Certified Community Behavioral Health Clinic Cost Report: Rhode Island Supplemental Technical Guidance

SFY 2024

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Executive Summary

The Executive Office of Health and Human Services (EOHHS), the Department of Behavioral Healthcare, Developmental Disabilities, & Hospitals (BHDDH), and the Department of Children, Youth, and Families (DCYF), have established the following technical guidance to support prospective Certified Community Behavioral Health Clinics (CCBHCs) with completion of the Centers for Medicare & Medicaid Services (CMS) CCBHC Cost Report Template. This guidance is intended to provide supplemental information necessary for completion of the cost report by any provider seeking CCBHC certification in state fiscal year (SFY) 2024.

Under the Section 223 Demonstration Program for CCBHCs, CMS established a prospective payment system (PPS) for CCBHCs. The CCBHC PPS is a Medicaid per-encounter rate set based on provider cost reporting that applies to services delivered either directly by a CCBHC or through a formal relationship with a Designated Collaborating Organization (DCO). There are two types of PPS: PPS-1, a per clinic daily encounter-based rate, and PPS-2, a per clinic monthly rate for attributed members.

RI selected the PPS-2 rate-setting methodology given the structure to best meet the needs of both Medicaid members and providers.

Submissions must:

- Follow CMS' CCBHC cost report instructions for PPS-2 (see Appendix A) and this technical guidance
- Use SFY 2022 (July 1, 2021 – June 30, 2022) as the base year for cost report data
- Include supplemental reports in Appendix F
- Include one report per organization (*not* one per site or catchment area)

The supplemental technical guidance includes:

- Attribution guidance
- Population definitions and assignment information
- Service definitions
- Outlier payment parameters
- Supplemental reports to support EOHHS' evaluation of the CCBHC cost reports

Please direct all cost report questions to the following address: OHHS.CCBHCReadiness@ohhs.ri.gov. As appropriate, the State will issue clarifications or amendments to this guidance.

Cost reports must be submitted no later than February 15, 2023, over secure email to OHHS.CCBHCReadiness@ohhs.ri.gov or reach out to EOHHS for instructions to submit via Secure File Transfer Portal (SFTP).

After submission, the State's review and validation process will begin. There will be ongoing engagement with organizations to clarify and verify costs submitted as the State develops provider-specific rates.

Appendix A: Federal Template and Instructions

CMS has detailed instructions for completing the CCBHC cost report that providers must follow to complete the CCBHC template. The template and instructions can be accessed on the EOHHS website:

- **Cost Report Template**:[1] https://www.medicaid.gov/medicaid/downloads/ccbhc-cost-report.xlsx
- **Instructions**: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-07/Cost%20Report%20Instructions.pdf

[1] *Note: On the [CC PPS-2 Rate] tab in the CCBHC cost report, there is a reference on line 10 of Part 2 to "[Monthly Visits], line 5". The formula in this row is referencing [Monthly Visits] row 14, which is line 3: "Number of months patients received CCBHC services directly from DCO (not included above)". EOHHS believes the formula should instead be referencing [Monthly Visits] row 16, which is line 5: "Total months patients received CCBHC services (sum of lines 2-4)". EOHHS has reached out to CMS to confirm this observation and provide an updated workbook. This will not impact organization's ability to complete the cost report, but you may notice this potential error on the PPS-2 Rate tab.

Appendix B: Attribution Guidance

Members will qualify for the CCBHC program based on their need for CCBHC services as determined by the providers and verified by BHDDH. Program eligibility will be initiated by the provider in the Gainwell eligibility system. BHDDH currently uses this eligibility portal to manage program admissions for programs such as Integrated Health Home (IHH), Assertive Community Treatment (ACT), and Opioid Treatment Program (OTP) health home. The State expects this portal to be used for CCBHC enrollment. For the initial cost report base data period, providers will use a combination of attribution in Behavioral Health Online Database (BHOLD) for existing programs that correlate with populations who will be included in the CCBHC program and claims data provided by EOHHS. BHDDH will facilitate a data reconciliation process with each prospective CCBHC.

A member may only be attributed to one CCBHC per member-month; attribution will be to the provider on record as of the end of the month. Members who wish to change the provider they are attributed to will complete a change request form, which will be submitted to BHDDH and trigger an update to the provider on record in the BHOLD provider portal.

Unattributed Medicaid members who meet defined criteria may be prospectively assigned to a CCBHC based on geographic proximity to the member's residence. The following events will trigger prospective assignment:

- Eleanor Slater Hospital Discharge
- Utilization of Mobile Crisis Team Service
- Mental Health Court Civil Outpatient Commitments

Note that EOHHS and BHDDH will consider additional criteria in future program years.

Payment will be made for attributed members that have at least one visit in the month.

A visit is a billable event when a client receives at least one face-to-face encounter or telehealth visit with a CCBHC qualifying staff person (as defined below), during which CCBHC services are provided, and which conforms to the criteria below:

1. The minimum requirement to bill a monthly PPS-2 rate is one face-to-face encounter or telehealth visit per consumer per service month.
2. Documentation in health record. Only those encounters that result in an entry in the CCBHC consumer's health record qualify as "visits."
3. Qualifying service settings. Encounters that take place in the following settings qualify as "visits":
    i. A CCBHC site
    ii. A DCO site
    iii. The consumer's home
    iv. A correctional facility
    v. A school-based clinic or other approved school setting
    vi. Primary care setting such as an individual practice or an FQHC
    vii. A homeless shelter
    viii. A CCBHC mobile service site (e.g., van)
    ix. A Senior Center

x. Another community-based site that has been approved by the Department

4. CCBHC qualifying staff person is an individual who fits one of the following categories:
    i. A psychiatrist
    ii. A clinical psychologist
    iii. A licensed clinical social worker
    iv. A licensed professional counselor
    v. A licensed marriage and family therapist
    vi. A Certified Peer Recovery Specialist
    vii. An advanced practice nurses
    viii. An employment specialist, case manager, housing specialist, or other staff person who provides direct consumer behavioral health services approved by the Department
    ix. Other personnel authorized to provide direct services by the BHDDH or RI Medicaid Program

