 2. Maintain 90% training level.*

B. Adult Required EBPs

1. Assertive Community Treatment (ACT) -- *This service/program may be required as a condition of application. If not, then ACT needs to be implemented fully within year 1 and staff trained appropriately according to plan developed by CCBHC and approved by BHDDH.*

2. Permanent Housing/Housing First (National Model) -- *Required of community psychiatric support team staff with 25% being trained by end of year 1 and 25% by end of year 2. Maintain a minimum level of 75% trained.*

3. Individual Placement and Support (IPS) -- *Train staff and implement service by end of year 1 with 50% staff trained in this EBP. 90% trained by end of year 2. Maintain level of 90% trained. (Supported employment individual placement support)*

4. Integrated Dual Diagnosis Treatment (IDDT) -- *50% of appropriate direct service staff trained by end of year 1 and 90% by end of year 2. Maintain 90% training level.*

5. Medication Assisted Treatment (MAT) Training and Implementation Strategies

a. For Opioid Use Disorder (2 out of 3 medication types) -- *Implement this service/program by end of year 1 and fully implemented by end of year 2. Staff would need to be appropriately trained. And develop a plan for training to be approved by BHDDH.*
b. For Alcohol Use Disorder -- *Implement this service/program by end of year 1 and fully implemented by end of year 2.*
c. Nicotine Replacement Therapy -- *Implement this service/program by end of year 1 and fully implemented by end of year 2.*

6. 12-Step Facilitation Therapy/Matrix Model -- *50% trained by end of year 1 and 90% trained by end of year two. Maintain level of 75% trained*

C. Children's Required EBPs

1. Dialectical Behavioral Therapy (DBT)-- *Required of all (direct service staff and clinical staff with 30% trained by end of year 1 and 60% trained by end of year 2. Maintain minimum level of 60% trained*

2. Teen ACT--*This program would need to be fully implemented within the first year and staff trained appropriately according to plan formulated by CCBHC and approved by DCYF.*

3. Evidence based practices supported by SAMSHA for the prevention and treatment of substance misuse and abuse by children and adolescents—*Shall be implemented and made available within the first year.*

Fidelity: General requirement that all required EBP's would be subject to annual fidelity evaluation (in addition to 6 months after implementation) using appropriately developed fidelity measures. Results of fidelity evaluation and follow up plans if any would be included in annual CCBHC report to BHDDH/DCYF/OHHS.