5. Staff person's relationship to CCBHC. The individual is:
    i. Employed by the CCBHC or a contractor under the direct supervision of the CCBHC; or
    ii. Employed by a DCO or a contractor under the direct supervision of the DCO

6. A face-to-face encounter is a visit that takes place in person (i.e., with the staff person and the consumer in the same room or via telephone or videoconference)
    i. A face-to-face encounter is provided in one of the following contexts:
        A. With only the consumer and staff person present;
        B. With the consumer, the staff person, and the consumer's family member(s) or representative present;
        C. With only the consumer's family member or representative and the staff person present, subject to the consumer's consent (an encounter in this context may not serve alone as a visit for the purpose of monthly billing); or
        D. With two or more consumers and a staff person present in a group setting.
    ii. An encounter provided via telephone or videoconference may only be considered a visit when such event is a minimum of 15 minutes, and otherwise meets the requirements for a billable outpatient visit under the RI Medicaid program, for example, in terms of clinical necessity, and relevance to the client's treatment plan.

7. Note that the expense of the following encounters is an allowable cost in the cost report, but may not serve alone as a visit for the purpose of monthly billing:
    i. A collateral encounter (i.e., one that occurs between a CCBHC staff member and an individual other than the identified client, with the client's permission, and involves the sharing of information in support of the client's treatment or service plan)
    ii. A care coordination encounter
    iii. An outreach encounter
    iv. Primary care screening encounter

Appendix C: Population Definitions

The PPS-2 rate structure will include four population rate categories:

1. High Acuity Adult
2. High Acuity Children and Youth
3. High Acuity Substance Use Disorder
4. General Population

Eligibility criteria for each population are specified below; detailed flowcharts follow.

Note that eligibility criteria for the High Acuity Children and Youth and High Acuity Substance Use Disorder populations will be phased in since the eligibility criteria for these populations include assessment tools that are not yet fully implemented. New assessment tools will be implemented in Year 1 in support of a transition to new eligibility criteria in Year 3; Year 1-2 attribution criteria are specified distinctly for these populations below.

Data sources for population category assignment could include the following. For reference, EOHHS has also attached (Appendix C – Population Assignment Grid) a population assignment grid that includes additional commentary on data sources anticipated to help identify if members meet the population criteria.

1. Behavioral Health Online Database (BHOLD)
2. Medicaid Management Information System (MMIS) claims
3. Gainwell eligibility portal

High Acuity Adult

An individual is in the High Acuity Adult Population if they are 18 or over and:

1) They are eligible for Rhode Island's I/DD services, **and** they have any behavioral health diagnosis (any F code, excluding F10-F19, and F70 - F89); **or**

2) They have a diagnosis of (with codes corresponding to any of these diagnoses):
    - Schizophrenia
    - Schizoaffective
    - Schizoid Personality Disorder
    - Delusional disorders
    - Psychosis
    - Bipolar
    - Major Depression
    - Severe OCD
    - Post-Traumatic Stress Disorder
    - Borderline personality disorder, **or**
    - Severe panic disorder; **and**
    - A DLA score of four or less

3) In addition, there is an exception process for assignment to the High Acuity Adult Population. CCBHCs serving individuals who pass the below test can apply to BHDDH to include the individual in the High Acuity Adult Population if:
    - They have been discharged from an inpatient psychiatric unit in past 30 days; **or**

- They have been released from incarceration within the past 30 days; **or**
- They are homeless; **or**
- They have been homeless within the last 30 days; **or**
- They meet at least three of the following conditions:
    - They have utilized crisis services at least three times in a 30-day period in the past six months
    - They have been homeless in the past six months
    - They are at risk of homelessness (unstably housed)
    - They have been charged with a crime in the past six months
    - They are at risk of becoming involved in the criminal justice system
    - They live in a supported environment and could move to a less restrictive setting if provided with intensive services
    - They are consistently unable to engage and benefit from other community-based mental health services
    - They are unable to perform practical daily tasks required for adult functioning
    - They have intractable severe major symptoms (i.e., affective, psychotic, suicidality)

High Acuity Children and Youth

Year 1-2: In Years 1 and 2, this population will be defined based on eligibility for Enhanced Outpatient Services (EOS). All attributed members in this category must have a Child and Adolescent Needs and Strengths (CANS) assessment completed in Year 1, in support of transitioning to the eligibility criteria specified below for Year 3.

Year 3+: An individual is in the Child and Youth High Acuity Population if they are under 18 and:

1) They had an inpatient psychiatric discharge in the past six months; **or**
2) They have a diagnosis of:
    - Adjustment Disorder
    - Anxiety Disorder
    - Any Feeding and Eating Disorders
    - Bipolar Disorder
    - Borderline Personality Disorder
    - Delusional Disorder and/or Psychotic Disorder
    - Disruptive Mood Dysregulation Disorder Disruptive
    - Impulse-Control and Conduct Disorder
    - Gender Dysphoria
    - Major Depressive Disorder, recurrent
    - Obsessive-Compulsive Disorder
    - Oppositional Defiance Disorder
    - Panic Disorders
    - Personality Disorder
    - Phobic Disorders
    - Pica
    - Post-Traumatic Stress Disorder

- Psychosis/dx w/psychotic features or episode
- Pyromania
- Reactive Attachment Disorder
- Schizoaffective Disorder
- Schizoid Personality Disorder
- Schizophrenia
- Selective Mutism
- Somatic Symptom and Related Disorders
- A similar diagnosis or condition that adversely impacts the child or youth's daily functioning; **or**

- They have a documented history that includes:
    - Sexual Exploitation related V or Z codes that may correspond to a history personal (of) abuse childhood, history family (of) abuse childhood, forced labor or sexual exploitation in childhood, forced labor or sexual exploitation, or other V or Z code that may reflect sexual exploitation; **or**
    - They are currently homeless or have been homeless in the last 30 days; **and**
- They received at least one score of 3 **or** two scores of 2 on the CANS Risk Behavior Screen; **and**
- They received at least one score of 3 **or** two scores of 2 on the CANS Needs Screen

High Acuity Substance Use Disorder

Year 1-2: In Years 1 and 2, this population will include any individual with a primary diagnosis of a substance use disorder regardless of degree of severity or complexity (who does not otherwise meet the criteria for the High Acuity Adult or High Acuity Children and Youth rate). The ASAM assessment criteria will be added in Year 3. In Year 1, all attributed members in this category must have an ASAM assessment completed, in support of transitioning to the eligibility criteria specified below for Year 3.

Year 3+: An individual is in the High Acuity Substance Use Disorder Population if:

1) They have a diagnosis of:
    - Opioid use
    - Marijuana use
    - Stimulant use
    - Sedative use
    - Hallucinogen use; **or**
    - Alcohol use; **and**

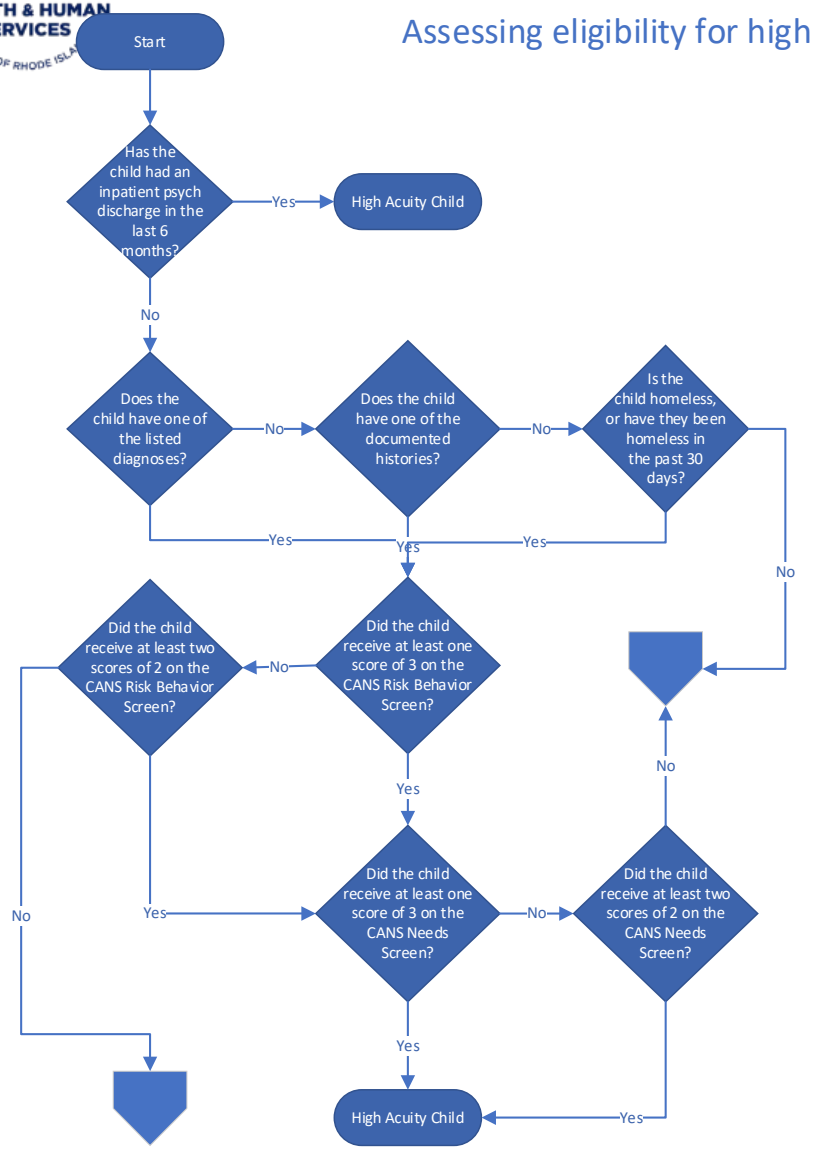
2) They were assigned a score of 2.1 or higher by the ASAM Criteria Assessment Interview or the ASAM Continuum software.

General Population

An individual is in the General Population if:

1) They are not included in one of the High Acuity populations

Assessing eligibility for high acuity children



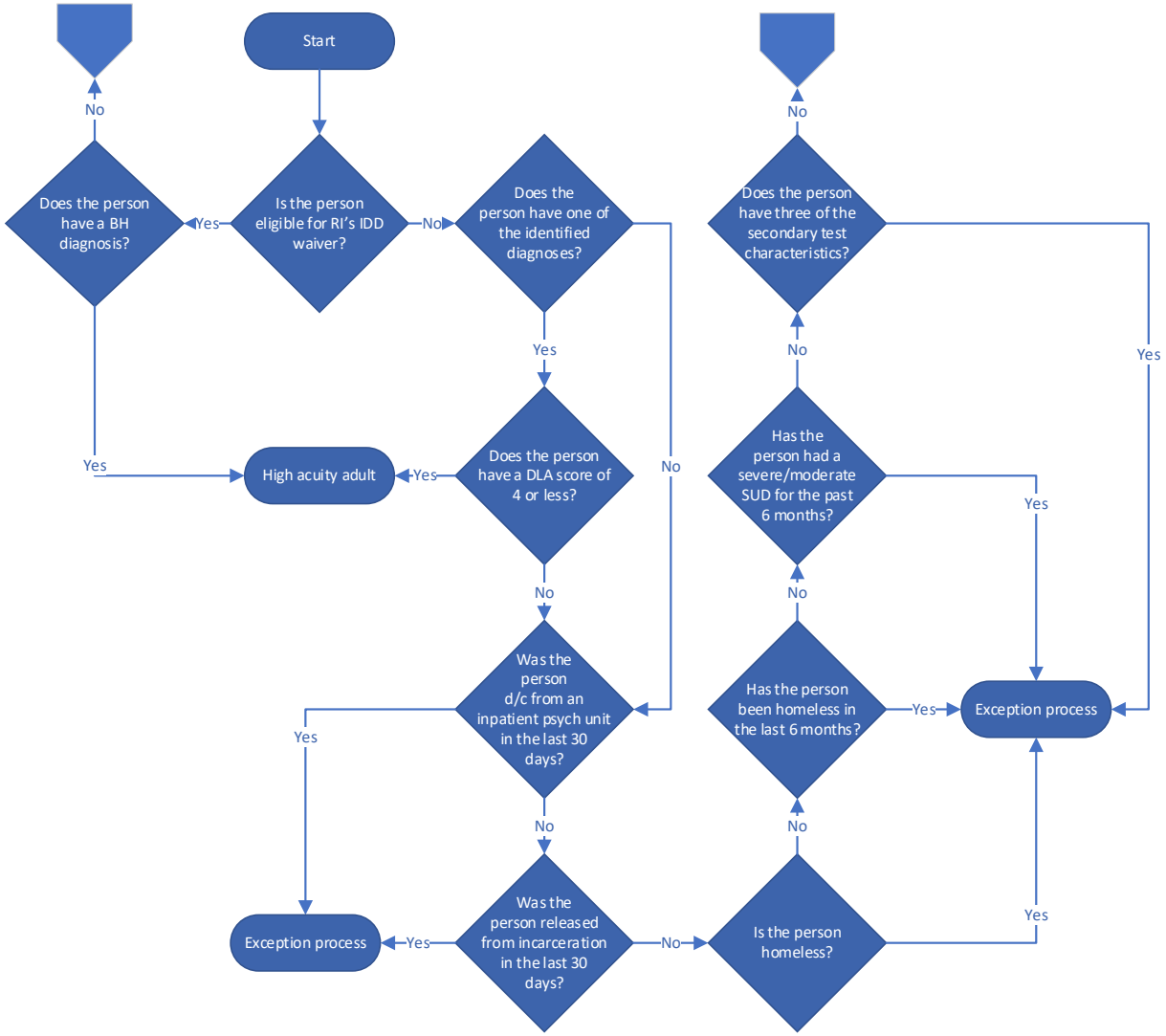
Listed Diagnoses

- Adjustment Disorder
- Anxiety Disorder
- Any Feeding and Eating Disorders
- Bipolar Disorder
- Borderline Personality Disorder
- Delusional Disorder and/or Psychotic Disorder
- Disruptive Mood Dysregulation Disorder Disruptive
- Impulse-Control and Conduct Disorder
- Gender Dysphoria
- Major Depressive Disorder, recurrent
- Obsessive-Compulsive Disorder
- Oppositional Defiance Disorder
- Panic Disorder
- Personality Disorder
- Phobic Disorder
- Pica
- Post-Traumatic Stress Disorder
- Psychosis/dx w/psychotic features or episode
- Pyromania
- Reactive Attachment Disorder
- Schizoaffective Disorder
- Schizoid Personality Disorder
- Schizophrenia
- Selective Mutism
- Somatic Symptom and Related Disorders
- A similar diagnosis or condition that adversely impacts the child or youth's daily functioning

Histories

- Sexual Exploitation related V or Z codes that may correspond to a history personal (of) abuse childhood, history family (of) abuse childhood, forced labor or sexual exploitation in childhood, forced labor or sexual exploitation, or other V or Z code that may reflect sexual exploitation

Assessing eligibility for high acuity adults



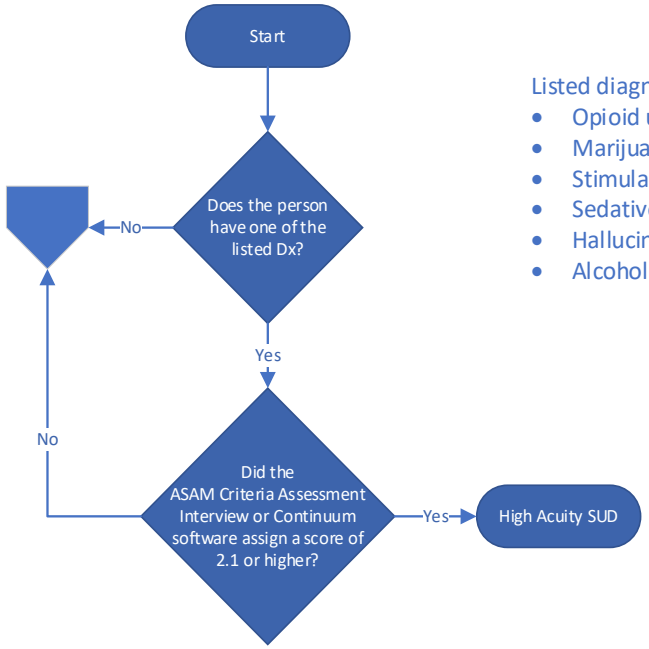
Listed Diagnoses

- Schizophrenia
- Schizoaffective
- Delusional disorders
- Psychosis
- Bipolar
- Major Depression
- Severe OCD
- Borderline Personality Disorder
- Severe panic disorder
- Post Traumatic Stress Disorder

Secondary test characteristics:

- Has the person utilized crisis services at least three times in a 30-day period in the past six months?
- Has the person had a mild SUD for the last six months?
- Has the person been homeless in the past 6 months?
- Is the person at risk of homelessness (unstably housed)?
- Has the person been involved **(need to define "involved")** in the criminal justice system in the past six months?
- Is the person at risk of becoming involved in the criminal justice system?
- Is the person living in a supported environment and could move to a less restrictive setting if provided with intensive services?
- Is the person consistently unable to engage and benefit from other community-based mental health services?
- Is the person unable to perform practical daily tasks required for adult functioning?
- Does the person have intractable severe major symptoms (i.e. affective, psychotic, suicidality)?

Assessing eligibility for high acuity SUD



Listed diagnoses

- Opioid use
- Marijuana use
- Stimulant use
- Sedative use
- Hallucinogen use
- Alcohol use

Appendix D: Service Definitions

Required Services

CCBHCs will be required to deliver nine services 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

For reference, attached to this guidance is a list of Fee-for-Service procedure codes for the above services, with a crosswalk between the codes and the above service categories (Appendix D – FFS Fee Schedule Crosswalk to CCBHC Services).

The following service enhancements will also be required:

1. Screening for Hepatitis A, B and C and HIV
2. Assertive Community Treatment (ACT)

*The provision of crisis response services will be subject to additional requirements:

- For overnight mobile crisis (coverage from 11 PM – 7 AM), any CCBHC serving a geography with fewer than 200,000 people must form a partnership with another CCBHC and establish a primary mobile crisis provider for the combined region overnight.

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.

**Participating entities will be required to include screening for unmet social determinants of health and required to have a reliable SDOH screening tool. Providers who do not currently have a screening tool in place, will be required to use the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) screening tool.

Required Services Provided by DCOs

CCBHCs must provide all required services, either directly or through a DCO relationship. 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. The DCO cost should be included as a contractual cost, and contractual payment terms should be specified and used as the basis for total cost (e.g., rate paid per service, or rate paid per member per month, and anticipated utilization).

Required Services by Population

Service requirements are articulated distinctly for each of the population categories, to enable providers to accurately project staffing needs (and the associated costs).

High Acuity Adult

a. **Individuals with Complex Severe and Persistent Mental Illness (Complex SPMI):** High Acuity Adult with a DLA score of 3 or lower

   Services to Complex SPMI would be provided by an ACT team

   i. ACT team with staff to client ratios of approximately 1:7 (100 clients per team) and average services per individual to follow the TEAM ACT fidelity model and with potential minimum monthly/hourly requirements by BHDDH.

   ii. **Minimum** staffing would include 1 team leader; 1 FTE Psychiatrist (or APRN), 3 RN's; 1 clinician; 1 Co-occurring Clinician; 1 SUD specialist; 1 rehab specialist and 4 CPST workers; and 1 certified Peer specialist for a total of 14 FTE's. Additional specific FTE positions and staffing patterns may be proposed specific to the needs of a Complex SPMI population by provider organizations and is subject to approval by BHDDH.

   iii. Health Home services would be provided by the ACT team

   iv. ACT services and operations would include

      a. Ten (10) hours of team active operation during weekdays and 4 hours per day on weekend and holidays

      b. On call 24/7 for client emergencies to triage with crisis workers

      c. Team would serve as individual's health home

      d. Core services would include integrated treatment, clinical treatment, rehabilitative and supportive services such as: crisis intervention; psychiatric medication; psychosocial rehab; Individual Placement and Support services; mental health and/or SUD evidenced based treatment; case management services; care coordination; health home services; and social skills and interpersonal relationship training

e. Use of wide range of evidence- based practices including for example Individual Placement and Support (IPS), Integrated Dual Diagnosis Treatment (IDDT), Family Psychoeducation, Housing First, and Peer Support

v. Additional guidelines and/or requirements may be issued pertaining to services and operations of ACT teams.

b. I**ndividuals with Severe and Persistent Mental Illness (SPMI):** High Acuity Adult with a DLA score between 3 and 4

SPMI services would be provided by an Integrated Community Treatment Team (ICTT)

i. Team with staff to client ratio of approx. 1:14 (200 per team).

ii. **Minimum** staffing would include: 1 team leader; 1 FTE Psychiatrist (or APRN); 3 RN's; 2 clinicians; 1 SUD specialists; 2 rehab specialists; 4 CPST workers; and 1 certified peer specialist for a total of 15 FTE's. Additional specific FTE positions may be proposed to address needs specific to the SPMI population by provider organizations and is subject to approval by BHDDH.

iii. Integrated community treatment team services and operations would include treatment and health home services:

a. Clinical, rehabilitation, recovery, prevention and supportive services, and crisis intervention as necessary to assist the individual in their treatment and recovery

b. Use of wide range of evidence- based practices including for example IPS, IDDT, Family Psychoeducation; Housing first; and Peer Support

c. Ten (10) hours of team active operation during weekdays and 4 hours per day on weekend and holidays

d. Providers would have the option to propose to BHDDH the establishment of ICCT teams serving 100 individuals with prorated FTE staffing

iv. Additional guidelines and/or requirements may be issued pertaining to services and operations of ICCT teams.

High Acuity Children and Youth

Intensive services and supports shall be made available to High Acuity Children and Youth. These intensive behavioral health services are delivered in the home and other community settings and are focused on safety planning, ameliorating the child or youth's acute symptomology, and improving parent and child functioning through the development of targeted knowledge and skills. Treatment includes individual and family therapy, skills training, care coordination, 24/7 emergency response, and medication management, when indicated. The long-term goal is to prepare the family for the transition to longer-term outpatient treatment to achieve lasting positive outcomes. Home visits occur 2-3 times per week with an average length of treatment from 12-16 weeks.

Service Descriptions:

i. Behavioral Health Therapy that includes individual and family therapy provided in the home/community by a master's level clinician for at least 2-3 hours/week.

ii. Skills Training and Development that includes at least 2-3 hours/week of education, coaching in behavior plans, or other interventions defined in the treatment plan, and care coordination, as a distinct set of activities from the behavioral health therapy. This service can be provided by either a master's or bachelor's level staff member. Any bachelor's level staff member providing the service must possess a degree in a human services field and one year of direct, relevant experience with the targeted population (e.g., substance abuse, developmental disabilities, sexual abuse, and post-traumatic stress disorder). If a staff member does not possess the required education and experience, the staff member must be approved for a waiver to provide services.

iii. A combination of Behavioral Health Therapy and Skills Training and Development services may take place simultaneously as deemed clinically appropriate by the provider with the expectation that separate and distinct services are being provided.

iv. Services are provided primarily in the home with some occurring in community-based settings as designated in the treatment plan.

v. The provider maintains an on-call system that allows a member access to clinical staff 24 hours per day/7 days per week. Response to the child and family is required within one hour of member outreach

vi. Provider staff coordinate treatment planning and aftercare with the child or youth's primary care physician, outpatient providers, and other community-based providers, involved state agencies, including court officials and the Rhode Island Training school, educational systems, community supports and family, guardian, and/or significant others when applicable.

vii. Medication management through the CCBHC shall be made available, when needed. Otherwise, service delivery shall be coordinated with the prescribing physician.

viii. Staffing should reflect the cultural, gender, and linguistic needs of the community it serves.

ix. Translation services appropriate to the needs of the population served shall be available.

x. The provider ensures that all staff delivering services are provided regularly scheduled weekly supervision by an independently licensed, master's level clinician or above.

High Acuity Substance Use Disorder

i. Team based services would include use of evidence based therapeutic practices; pharmacological intervention; MAT services; active physical health care management; individual, family and group treatment, case management and outreach services; and care coordination services. Ambulatory Withdrawal Management ASAM 1-WM (for mild withdrawal with daily or less than daily outpatient supervision) and ASAM 2-WM (for moderate withdrawal not requiring 24-hour support) will need to be provided directly by the CCBHC.

ii. Treatment could be delivered through:

a. Partial hospitalization (ASAM level 2.5) of 20 or more hours of services per week and

b. Intensive outpatient services (ASAM level 2.1) of more than 9 hours of services per week.

General Population

Depending on the diagnosis, and level of functioning, services can be provided on a continuous or episodic basis based on medical necessity. Care coordination, case management, peer support services would be made available based on the established criteria and medical necessity. Ambulatory Withdrawal Management ASAM 1-WM (for mild withdrawal with daily or less than daily outpatient supervision) is a required service.

Allowable Services

The following services will be considered an allowable CCBHC cost, although they are not required services:

1. Clubhouse model (psychosocial rehabilitation)
2. Intensive Outpatient Program (IOP)
3. Partial Hospitalization Program (PHP)
4. Home Stabilization
5. Healthy Families America (HFA)
6. Home Based Therapy – Specialized Treatment/Treatment Support (HBTS)
7. Personal Assistance Services and Supports (PASS)

Required Evidence Based Clinical Practices or Programs

CCBHCs will be required to adopt a minimum set of Evidence Based Clinical Practices or Programs, as listed below. CCBHCs should expect that required EBPs will be subject to an annual fidelity evaluation (in addition to 6 months after implementation) using appropriately developed fidelity measures. Results of the fidelity evaluation and follow up plans (if any) would be included in the annual CCBHC report to BHDDH/DCYF/OHHS.

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.

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 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) -- *Medical Staff will be trained at the time of award.*
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. Dialectical Behavioral Therapy (DBT)-- *Required of all (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. 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.*
3. 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.*
4. 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)*
5. 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.*
6. 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.*
7. 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 (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 needs 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 SAMHSA for the prevention and treatment of substance misuse and abuse by children and adolescents—*Shall be implemented and made available within the first year.*

Appendix E: Outlier Thresholds and Allocation Guidance

The PPS-2 rate reimbursement methodology includes an outlier payment mechanism to reimburse clinics for costs above the state-defined threshold. Federal regulation requires outlier payments to be made based upon allowable CCBHC costs for each member on either a monthly or annual basis. For demonstration year one, EOHHS will implement an annual basis outlier threshold.

The following worksheets of the CCBHC cost report require actual and anticipated visits and charges to be stratified by whether the visit for a patient exceeded the outlier threshold.

- [Monthly Visits] worksheet, reported actual and anticipated visit months
- [CC PPS-2 Rate] worksheet, reported actual and anticipated charges

The following table illustrates the annual outlier threshold for Demonstration Year 1 by population.

RI CCBHC Program Demonstration Year 1 Outlier Thresholds	
Population/Condition Group	**Annual Per-Member Value**
General	$15,000
High Acuity Adults	$20,000
High Acuity Children and Youth	$25,000
High Acuity Substance Use Disorder	$7,500

Charges must be allocated to population/condition groups based on guidance in Section 14 of the CCBHC cost report instructions. Member level billed service charges should be used when applying the outlier threshold. Refer to the CCBHC cost report instructions linked in Appendix A for additional guidance on application of the outlier threshold.

Charges for IHH and ACT services should reflect the charges for the actual services provided, as opposed to the bundled rates. The charges assigned to the services provided via IHH and ACT should be consistent with the fee schedule used for all other charges.

Outlier costs and visits will be withheld from the initial PPS-2 rate development, consistent with CCBHC cost report instructions. The PPS-2 rate will be modified to include the portion of the outlier cost to be retained by the CCBHCs. EOHHS will determine the retention percentage based upon its review of CCBHC cost report submissions and discussions with prospective CCBHCs. The outlier adjustment to the PPS-2 rate and outlier payment in the rate year will be performed consistent with Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHCs Planning Grants guidance[2].

EOHHS will review the impact of the outlier threshold and retention percentage on the PPS-2 rate development based on the CCBHC cost report submissions and may modify these values at its discretion prior to finalizing the PPS-2 rate.

[2] https://www.samhsa.gov/sites/default/files/grants/pdf/sm-16-001.pdf

Appendix F: Supplemental Reports

The following supplemental reports are requested as part of the annual CCBHC cost report submission package:

A. Detailed Visit Report
B. DCO Support
C. Financial Statement Reconciliation
D. Wage Detail
E. Additional Allowable Service Detail

The reports will be used to review information submitted in the CCBHC cost report and support overall PPS rate development activities. Information contained in the supplemental reporting may contain PHI and should be submitted to EOHHS via secure email or secure FTP.

A. Detailed Visit Report

The CCBHC shall complete the [Detailed Visit Report] template, included in 'Appendix F – Reporting Templates.xlsx'. The report will contain information on all patient visits recorded by the CCBHC, inclusive of visits attributable to a DCO. The report template includes the following key fields:

- Claim Number: Claim identification number
- Recipient ID: Recipient identification number
- Date of Service: Date service rendered, in MM/DD/YYYY format.
- Procedure code: The CPT/HCPCS code for the rendered service.
- Payer: The payer of the claim (health plan, state fee-for-service, self-pay, etc.)
- Line of Business: Medicaid, Commercial, or Other (with description provided on the Notes tab)
- Billed Amount: The billed amount for rendered service.
- Paid Amount: The paid amount for rendered service.
- DCO Flag: Identification flag for services rendered by a DCO (2) or by the CCBHC (1).

The attached template (Appendix F – Reporting Templates) should be used by the CCBHC to provide the requested information in a consistent manner with the visit information provided within the CCBHC cost report. Please note the following when completing this report.

- The number of unique Recipient IDs and months of service is anticipated to be consistent with the visits reported in Line 2 (Number of months patients received CCBHC services directly from staff) and Line 3 (Number of months patients received CCBHC services directly from DCO (not included above)) of the [Monthly Visits] worksheet in the CCBHC cost report. To the extent there is a variance, please provide an explanation in the [Notes] worksheet.
- The sum of the Billed Amount is anticipated to be consistent with the charges reported in Line 1 (Actual charges) of the 'CC PPS-2 Rate' worksheet. To the extent there is a variance, please provide an explanation in the [Notes] worksheet.

B. DCO Support

CCBHCs establishing a formal relationship with a DCO must provide the following details for each DCO arrangement:

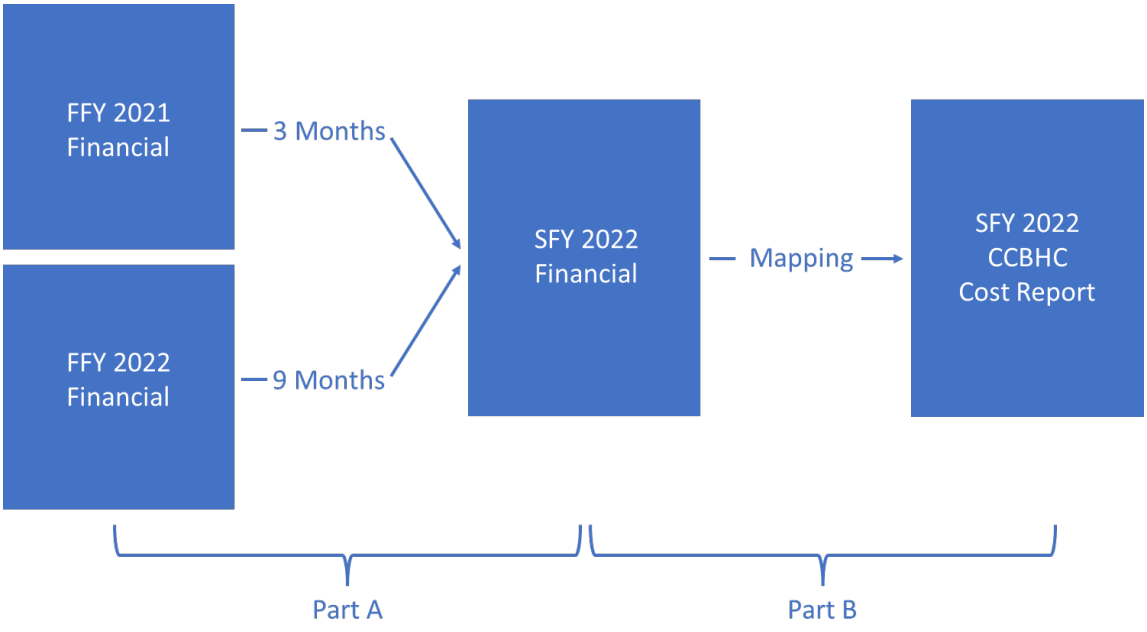
- The full financial terms of the agreement between the CCBHC and the DCO.
- Appropriate documentation and support (e.g., existing experience for historical relationships, detailed support for anticipated future relationship) for reported costs ([Trial Balance] Lines 19 and 20) and visits ([Monthly Visits] Line 3 and Line 4, if applicable) included in the CCBHC cost report submission.
- Comprehensive list of services anticipated to be provided by the DCO.

This information will be used to evaluate the DCO historical cost and visit information provided in the CCBHC cost report. EOHHS may require additional information upon review of the DCO documentation initially received.

C. Financial Statement Reconciliation

CCBHCs shall reconcile the expense information reported in the CCBHC cost report to financial statements. To the extent possible, the reconciliation should start with audited financial statements and illustrate the adjustments resulting in the values reported in column 1 and column 2 in the [Trial Balance] worksheet of the CCBHC cost report. In certain cases, audited financial statements may not be available at the time of completion of the CCBHC cost report, and unaudited financial statements shall be utilized in these cases.

The graphic below provides an example of how financial statements audited on a federal fiscal year (FFY; October to September) basis may be reconciled to the CCBHC cost report. In Part A, multiple financial statements are combined to form a state fiscal year (SFY) reporting basis. In Part B, the audited financial statement financial categories are mapped and adjusted as needed to the CCBHC cost report expense categories.



The financial statement reconciliation is a free-form exercise but should provide sufficient information to understand how the expenses submitted in the CCBHC cost report relate to the provider's financial statements. Please provide a narrative as appropriate with the reconciliation.

D. Wage Detail

The CCBHC shall complete the [Wage Detail] template, included in 'Appendix F – Reporting Templates.xlsx'. The report will provide information on full-time equivalent (FTE) staff, wages, taxes, and other employee related expenses for the base year and anticipated FTE and expenses for the year in which the PPS rate is effective (Rate Year).

Please stratify the staff wages, taxes, and other employee related expenses in the corresponding columns:

- **Wages:** Include financial compensation to staff, excluding taxes and other employee related expenses as defined below.
- **Taxes:** Federal Insurance Contributions Act (FICA) taxes, Federal Unemployment Tax Act (FUTA) taxes, and State Unemployment Insurance (SUI) taxes.
- **Employee Related Expenses:** Fringe benefits, such as workers compensation, insurance, and retirement contributions.

Please provide this information using the staff descriptions listed in the template, including the following office salary categories:

- **Human Resources**: Manage the employee continuum of work experience and administer employee benefits
- **Quality:** Plan, measure, analyze, and report on quality metrics for continuous improvement of products and services
- **Compliance:** Ensure that a business meets external regulations and internal controls
- **Billing:** Manage the ingestion, adjudication, and payment of claims
- **IT/EHR (Electronic Health Record):** Manage technological assets and provide technical support
- **Training:** Provide educational activities to enhance the knowledge and skills of employees
- **Executive:** Establish and carry out departmental or organizational goals, policies, and procedures
- **Program/Management:** Support the management and/or functioning of the program

Please note that "Legal" and "Accounting" are also included in the CCBHC cost report, and therefore not included in the additional stratification above.

The attached template (Appendix F – Reporting Templates) should be used by the CCBHC to provide the requested information in a consistent manner with the information provided within the CCBHC cost report. Please note the following when completing this report:

- The Number of Full-Time Equivalent (FTE) Staff for the base year is anticipated to be consistent with Column 1 (Number of Full-Time Equivalent (FTE) Staff) of the [Services Provided] worksheet in the CCBHC cost report. To the extent there is a variance, please provide an explanation in the [Notes] worksheet.
- The Number of Full-Time Equivalent (FTE) Staff for the Rate Year is anticipated to be consistent with the sum of the base year FTE and Column 1 (Additional Required Full-Time Equivalent (FTE) Staff) of the [Anticipated Costs] worksheet in the CCBHC cost report. To the extent there is a variance, please provide an explanation in the [Notes] worksheet.
- The sum of the reported Wages, Taxes, and Employee Related Expenses for the base year is anticipated to be consistent with Column 1 (Compensation) of the [Trial Balance] worksheet in the CCBHC cost report. To the extent there is a variance, please provide an explanation in the [Notes] worksheet.

Use the 'Comments' column to further explain the reported staff and expenses as necessary.

E. Additional Allowable Service Detail

The CCBHC shall complete the [Allowable Service Detail] template, included in 'Appendix F – Reporting Templates.xlsx' to the extent any of the Allowable Services described in Appendix D are provided. The report will provide information on the number of full-time equivalent (FTE) staff for additional Allowable Services, which should be a subset of [Services Provided] Column 1. Please report partial FTE values for staff providing both required and allowable services. Use the 'Comments' column to further explain the reported staff as necessary. The report template includes the following Allowable Service fields:

- Clubhouse Model
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Home Stabilization
- Healthy Families America (HFA)
- Home Based Therapy – Specialized Treatment/Treatment Support (HBTS)
- Personal Assistance Services and Supports (PASS)

If allowable services are provided by a DCO, please provide commentary in the [Notes] worksheet on the estimated percentage of DCO costs included in Lines 19 and 20 of [Trial Balance] that are attributed to allowable services.